

The impact on mental health practitioners of the death of a patient by suicide: A systematic review

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Abstract

There is a growing body of research investigating the impact on mental health professionals of losing a patient through suicide. However, the nature and extent of the impact is unclear. This systematic review synthesizes both quantitative and qualitative studies in the area. The aim was to review the literature on the impact of losing a patient through suicide with respect to both personal and professional practice responses as well as the support received. A search of the major psychological and medical databases was conducted, using keywords including suicide, patient, practitioner, and impact, which yielded 3,942 records. Fifty-four studies were included in the final narrative synthesis. Most common personal reactions in qualitative studies included guilt, shock, sadness, anger, and blame. Impact on professional practice included self-doubt and being more cautious and defensive in the management of suicide risk. As quantitative study methodologies were heterogeneous, it was difficult to make direct comparisons across studies. However, 13 studies (total $n = 717$ practitioners) utilized the Impact of Event Scale, finding that between 12% and 53% of practitioners recorded clinically significant scores. The need for training that is focused on the impact of suicides, and the value placed upon informal support was often cited. The experience of losing a patient through suicide can have a significant impact on mental health professionals, both in terms of their personal reactions and subsequent changes to professional practice. The negative impact, however, may be moderated by cultural and organisational factors and by the nature of support available.

KEYWORDS

clinicians, impact, mental health, suicide, systematic review

1 | INTRODUCTION

Approximately 135 people, on average, are exposed to each death by suicide (Cerel et al., 2016), where exposure is defined as knowing or identifying with the deceased, and it is estimated that 35% of the population experience moderate to extreme emotional distress as a consequence of a suicide death during their lifetimes

(Feigelman, Cerel, McIntosh, Brent, & Gutin, 2018). Bereavement by suicide is also a recognized risk factor for suicide attempts (Pitman, Osborn, Rantell, & King, 2016). Among those exposed to loss of life by suicide are mental health practitioners. In the United Kingdom, it is estimated that 27% of those who take their own lives are individuals who had been in contact with mental health services in the 12 months prior to death (National Confidential

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Inquiry into Suicide and Homicide by People with Mental Illness [NCISH], 2014). For mental health practitioners, the tragedy of a patient's suicide has been described as a rare event, although one that is likely to be experienced at some point in their careers (Foley & Kelly, 2007) and one that is likely to evoke strong emotional distress (Feigelman et al., 2018). One study found that 58% ($n = 704$) of responding mental health practitioners working in institutions had experienced a patient suicide (Castelli Dransart, Heeb, Gulfi, & Gutjahr, 2015).

Recognizing and understanding the impact of this are necessary precursors to identifying how best to support health professionals who experience the suicide of a patient. This matters on a personal level, in order to ameliorate the level of distress and prevent long-term effects and in terms of professional practice, that is, ensuring risk is effectively managed and at a service level, for example, protecting against staff burnout and promoting staff retention. A growing body of studies has investigated the impact on mental health professionals of losing a patient through suicide, although the majority of these studies have investigated the effects on psychiatrists or psychologists (Foley & Kelly, 2007; Lafayette & Stern, 2004). In a previous literature review, Lafayette and Stern (2004) concluded that mental health professionals' reactions may be strong or overwhelming and may be similar to grief responses. They also highlighted that studies often differentiated between the impacts on personal life and those on professional practice. Foley and Kelly (2007) concluded that the impact on mental health professionals could be pronounced, prolonged, and profound. They noted, among other reactions, signs of stress, guilt, symptoms of post-traumatic stress disorder (PTSD), more defensive approaches to risk, and consideration of retirement. They also commented that the perceived risk of patient suicide as well as suicide itself contributed to exhaustion and depression among psychiatrists. The latest synthesis of evidence was a literature review of studies completed up to 2012 (Séguin, Bordeleau, Drouin, Castelli-Dransart, & Giasson, 2014), which focussed on studies that had employed a psychological well-being outcome measure and concluded—in contrast to other reviews—that stress reactions or affective-related symptomatology were minimal. There was, however, an impact on the way professionals conducted their clinical assessments and reached subsequent treatment decisions (Séguin et al., 2014).

To our knowledge, there have been no systematic reviews of the research into the impact of losing a patient to suicide on mental health professionals more broadly. The (non-systematic) narrative reviews that have been published present mixed evidence for both the professional and personal consequences for mental health professionals of losing a patient through suicide, although the studies themselves do seem to converge on the idea that there is a notable effect on both areas. A thorough synthesis of all the evidence is important if organizations are to be encouraged to respond proportionately in supporting practitioners. We therefore undertook a systematic search of both quantitative and qualitative studies. Specifically, our three main aims were to synthesize the research evidence on (1) the impact of a patient's suicide on both personal (emotional/coping) and professional practice (confidence/behaviour/attitude) responses; (2) the support

Key Practitioner Messages

- The death of a patient by suicide can have a considerable, and lasting, emotional impact on mental health professionals most commonly manifested as guilt, blame, shock, anger, sadness, anxiety, and grief.
- The impact is comparable with that of other traumatic life events, and therefore, active monitoring of practitioners for symptoms of PTSD is recommended.
- There were notable impacts on professional practice including self-doubt and being more cautious and defensive in the management of suicide risk.
- More should be done to prepare and support mental health professionals for the event that they may lose a patient through suicide.

received; and (3) the factors or interventions that help to minimize negative sequelae.

2 | METHOD

2.1 | Search strategy and screening of results

The protocol for this systematic review was registered on Prospero (registration number CRD42017052807). A keyword search of the major psychological and medical databases (Medline, PsychInfo, CINAHL, ERIC, and EMBASE) was conducted using the search terms detailed in Table 1. The screening process followed PRISMA guidelines (Moher, 2009). See Figure 1 for flowchart.

2.2 | Inclusion and exclusion criteria

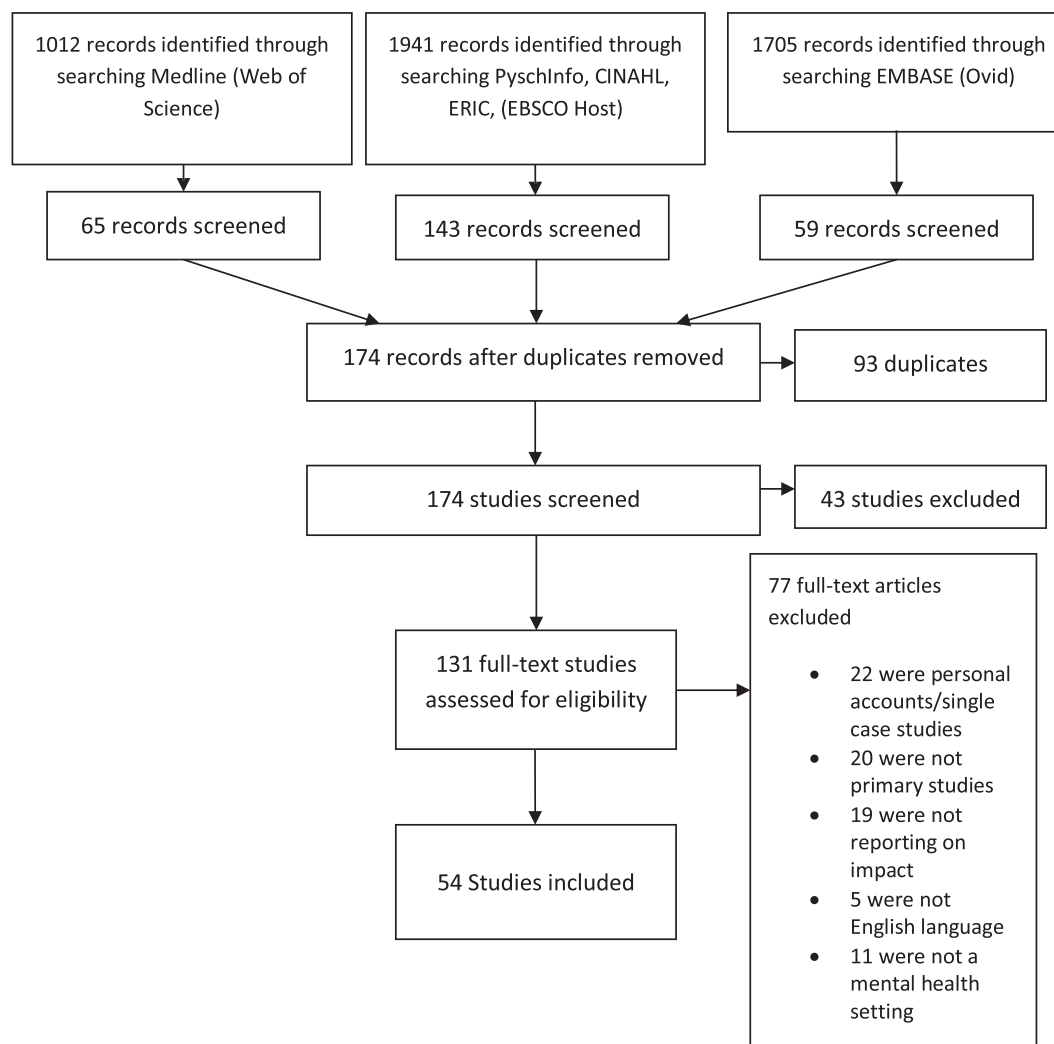
The inclusion criteria were that (i) the study must be published primary research in the English language, and (ii) the studies must have reported on the impact on mental health professionals or teams of mental health professionals of having experienced the loss of a patient through suicide (either in active treatment or post-discharge). Studies were excluded if they were single case studies or personal accounts. To be comprehensive, we included both qualitative and quantitative studies.

2.3 | Quality assessment

A quality assessment was performed on the included studies, and this was subsequently used to give a weighting to findings reported in the results section. A quality assessment framework was adapted from

TABLE 1 Search strategy

Eligibility: Information sources:	Databases searched from inception to 2019, search not limited by study design, studies restricted to English language		
	Medline via Web of Science.	CINAHL, ERIC, PsychInfo, Via EbscoHost.	EMBASE. Via Ovid.
Search terms:	TS = ((Suicide AND (Patient OR Client OR Service User)) AND ((professional OR practitioner OR clinician OR nurse OR worker OR therapist OR psychologist OR psychiatrist OR counsellor OR OT OR GP) AND (reaction OR impact OR effect)))	TX (suicid*) AND (TX patient* OR TX client* OR TX service user*) AND TX (professional* OR practitioner* OR clinician* OR nurse* OR worker* OR therapist* OR psychologist* OR psychiatrist* OR counsellor* OR ot OR GP) AND TX (reaction* OR impact* OR effect*)	(suicid*) AND (patient* OR client* OR service user*) AND (professional* OR practitioner* OR clinician* OR nurse* OR worker* OR therapist* OR psychologist* OR psychiatrist* OR counsellor* OR ot OR GP) AND (reaction* OR impact* OR effect*)

**FIGURE 1** Procedure for identifying, screening, and determining the eligibility of studies for inclusion in the review

the Mixed Methods Appraisal Tool (see Figure 2; Pluye, Gagnon, Griffiths, & Johnson-Lafleur, 2009).

The quality assessment was carried out by the first author and then 13 (25%) were independently assessed by the third author.

There were discrepancies in rating 3 out of 92 (3%) individual assessment items, which equated to 3 differences in assigned quality ratings and yielded an intraclass correlation of $k = 0.71$. This compares well with the estimation of correlation of 0.8 made

Types of mixed methods study components or primary studies	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?				
	Do the collected data address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).				
	<i>Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?				
	1.2. Is the process for analysing qualitative data relevant to address the research question (objective)?				
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?				
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?				
2. Quantitative descriptive	2.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?				
	2.2. Is the sample representative of the population understudy?				
	2.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?				
	2.4. Is there an acceptable response rate (60% or above)?				
3. Mixed methods	3.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?				
	3.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?				
	3.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?				
	<i>Criteria for the qualitative component (1.1 to 1.4), and criteria for the quantitative component (2.1 to 2.4), must be also applied.</i>				

FIGURE 2 Mixed Methods Appraisal Tool (Pluye et al., 2009)

following pilot testing of the appraisal tool (Pace et al., 2010). The disagreements were resolved through discussion between the first and third authors (see Table 5). The data extraction was carried out by the first author using a data extraction form that had been agreed by all four authors.

3 | RESULTS

For the current synthesis, we focused on the following areas: personal responses of practitioners, impact on professional practice, variables associated with the extent of the impact on practitioners, and support that helps minimize negative sequelae. Fifty-four studies were included (see Table 3), 21 were quantitative studies, 16 were qualitative studies, and a further 17 studies adopted a mixed-method design. The majority (15 studies) investigated the impact on psychiatrists, and 13 studies focussed on psychologists or psychotherapists, with a further six studies including both psychiatrists and psychologists. Other professional groups represented within this review were social workers (five studies), nurses (four studies), general practitioners (GPs) (three studies), and counsellors (two studies). Nine studies were based on a mixed group of mental health workers. In terms of geographical location, 23 studies recruited participants from North America, nine from the United Kingdom, seven from Ireland, 11 from elsewhere in Europe, two from Australia, and one each from Thailand and China. Intervals between the death and the time of the study varied

markedly both within and across studies; for example, the range in Alexander, Klein, Gray, Dewar, and Eagles (2000) was between 1 month and 20 years (median 3 years).

3.1 | Personal responses to death of a patient by suicide

The most common personal reactions recorded across the studies were guilt (22 studies), blame (16), shock (14), anger (12), sadness (12), anxiety (11), and grief (9).

Although the methodologies in the quantitative studies were heterogeneous, making comparisons difficult, 13 studies (total $n = 717$) utilized the Impact of Event Scale (IES or IES-R, Horowitz, Wilner, & Alvarez, 1979; Weiss & Marmar, 1996) and reported that between 12% and 53% of their samples recorded clinically significant scores in the time immediately following the suicide (see Table 2). Of the other quantitative and mixed-method studies, Finlayson and Graetz Simmonds (2016) included 12 items in their study questionnaire to capture intensity of emotions and reported that sadness was rated most highly, followed by shock, helplessness, anger, and pain. Gulfi, Castelli Dransart, Heeb, and Gutjahr (2010) used nine items from an adapted Long-term Emotional Impact Scale and reported low to moderate impact overall, with increased sensitivity to signs of risk and increased anxiety when working with

TABLE 2 Studies utilizing IES/IES-R

Study	Population	Number	Measure	Total means (SD)	Weeks after DSP		Prior to survey		Clinical significance initially: no reaching, % (cut off)
					Mean intrusion (SD)	Mean avoidance (SD)	Mean intrusion (SD)	Mean avoidance (SD)	
Chemtob, Hamada, Bauer, Kinney, and Torigoe (1988)	Psychiatrists	72	IES Two time points (2 weeks following DSP, 2 weeks prior to survey)	24.6	14.3 (9.1)	10.3 (9.3)	Not reported	Not reported	65, 53% (.)
Chemtob et al. (1988)	Psychologists	70	IES Two time points (2 weeks following DSP, 2 weeks prior to survey)	22.2	13.3 (9.0)	8.9 (6.6)	Not reported	Not reported	Intrusion: 34, 49% (13) Avoidance: 19, 27% (13)
Cryan, Kelly, and McCaffrey (1995)	Psychiatrists	86 (84)	IES Two time points (2 weeks following DSP, 2 weeks prior to survey) 1st DSP	16.6	10.8 (6.4)	5.8 (7.2)	2.0 (4.4)	0.9 (2.1)	Intrusion: 31, 36% (12) Avoidance: 15, 17.5% (10)
Jacobson, Ting, Sanders, and Harrington (2004)	Social workers	209	IES Most affecting DSP At time of the DSP.	32.41	17.76 (5.67)	14.65 (4.31)	—	—	—
Kleespies, Smith, and Becker (1990)	Psychology trainees	8	IES Two time points (2 weeks following DSP, 2 weeks prior to survey) Last DSP (or first-one only)	33.4	20 (10.3)	13.4 (6.7)	Not reported	Not reported	—
Kleespies (1993)	Psychology trainees	32	IES Most distressing DSP Two time points (2 weeks following DSP, 2 weeks prior to survey)	28.8 (12.1) 8.0 (8.6)	16.7 (7.5)	12.1 (7.6)	3.8 (3.3)	4.2 (6.4)	—
McAdams and Foster (2000)	Counsellors	97	IES The week following the DSP and the week prior to the survey.	30.2 (13.1)	16.3 (8.3)	13.9 (6.7)	DSP within 18 months (n = 37) 11.5 (12.2) >18 months (n = 52) 4.51 (7.0)	10.7 (11.2) 4.81 (7.1)	—(19)
Pieters, De Gucht, Joos, and De Heyn (2003)	Psychiatric trainees	79	IES Most distressing DSP Current impact	—	n/a	n/a	—	—	Intrusion: 9, 12% (12) 5, 7% (10)
Ruskin (2004)		120	IES	14	8 (6)	6 (5)	—	—	29, 24% (12)

(Continues)

TABLE 2 (Continued)

Study	Population	Number	Measure	Total means (SD)	Weeks after DSP		Prior to survey		Clinical significance initially: no reaching, % (cut off)
					Mean intrusion (SD)	Mean avoidance (SD)	Mean intrusion (SD)	Mean avoidance (SD)	
	Psychiatrists and Psychiatry trainees		First DSP At time of DSP.						28, 23% (10)
Yousaf, Hawthorne, and Sedgwick (2002)	Psychiatric trainees	23 (21)	IES Two time points, immediately after DSP and at time of study	21.6	11.9 (8.5)	9.7 (9.21)	"no significant reduction" Median change = 0	"no significant reduction" Median	change = -2
11, 52% (20)				24.86					
Castelli Dransart, Gutjahr, Gulfi, Kaufmann, Didisheim, and Séguin (2014)	Mental health professionals	258	IES-R Most recent DSP within last 5 years Time point = during the month following DSP	12.12 (10.66)	6.88 (5.38)	3.76 (4.50)	—	—	31, 12% (25)
Castelli Dransart et al (2015)	Mental health professionals	666	IES-R Most recent DSP within last 5 years Time point = during the month following DSP	13.1 (11.7)	7.4 (5.8)	3.8 (4.5)	—	—	93, 14% (25)
Takahashi et al. (2011)	Psychiatric Nurses	292	IES-R	11.4	—	—	—	—	40, 13.7% (25)

Abbreviations: DSP, death by suicide of a patient; IES/IES-R, Impact of Events Scale-Revised.

TABLE 3 Duration of impact

Study	Duration less than 1 month % (n)		Duration greater than 3 months % (n)	
	Personal	Professional	Personal	Professional
Alexander et al. (2000)	39 (19)		29 (14)	
Finlayson and Graetz Simmonds (2016)	65 (35)		20 (11)	
Gibbons et al. (2019)				44 (29)*
Kelleher and Campbell (2011)	81 (9)	62 (8)	9 (1)	15 (2)
Kleespies et al. (1990)	88 (7)			88 (7)
Landers et al. (2010)	62 (83)	42(41)	22(31)	67(85)
Linke et al. (2002)	60 (23)	55 (21)		
Murphy et al. (2019)			10 (6)**	
Roths et al. (2013)	61 (52)		13 (11)	
Ruskin (2004)	36 (43)		7 (8)	29 (35)
			**Duration greater than 12 months	*Duration greater than 6 months

suicidal patients being the highest rated items. The most frequently endorsed emotional reactions by Midence, Gregory, and Stanley's (1996) study of nursing staff were sadness and helplessness, followed by shock, and feeling guilty and angry. Ruskin (2004) employed a 25-item scale based on the DSM IV (American Psychiatric Association, 2013) criteria for acute stress or PTSD to assess psychiatrists and psychiatry trainees and reported that 22% of their sample met criteria for acute stress disorder and 20% met criteria for PTSD. Gibbons et al. (2019) found that the majority of their sample of psychiatrists (92%, $n = 105$) rated the effect on their emotional well-being above 50 on a 0–100 scale anchored at 0 = "no effect," 50 = "some," and 100 = "a very severe response," with an average rating of 66. Finally, Wurst et al. (2010, 2011, 2013) used a 100-mm visual analogue scale to measure emotional responses in three studies. The items measured were grief, guilt, anger, relief, shock, shame, disbelief, feeling offended, feeling insufficient, and an overall rating for total distress. Their three respective samples of therapists reported mean ratings of overall distress of 62 (Wurst et al., 2010), 63 (Wurst et al., 2011), and 63 (Wurst et al., 2013) with shock and sadness being the highest rated emotional responses.

Nine studies attempted to quantify the proportions of practitioners who were affected after the loss of a patient through suicide, although the thresholds used to define this were unclear, and the estimates showed considerable variation. In one survey (Landers, O'Brien, & Phelan, 2010), 97% ($n = 139$) of psychiatrists reported some effect on personal life following their most distressing suicide loss, and 87% ($n = 124$) reported some disturbance following their most recent suicide loss. Just 9.7% ($n = 8$) of the sample in Murphy et al.'s (2019) study reported no impact, with 55% ($n = 46$) describing some impact, 24% ($n = 20$) quite an impact, and 11% ($n = 9$) reporting a major impact. For Saini, Chantler, While, and Kapur (2016), 66% of their sample reported being affected in some way. With Courtenay and

Stephens (2001), emotional impact was considered severe in 24% ($n = 40$), moderate in 51% ($n = 85$), and absent or minimal in 14% ($n = 23$) of the participants. In Alexander et al.'s (2000) study, 33% ($n = 54$) reported being personally affected (lowered mood, poor sleep, increased irritability), whereas Dewar, Eagles, Klein, Gray, and Alexander (2000) reported that for 31% ($n = 15$) of clinicians, the suicide had an adverse impact on some aspect of their personal lives. Hendin, Lipschitz, Maltsberger, Haas, and Wynecoop (2000) reported 38% ($n = 13$) as being severely distressed. In contrast to the above, Halligan and Corcoran (2001) found that more than 80% ($n = 84$) in their survey noted no personal effect other than for guilt feelings (35% [$n = 37$], experiencing feelings of guilt), and in a further study (Pieters et al., 2003), 84% ($n = 66$) of the participants did not recall an adverse impact on personal life.

3.2 | Impact on professional practice

Thirty-four of the studies reported on the impact upon professional practice experienced by practitioners. As summarized below, practitioners reported a greater focus on risk assessment. They also became more cautious and adopted a more defensive management of suicide risk. Others also reported increased self-doubt related to their own judgement and decision-making.

3.2.1 | Risk assessment

Fourteen studies described changes that relate to risk assessment. Heightened awareness of risk was frequently cited (Alexander et al., 2000; Bowers et al., 2006; Draper, Kolves, De Leo, & Snowden, 2014; Kelleher & Campbell, 2011; Landers et al., 2010; Murphy et al., 2019), as was attentiveness to risk assessment (Bowers

TABLE 4 Studies included in systematic review

Qualitative studies <i>n</i> = 16, DSP = death by suicide of a patient				
Study, country, quality assessment (QA) rating	Design	Sample, number, setting	Results—impact	Results—factors related to impact and recovery
Bowers et al. (2006) England QA rating = **	Semi-structured interview	• Ward managers (16), F grade MH nurses (17), OTs (14), consultant psychiatrists (9) • 56	• Impact on morale. • Ruminations, search for understanding. • Depression and demoralization of ward team. • Upset, loss, and grief. • Guilt and dismay. • Anxiety and worry—happen again, best efforts not enough. • Incidents though distant in time were still having an influence on practice in the present. • Impact across hospital (not just ward of occurrence). • Heightened alertness. • Attentiveness to risk assessment. • More rigorously pursued policies. • Greater use of containment methods.	• Time patient known to staff. • Strength of relationship. • Availability or lack of support and aftercare directly after. • Perception of whether DSP could have been prevented. • Managerial responses. • Culture of blame. • Severity/outcome of incident. • Pressure of work preventing time to deal with feelings. • Shock—all the more devastating.
Cotton, Drake, Whitaker, and Potter (1983) USA QA rating = **	Interviews	• Psychiatrists, psychiatric residents, social workers, nurses, and mental health workers • 23 • Psychiatric inpatient unit	• Working in shock (maximal vulnerability, minimal coping) • Emergence of overwhelming feelings, rage. Guilt, depression, anxiety • New growth around emotional scars	• Minimal contact • Staff who attended meetings, drew strength from peer supports, and talked easily with others recovered more quickly than did those who behaved in a more solitary way. • Previous medical experience with death
Darden and Rutter (2011) USA QA rating = ***	17 Q semi-structured interview	• Clinical psychologists • 6 • University counselling, private practice, state hospital	• All met the criteria for prolonged grief. • None questioned their clinical skills after the suicide, citing client's choice outside of their control	• Male clinicians (in contrast to female respondents) reported no personal impact • Work settings significantly influenced the recovery process. • Understanding of the client's choice to suicide being outside of their control.
Davidson (2011) Denmark QA rating = ***	IPA semi-structured interviews	• GPs • 13 • Primary care	• Guilt, failure, and self-scrutiny	• Whether risk realized and explored • If difficulty with emotional contact with the patient • Especially shocked if treatment considered appropriate • No difference between GPs who joined supervision groups and expressed interest in mental disorder and those who expressed less interest

TABLE 4 (Continued)

Qualitative studies $n = 16$, DSP = death by suicide of a patient			
Study, country, quality assessment (QA) rating	Design	Sample, number, setting	Results—impact
Dewar, et al. (2000) Scotland QA rating = **	Questionnaire	- Psychiatry trainees 90 - Inpatients	Results—factors related to impact and recovery - Not seem related to their overall propensity to talk about suicide ideation, their therapeutic mindedness, or their age or sex - If only experienced suicide - First suicide most distressing - If unexpected or not predicted occurring when appearing to be improving or making plans for future - If feeling of blame - Young patient who had children - Knowing patient well - Disliking the patient - Method - Blame of relatives - Last to speak to patient Results—impact 31% reported impact on personal lives: - Preoccupation about the suicide and how it could have been prevented. - Problems with anxiety, guilt, insomnia, and loss of confidence. 39% reported impact on professional practice: - Increased anxiety and difficulty in making decisions, particularly when this involved patients with recognized increased risk of self-harm. - Management became overcautious, specifically when deciding on observation levels, passes, and discharge for in-patients. 9% reported: - Giving consideration to a change of career
Goldstein and Buongiorno (1984) USA QA rating = **	Structured interviews	- Psychotherapists 20 - Private - Hospital	- Shock, disbelief, anger, guilt, self-blame, loneliness - Grief, despair, loss of self-esteem and self confidence - More direct questioning re suicide risk - More explicit exploration of past suicide behaviour - Chart reviews and psychological autopsies helpful to some but compounded doubt in others. - Discussion with colleagues helpful.
Hendin et al. (2000) USA QA rating = **	Semi-structured questionnaire Case narratives, workshop	- Psychotherapists (psychiatrists, psychologists, social worker) 26 - Not noted	- Shock, grief, guilt, fear of blame, self-doubt, shame, anger, and betrayal were the major emotional reactions. - In 21 out of 26 cases, therapists identified at least one major change they would have made in their patients' treatments; most frequently mentioned were changes in medication, hospitalization of the patients, and consultation with the patients' previous therapists - Impact independent of the therapist's age, years of experience, or practice setting

(Continues)

TABLE 4 (Continued)

Qualitative studies n = 16, DSP = death by suicide of a patient				
Study, country, quality assessment (QA) rating	Design	Sample, number, setting	Results—impact	Results—factors related to impact and recovery
Hendlin, Haas, Maltzberger, Szanto, and Rabinowicz, (2004) USA QA rating = **	Semi-structured questionnaire Case narratives, workshop	- Psychiatrists, psychologists, psychiatric social worker 34 - Private practice - Hospital	- Some of the therapists were reluctant to accept subsequent suicidal patients into their practices. 38% (N = 17) categorized as severely distressed. - Most prominent reactions: - Grief - Guilt - Anger - Shock	- Failure to hospitalize an imminently suicidal patient who then died - A treatment decision the therapist felt contributed to the suicide - Negative reactions from the therapist's institution - Fear of a lawsuit by the patient's relatives
Kayton and Freed (1967) USA QA rating = ***	Retrospective, cross-sectional At time of DSP Questionnaire	- Nursing, nursing aides 35 - Inpatient	- An almost compulsive urge to help the patients - Variable intensities of insecurity - Moderate shock and numbness - Anger, ambivalence, and guilt - A residual sadness and sympathy for the victim	- Free expression of resentment helpful - Support swiftly mitigated stress - Reaction to the stress is milieu dependent - Group discussion is helpful in diluting the intensity of guilt.
Kolodny, Binder, Bronstein, and Friend (1979) USA QA rating = **	Discussion in supervision group	- Trainee psychiatrists 4 - Inpatient	- Panic, doubt, anger, upset, worry - sadness, disbelief, denial, shame - embarrassment, defensive curiousness, loss, cautiousness, guilt grief, helplessness, loneliness, regret - responsibility, stunned fear, tears, fondness.	- Peer support - Supervision
Litman (1965) USA QA rating = **	Unstructured interview	- Psychotherapists 200 + - institutions/private practice	Grief, guilt, depression, denial, personal inadequacy, anger, accident proneness.	Specifics of relationship
Menninger (1991 a) USA QA rating = **	Questionnaire	- Psychotherapists 41 - Psychotherapy clinic and other	- Shock, sadness, anger, guilt, worry, and fear of criticism. 66% reported changes in practice. - More conservative treatment (especially at termination) - More careful listening to suicidal ideation - Greater vigilance to hopelessness or wishing to end it all - More clinical notes and consultation - Quicker to hospitalize and follow up - More accepting of suicide as a possibility	- Discussion with colleagues - Consultation

TABLE 4 (Continued)

Qualitative studies $n = 16$, DSP = death by suicide of a patient					
Study, country, quality assessment (QA) rating	Design	Sample, number, setting	Results—impact	Results—factors related to impact and recovery	
Robertson, Paterson, Lauder, Fenton, and Gavin (2010) Scotland QA rating = ****	Discourse analysis	- Psychiatric nurses 2 - Acute psychiatric ward	Self-blame	Perception of accountability	
Sanders, Jacobson, and Ting (2005) USA QA rating = **	Questionnaires Thematic analysis	- Social workers 145	78 deep sadness and depression 60 trauma and shock 44 feelings of professional failure 25 anger and irritability 25 self-blame 11 worries and fears 20 changes in practice	Reactions persist over time	
Tillman (2006) USA QA rating = **	Interviews	- Psychoanalysts 12 - Institutions and private practice	- Traumatic loss and grief - Numbness, shock, crying, sadness, anger, fear of reprisal	- Supervision - Psychoanalysis - Peer relationships—both source of support and of shame - Contact with patient's family—source of comfort for some but painful for others	
Wang et al. (2016)	Semi-structured interviews	- Nurses 15 - Hospital inpatient	- Shock - Sense of fear - Self-accusation/guilt - Frustration/self doubt - Stress - Excessive vigilance - Burnt out	- Managers' comfort - Supervisors' understanding - Days off - Family and friends - Avoidance of suicide scene	
Quantitative studies $n = 21$ DSP = death by suicide of a patient					
Study, country, quality assessment (QA) rating	Design	Sample, number included, setting	Measures	Results—impact	Results—factors related to impact and recovery
Castelli Dransart et al., (2014) Switzerland QA rating = ***	Retrospective, cross-sectional Most recent DSP within last 5 years Time point = during the month following DSP	- Nurses, social workers, psychiatrists, educational psychologists 258 - Psychiatric hospitals and outpatient psychiatric services, social and medical services, residential homes for people with mental health or addiction problems, care homes for elderly, and prisons	IES-R (Impact of Event Scale-Revised) 5 pt scale; AEIS (Acute Emotional Impact Scale) 7 pt scale from Kleeppies, 1993	- Low emotional response on the AEIS ($M = 2.08$, $SD = 0.59$). 15.5% ($n = 40$) of the respondents were above the cut off. - Shock, helplessness, and sadness however markedly higher. - Low impact (IES-R total score: $M = 12.12$, $SD = 10.66$, range 0–88).	AEIS: - Feeling emotionally close to the patient, feeling responsible for the patient's care, receiving insufficient support, being 30–39 years old, and receiving professional counselling significantly predicted emotional response (higher scores). IES-R - Feeling emotionally close to their patient or received insufficient support after the suicide reported significantly

(Continues)

TABLE 4 (Continued)

Quantitative studies $n = 21$ DSP = death by suicide of a patient					
Study, country, quality assessment (QA) rating	Design	Sample, number included, setting	Measures	Results—impact	Results—factors related to impact and recovery
Castelli Dransart et al. (2015) Switzerland QA rating = ***	Retrospective, cross-sectional Most recent DSP within last 5 years Time point = during the month following DSP	- Psychiatrists, nurses, nursing auxiliaries, psychologists, social educators, and social workers 666 - Psychiatric hospitals, outpatient psychiatric services, social and medical services, residential homes for persons with mental health or addiction disorders, homes for the elderly and prisons - Private practice	IES-R	- One in 10 respondents (12%, $n = 31$) had a score above the clinical cut-off (≥ 25) Impact categorized into groups based on mean IES-R total score: 55.8%, low impact (≤ 11.1), 36.6%, medium impact ($= 16.0$) 7.7% high impact ($= 21.2$).	- Relationship to the patient - Exposure to suicide - Support and training Five profiles were identified: 3 low-impacted: - Anticipators with high support - Emotionally distant - No more contact at the time of death 1 medium impacted: - Emotional closeness to and responsibility for the patient 1 highly impacted: - Emotionally close to the patient and lacked support higher overall traumatic impact than others
Chemtob, Bauer, Hamada, Pelowski, and Muraoka (1989) (n.b. follow up to Chemtob et al., 1988 with aim of analysis of predictor variables and adding in AIM scale so included in this review) USA QA rating = ***	Retrospective, Time point = two time points (2 weeks following DSP, 2 weeks prior to survey)	- Psychiatrists, psychologists 431 - Private practice Psychiatric hospital Outpatients	IES, AIM (Affect Intensity Measure)	Significant acute impact on the professional and personal lives of a substantial number of therapists - No therapist characteristics correlated with impact - Therapists who spent more time conducting therapy reported greater impact	
Chemtob et al. (1988) USA QA rating = ***	Retrospective, Two time points (2 weeks following DSP, 2 wks prior to survey)	- Psychiatrists 259 - Private practice Psychiatric hospital Outpatients	IES, 19-item impact on professional and person life 7 pt Likert scale	57% experienced post-trauma symptoms comparable with those found in clinical groups. 13 of 19 items indicated moderate response. Psychiatrists reported - Feeling anger and guilt - Experiencing loss of self-esteem - Having intrusive thoughts about the suicide	Older psychiatrists experienced lower levels of - Guilt ($r = 0.24$, $df = 123$, $p < 0.01$) - Social withdrawal ($r = -0.19$, $df = 123$, $p < 0.05$) More years of practice associated with smaller reactions in: - Guilt ($r = 0.30$, $df = 117$, $p < 0.001$), - Social withdrawal ($r = 0.19$, $df = 117$, $p < 0.05$), - Loss of self-esteem ($r = -0.17$, $df = 118$, $p = 0.05$), Disruption of

TABLE 4 (Continued)

Quantitative studies $n = 21$ DSP = death by suicide of a patient				
Study, country, quality assessment (QA) rating	Design	Sample, number included, setting	Measures	Results—impact Results—factors related to impact and recovery
Chentob et al. (1988) USA QA rating = ****	Retrospective, Two time points (2 weeks following DSP, 2 weeks prior to survey)	- Psychologists 81 - Not stated	IES, 19 item impact on professional and person life 7 pt Likert scale	No relationship was found between years of practice and impact Age significantly related to - Increased conservatism in patient selection ($r = -.25$, $p < 0.03$). Results—impact - Increased focus on suicide cues - Increased attention to legal aspects - More conservative record keeping - Increased concern with death issues Results—factors related to impact and recovery - relationships with friends ($r = -0.18$, $df = 118$, $p < 0.05$).
Cryan et al. (1995) Ireland QA rating = ****	Retrospective, Two time points (2 weeks following DSP, 2 weeks prior to survey) 1st DSP	- Psychiatrists 146 - Not stated	IES, 5 item, 4 pt scale effect on practice	No sig difference between IES scores for in training and in practice No sig difference between those who attended a review or not (but small numbers 20, 64) Clinical levels of intrusion were reported by 36% and avoidance by 17.5%. 15% likelihood to admit patients to hospital 31% detailed record keeping 25% increased use of peer consultation 25% increased attention to the legal aspects of practice 58% increased focus on suicide

(Continues)

TABLE 4 (Continued)

Quantitative studies $n = 21$ DSP = death by suicide of a patient					
Study, country, quality assessment (QA) rating	Design	Sample, number included, setting	Measures	Results—impact	Results—factors related to impact and recovery
Finlayson and Graetz Simmonds (2016) Australia QA rating = ***	Retrospective, cross-sectional DSP with most impact Time point = at time of DSP	- Psychologists 56 - Private - Community Hospital, Academic, Other	16 items impact on practice (y/n/na) 12 items, 5 pt scale intensity of emotion 17, 5 pt helpfulness of coping strategies	- Shock, anger, guilt, distress, and sadness 41% for 1 week to 1 month 24% less than 1 week 15% between 1 and 3 months 7% between 3 and 6 months 13% more than 6 months.	- Heightened feelings of responsibility for death associated with greater emotional and professional impacts. - Unexpected suicide that contradicts the psychologists' assessment of risk associated with increased shock and confusion
Gulfi et al. (2010) Switzerland QA rating = ***	Retrospective, Most recent DSP First month after DSP and at time of survey.	- Psychiatrists, nurses, psychologists, social care professionals 275 - Hospitals, residential homes, socio-medical, prisons.	Long-term Emotional Impact Scale 9 items, 5 pt scales Professional Practices Impact Scale 9 item, y/n.	Impact reaction personal: - Low to moderate impact on their professional reactions - Increased focus on suicide cues more anxious about working with at-risk patients Impact on practice: - For at least three of the nine items, 67.9% of respondents reported changes during the month following patient suicide and 57.1% at the time of the survey. - Most commonly reported changes were 65.1% increased interest in suicide-related issues 61.1% greater tendency to hospitalize at-risk patients 57.5% greater tendency to consult colleagues 53.1% greater attention to legal matters	Impact related to - Location of the suicide, (hospital > home) - Gender (> female) - Feelings of responsibility - Emotional attachment to the patient But not to - Professionals' age - Years of professional experience - Number of suicides they experienced - Work setting - Type of profession - Time that had elapsed - Having seen or discovered the body - Previous suicide attempts by the patient
Jacobson et al. (2004) USA QA rating = ***	Retrospective, cross-sectional Most affecting DSP At time of the DSP.	- Mental health social workers 230 - Not stated	IES	Mental health social workers who experience fatal client suicidal behaviour feel some degree of stress as a result of the experience.	Female social workers experienced higher levels of intrusion than males. Males reported more avoidance reactions
Kleespies (1993) USA QA rating = ****	Retrospective, Most distressing DSP	- Predoctoral psychology interns 33 - Various	IES	Shock, disbelief, failure, sadness, self-blame, guilt, shame, and depression.	Interns or trainees as vulnerable, if not more vulnerable as are professional

TABLE 4 (Continued)

Quantitative studies $n = 21$ DSP = death by suicide of a patient				
Study, country, quality assessment (QA) rating	Design	Sample, number included, setting	Measures	Results—impact Results—factors related to impact and recovery
Landers et al. (2010) Ireland QA rating = ****	Two time points (2 weeks following DSP, 2 weeks prior to survey)			Suicidal behaviours or ideation. level clinicians. Impact (by IES) significantly reduces over time.
	Retrospective, cross-sectional Most Recent and Most distressing DSP. At time of DSP.	- Psychiatrists 143 - Urban and rural settings	Questionnaire	Factors that contributed to distress: 21% either an inpatient or had been recently seen and assessed 20% the effect on the patient's family, when the patient was a parent of young children. 17% being unpredicted 9% Negative reactions from the patient's family or health service executive staff and media publicity Most recent: Effect on personal life: reported by 87%: 84% preoccupation with the suicide 69% guilt or blame was reported by 27% disturbed sleep 21% low mood Effect on professional life reported by 88%: 87% heightened awareness of risk 52% confidence was affected 25% had altered their Work practices: 17% increased nursing observation 8% detention under the Mental Health Act 15% sense of failure was Most distressing: 97% acknowledged an effect on their personal life 97% preoccupation with the suicide 82% a sense of guilt or responsibility 42% disturbed sleep 36% low mood Effect on professional life: 52% greater awareness of risk 68% decreased confidence

(Continues)

TABLE 4 (Continued)

Quantitative studies $n = 21$ DSP = death by suicide of a patient					
Study, country, quality assessment (QA) rating	Design	Sample, number included, setting	Measures	Results—impact	Results—factors related to impact and recovery
McAdams and Foster (2000) USA QA rating = ***	Retrospective, The week following the DSP and the week prior to the survey.	• Counsellors • 89 • Various	Questionnaire IES	• 26% greater use of increased nursing observation • 11% reported increased use of the Mental Health Act	Impact decreased with increased: • Age • Years of practice • Time elapsed Impact not related to: • Gender • Work role • Work setting
Midence et al. (1996) Wales QA rating = ***	Retrospective, cross-sectional At time of DSP	• Nurses • 23 • Inpatient	Questionnaire	Effect: • 74% sad and helpless • 33% shocked • 30% guilty and angry • 11% frightened • 22% no effect	Impact greater if: • Having nursed the patient Preferred coping: • 85% talk to colleagues or partner • 80% team discussion • 75% discussion with managers • 70% support group • 67% knowledge important to cope
Pieters et al. (2003) Belgium QA rating = ****	Retrospective, cross-sectional Most distressing DSP Current impact	• Psychiatry trainees • 79 • Not stated	IES, Questionnaire (after Dewar)	• 16% adverse effect on personal life • 18% adverse effect on professional life • 52% changes in clinical practice IES: • 7% clinical significant for avoidance • 12% clinically significant for intrusions	Apart from it being the only suicide experienced, several trainees felt that the first suicide was the most painful one. • Confrontation with the body or involvement in resuscitating the patient was traumatic. • A long and intense involvement with the patient or his/her family • A good doctor–patient relationship • Particularly difficult therapeutic relationship. During time off • Patient's young age, high intelligence, and aspects of the family situation

TABLE 4 (Continued)

Quantitative studies <i>n</i> = 21 DSP = death by suicide of a patient				
Study, country, quality assessment (QA) rating	Design	Sample, number included, setting	Measures	Results—impact
Ruskin (2004) Canada QA rating = ***	Retrospective, cross-sectional First DSP At time of DSP.		Questionnaire 25 item based on DSM for ASD + PTSD IES Social Relationship Scale.	Results—factors related to impact and recovery • Confrontation with family members • Absence of support • Helpfulness of support: • 93% other trainees • 83% own partner or family • 80% personal friend • 56% discussion with patient's family • 52% discussion with supervisor On almost every measure, the distress and symptom levels were significantly greater for those whose first experience of patient suicide occurred during training. Distress and symptom levels: • Training > post-graduation. • Less social integration to professional network > more. • Previous personal experience of suicide in their family or friends did not affect their scores on the acute stress disorder, PTSD, and IES.
				69% considerable emotional impact, including shock Following their first patient suicide: • 71% felt helpless • 55% recurrent feelings of horror • 44% substantial feelings of anxiety • 33% recurrent recollections • 79% felt professionally devalued and that they would henceforth not be respected professionally. • 22% met clinical criteria • for acute stress disorder (3 or more criteria) • 20% met criteria for PTSD. IES: • 25% clinical impairment • 25% acute stress • 20% PTSD
Takahashi et al. (2011) Japan QA rating = ****	Retrospective, cross-sectional Any DSP	• Psychiatric nurses • 292 • Psychiatric hospitals	IES-R	15.8% reported availability of mental health care programmes for staff.
Trimble et al. (2000) Australia QA rating = ***	Retrospective, cross-sectional Any DSP At time of death	• Psychologists • 170	Questionnaire based on Chemtob	Helpful coping strategies: • 35% recognized not responsible • 29% talked with colleagues • 27% increased acceptance of suicide as possible • 22% talked with supervisor

(Continues)

TABLE 4 (Continued)

Quantitative studies n = 21 DSP = death by suicide of a patient					
Study, country, quality assessment (QA) rating	Design	Sample, number included, setting	Measures	Results—impact	Results—factors related to impact and recovery
Wurst et al. (2011) Germany QA rating = ***	Retrospective, Each DSP three time points: immediately after the suicide, 2 weeks later, and 6 months later	Therapists (psychiatry trainees, psychiatrists, psychologists, other) • 121	Questionnaire Y/N and VAS (visual analogue scale)	• 14% loss of self-esteem • 12% intrusive thoughts • 10% social withdrawal • 9% family relationships • 4% friends relationships • 2% colleagues relationships Professional impact: • 84% increased focus on suicide cues • 72% increased collegial consultation • 71% increased peer consultation • 61% increased attention to legal aspects • 42% more conservative record keeping • 33% increased concern with death issues • 25% increased tendency to hospitalize • 10% more conservative patient selection	• 11% talked with client's family • 9% tried to discover reasons • 9% talked with own family • 8% attended funeral • 5% psychological autopsy • 5% worked • 3% counselling • 2% talked with friends • 1% took a break • 1% read about suicide • 1% wrote a paper • 1% knew I did best I could • 1% ruminated
				Mean rating of distress 63/100. 29% suffer severe distress Mean scores on 100-mm analogue scale: • 67 sad • 32 guilty • 19 angry • 1 relieved • 81 shocked • 10 ashamed • 14 unbelieving • 5 offended • 24 insufficient	• Psychiatrists in training felt more shocked immediately after suicide than their colleagues with longer professional experience. • No correlation between the overall distress and the age of the therapist or with years of professional experience.
Wurst et al. (2013) Germany	Retrospective, Each DSP	Therapists: psychiatry trainees, psychiatrists, psychologists, other	Questionnaire	39.6% suffer severe distress	The global item "overall distress" can be used as an indicator to identify a

TABLE 4 (Continued)

Quantitative studies $n = 21$ DSP = death by suicide of a patient					
Study, country, quality assessment (QA) rating	Design	Sample, number included, setting	Measures	Results—impact	Results—factors related to impact and recovery
QA rating = ***	three time points: immediately after the suicide, 2 weeks, and 6 months later	164	Y/N and VAS (visual analogue scale)	Mean scores on 100-mm analogue scale: 66 sad 30 guilty 20 angry 1 relieved 80 shocked 10 ashamed 17 unbelieving 5 offended 25 insufficient	subgroup of therapists that might need individualized postvention. No significant difference in overall distress experienced was observed between professional groups and at different levels of care. Highly distressed therapists were - More likely to be female - Felt less supported by their colleagues and institution - Had a higher fear of lawsuit - Were more afraid of reactions of the relatives, would make changes in treatment retrospectively - Are more cautious now - Were not able to continue work as usual.
Wurst et al. (2010) Germany QA rating = ***	Retrospective, Each DSP three time points: immediately after the suicide, 2 weeks after, and 6 months later	- Therapists: psychiatry trainees, psychiatrists, psychologists 61 - Not stated	Questionnaire Y/N and VAS (visual analogue scale)	34.5% suffered severe distress Mean scores on 100-mm analogue scale: 67 sad 27 guilty 27 angry 2 relieved 69 shocked 4 ashamed 17 unbelieving 17 offended 28 insufficient	- Psychiatric therapists significantly more distressed than psychologists. - No difference with age or years of experience. - Significant correlation between age of patient at death and overall distress.
Yousaf et al. (2002) England QA rating = ****	Retrospective, Two time points, immediately after DSP and at time of study	- Psychiatry trainees 23 - Not stated	IES Questionnaire (Chemtob)	Initial reactions: 83% shock 70% self-blame/guilt 39% grief 30% fear of negligence 13% anger 70% difficult experience 52% useful learning 9% do not want to talk	None reported

(Continues)

TABLE 4 (Continued)

Quantitative studies $n = 21$ DSP = death by suicide of a patient					
Study, country, quality assessment (QA) rating	Design	Sample, number included, setting	Measures	Results—impact	Results—factors related to impact and recovery
Mixed method studies $n = 17$					
Study/country/quality assessment rating	Design	Sample: profession, number, setting	Measures	Results—impact	Results—predictor variables identified factors that exacerbated or modulated the effect
Alexander et al. (2000) Scotland QA rating = ***	Retrospective, cross-sectional Most distressing DSP	- Psychiatrists 167 - Various	Questionnaire designed for study	54 (33%) personally affected: - Low mood, poor sleep, irritability, difficulties at home, preoccupation 69 (42%) changes in professional practice: - A more structured approach to the management of risk - Increased use of mental health legislation. - More cautious and defensive approach and use of observation - Heightened awareness 24 (15%) - Considered taking early retirement	- Colleagues and family or friends were the best sources of help and team and - Critical incident reviews were also useful - Of 56 consultants who had been aware of publicity in the media 27 found the publicity extremely or moderately distressing. 33 of the 159 were extremely or moderately distressed at the prospect of litigation.
Courtenay and Stephens (2001) UK QA rating = **	Retrospective, cross-sectional Any DSP	- Psychiatry trainees 109 - teaching hospitals	Questionnaire designed for study	Impact categorized as - Minimal 14% (absent or minimal response) - Moderate 51% (shorter-term shock, guilt, and self-blame) - Severe 24% (prolonged extreme guilt, anger, and devastation) 68% reported impact on practice: 77% beneficial, (learning, developed risk assessment skills) 23% adverse, (afraid, felt isolated, disillusioned, vulnerable, loss of confidence, concerned for legal consequences)	Helpful: - All support appreciated - Ventilation of feelings, normalization, dissipation of feelings of guilt, blame, isolation. - Strong positive and supportive consultant supervision - Friends and peers Unhelpful: - Outside counsellors providing debriefing
Draper et al. (2014) Australia QA rating = **	Retrospective, cross-sectional	- Psychiatrists, psychologists, mental health nurses, GPs, and medical specialists 211 - Private - Public - Community	Semi-structured interviews	Personal life: - Shock, sadness, anxiety, feeling upset, grief, anger, and guilt, but these were mainly described as short-term effects. Professional life: - Increased vigilance and awareness of suicide risk - Being more proactive in assessment (e.g., asking about suicide ideation) and management (e.g., try harder to contact patient)	Factors most associated with an impact upon personal life: - Being female - The suicide occurring within a week of the last consultation - Receiving support or counselling after the death, particularly if it was not enough. Factors most associated with an impact upon professional life:

TABLE 4 (Continued)

Mixed method studies <i>n</i> = 17				
Study/country/ quality assessment rating	Design DSP = death by suicide of patient	Sample: profession, number, setting	Measures	Results—impact
				Results—predictor variables identified factors that exacerbated or modulated the effect
				• Increased caution and carefulness in aspects of management • Increased referral of patients to a psychiatrist • Further training to increase skills. Feelings of sadness at work, reduction of workload and loss of professional confidence impacting professional life.
Gaffney et al. (2009) Ireland QA rating = *	Retrospective, cross- sectional	• Nursing and all hospital staff • 83 • Regional, community, and acute hospital services	Questionnaire	• Men seemed more likely than women to report no effect on their functioning. • Loss of sleep, irritability, and lack of concentration reported equally by men and women. • Professional self-doubt was expressed more often by women.
Gibbons et al. (2019)	Retrospective	• Psychiatrists • 140 • General adult, Older adult, CAMHS, forensic, other.	42 question web-based survey	Emotional effect: • 71% sadness • 33% worry, anxiety, fear • 31% guilt, self-blame • 20% regret • 19% anger • 13% shame • 12% shock • 3% blaming others Clinical duties: • 98% detrimental effect on clinical duties What helped: • 48% (<i>n</i> = 43) Support from colleagues • 18% (<i>n</i> = 16) Engaging with families of deceased • 16% (<i>n</i> = 14) Nothing What did not help: • 19% (<i>n</i> = 15) Serious incident process • 11% (<i>n</i> = 9) Coroner's court • 5% (<i>n</i> = 4) Families angry or taking legal action Effect on clinical duties <i>F</i> > <i>M</i>
Grad et al. (1997) Slovenia QA rating = **	Retrospective, cross- sectional	• Psychiatrists and clinical psychologists • 62 • Inpatient and outpatient	15 y/n items, 3 open-ended questions	• Gender differences reported in 5 reactions: working as usual, shame, consolation needed, doubts in own professional knowledge, feeling guilt (women > men) • No difference based on seniority, vocation or work setting. Reasons for lower impact: • Not attending scene of suicide • Victim being an infrequent attendee • Shared care with other professionals • High impulsivity of suicide
Halligan and Corcoran (2001) Ireland QA rating = **	Retrospective, cross- sectional Last DSP At time of DSP	• GPs • 103 • GP practices	25-item questionnaire designed for study	• >80% reported no personal effects following patient suicide apart from feelings of guilt. • 35% reported feeling guilty • 24% disruption of relationship with the victim's family • 22% disturbed sleep • 54% increase in psychiatric referrals 50% more accurate record keeping • 40% increase in antidepressant prescribing

(Continues)

TABLE 4 (Continued)

Mixed method studies <i>n</i> = 17				
Study/country/ quality assessment rating	Design DSP = death by suicide of patient	Sample: profession, number, setting	Measures	Results—impact
Kelleher and Campbell (2011) Ireland QA rating = ****	Retrospective, cross- sectional	- Psychiatrists 40 - Public and private service	Questionnaire (from Alexander et al.)	36% increased use of colleague consultation 11 (27.5%) personal lives affected: - Personal sadness, low mood, and self-doubt. 13 (32.5%) professional lives affected: - Sense of helplessness, making decisions, reluctant to discharge patients. 23 (57.5%) future management: - More aware of risk assessment and the importance of meticulous documentation. - More anxious to establish links with a patient's family, to admit patients to the ward, and to prescribe antidepressant medications
				Results—predictor variables identified factors that exacerbated or modulated the effect Rated "very helpful" or "helpful": 34 (85%) family 29 (73%) peers 25 (62.5%) team support 26 (65%) team meetings 10 (47.5%), patient's family Also: - Other consultants whose patients had died by suicide helpful - Need to ensure no blame or scapegoats at team meetings 15 (37.5%) aware of publicity in the media. However, the majority of consultants did not find this distressing.
Kleespies et al. (1990) USA QA rating = ****	Retrospective, cross- sectional At time of DSP and currently	- Predoctoral interns in clinical psychology 8 - Veterans Administration Medical Center	IES Semi-structured interview	- Intrusion (<i>M</i> = 20.0) and avoidance (<i>M</i> = 13.4) scores nearly equivalent to those of a patient sample with bereavement. 6 (75%) described "shock" as their initial reaction. After shock, they mentioned (in order of frequency) guilt or shame, denial or disbelief, feelings of incompetence, anger, depression, a sense of being blamed, relief, and fear. - On a scale from 1 (<i>none</i>) to 5 (<i>very strong</i>), the average rating of the severity of the emotional impact was 4.25 (<i>SD</i> = 0.71). - Longer-term emotional effects. In order of frequency: - Feeling either more or less competent in evaluating suicidal patients - Considering larger numbers of patients as being at risk for suicide - Heightened anxiety when evaluating such patients. - Sadness about the patient - Acceptance of death/suicide - Feelings of helplessness, guilt - Repeated thoughts of the event - Feeling humbled Stress levels equivalent to that found in patient samples with bereavement and higher than that found with professional clinicians.
Linke et al. (2002) England QA rating = **	Retrospective, cross- sectional	- Community Mental Health team 38 - Community	Questionnaire (based on Alexander et al.)	The majority reported significant adverse effects on personal and professional lives: - Grief, sadness, preoccupation with work avoiding clients who abuse alcohol and drugs, increased anxiety at work, Most helpful sources of support: 30 (79%) team colleagues 21 (55%) family 21 (55%) friends

TABLE 4 (Continued)

Mixed method studies <i>n</i> = 17					
Study/country/ quality assessment rating	Design DSP = death by suicide of patient	Sample: profession, number, setting	Measures	Results—impact	Results—predictor variables identified factors that exacerbated or modulated the effect
	Most distressing DSP			irritability with employers, increased distance between self and clients and an increased desire to change jobs • A small number reported positive effects such as improved note keeping and an increased likelihood to seek support and peer supervision from colleagues. • 3 (7%) took time off work	• 18 (47%) space to discuss reasons why • 14 (37%) regular staff meeting • 12 (32%) special staff meeting • 12 (32%) other colleagues
Murphy et al. (2019)	Retrospective, cross- sectional Most distressing DSP	Mental health professionals 83	Questionnaire (based on Landers et al., 2010)	Personal: • 80% sadness • 75% shock • 69% surprise • 65% guilt Professional: • 99% heightened awareness • 67% decreased confidence • 54% fear of negative publicity	• Female and older MHPs reported greater levels of sadness. • No difference on impact based on gender of service user, site of suicide, professional group.
Pilkinton and Etkin (2003) Canada QA rating = **	Retrospective, cross- sectional	Psychiatric trainees 121		Greatest impact: • Emotional health • Assessment of patients • Medicolegal aspects • Admissions	• Impact unrelated to gender and postgraduate year Most commonly used supports: • Fellow residents • Friends • Supervisors
Rothes et al. (2013) Belgium QA rating = **	Retrospective, cross- sectional Most distressing DSP, at time of death	Psychiatrists 98	Patient Suicide Experience Questionnaire	Feelings: • 47% emotional suffering or distress • 26% impotence, powerlessness • 24% concerns, doubts, fear • 20% guilt, self-blame, regret • 20% failure or defeat • 20% Understanding, acceptance • 19% surprise, shock • 15% negative towards patient	Not related to years of practice or having had suicide training. Not related to gender apart from feelings of failure and defeat (females (31%), males (10%). Distress affected by: • Predictability and preventability expectations • Attitude of understanding and acceptance
Saini et al. (2016) England QA rating = ***	Retrospective, cross- sectional	GPs 198	Questionnaire and semi- structured interviews	• 66% affected (grief, guilt, self-scrutiny) • 7% not affected • 27% did not know	• Fewer years in practice perhaps more affected. • Supported from peers, colleagues, friends, or family valued.
Scocco, Toffol, Pilotto, and Pertile (2012)		Psychiatrists 11		Most frequent: • 90% sadness	• Only disbelief showed significant reduction with time.

(Continues)

TABLE 4 (Continued)

Mixed method studies <i>n</i> = 17					
Study/country/ quality assessment rating	Design DSP = death by suicide of patient	Sample: profession, number, setting	Measures	Results—impact	Results—predictor variables identified factors that exacerbated or modulated the effect
Italy QA rating = **	Retrospective, cross- sectional Time of DSP and when completing		Questionnaire designed for study	• 82% self-doubt • 73% disbelief • 64% guilt • 55% shock • 55% fear • 55% helplessness	
Sherba et al. (2019)	Retrospective, cross- sectional Most distressing DSP	Social workers and counsellors 121	Questionnaire and semi- structured interviews	22% aware of publicity with 92% of these reporting distress as a result 45% distress at possibility of litigation 15% considered early retirement 34% considered career change 10% took time off work	Helpful organizational response: • 78% team meeting review • 58% critical incident review Helpful individual support: • 90% Team colleagues • 79% Family/partner • 84% Clinical colleagues • 76% Friends • 83% Other MHPs
Thomyangkoon (2008) Thailand QA rating = ***	Retrospective, cross- sectional	Psychiatrists 94	Questionnaire	• >50% sadness, depression, hopelessness, guilt • 75% professional reactions. e.g., review of practice	• Working through with colleagues • Friends and family • Prayer

et al., 2006; Pilkinton & Etkin, 2003) and increased attentiveness/focus on suicide cues (Chemtob et al., 1988; Cryan et al., 1995; Finlayson & Graetz Simmonds, 2016; Gulfi et al., 2010; McAdams & Foster, 2000; Trimble, Jackson, & Harvey, 2000).

3.2.2 | More cautious management

There were also a number of examples where more cautious management of those at potential risk of suicide was reported following the loss of a client to suicide: increased caution (Draper et al., 2014; Finlayson & Graetz Simmonds, 2016; Grad, Zavasnik, & Groleger, 1997), excessive vigilance (Wang, Ding, Hu, Zhang, & Huang, 2016), more frequent risk assessments (Murphy et al., 2019), more referrals to psychiatry (Draper et al., 2014; Halligan & Corcoran, 2001), more antidepressant prescribing (Halligan & Corcoran, 2001; Kelleher & Campbell, 2011), and an increase in the number of patients assessed as being at risk for suicide (Kleespies et al., 1990). Increased use of hospital admission or use of mental health legislation to detain those thought to be at risk (Alexander et al., 2000; Cryan et al., 1995; Gulfi et al., 2010; Kelleher & Campbell, 2011; Landers et al., 2010; McAdams & Foster, 2000; Menninger, 1991; Pilkinton & Etkin, 2003; Trimble et al., 2000) was also frequently reported.

Some avoidance behaviours were highlighted, for instance, reluctance to accept suicidal patients (Hendin et al., 2000; Ting, Sanders, Jacobson, & Power, 2006), more conservative patient selection (Trimble et al., 2000), avoidance of the scene of the suicide (Wang et al., 2016), change of role (Ting et al., 2006), or considering taking early retirement/change of career (Alexander et al., 2000; Dewar et al., 2000; Gibbons et al., 2019; Kelleher & Campbell, 2011; Sherba, Linley, Coxe, & Gersper, 2019).

Nine studies detected more conservative record keeping (Chemtob et al., 1988; Finlayson & Graetz Simmonds, 2016; McAdams & Foster, 2000; Trimble et al., 2000) or more detailed record keeping, (Cryan et al., 1995; Halligan & Corcoran, 2001; Kelleher & Campbell, 2011; Linke, Wojciak, & Day, 2002; Menninger, 1991). Greater attention to legal aspects was also regularly reported upon (Chemtob et al., 1988; Courtenay & Stephens, 2001; Cryan et al., 1995; Gulfi et al., 2010; McAdams & Foster, 2000; Pilkinton & Etkin, 2003; Trimble et al., 2000).

3.2.3 | Acceptance

The experience of losing a patient to suicide resulted in some practitioners being more accepting of suicide as a possibility (Kleespies et al., 1990; Linke et al., 2002) or having an increased awareness of the limits of their professional ability to prevent suicide (Goldstein & Buongiorno, 1984; Gulfi et al., 2010; Ting et al., 2006). Other studies detected increased acceptance of suicide itself (Finlayson & Graetz Simmonds, 2016) or feelings of understanding or acceptance of suicide as an option (Roths, Scheerder, Van Audenhove, & Henriques, 2013; Ting et al., 2006).

3.2.4 | Suicide risk (for staff)

One study concluded that the experience of a patient's death may increase suicide risk for the practitioner, noting suicidal behaviours or ideation (Kleespies, 1993) as a consequence. Castelli Dransart et al. (2015) reported that 10% of the people in their study experienced their own suicidal ideation following the death by suicide of a patient, but no causal link was investigated.

3.2.5 | Uncertainty or issues around confidence

An impact on confidence (Courtenay & Stephens, 2001; Landers et al., 2010; Murphy et al., 2019) and professional self-doubt (Finlayson & Graetz Simmonds, 2016; Gaffney et al., 2009; Grad et al., 1997) were also reported. For example, some practitioners were anxious and expressed difficulty making decisions (Dewar et al., 2000; Kleespies et al., 1990). Others reported uncertainty (Halligan & Corcoran, 2001; Roths et al., 2013) and an increase in consultation with colleagues and peers (Cryan et al., 1995; Grad et al., 1997; Gulfi et al., 2010; Halligan & Corcoran, 2001; Linke et al., 2002; McAdams & Foster, 2000; Menninger, 1991; Trimble et al., 2000).

3.3 | Change over time

The quantitative and mixed method studies included in this review varied in the timeframes of reference when collecting the retrospective data on the impact of a patient's death by suicide. Most asked participants to report on their reaction immediately following hearing of the death, whereas some also collected information about the impact at the time the study was conducted. The qualitative studies included in this review did not specify a time point and explored reactions more broadly across time. Findings from Sanders, Jacobson, and Ting (2005) and Bowers et al. (2006), for example, indicated that reactions persisted over time to the extent that those deaths that were some time in the past were still having an influence on practice in the present. Similarly, another study indicated that among a wide range of impacts, only disbelief showed a significant reduction with time (Saini et al., 2016).

Of the 13 quantitative studies that collected retrospective information on the period immediately following the incident and again at the time of the study, all indicated a reduction in the severity of impact over time, although Yousaf et al. (2002) reported that this reduction was not significant (Table 2).

3.4 | Duration of impact

Ten studies collected data on the duration of the initial impact following the death by suicide of a patient although the manner of recording and reporting varied. For example, Kleespies et al. (1990) found that the duration of the initial emotional impact was reported

to have lasted a week or less for 37% ($n = 3$) of practitioners, between 1 and 4 weeks for 50% ($n = 4$) and between 1 and 4 months for 13% ($n = 1$) of the practitioners. However, longer-term effects related to professional practice were reported as still being present at the time of the study in 88% ($n = 7$) of practitioners. In Alexander et al. (2000) paper, 8% ($n = 4$) of psychiatrists stated that the effects had lasted up to a week, 31% ($n = 15$) up to 1 month, 31% ($n = 15$) up to 3 months, and 29% ($n = 14$) over 3 months. Gibbons et al. (2019) found that 39% ($n = 45$) reported a detrimental effect on professional duties, which lasted between 1 week and 6 months; 21% ($n = 18$) felt that the effects lasted between 6 months and 2 years; and 13% ($n = 11$) reported having ongoing effects. Murphy et al. (2019) indicated that although the emotional impacts predominately lasted less than 6 months, for nearly 10% ($n = 8$), the impact lasted more than 12 months. Finlayson and Graetz Simmonds (2016) reported that for nearly a quarter of their sample, 24% ($n = 13$), the feelings lasted less than 1 week. However, for 41% ($n = 22$), feelings lasted from between 1 week and 1 month, for 14.8% ($n = 8$) between 1 and 3 months, for 7% ($n = 4$) between 3 and 6 months, and 13% ($n = 7$) experienced the feelings for more than 6 months (see Table 3).

3.5 | Variables associated with the extent of the impact on practitioners

The studies included in this review examined a wide range of factors that may account for variability in impact on practitioners. The most frequently identified factors are summarized under five broad themes: practitioner characteristics; the therapeutic relationship; patient characteristics; the response from others, and fear of litigation and publicity.

3.5.1 | Practitioner characteristics

Seven studies found that impact was not related to the age of the practitioner (Chemtob et al., 1989; Davidsen, 2011; Hendin et al., 2000; Gulfi et al., 2010; Rothes et al., 2013; Wurst et al., 2010, 2011), and whereas four studies found that impact was independent of years of experience (Chemtob et al., 1988; Gulfi et al., 2010; Hendin et al., 2000; Pilkinton & Etkin, 2003), five studies concluded that greater number of years in practice had a protective influence on impact (Chemtob et al., 1988; Draper et al., 2014; Hendin et al., 2004; McAdams & Foster, 2000; Saini et al., 2016).

Findings related to the relationship between gender and impact were also mixed. Impact was found to be unrelated to gender by Castelli Dransart et al. (2014), Chemtob et al. (1989), Davidsen (2011), McAdams and Foster (2000), and Pilkinton and Etkin (2003) and yet was found to be greater among females in the studies by Darden and Rutter (2011), Draper et al. (2014), Gulfi et al. (2010), and Wurst et al. (2013).

Although the studies covered a wide range of professions, as the majority focussed on single professional groups, it was difficult to make direct comparisons. Castelli Dransart et al. (2014), Gulfi et al. (2010), Grad et al. (1997), and McAdams and Foster (2000), however, reported that impact was unrelated to work role.

The practitioner's perception that they were in some general way accountable or responsible for the death, (Castelli Dransart et al., 2014; Dewar et al., 2000; Finlayson & Graetz Simmonds, 2016; Gulfi et al., 2010; Robertson et al., 2010) or that a decision they had made had contributed to the death (Hendin et al., 2004) emerged as a factor that was associated with a negative impact. This was also the case with the perception that the death could have been prevented (Bowers et al., 2006; Landers et al., 2010; Rothes et al., 2013) or was unexpected (Davidsen, 2011, Finlayson & Graetz Simmonds, 2016). Two studies reported that for some practitioners, reduced impact was associated with holding the belief that suicide was the client's choice and outside of the practitioner's control (Darden & Rutter, 2011; Draper et al., 2014; Rothes et al., 2013).

Linke et al. (2002) found that the majority of their sample had felt inadequately prepared for dealing with a suicide by their initial professional training, although they all felt trained in risk assessment. However, in another study, previous training in suicide risk assessment was associated with practitioners reporting a reduced sense of burn-out (Murphy et al., 2019). Castelli Dransart et al. (2015) categorized the group within their respondents who reported low impact as "anticipators with support," that is, people who had been aware of the risk of losing a patient to suicide and were also well supported following the actual loss. Cotton et al. (1983) reported that professionals whose previous experience had been more likely to expose them to the death of patients, for example, those with previous medical experience, suffered less than other disciplines such as mental health workers.

3.5.2 | Therapeutic relationship

Elements of the therapeutic relationship were cited in various studies as being related to differential reactions after a death. Litman (1965) noted in general terms that the impact was dependent on specifics of the relationship but without indicating what these specifics were or the direction of the association. The relationship to the patient (Castelli Dransart et al., 2015), the length of time the patient was known to staff (Bowers et al., 2006), the strength of relationship (Bowers et al., 2006), emotional closeness or attachment, (Castelli Dransart et al., 2014; Gulfi et al., 2010), and either knowing the patient well or disliking the patient (Dewar et al., 2000) were all reported as increasing the negative impact of the death. Likewise, difficulty with emotional contact with the patient (Davidsen, 2011), a long and intense involvement with the patient or their family (Murphy et al., 2019; Pieters et al., 2003), or a particularly difficult therapeutic relationship (Pieters et al., 2003) were all linked to an increase in negative impact.

TABLE 5 Quality assessment

Study	Screening Q1	Screening Q2	Qualitative				Quantitative				Mixed			MMR* rating * to ****
			1.1	1.2	1.3	1.4	2.1	2.2	2.3	2.4	3.1	3.2	3.3	
1 Alexander et al. (2000)	1	1	1	1	0	0	1	1	1	1	1	1	0	**
2 Bowers et al. (2006)	1	1	1	1	0	0								**
3 Castelli Dransart et al. (2014)	1	1					1	1	1	0				***
4 Castelli Dransart et al. (2015)	1	1					1	1	1	0				***
5 Chemtob et al. (1989)	1	1					1	1	1	0				***
6 Chemtob et al. (1988)	1	1					1	1	1	0				***
7 Chemtob et al. (1988)	1	1					1	1	1	1				****
8 Cotton et al. (1983)	1	1	1	1	0	0								**
9 Courtenay and Stephens (2001)	1	1	1	1	0	0	1	1	0	0	1	1	0	**
10 Cryan et al. (1995)	1	1					1	1	1	1				****
11 Darden and Rutter (2011)	1	1	1	1	1	0								***
12 Davidsen (2011)	1	1	1	1	1	0								***
13 Dewar et al. (2000)	1	1	1	1	0	0								**
14 Draper et al. (2014)	1	1	1	1	0	0	1	1	0	0	1	0	0	**
15 Finlayson and Graetz Simmonds (2016)	1	1					1	1	1	0				***
16 Gaffney et al. (2009)	1	1	1	1	0	0	1	0	0	0	1	1	0	*
17 Gibbons et al. (2019)	1	1	1	1	0	0	1	1	0	0	1	1	0	**
18 Goldstein and Buongiorno (1984)	1	1	1	1	0	0								**
19 Grad et al. (1997)	1	1	1	1	0	0	1	1	1	1	1	0	0	**
20 Gulfi et al. (2010)	1	1					1	1	1	0				***
21 Halligan and Corcoran (2001)	1	1	1	1	0	0	1	1	1	1	1	1	0	**
22 Hendin et al. (2004)	1	1	1	1	0	0								**
23 Hendin et al. (2000)	1	1	1	1	0	0								**
24 Jacobson et al. (2004)	1	1					1	1	1	0				***
25 Kayton and Freed (1967)	1	1	1	1	1	0	1	1	1	0	1	1	0	***
26 Kelleher and Campbell (2011)	1	1					1	1	1	1				****
27 Kleespies (1993)	1	1					1	1	1	1				****
28 Kleespies et al. (1990)	1	1					1	1	1	1				****
29 Kolodny et al. (1979)	1	1	1	1	0	0								**
30 Landers et al. (2010)	1	1					1	1	1	1				****
31 Linke et al. (2002)	1	1	1	1	0	0	1	1	1	0	1	1	0	**

(Continues)

TABLE 5 (Continued)

Study	Screening Q1	Screening Q2	Qualitative					Quantitative					Mixed			MMR * rating to ****
			1.1	1.2	1.3	1.4		2.1	2.2	2.3	2.4		3.1	3.2	3.3	
32 Litman (1965)	1	1	1	1	0	0										**
33 McAdams and Foster (2000)	1	1						1	1	1	0					***
34 Menninger (1991)	1	1	1	1	0	0										**
35 Midence et al. (1996)	1	1						1	1	1	0					***
36 Murphy et al. (2019)	1	1	1	1	0	0		1	1	0	0		1	1	0	**
37 Pieters et al. (2003)	1	1						1	1	1	1					****
38 Pilkinton and Etkin (2003)	1	1	1	1	0	0		1	1	1	0		1	0	0	**
39 Robertson et al. (2010)	1	1	1	1	1	1										****
40 Rothes et al. (2013)	1	1	1	1	0	0		1	1	1	0		1	1	0	**
41 Ruskin (2004)	1	1						1	1	1	0					***
42 Saini et al. (2016)	1	1	1	1	1	0		1	1	1	0		1	1	0	***
43 Sanders, Jacobson, and Ting (2005)	1	1	1	1	0	0										**
44 Scocco et al. (2012)	1	1	1	1	0	0		1	0	1	0		1	0	0	**
45 Sherba et al. (2019)	1	1	1	1	0	0		1	1	1	0		1	1	0	**
46 Takahashi et al. (2011)	1	1						1	1	1	1					****
47 Thomyangkoon (2008)	1	1	1	1	1	0		1	1	1	0		1	1	0	***
48 Tillman (2006)	1	1	1	1	0	0										**
49 Trimble et al. (2000)	1	1						1	1	1	0					***
50 Wang et al. (2016)	1	1	1	1	0	0										**
51 Wurst et al. (2011)	1	1						1	1	1	0					***
52 Wurst et al. (2013)								1	1	1	0					***
53 Wurst et al. (2010)								1	1	1	0					***
54 Yousaf et al. (2002)	1	1						1	1	1	1					****

3.5.3 | Patient characteristics

A small number of studies noted a link between characteristics of the person who died and the impact on the practitioner, finding that the impact was greater when the patients were younger (Dewar et al., 2000; Murphy et al., 2019; Pieters et al., 2003; Wurst et al., 2010) and when patients had young children (Dewar et al., 2000; Landers et al., 2010; Murphy et al., 2019). Chemtob et al. (1989), found that working with people with problems with substance abuse was associated with lower impact, and whilst recommending that this warranted further research, they questioned whether this may relate to practitioners being more prepared for the suicide with the knowledge that there was ready access to lethal means and to them believing that they had less influence over their patients.

3.5.4 | Response of others

The fear of blame by relatives or fear of their reactions (Dewar et al., 2000; Landers et al., 2010; Wurst et al., 2011, 2013) or the fear of blame more broadly (Alexander et al., 2000; Bowers et al., 2006; Dewar et al., 2000; Hendin et al., 2000; Kleespies et al., 1990; Landers et al., 2010) was associated with higher levels of distress. Furthermore, Pieters et al. (2003) and Gibbons et al. (2019) found that actual confrontation with family members contributed to increased adverse impact. Castelli et al. (2004), however, described that overall, their sample experienced little blame (11% reporting blame from relatives), and they did not report any association with level of impact. Less specifically, managerial responses, (Bowers et al., 2006), negative reactions from health service executive staff (Landers et al., 2010), and negative reaction from the institution in which the practitioners worked (Gibbons et al., 2019; Hendin et al., 2004) were cited as factors that increased the negative impact.

3.5.5 | Fear of litigation and publicity

Alexander et al. (2000) found that 13% ($n = 21$) of practitioners were moderately distressed, and a further 7% ($n = 12$) were extremely distressed at the prospect of litigation, and fear of litigation was similarly associated to increased impact in studies by Hendin et al. (2004), Murphy et al. (2019), Tillman (2006), Wurst et al. (2011), and Wurst et al. (2013).

Five studies noted that publicity in the media contributed to the impact that practitioners experienced (Alexander et al., 2000; Dewar et al., 2000; Landers et al., 2010; Midence et al., 1996; Sherba et al., 2019), with all being in agreement that awareness of publicity heightened the distress experienced.

3.6 | Support that helps minimize negative sequelae

The vast majority of the studies that reported on the support accessed following the death of a patient cited informal support

through colleagues, peers, family, or friends as having been the most helpful (e.g. Alexander et al., 2000; Cotton et al., 1983). In terms of more formal provision, supervision was also reported as offering valued support (Courtenay & Stephens, 2001; Kleespies et al., 1990; Ruskin, 2004; Trimble et al., 2000), but evidence for other formal procedures was more mixed. Team meetings were found helpful by some (Alexander et al., 2000; Courtenay & Stephens, 2001; Cotton et al., 1983; Pieters et al., 2003) but either unhelpful by others (Hendin et al., 2000), or the need for careful management of meetings was noted (Kelleher & Campbell, 2011; Linke et al., 2002). Some studies found that critical incident debriefs or case reviews were useful (Alexander et al., 2000; Kleespies, 1993; Kleespies et al., 1990; Landers et al., 2010; Pieters et al., 2003; Rothes et al., 2013; Sherba et al., 2019), but other studies described them as unhelpful (Bowers et al., 2006; Hendin et al., 2000), specifically if experienced as insensitive or persecutory (Gibbons et al., 2019). One study reported that the use of external reviewers to guide debriefing was unhelpful (Courtenay & Stephens, 2001).

More generally, Bowers et al. (2006) found that any support was received positively, and Castelli Dransart et al. (2014) found that receiving insufficient support significantly increased the overall impact in terms of emotional impact and trauma symptoms.

4 | DISCUSSION

This review had three main aims, to synthesize the evidence on (1) the impact of a patient's suicide on both personal and professional practice responses; (2) the support received by health professionals; and (3) which factors helped to minimize negative sequelae. Our key findings were that the death of a patient by suicide can have a considerable, and lasting, emotional impact (most often manifest as shock and/or guilt) on mental health professionals. This impact is comparable with that of other traumatic life events. There were notable impacts on their professional practice including self-doubt and being more cautious and defensive in the management of suicide risk. Informal support was highly valued, however more needs to be done to help to prepare and support practitioners for this rare but likely experience.

4.1 | Impact on personal and professional practice

There is extensive evidence in the literature that the loss of a patient through suicide has considerable impact on many practitioners. The reported incidence and severity of this impact varied considerably across the studies included in this systematic review. Those studies that reported on change in reactions over time all concluded that there was a reduction in impact over time. This would be expected given what is known about the processes of grief and of recovery following trauma (Kleber, 2019; Zisook & Shear, 2009).

Many studies used a PTSD outcome measure, the IES/IES-R, to assess the emotional impact of losing a patient to suicide. This seems

reasonable given that such an experience would meet the event criteria of diagnostic guidelines for PTSD (American Psychiatric Association, 2013). A previous review of these studies (Séguin et al., 2014), concluded that, on the basis of the IES/IES-R scores, overall emotional impact on practitioners was low. However, in the current systematic review, for the studies utilizing the IES or IES-R, between 12% and 53% of their samples recorded clinically significant scores in the time following the suicide (see Table 4). To place these findings in context, although the majority (90%) of the general population will experience a traumatic event in their lifetimes, a relatively small proportion (8%) will develop PTSD (Kilpatrick et al., 2013). In light of this, it is fair to conclude that the emotional impact on practitioners of a loss of a patient to suicide is significant and comparable with the impact of other traumatic life events. Current guidelines for the prevention of PTSD (National Institute for Health and Care Excellence [NICE], 2018) recommend that individuals presenting with sub-threshold symptoms (i.e., on a PTSD measure such as the IES-R) in the month following a traumatic event should be actively monitored, and those with above threshold symptoms should be offered trauma focussed treatment within 1 month of the event. Psychological focussed debriefing is not recommended.

Although many of the studies included in this review reported the impact on their professional practice, often the studies did not differentiate between those changes that were beneficial (e.g., improved patient care and better risk management) or detrimental (e.g., defensive practice and avoidance) to patient safety and well-being. Some studies, however, did report positive changes as a consequence of the adversity of the experience, described in Cotton et al. (1983) as “new growth on emotional scars.” Some studies concluded that to achieve such growth requires a facilitative working environment that recognizes the importance of learning through experience (Courtenay & Stephens, 2001; Gulfi et al., 2010; Kolodny et al., 1979).

4.2 | Support received by health professionals

All studies concluded that further action is needed to prepare and to support practitioners, and a number of studies recommended that efforts to prepare staff for the possibility of losing a patient to suicide could be beneficial (Bowers et al., 2006; Chemtob et al., 1989; Gibbons et al., 2019; Hendin et al., 2000; Jacobson et al., 2004; Sherba et al., 2019; Wang et al., 2016; Wurst et al., 2011). It is conceivable that suicide prevention training itself may not fulfil the function of preparing practitioners for the death of a patient unless specific information is included about the probability of experiencing the suicide of a patient at some stage in their career: the likely impact, the procedures to be followed, and the support available. Increasing awareness of the incidence of suicide could improve risk management whilst also serving a protective function for the practitioner in the event of a death.

The majority of studies indicated that informal supports were most helpful, although it is not clear if this is partly due to an

inadequacy of more formal supports or a preference for a more individualized approach. When formal support was reported, individual supervision appeared to be the most valued support whilst the responses to group procedures such as team meetings and debriefs were more mixed. However, generally not enough detail was provided to make meaningful comparisons between different group supports. Although the current evidence points most clearly towards a preference for individual support, either informally or through supervision, this should be treated with caution. Group procedures have the benefit of facilitating the sharing of learning and of heightening awareness of risk, therefore helping practitioners to be better prepared in the event of losing a patient through suicide. If the emphasis is on individual support, then other ways of achieving these functions would need to be found.

4.3 | Factors that helped to minimize negative sequelae

There was no strong evidence that the demographic characteristics of practitioners (e.g., gender, age, profession, and length of experience) were associated with the impact of a suicide. It is possible that further research could be warranted so that certain groups of practitioners could be targeted by interventions to help reduce impact; however, it is more likely that such measures would best be directed to the whole workforce. The findings from this review support Castelli Dransart et al.'s (2014) conclusion that we need more research focussed on the relationship with the patient, rather than limiting our attention to the socio-demographic characteristics of the professionals and their patients. This association between the therapeutic relationship and impact is further supported by Cerel et al.'s (2016, 2017) research indicating that perceived closeness to the deceased increased the chance of depression, anxiety, and PTSD. Consequently, one's perceived closeness to the deceased is likely to be an important factor in identifying those at greatest risk of adverse impact.

The finding that more negative impacts were associated with practitioners' perceptions that they were accountable or responsible (in some way) for the patient's death could be linked to the common personal reactions of guilt and fear of blame and the experience of reduced professional confidence and uncertainty. It would be beneficial to gain a better understanding of this relationship. For instance, is guilt exacerbated by reduced confidence in one's ability to assess and manage risk, or inversely, is greater confidence in one's ability protective against ruminations such as “did I miss something?” or “I should have known?” Further research would also be beneficial to investigate the influence of blame (self-blame, fear of blame, and actual experience of blame) and to investigate if blame is moderated by, for example, cultural factors, institutional factors, the frequency of suicide within an institution, attitudes towards suicide (e.g., if there is a more prevalent cultural belief that suicide is a valid option), and confidence in one's ability to assess and manage risk.

Castelli Dransart et al. (2014) suggested that a number of factors might have accounted for what they described as the relatively low impact of the death of a patient in their study. These included whether (i) the majority of their sample had experienced several patient suicides (with potential habituation effects), (ii) practitioners worked in team settings, (iii) they reported receiving sufficient support, and (iv) they worked in a socio-cultural setting in which they felt little sense of blame or fear of litigation.

4.4 | Professional implications

Feeling unprepared for the loss, also potentially related to the sense of shock, involved several different aspects: first, a general lack of awareness of the likelihood that the practitioner's profession may expose them to such an event; second and more specifically that the death by suicide of an individual patient in their care was unexpected, and finally uncertainty of the implications of the loss in terms of personal impact and service procedural requirements. Whilst awareness would be best raised during initial training, given the relative rarity of the event, sharing of learning following a death could help to maintain the level of awareness throughout a practitioner's career.

The evidence regarding the acceptability and benefits of formal support was mixed; however, several recurring themes were identified that could provide useful targets for additional focus when supporting health professionals who have lost a patient to suicide. Moderating the impact of guilt, a ubiquitous response across the studies included within this review, and improving understanding of how services can create an environment that reduces the fear of blame and promotes an atmosphere of learning from adverse events are both areas that could be improved.

Given the relative homogeneity of the responses reported in the studies, it is likely that the synthesis of these findings would generalize to a broader range of mental health practitioners than those already covered. However, further research is required to confirm this.

4.5 | Strengths and limitations

The findings of the current review must be interpreted within the context of its limitations. Only English language publications were included, and unpublished papers or research from the "grey literature" were excluded. Inclusion and exclusion criteria were deliberately set to cover a broad range of studies, but comparison of findings was challenging given the varied methodologies employed. The reference lists of all included studies were checked, but no additional studies meeting the criteria for this review were found. All included studies were retrospective cohort studies, based on self-report measures. Methodologies of the studies varied: Some required participants to report on their reaction to their first, last, or most distressing experience, whereas for other studies, this was not specified at all. The time since the participants experienced the death of a patient also

varied greatly. Furthermore, studies ranged in the time point at which participants were asked to report on their reactions, that is, whether to retrospectively describe reactions immediately following the event and/or at the time of the study. Understandably, reports of impact were likely to be subject to recall bias (Spencer, Brassey, & Mahtani, 2017).

Like most research of this kind, all studies had possible self-selection bias, because participation in the studies was voluntary. Practitioners with more or less severe stress reactions might have chosen not to participate in such studies because they anticipated taking part to be distressing, or they may have thought that they had little to contribute. In terms of sampling frames, none of the studies reported information on those practitioners who had experienced a patient suicide but who did not take part in the study. As a result, it is not possible to comment on the representativeness of participants included within this systematic review. Nonetheless, the current review has a many strengths. The review was systematic and included both quantitative and qualitative studies. We also used a validated quality assessment tool (Pace et al., 2010), which allowed the quality of both the qualitative and quantitative studies to be appraised. Additionally, the protocol for our systematic review was pre-registered on Prospero to facilitate transparency. A further strength of our review is that whereas other reviews, for example, Foley and Kelly (2007) and Leaune et al. (2019), focused primarily on psychiatrists or psychologists, we included studies with a range of mental health professionals, broadening the potential utility of our findings.

5 | CONCLUSION

The experience of losing a patient through suicide can have considerable impact on mental health professionals, both in terms of their personal reactions, which are typically characterized by feelings of guilt and shock and subsequent changes to professional practice that may be potentially positive or negative. Demographic characteristics of practitioners did not appear to be associated with impact. The most significant risk factors for negative impact were a sense of fear or blame and feelings of self-blame. In a small but important proportion of practitioners, the personal impact met the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic criteria for PTSD and could be long lasting. This impact, however, may be moderated by tailored training (awareness of the occupational risk of loss through suicide), characteristics of the employing organization (i.e., a non-blame seeking approach, a culture of learning through adverse events) and by the level and nature of support available (tailored to the individual, opportunities for informal support).

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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