When a Psychiatry Resident’s Patient Commits Suicide: Transference Trials and Tribulations

Donald A. Misch

Abstract: It is an unfortunate reality that a substantial proportion of psychiatry residents will experience the suicide death of one or more of their patients during the course of their training. The psychological impact of such deaths may result in marked repercussions on the treating resident; but, in addition, many other individuals and entities—resident peers, supervisors, other mental health professionals and staff, training directors, training programs, psychiatry departments—may be affected as well to a greater or lesser extent. This paper explores one manifestation of the impact on a psychiatry resident of a patient’s suicide death: the activation of transference reactions and transference enactments on the part of both a resident and a residency training director. The author argues that the very breadth and depth of such transference responses offer invaluable opportunities for self-observation, psychological introspection, and personal growth if involved individuals have sufficient courage and supportive mechanisms for processing of the patient suicide and its aftermath. The failure of many current psychiatric trainees to undergo personal intensive psychotherapy is identified as a major obstacle to turning such potentially destructive experiences into learning and growth opportunities.

The psychiatrist-in-training is invariably confronted with a host of difficult moments, times when he or she is challenged intellectually, ethically, emotionally, and even physically. At stake may be more than simple embarrassment, guilt, or shame; indeed, one’s very identity may be threatened. One such difficult moment, and, unfortunately, a moment experienced by a substantial proportion of psychiatric trainees (Brown, 1987a; Brown, 1987b; Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988; Goldstein & Buongiorno, 1984; Henn, 1978; Kahne, 1968; Sacks, 1989; Sacks, Kibel, & Cohen, 1987), occurs when a psychiatry resident’s patient commits suicide. This dramatic and often unexpected event has enormous repercussions on the resident. It is usually a public event, at least insofar as faculty, staff, and colleagues in the department or training program are aware of the occurrence (which they inevitably are). Moreover, a patient’s suicide invariably raises the question of physician error: did the psychiatry resident handle the case poorly? The very fact
of the patient’s death often appears to present a *prima facie* case of psychiatric mismanagement, such that the “accused” psychiatry resident is often forced to prove his or her innocence rather than benefit from the “innocent until proven guilty” dictum of the courts. The suicide death of a patient strikes at the very heart of many physicians’ not-so-secret insecurity: the fear that they are not really intelligent or competent and, worse yet, that sooner or later this sad truth will be revealed to all (Gabbard & Menninger, 1988; Vaillant, Sobowale, & McArthur, 1972).

The repercussions of a trainee’s patient’s death by suicide extend beyond the mental life of the trainee. Just as a stone thrown into a pond produces waves that ripple out from the point of impact and, ultimately, travel throughout the pool of water, so, too, does the suicide death of a resident’s patient affect, to a greater or lesser extent, everyone around him or her. The resident’s supervisor, the director of the training program, the Department of Psychiatry, other residents, and mental health staff—these individuals and entities may all be impacted by the death.

The suicide death of a resident’s patient always occurs in a context, indeed, in multiple contexts. On the one hand, there are the real and immediate contexts of the Psychiatry Department, the training program, and the actual death of a patient. On the other hand, an important additional context is that of the historical and transference milieu in which the involved individuals interpret the actual events. The focus of this paper is less on the common and expectable reactions to the suicide death of a resident’s patient than on the psychodynamic issues that the event participants bring to the experience.

Rather than provide a comprehensive taxonomy and description of the many repercussions of the suicide death of a resident’s patient, this paper will highlight a specific occurrence and its aftermath, underscoring the breadth and depth of transference phenomena in such a context. My purpose is to encourage all those involved in such events to look for, and encourage processing of, the psychodynamic issues that inevitably arise, albeit perhaps not so severely as in this instance. Terrible though a patient’s suicide is—for the patient himself or herself, the family, and others affected—it is also a potential learning opportunity. The “suicide survivors,” including the mental health professionals involved in the patient’s treatment, can use such tragic events to learn more about themselves as individuals.

The events to be described in this paper took place during the course of my tenure as the Director of Psychiatry Residency Training (DPRT) within a medical school Department of Psychiatry. In order to protect the identity and privacy of the individuals involved, excluding myself,
I have altered a variety of details and provided no indication as to when and where the events actually occurred.

**CASE PRESENTATION**

A female, third-year psychiatry resident—“Jane”—had been engaged for months in individual psychotherapy with a second-year medical student. The medical student, although doing well academically, suffered from recurrent depression with intermittent suicidal thoughts. Over the course of several weeks, the latter had become more frequent and pressing, such that some of the medical student’s close friends and family had become concerned as to her safety. Jane and her faculty supervisor, the Chair of the Department of Psychiatry, struggled with the difficult situation, frequently getting together to discuss the current psychological state of the medical student and which interventions were appropriate. As often occurs in work with depressed professionals, the medical student insisted that, despite her increasing suicidality, she was physically safe and in control; as a consequence, she would not entertain a proposal for voluntary psychiatric hospitalization. To the great dismay of all concerned, the medical student ultimately committed suicide. Within hours, virtually all of her medical school classmates knew of the event, and the next day classes were cancelled while the Dean and other academic officials met with the class as a whole as well as with various individual friends of the medical student. Great efforts were directed towards helping the medical student’s classmates understand and deal with her suicide. The medical student’s suicide was, consequently, a very public event, resulting in a veritable maelstrom of fervent discussion, questions, and emotions throughout the medical school.

In the midst of this tumult, Jane, the psychiatric resident, experienced the panoply of emotions that typically accompany the suicide death of a psychiatrist’s patient (Brown, 1987a, 1987b; Chemtob et al., 1988; Gitlin, 1999; Goldstein & Buongiorno, 1984; Hendin, Lipschitz, Maltsberger, Haas, & Wynecoop, 2000; Henn, 1978; Horn, 1994; Jacobs, 1992; Kolodny, Binder, Bronstein, & Friend, 1979; Litman, 1965; Maltsberger, 1999; Maltsberger & Buie, 1974; Sacks, 1989; Schnur & Levin, 1985; Zee, 1972). Her feelings—especially her shame—were exacerbated by the widespread knowledge of, and discussion about, the suicide; indeed, it seemed that the unexpected death of the young medical student was part of every conversation throughout the medical school. An important subtext of these discussions, at least from Jane’s point of view, were questions of
responsibility and blame. Had the medical student been seeing a psychiatrist? Was the psychiatrist at fault? Had he or she “blown the case?” The latter questions are invariably part of the subsequent processing of patient suicide deaths among psychiatric professionals and trainees, although often discussed in private. In this instance, however, such questions arose not simply among the faculty, trainees, and staff of the psychiatry training program but also throughout the medical community.

Jane looked to be under considerable stress, although she indicated that while shaken, she was still able to function and maintain some objectivity about the event. The decisions and therapeutic interventions preceding the suicide were processed, to a greater or lesser extent, with her faculty supervisor, various fellow trainees, and with me in my role as the DPRT. Much of the first few days following the suicide focused on determining exactly what had happened in the course of a complicated series of events as well as on how Jane and her supervisor would relate with the surviving family members. Although looking haggard and distressed, and obviously grief-stricken as well as depressed, Jane seemed to be bearing the strain of the suicide death of her patient as well as could be expected in the immediate aftermath of the event.

It was the following week, when the officially required Quality Assurance (QA) Review of the suicide death of the patient took place, that Jane’s overt sadness, guilt, and shame appeared to be replaced by unrelenting anger.

Before proceeding with the narrative, I must provide some details as to my own experience with patient suicide. As is the case for most any psychiatrist in practice over an extended period of time, I have had numerous patients make suicide attempts and I have had two patients successfully commit suicide. One patient—an elderly, infirm woman—had seen me only once, ostensibly to speak about her sister; indeed, her visit with me had been construed as a consultation about her sister rather than a personal visit. Thus, I had little reason to suspect that she was acutely suicidal. Nonetheless, I felt very guilty about her death and wondered what I might have missed in that single interview. Of greater significance to the discussion at hand, however, was the other patient of mine who committed suicide.

This latter patient was a middle-aged, successful, wealthy professional, well-known within his particular circle of influence, and at the height of his career. Nevertheless, he had become very depressed with thoughts of suicide. As was the case with Jane and her medical student, I struggled with the patient over psychiatric hospitalization. The patient finally agreed to a psychiatric admission, but he was only willing to be placed—these were the “olden days” of psychiatry—on an open, non-secure unit. Be-
cause formal “suicide precautions” would have necessitated transfer to the more secure inpatient unit, he insisted that, while unquestionably having suicidal thoughts, he had no imminent intent or plans to harm himself and that he would be quite safe on the open unit. A week or so later, after a long series of interventions and seemingly endless negotiations, the patient succeeded in hanging himself while still a psychiatric inpatient.

For me, as for Jane, this suicide death became a very public event, in marked contrast to the suicide of the elderly, isolated woman noted previously. Not only did the news of this suicide rapidly circulate within the hospital, but within one to two days most of the academic psychiatrists within the large city where I worked had heard of the occurrence. Moreover, because of the patient’s career and connections, his unexpected death at a relatively young age was discussed and debated within powerful circles in the city at large. Thus, I, like Jane, felt very exposed and vulnerable as well as publicly castigated and shamed.

While Jane did not have the dreadful task, as did I, of informing the family that their loved one was dead, nonetheless, she, too, had to speak with bereaved family members. In the case of my patient, although his family was well aware of the risk of suicide, they had certainly expected him to be physically safe while hospitalized on an inpatient psychiatric unit. Similarly, in Jane’s case the medical student’s family knew that she was seriously depressed, but even so the actual suicide was a shocking outcome for them. Furthermore, like Jane, I, too, was quite conscious of my friends’ and colleagues’ reaction to the suicide; and I knew perfectly well that many were questioning—out of my presence—my actions and competence. Finally, again like Jane, I, too, was required to undergo a formal “QA Review” of the “sentinel event”—an interesting euphemism for the tragedy that had befallen my patient and the difficult situation in which I found myself.

My memory of that meeting was that it took place in a small room with fewer people than was to be the case in Jane’s instance, but I felt very threatened. No one had provided me with any guidance—legal or otherwise—prior to the meeting, and I was unclear as to my rights, unsure if I should answer any questions at that time, and very frightened about possible subsequent professional and legal repercussions. I felt very alone and very vulnerable. Although not directly disparaged or accused during the QA Review, I worried that the unit Medical Director was not impartial in his investigation, insofar as there were critical differences between the nurses’ and my account of the events on the day of the patient’s death. My fear was that I would be abandoned in the interests of protecting the hospital and its staff. These fears would prove to be at least partially warranted.
Therefore, prior to Jane’s QA Review, I had invited her to speak with me about the impending proceedings. This was an invitation that I had extended to several other residents whose patients had committed suicide during the years of my service as a Director of Psychiatry Residency Training. With Jane, as with the other residents, my objective was to prepare her for the meeting; indeed, it was my intent to specifically ensure that Jane not attend such a meeting as ill-informed and unprepared as I had been following the inpatient death of my own patient. Furthermore, as her training director I felt it my responsibility to support Jane, in that meeting and elsewhere. I had no intention of subverting the truth or attempting to improperly alter the findings of the various investigative proceedings, but I felt that there were a plethora of competent individuals attempting to determine exactly what had happened to Jane’s patient and whether the case had been appropriately handled. Thus, I believed my role was to ensure that, whatever the outcome, Jane feel that she had a professional ally in a relatively important position who would safeguard her rightful interests and ensure that she was treated fairly.

It was my intention at my “pre-QA Review” meeting with Jane to provide her with sufficient information so that she would understand the purposes, procedures, and possible outcomes of the meeting. I emphasized, in particular, that the required review was in no way intended to be a witch hunt dedicated to the identification of scapegoats nor a mechanism for deflecting blame. Instead, it was an exploratory endeavor designed to help all concerned understand what had happened and how similar situations might be handled differently in the future. I informed Jane that, with the exception of one hospital representative I did not know, everyone else at the QA Meeting would be a departmental colleague familiar to her; indeed, most of the participants would be her friends. Finally, I outlined some of the likely questions that she would be asked, based on my involvement in similar meetings in the past. At least in my mind at the time, I had provided Jane with ample information. In retrospect, however, I wonder if, in fact, I had given her less preparation than I thought.

The QA Review of Jane’s patient’s suicide occurred perhaps four or five days after the actual death. Unbeknownst to me prior to the meeting, a decision had been made to proceed with the review even though the Chair of the Department—Jane’s faculty supervisor on the case in question—was out of town and unavailable. I was informed of the Chair’s absence at the very start of the meeting, yet neither I nor any other individual present asked that the review be postponed.

With the exception of Jane, virtually every participant had similar memories of what occurred at the QA meeting and the emotional tone
accompanying the investigation. All felt that Jane had been questioned with great care and sensitivity and that considerable effort had been made to avoid placing blame on any particular individual. Indeed, only one meeting member voiced any question as to whether Jane might have handled her patient differently. This question was raised by a senior faculty member nearing retirement, an undisputedly kind and caring older psychiatrist who, throughout his career, had demonstrated great concern for his supervisees and provided them with much support. Nonetheless, this particular faculty member wondered aloud whether the depressed medical student might have done better if she had actually seen Jane less often in psychotherapy. Rather than elaborate on the thought process behind this question, I will simply note that in subsequent discussion no other meeting participant agreed that the medical student had been seen too frequently by Jane. For reasons that will become apparent below, I emphasize that I, serving in my role as DPRT, was very active in this aspect of the discussion, and I was quite specific in my belief that the medical student had needed, and benefited from, the intensive care that Jane had been providing. The overall conclusion from the QA Review was that Jane had handled this very difficult case in a thoughtful, compassionate, and thoroughly professional manner. Every participant at the meeting, including the senior faculty member who had raised the question of the frequency of psychotherapy, ultimately concurred in this assessment; all felt that they would have made very similar decisions and employed therapeutic interventions in the same manner as had Jane.

Jane’s recollection of the QA Review was entirely different. From her perspective, the meeting participants had been unrelenting and merciless in their questions, finding fault with virtually every aspect of her care of the patient. She felt her judgment—as a psychiatrist, as a physician, and perhaps even as a person—to be under full-scale assault. I, too, was included in Jane’s list of perpetrators; and, as she subsequently made clear, she felt that I had been particularly negligent in my discussion with her prior to the meeting and in my defense of her during the meeting. Although not stated precisely in these words, Jane seemed convinced that I had sat idly by as she was aggressively manhandled by the QA Review members.

Shortly after the meeting I learned that Jane was particularly angered that the review had occurred in the absence of her supervisor, the Chair of the Department. Although not voiced directly during the QA Review nor to me until at least one or two months after the event, Jane asked some of her residency peers this question: “If any other faculty member beside the Chair had been my supervisor on this case, would this meet-
ing have been held without him or her?” From her perspective she had not only been abandoned by the Chair in his supervisory role, but she also felt that the QA Committee had lacked the courage to postpone the meeting until he—the Chair of the Department—was available. Finally, Jane appeared to target me, as the DPRT, with special venom, again in the belief that I had abandoned her at the very time when my “parental authority” was most needed.

The full intensity of Jane’s anger about her supervisor’s absence, and my failure to halt the QA Review as a result, did not become clear to me for some time (perhaps weeks) after the meeting. On the other hand, immediately following the meeting I specifically apologized to Jane for failing to intervene at that juncture, recognizing myself that it had been a serious error on my part. For that matter, in retrospect a number of the other QA Committee members expressed similar regrets. Indeed, many of us felt ashamed of our acquiescence and, like good mental health professionals, wondered why we had allowed such an obvious procedural and ethical irregularity to occur.

The damage, however, had been done; and, following the QA Review, Jane’s demeanor changed from one of depression, sadness, guilt, and exhaustion to intense anger and bitterness. While much of her anger was directed at the absent Chair of the Department as well as the QA Committee, she appeared especially irate with me. Although Jane rarely confronted me directly, she took almost every opportunity in my presence to make sarcastic, derogatory comments under her breath about the training program and the Department with the obvious implication that I was responsible for most of the deficiencies. Thus, for example, at our weekly meeting for all psychiatry residents, Jane would interject venomous remarks during my announcements and discussion of various training and departmental issues. In contrast, to the best of my knowledge Jane never expressed such direct hostility to the Department Chair who had truly abandoned her at the QA Review. Certainly he was fully capable of insisting that the meeting be postponed until his return.

The other psychiatry residents watched closely to see how I would respond to these overt, bitter attacks. I found myself in a difficult and confusing position. Should I allow Jane’s behavior to continue, providing her freedom to express her anger with the hope that it would abate with time? On the other hand, should I confront her? If I were to elect the latter course, would Jane feel persecuted yet again? In the course of pondering these questions, I was well aware of my own escalating anger at Jane. I was tired of being publicly assaulted on the basis of Jane’s perceptions about the Department, training program, QA meeting, and me, especially insofar as I felt those perceptions to be incorrect and unfair. I freely acknowl-
edged that I had mishandled the QA Review by failing to insist that it be postponed until the Department Chair was available. Nevertheless, with this exception, I honestly believed that I had both consistently tried to act, and more often than not succeeded in acting, in Jane’s best interests. Indeed, it was not simply wishful thinking on my part to believe that other residents viewed me quite differently. Few would dispute that as a group our psychiatry residents found me to be a very personable and supportive training director, one who regularly and aggressively advocated on their behalf. Thus, I felt unfairly vilified.

Perhaps the most interesting, and unexpected, commentary on the situation occurred during an informal discussion among three or four residents and myself. Although the initial topic of conversation had been outpatient clinic issues, the residents, themselves, broached the subject of Jane’s continued public, verbal assaults on my character and performance. In the course of the subsequent exchange, one of the residents declared, “Now, finally, we understand transference!” Although trying to maintain a professional demeanor, I was not-so-secretly pleased by this remark. On the one hand, its implication was that the residents, too, shared my conviction that Jane was reacting to me as if I were someone else and that her criticisms were entirely out of proportion to any actual “crimes” I might have committed. On the other hand, as the primary instructor and seminar leader for much of the residents’ training in psychodynamic psychotherapy, I was gratified to learn that perhaps my words had not fallen uselessly on biological psychiatry-deafened ears.

The issues between Jane and me were never resolved, although her verbal assaults decreased in number and intensity over the course of months and as her own graduation from psychiatry residency neared. Although we were eventually able to discuss other subjects and maintain some kind of working relationship, at least from my perspective I never found Jane willing to explore her feelings about me and the events surrounding the suicide of her medical student patient. For my part, I was reluctant to push the issue, not only because of the gradual waning of her remarks, but also because I was concerned about opening a host of issues without proper processing. To the best of my knowledge, Jane was not then in any formal sort of individual psychotherapy, and I worried that subsequent discussion with me would reactivate various conflicts. There were, however, other, more personal reasons for my decision not to pursue some understanding between us; and, as I will discuss below, I was well aware of a number of my own dynamic conflicts related to Jane, my previous experiences with suicide and subsequent mandated review, my role as DPRT, and various transference issues related to my own family.
DISCUSSION

Insofar as I had no formal therapeutic role with Jane, I possessed only limited knowledge of the psychodynamic issues activated by the suicide death of her medical student patient. Nevertheless, Jane’s reactions to me were consistent with what I knew about her generally. Jane came from a dysfunctional family in which alcoholism was a significant factor. Throughout her residency training, Jane often felt abandoned and/or victimized by those around her, especially men. My position as DPRT naturally cast me in the transferential role of father to my trainees in general, and this appeared to be particularly so for Jane, even prior to her patient’s suicide. I had always felt that, in spite of our apparently good relations in general, she nonetheless regarded me with a certain amount of suspicion as if she were simply waiting for the inevitable evidence of my failure as a parental figure and a male. The suicide death of her patient provided a ready opportunity for activation of such transference feelings.

Indeed, although I felt I had been very supportive to Jane throughout her training and even in the context of her patient’s suicide, it was nevertheless true that I had abandoned her in at least one important respect—failing to insist that no QA Review occur in the absence of her supervisor, the Chair of the Department. Not only had I been found wanting in this particular “parental” protective function, but, in so doing, I had also contributed to the atmosphere of denial that attended the QA meeting. Jane could quite rightly conclude that I, and the other meeting participants, had silently colluded to avoid challenging our Department Chair and any role that he might have had in the patient’s suicide. His behavior appeared “off limits” to inspection and evaluation, not unlike that of an alcoholic father surrounded by a family’s denial of his illness. In point of fact, the Chair’s frequent absences on what the faculty often considered to be “personal business” were an ongoing issue within the Department, but one that no faculty member was willing to raise openly. To the extent that these departmental dynamics intersected with Jane’s personal issues, the stage was set for an intense transference reaction to me. Like a poor father, I had failed to protect my child, denied the reality of the situation in which she found herself, and abandoned her to the predations of dangerous others, i.e., the QA Review members. Moreover, it is likely that Jane not only felt abandoned but also felt unfairly blamed, as if the death of her patient had been her failure alone, rather than an event for which an entire team (“family”) of mental health professionals had responsibility. Certainly, the QA Review had been structured in such a way that she was the only individual being questioned as
to the care of the patient. From Jane’s perspective, the dysfunctional departmental “family” had made her the scapegoat, denying any responsibility on its part.

Jane’s very public and vituperative attacks directed towards me and my training program seemed to be based on several kernels of truth that allowed a full-blown transference rage to emerge. For my part, at least in some ways I had admirably fulfilled her stereotype of a dysfunctional parent. On the other hand, this was but one part of my interactions with her over the death of her patient; and, as noted by her fellow residents, her reaction seemed greatly out of proportion to my “crimes” in this particular regard, especially against the background of my generally supportive relations with my trainees.

I felt that Jane’s angry outbursts at me represented more than simply the unadulterated expression of transference rage. I wondered whether her behavior, and my increasing anger towards her as a response, did not reflect the presence of projective identification and counteridentification (Ogden, 1982). I had already apologized quite sincerely to Jane for what I readily acknowledged to be my shortcomings with respect to the QA Review; but, as noted earlier, I did not feel that Jane’s total negation of any positive behavior on my part was warranted or fair. It felt to me as though Jane were purposely, albeit unconsciously, provoking me to anger and counterattack, thus completing the self-fulfilling prophecy that father figures not only fail in their protective roles and invariably abandon their children sooner or later, but that they also become enraged at their innocent victims. I felt pressured to conform to Jane’s projection of her own angry internal objects, and I was aware that at least one factor in my decision to allow Jane latitude to verbally assault me was my desire to resist this counteridentification.

At the same time, I wondered if, and perhaps hoped that, Jane’s unrelenting attacks on me might represent her unconscious realization that I was, in fact, a generally good person and one who could withstand, and process, her anger. Perhaps she attacked me so vehemently not only for the manner in which one particular aspect of my behavior activated old transferences, but also because, at another level, she knew that I was a “safe” person to assail. My residents knew that I could be tough and enforce order when necessary, but neither Jane nor the other residents had ever seen me launch a public counterattack on a hostile resident. Was Jane’s decision to withhold her angry feelings from the Chair of the Department simply tactical—it is dangerous to threaten a Department Chair—or, in addition, did it reflect the unconscious belief that I would be much better able than he to withstand and process her anger?
My struggle as to how best to internally process, and interpersonally respond to, Jane’s behavior was, of course, determined in part by my own transference issues. In my conflictual relationship with my own mother, I had a lifetime of experience being repeatedly accused—unfairly in my mind—of being a “bad son” who failed to meet his mother’s needs. From my perspective, I had been the loyal son; unlike my older brother who left the household and even the state where we grew up, never to return other than for brief visits, I had remained mostly in the same metropolitan area and spent much of the first 30 years of my life trying to alleviate my mother’s distress. Nonetheless, like Jane, my mother had not been subtle in her disappointment with me; her aggressive verbal and non-verbal behavior left no question as to how she felt. Not surprisingly, these had been significant issues in my own psychoanalysis, and I had come to understand at least some of the many ways in which I had been the object of my mother’s projections. Of particular import with respect to my interactions with Jane, by the process of projective counteridentification with my mother I had often felt guilty, neglectful, selfish, and generally angry. Jane’s behavior towards me reactivated many of these issues: again I felt accused of being a disappointment and failure even though I believed I had tried very hard not to be so. With Jane I found myself the target of an aggressive woman finding fault with my every action, and my decision to simply bear this torment reenacted my masochistic submission to similar behavior on the part of my mother. Indeed, the reversal of roles within the residency training program was clear: Jane, the victim, had become persecutor, and I, the persecutor, had become victim. But if I were to assertively address these injustices with Jane I would simply confirm, as I had learned from my mother, that it was I—not Jane—who harbored the great inner hostility and bitterness towards others. Moreover, my mother had also made clear that if I were to confront her about her behavior she would either descend into serious depression and/or counterattack in an even more vituperative manner. My feelings about these past experiences were easily transferred to Jane and her circumstances because, as is often the case, Jane was, in reality, a good fit with such transference distortions. Jane had seemed chronically depressed and, with the burden of her patient’s suicide, appeared very emotionally fragile. An escalation of angry outbursts might result from confrontation with her, but equally likely would be crushing depression, leaving me feeling guilty for having been the proximate cause—the proverbial “straw that broke the camel’s back.”

Compounding these issues was a sense of guilt on my part for having actually abandoned Jane in her time of need. Whatever the issues, trans-
ferential or otherwise, why had I failed to insist that the QA Review be postponed? Had I failed to do so in order to avoid a confrontation with the Chair of my Department, thus leaving Jane to be the victim of my own cowardice? Perhaps, in addition, my intense desire to minimize any reminders of my own ordeal with a very public suicide of a patient played a significant role in my failure to intervene. It was hardly a matter of mere chance that every physician and staff member significantly involved in my patient’s suicide had, within a year, left the hospital where the death occurred; all appeared to have been so severely affected that they could no longer bring themselves to even set foot on the psychiatric unit. An even more disturbing possibility was that I was simply so glad that it was Jane, rather than me, having to deal with a patient suicide, that I did not really think about her at all: “What really matters here is that it wasn’t my patient; it was someone else’s.” What if I had, in fact, failed to adequately prepare Jane for the QA Review, minimizing its possible emotional impact on her so as to avoid distressing recollections of my own experience with such a meeting? If even one, much less some combination, of these factors were operative, however, I would have to ascribe my failure to intervene on Jane’s behalf at the QA Review as selfish. In spite of my conscious intentions, it seemed that I was willing to sacrifice Jane’s needs to my own, thus abdicating my parental role as training director. Returning to my own transference issues, had not my mother repeatedly charged me with the very same offense—caring more about myself than about her? Finally, was it not possible that I had refrained from confronting Jane on her inappropriate behavior with me because I unconsciously felt that I deserved the abuse and punishment she liberally provided? If, indeed, I was selfish and more concerned about myself than others, I deserved the harsh castigation from Jane, even if she were motivated primarily by transference rage rather than an even-tempered consideration of just retribution.

Thus, in trying to understand my own thoughts, feelings, and behavior in the aftermath of the suicide death of Jane’s patient, I found myself confused and frustrated. Certainly a conscious and well-intentioned rationale for allowing Jane to repeatedly express her anger towards me was my empathy with her distress and my desire to be as supportive as possible under such circumstances. On the other hand, I was also aware of the pressure I felt to conform to Jane’s projected bad objects, and I wondered if, as a result, I was trying too hard to avoid being provoked by her. Perhaps I should have confronted her in private: “You know what Jane, I screwed up in the QA Review and I’m sorry, but enough is enough; you’re certainly free to feel any way you like about me, but I’ve reached my limit for angry and sarcastic comments about me in public.” Then,
in conjunction with these concerns, I struggled with my own issues related to my earlier patient’s very public suicide and my transference reactions based on my own family of origin. And finally, I tried to consider the effect of my response, or lack of response, to Jane’s attacks on the other residents in the training program who were watching intently to see how I would handle the situation.

I assume, but cannot prove, that Jane similarly struggled with her reactions to the suicide of her patient. Unfortunately, and again to the best of my knowledge, I do not believe that Jane was undergoing any intensive individual psychotherapy at the time. The suicide death could not be undone, but it could be used as a stimulus to better understanding and future treatment of similar patients. Similarly, both Jane and I had behaved in the ways that we had chosen to behave, but those choices and actions could also be transformed into productive learning experiences. Certainly I felt that I had thought long and hard about my actions and the reasons for them. My fear, and regret, is that Jane never found the necessary supportive structures to similarly process these events and their psychodynamic repercussions.

CONCLUSIONS

Transference reactions and enactments may, of course, occur at any time or in any circumstance, but they are especially likely in the context of stressful events which precipitate regressive mental processes. The suicide death of a resident’s patient is one such stressful event, and while the psychodynamic issues and transference responses are usually less severe than in this particular instance, they are always there, lurking beneath the surface if not openly displayed or enacted. These emotional and behavioral reactions are not limited to the resident who treated the deceased; they may affect resident colleagues, supervisors, the Director of the Residency Training Program, as well as other faculty and staff.

Of particular concern is that today’s psychiatrists-in-training are perhaps less prepared to deal with these tumultuous feelings than their predecessors. Whereas in the not-so-distant past many, if not most, psychiatry residents were in psychotherapy themselves, over the past several decades fewer and fewer trainees have chosen to undergo any type of personal psychotherapy, much less psychoanalysis. The reasons for this change are many and varied, ranging from the general deemphasis of psychotherapy with the concomitant ascendancy of the biological paradigm in psychiatry, the expectation of many psychiatry residents that intensive or exploratory psychotherapy will constitute, at best, a mini-
mal part of their future practice, and changing personal psychotherapy expectations on the part of both trainees and their training programs. While even twenty years ago a resident’s unwillingness to undergo his or her own intensive psychotherapy was inconsistent with the cultural norms of one’s trainee peers and the training program, now the resident in intensive psychotherapy or psychoanalysis is often the exception to the rule. Indeed, there are still many mid-career and senior psychiatrists who recall a time in the not-so-distant past when trainees were not only expected to be in their own psychoanalysis, but the training program provided financial reimbursement for the therapy.

Thus, in today’s very different training milieu, most residents do not have the benefit of an intensive, individual psychotherapy to assist them in dealing with the many issues that arise in their work as psychiatrists (Goin & Kline, 1976; Rao, Meinzer, & Berman, 1997). When confronted with the unavoidably taxing aspects of therapy with suicidal patients (Brown, 1987a; Brown, 1987b; Chemtob et al., 1988; Gitlin, 1999; Goldstein & Buongiorno, 1984; Hendin et al., 2000; Henn, 1978; Horn, 1994; Jacobs, 1992; Kahne, 1968; Kolodny et al., 1979; Litman, 1965; Maltzberger, 1999; Maltzberger & Buie, 1974; Sacks, 1989; Sacks et al., 1987; Schnur & Levin, 1985; Zee, 1972), current trainees find themselves with few options to assist them in processing and working through such issues. Of course, an astute and supportive supervisor may be of great value in such situations, but he or she is no substitute for a personal psychotherapist. Most supervisors are wary of the boundary and privacy dangers of confounding resident supervision with resident psychotherapy (Berman, 1997; Gordan, 1996; Jacobs, David, & Meyer, 1995; Spiegel & Grunebaum, 1977).

The absence of a personal psychotherapist on the part of most psychiatry residents is even more problematic in the context of patient suicide. Under these circumstances, the people with whom the resident may speak are further limited by the threat of legal repercussions. While peer reviews (e.g., QA meetings) are generally legally protected, impromptu discussions with peers, staff, colleagues, or friends are not confidential, and all such conversation, including the mere expression of a sense of guilt by the resident, may be used in subsequent legal proceedings. In contrast, the confidential nature of the psychotherapist-patient relationship allows the resident to express his thoughts and feelings without fear that his words may appear in a legal context. Whether they relate to the deceased patient and his or her family, a supervisor or training director, involved staff, or public agencies, the psychiatry resident in individual psychotherapy has an important outlet for safe exploration of the events and his or her feelings about them.
Finally, precisely because the suicide death of a resident’s patient and its aftermath invariably present a host of personal issues on the part of involved individuals, this tragedy can be used to advantage. It can serve as a stimulus to productive introspection and significant learning, not only about psychiatric patients and psychiatric care but about oneself as a therapist, supervisor, training director, and person. In the process, a potentially destructive event—the suicide of a patient—may be transformed into the difficult but ultimately beneficial lessons of hard-won experience. It is the obligation of all concerned—resident, supervisor, training director—to seize such potential learning opportunities, and to make the most of a dreadful circumstance while acknowledging its very dreadfulness. After all, this is precisely what we ask of our patients in psychodynamic psychotherapy. Should we do no less with our trainees and ourselves?

References


1459 Laney-Walker Blvd.
Augusta, GA 30907
(706) 721-8982
E-mail: dmisch@mail.mcg.edu