what remains:

The Aftermath of Patient Suicide

by Margaret Clausen, PsyD

Psychologist Margaret Clausen shares poignantly about the loss of her client to suicide, the steps she took to heal her grief, and the isolation and shame that many clinicians needlessly suffer in the wake of client suicide.

Note: Clinical material in this article is taken across various venues and years of treatments. Identities are disguised to protect confidentiality. References used in writing this article, as well as resources for clinicians, can be found at the bottom of this page.

SILENT MOURNERS

The memory is quite clear: several years ago, early one morning checking my voicemail, two messages in I came upon a message from my patient, Jill. The message was date-stamped the evening before. She said she would miss today's session due to a need to find new housing; she thanked me for our work thus far (as she frequently did, sometimes out of social politeness or her fears of abandonment, other times out of sincere heartfelt gratitude, something we frequently explored). This time her gratitude sounded heartfelt in tone. Her message also left me perplexed, as we had not talked of housing, and I saved it. Another message, left moments before I checked my voicemail, was from Jill's psychiatrist, Brian, asking me to give him a call when I got in the office. Brian and I spoke frequently of Jill, her ongoing medical decline at a relatively young age, and her persistent depression and posttraumatic stress. We followed her carefully, exchanged perspectives, and possessed mutual respect for one another's clinical skills.

I called him immediately. "Are you in your office?" he asked, his voice ominous.

"Yes," I replied, feeling my stomach tightening.

"Are you aware of the events related to Jill?"

"No," my heart now pounded from my chest into my throat.

"Jill killed herself by handgun . . . "

I do not remember what he said next, just that he was still talking. I gasped, crying, while simultaneously attempting to hide my upset.

"Margaret, there was nothing, nothing you could have done to prevent this," Brian continued, his voice clear and emphatic, speaking from his decades of experience, his knowledge of Jill, and his knowledge of our work together."

Margaret, there was nothing, nothing you could have done to prevent this."

We talked for some time, and I could feel myself wanting to hang up the phone and be alone, but Brian insistently kept me on the line, wisely, for forty-five minutes.

That was enough time for both of us to begin feeling the immensity of Jill's death, and to begin the longer process of inquiry and reflection into her suicide and its after-effects. It was a process that would continue for a few months between us, and for more than a year for me.

Clinicians who lose patients to suicide are sometimes referred to as "silent mourners." Some describe this kind of grief as disenfranchised. For me, I think of this grief as a kind of lived experience that catapults you into another environment which is foreign and therefore scary; a kind of grief that is uniquely solitary to bear and therefore devoid of larger community to bear it with you; a kind of grief that is intensely intertwined with shame; and a traumatic grief that possesses all the hallmarks of interpersonal trauma, whose impacts often continue reverberating long after the initial shattering experience has occurred. All of these facets and more underscore the particular experience of clinicians grieving suicide loss.

The differences are rather key in understanding how to be with our selves and also how to respond to colleagues who experience this kind of loss personally or professionally. My hope in writing this article is to buoy understanding, widen the circles of support for clinicians who have experienced suicide loss, and to offer some guideposts along the way of grieving. This topic and these aims are one of my life-long passions in my career. I have had the unfortunate experience of surviving two siblings' suicides, the sudden death of a third sibling that suggested passive suicide, and the deaths of both parents from organic causes that were informed by these traumatic losses. My terrain of grief and traumatic loss was quite familiar to me by the time I met Jill, having traversed its intricacies in feeling, thought, and body using psychotherapy, meditation, long-distance hiking, body work, and writing, for many years. My experience served me well in working with Jill while she was alive, as well as holding what remained after her death. I was and am, after all, a wounded healer, meeting her suffering in life and in death.

OUR PRIVILEGED INTIMACY, OUR PRIVATE MOURNING

By its very nature, psychotherapy is a privileged space. The therapeutic relationship is characterized by a unique emotional intimacy with each patient. As therapists we are honored by our patients' presence, the trust that is hard won, and the growing capacities through the course of psychotherapy we witness. We accompany and guide, inquire and curiously explore in a most particular way with each patient. With each patient, a slightly different relationship forms. We are slightly different therapists with each patient we encounter.

The extent to which we as therapists may deny the singular relationship with and presence of our patients in our lives contributes to the complications of grieving their departure in any form —from treatment termination to physical death. Approximately fifty per cent of psychiatrists and thirty percent of psychologists experience patient suicide.In her article, "Necessary and unnecessary losses: the analyst's mourning" (2000) Sandra Buechler reflects that, because our work asks us to cultivate objectivity, and objectivity is often (over) emphasized in the work (and in training), it becomes a norm without critical thinking or reflection. This clinical cultural norm may also encourage a sense that we can (or should, perhaps) simply "move-on" when a patient departs.

A therapist's stance of distance may additionally complicate the grieving picture, especially in the case of loss by suicide. That stance may feed defenses of denial, encourage guilt, and amplify feelings of shame.

The great Jungian, James Hillman, stated that the suicide of patients is a "wrenching agony of therapeutic practice." It is also a reality of practice that we fantasize will not touch us, despite the statistics. Depending upon the research reviewed, approximately fifty per cent of psychiatrists and thirty per cent of psychologists experience patient suicide. The statistics are incomplete and varied, often reflective of response rates to inquiry.

In our work, moving away from our feelings can feed psychotherapeutic cynicism, burnout, and depression. It can also lead to problematic clinical decision-making and ethical lapses in judgment. Our willingness to open, receive, and make contact with our patients within the therapeutic work is an offering toward healing—if we choose to risk it. From a relational perspective, certainly, our willingness in these ways is a vital vehicle in the process of transformation found within the therapeutic endeavor. Upon the suicide of a patient, it is tempting to shut down in response to profound relational loss and loss of the therapeutic framework upon which we rely.

BEING WITH GROUNDLESSNESS

"The dead leave us starving with mouths full of love," the poet Anne Michaels writes. Jill left me starving and full. Her message to me left me full. The timing of her departure left me starving, questioning. She left me loving her, yes, but also left me with a myriad of other feelings including meaninglessness, impotence, frustration, and raw sadness. I was, because of my life experiences, immediately aware that I needed to take seriously the particular kind of loss I was experiencing—the loss of an incomplete, torn-apart relationship, the loss of who Jill was to me, a loss of clinical voice, and the loss of who I was as a psychotherapist with Jill.

There is ineffability—an unspoken quality— in this kind of traumatic loss. Psychoanalyst Ghislaine Boulanger distinguishes between child and adult onset trauma, noting how core self experience and self-in-relation experiences are undermined. Adult onset trauma shatters illusions of omnipotent control, ever-shaking the normative expectation of personal agency and healthful denial of omnipresent mortality. The suicide of a patient shatters illusions of therapist omnipotence, shaking expectations of potential positive influence upon patients, and calls into question core identity as well as identity-in-relationship to other patients and colleagues.

Western psychology rests within a worldview of personal agency. It is a worldview imbued with Euro-American, individualistic, educated, and moneyed values—all of which are crushed in the face of adult onset trauma. It is the very nature of this kind of traumatic loss that it rocks our assumptive world as therapists: questioning whether our endeavors are life giving, whether our efforts possess meaning and influence; and whether our chosen profession is worthwhile.

There was Todd, a patient-therapist in my practice who came to me after his long-term patient completed suicide. Todd had fifteen years of clinical experience and before that eight as a university professor. He was well versed in suicide prevention and intervention. After his patient's death, he refused to ever work with a patient again who even mentioned suicidal feeling states; he would refer them.

After his patient's death, he refused to ever work with a patient again who even mentioned suicidal feeling states; he would refer them. His stance is maintained to this day, six years later. His way of coping is not unusual among therapist-patients in my practice or across the profession. Whenever I present a paper on this topic, I hear stories of mental health professionals at all levels responding similarly. So understandably haunted, they desire to avoid any chance of experiencing a suicide loss again; some believe they can no longer objectively assess risk; and others feel traumatized, unable to clinically engage with a patient experiencing suicidal ideation or self-harm.

There are some other common coping approaches among therapist-survivors. They include all the ways we may become vigilant in our practice: taking numerous, even if repetitive, trainings on ethics and suicide prevention; developing a rigid stance in responding to patients expressing suicidal thoughts or intent; and intervening in overly-conservative ways that communicate anxiety to the patient rather than clinical engagement. In her essay for the collection, Further, we do not, to my knowledge, have statistics on the numbers of mental health professionals who have experienced suicide loss within their personal circles of close family-friend relations, but it is fair to consider the percentages may be slightly higher if these were included.

For clinicians, suicide challenges every value we place in the therapeutic endeavor. It can raise fears of litigation, cloud clinical decision-making, and spark feelings of professional isolation. Suicide of a patient can challenge personal and professional identities, career trajectory, and sense of professional security. In its wake, patient suicide can leave posttraumatic stress symptoms behind as well as complicated grief. Interestingly, in my work with therapists who have experienced suicide loss of family or other close relations, they experience similar dilemmas. The sense that as a clinician he or she did not serve their family member or friend well, the questioning of clinical acumen, the guilt of feeling as though he or she should have done something to be of help and more, are common. As clinicians, suicide loss in any arena of our lives is experienced through the lens of our clinical knowledge, expertise, and experience.

There is little personal discussion on how therapists weather such a loss. Lay survivors of suicide are in an unknown country, inhabiting a strange landscape. Therapists surviving the suicide of a patient are in a similar land and yet there are important differences: there is no institutionalized ritual, no community of mourners, no one, really, who knew the patient as the clinician knew the patient. There is no institutionalized ritual, no community of mourners, no one, really, who knew the patient as the clinician knew the patient.There is no one who witnessed first-hand (as best anyone can) the relationship between a certain patient and a certain therapist, yet the specific dyadic relationship is never to be experienced again. It is never to be remembered by anyone else but the therapist. In specific ways, we are the only one who holds our patient in mind. Even in the case of Jill, Brian held one particular relationship with her, and I another. Although Jill sometimes spoke of us to one another, the bulk of our memories of her are solitary, and the texture of our relationship with her singular.

Therapists are usually left alone with what remains in the aftermath of patient suicide. These remnants include all that was unsaid, unprocessed within the therapeutic relationship—both the regrets of what was not named and processed that are possibly linked to the suicide, and certainly all that had no chance to be felt and spoken of together that more time would have provided. Additionally, all that the therapist retains of his or her patient remains inside the therapist's memory.

Further, who the therapist was with this particular patient is lost. This leaves open the question of who we are as therapist now. The process of mourning for therapist-survivors asks that we delve into the question of who we are now that our patient has left in this self-destructive way. And who are we, as therapist, the one here to facilitate healing—to engender life, if we have that kind of perspective—in the face of chosen death?

It can be alluring as the therapist-survivor for all these reasons to move far from the confusing thicket of feelings left by patient suicide. The cultural context and identity as therapist can encourage this moving away from honest reflection and processing too. Our ongoing enlivening as therapists—let alone simply as human beings—asks us to feel our grief, and find meaning in our grieving.Yet as we know with our patients, moving away from the real experience of the here and now can lead to a dulling of living, a numbing. The Therapist in Mourning: From the Faraway Nearby (2013), Catherine Anderson describes these kinds of responses as part of the working through process with "a desperate need to understand what had happened and a magical wish to protect [oneself] against any future vulnerability."

Another common response is to avoid examining clinical missed opportunities and errors, to defend against the pain, shame, and perhaps guilt that are simmering. Gina, a patient-clinician of mine, experienced a patient suicide after two sessions. When the patient did not show to the third session, Gina called. Subsequently, the patient's father contacted Gina. He told her his son killed himself the day after the second session. It was excruciating for Gina to slowly begin to examine her state of mind during the sessions. She came to realize that she was, due to many factors, defending against making genuine a connection with this patient, and was more distant than usual. Her past clinical experience told her that when she has that kind of response, she hesitates exploring avenues that would be productive, and that she overlooks what later, when less defensive, was there all along. That was her missed opportunity. Of course, there is no telling if Gina had been less defended if that would have made a difference—given her a vital piece of clinical information that she could capitalize upon to then help the patient. It was crucially important, however, to Gina's healing process to bring into consciousness what she already actually knew about herself in her brief work with the patient.

The ground of my being was continually moving beneath me after Jill's suicide. Because of my life history and my working with it in therapeutic ways, I knew my footing could be regained, but I questioned when that would happen. I returned to writings that reminded me about how vulnerable groundlessness really is and how inevitable it is as well. Pema Chodron, in When Things Fall Apart, writes:

"[T]hings don't really get solved. They come together and they fall apart. Then they come together again and fall apart again. It's just like that. The healing comes from letting there be room for all of this to happen: room for grief, for relief, for misery, for joy."

Her perspective, for me, reflects what I believe and practice in my private and professional life, but can easily forget in times of great tumult. It is a kind of perspective that provides me refuge.

I knew from my history that if I refused to directly experience what was present within me I would only harden my heart. Cutting myself off by armoring my heart would negatively impact my relationships with other patients, let alone the relationships in my personal circle and my relationship to life itself.

The practice of mindfulness meditation is one way I engage my direct experience, and it had been a practice of mine for many years before I began my clinical work. Profound shame, futility, anger, banality, and sorrow as well as heartache and headache were some of the many storms I weathered sitting quietly on my meditation cushion.I returned to intensive practice after sustaining the many family deaths in quick succession aforementioned; I spent a month on a silent meditation retreat as well.

The amount of silence offered was an integral experience for my body, heart, and mind to begin having room to feel through those traumatic losses. With Jill's death, I returned to steady meditation practice again, in order to create room inside myself for the range of feelings I was experiencing. It sounds, perhaps, so simple, so easy, and yet it is not. Silently meditating twice daily confronted me with every vulnerability, every feeling, body sensation, and thought I possessed. Profound shame, futility, anger, banality, and sorrow as well as heartache and headache were some of the many storms I weathered sitting quietly on my meditation cushion. Yet it was the silence and the generous observing accompaniment to myself that were central in my finding footing again.

RITUAL AS SCAFFOLDING

James Hillman suggests that in the face of patient suicide the clinician go into the context of the death—not to stay on the surface. His advice speaks to delving into our interior world, and grieving, but also something more. He suggests lending all of our knowledge of our patient to the endeavor as well, exploring as thoroughly as possible nuances of our patient's suicide.

With Jill, intuitively I knew I needed rituals as a frame in my quest to deeply understand her suicide to the best of my abilities, as well as to mourn her death and all of the losses accompanying it. One ritual that was obvious was the therapy itself. There are the set days and times of sessions; the usual pattern of entering and exiting sessions with some of their inevitable variability; the parameters of the relationship.

Keenly aware of how groundless I felt, I longed for grounding in the ritual of my sessions with Jill. I could not fathom scheduling another patient in Jill's session times. I realized what I wanted was to keep my appointment with Jill. So I did just that: I kept my appointments with Jill for one year.I could not fathom scheduling another patient in Jill's session times. I realized what I wanted was to keep my appointment with Jill. So I did just that: I kept my appointments with Jill for one year. Sometimes I went to a meditation space near my office for the appointment; sometimes I was in a natural setting. Other times, I spent it in my office. Wherever I chose to spend the sessions, I also was with Jill. Sometimes reading a book of poetry that evoked Jill, or intentionally recollecting parts of sessions.

By the second week of appointments with Jill, I began writing during the time. I used poetry as a companion. Sometimes I wrote to Jill, sometimes extemporaneously to the Reader with a capital R. An excerpt follows of one of my writings:

I reviewed notes on Jill I came across; process notes. Notes when Brian spoke with me several weeks ago. There is much that remains unsolved in my heart.

And it's in my heart, especially, that time takes its own rhythm, a time that doesn't match up with the clocks and the calendars. It's sorrow or poignancy, both, being touched by Jill—I'm feeling right now. Knowing I'm not alone, really, in such an experience ultimately—like anyone grieving anything how universal and connected to the everyday human experience this actually is. Paradoxically how alone and singular I feel. Alien among colleagues who have not experienced such a violent loss. A lone mourner.

Jill suffered in body and mind, physical and emotional pain. Her physicality used to be a route to survival as a child and a young adult. Her physicality was already failing her. The grief she felt was so layered and frequently linked to all the losses felt trans-generationally across her family history. And even this doesn't say all she felt and lived with.

I can and do write circles of theory or case formulation but that is not what I'm desiring here. I feel almost desperate to continue delving into this process with her in this kind of way, unsure of where it is leading.

Strange, I guess, to feel the shock, still, that she is dead. I just know the only way to move with this, through this, to be with it all, is to do what I'm doing. Let it come in words or feelings. Let it come through me, in silence.

Of course, the questions remaining in the aftermath of suicide usually cannot be fully answered, but answering all the questions is not the point of such a process. If there is an aim, it is the recognition that the clinician continues in relationship without her (or his) partner in the dyad. Feeling and thinking alongside that recognition is the heart of the process. Psychologist Robert Gaines would call this the stitching together of continuity our relationship to the dead. Finding a relational home once again. Finding one's clinical and human voice again.

Other rituals also occurred to me related to mourning, whether a formal memorial or an informal honoring, as well as creating continuity. By the end of the second week of appointments with the spirit of Jill, I realized I needed two additional things: to visit where she died, and to create some kind of memorial. There was no funeral service for Jill; she had no family or close community. Something of our process together needed representation. Something of her treasured symbols shared with me needed representation. And something of our relationship needed representation too.

Brian drew me a virtual map in verbal description as to where she died. Over the next four appointments with the spirit of Jill, I developed a memorial. A colleague accompanied me on the day that I set, and we drove to the place close to where Brian described. We walked the remainder of the way. Although Jill chose a place where she surely would be discovered, it was not an overly exposed public place. When I got there, I wept. I wept not because of her death in that moment but because of the purposefulness of the place. I recognized it, immediately, based on our work together. Based on what Jill shared with me. I could see how Jill, with her particular perspective, felt beauty in this place. The place fit into the story of her life, the story she shared with me. The story we made sense of together. The place symbolized what she would frequently discuss and feel, the existentials of existence, and the evolution of her life.

The ritual included flowers, some writing I read to commemorate Jill, and a prayer combined with poetry I put together to reflect our relationship. My colleague and I sat in silence afterward, listening to the sounds around us. I felt close to Jill in the moment. Through the scaffolding of this ritual, as well as the ritual of appointments with her, I began to understand some meanings in her death, and I regained my voice once again.

Jill genuinely affected me—her life as well as her death. Destruction, and particularly self-destruction, surrounded her in the history of her life yet she developed into a highly deliberate, aesthetically-minded, symbolically-attuned woman who struggled with looming thoughts that dragged her into familiar mire she was accustomed to escaping by vigorously and creatively using her body, no longer available to her. Her suicide was equally aesthetically minded—if you forgive the stretch of the word in this context but rather feel into the contour of its meaning. I noticed this in numerous ways from the evidence she left behind, the chosen place of her death, the timing of her death, to her message left for me.

I was acutely aware in working with Jill of my family standing with me, for they are there, always, in the background of my mind and heart, like a luminous shawl. How the experience of their tragic, violent, and sorrowful deaths created, initially, a nuclear-sized crater within me that since healed—and continues to evolve in healing—with scarred but incredibly strong layers. Layers of capacity and depth for ambiguity, curiosity, and love in the face of enormous challenge, rejection, and destruction. I never revealed to Jill my personal history, yet I felt it was these very experiences and my working with them, through them, that enabled me to meet Jill in the dark and light of her psyche without collapsing. All of these details and their meaning that I came to understand over time enabled me to continue to serve fully in my life in all ways professionally and personally with openness.

RELATIONAL HOME FOR ONE ANOTHER

Clinician-survivors come in contact with the real attachment felt for the person who died in the process of mourning. Regardless of theoretical orientation or therapeutic stance, there was (and is) a relationship. The basis of the relationship is connection, care, and likely love. Therapists may have difficulty admitting they love their patients; some secretly do so with shame as if caring were untoward. When working in my practice with therapists mourning a suicide, moving through the shame of caring to the healing and human quality of caring is vital.

Clinician-survivors ask me to be their therapist initially because they find my contact information from the American Association of Suicidology's website. Therapists may have difficulty admitting they love their patients; some secretly do so with shame as if caring were untoward.There, among numerous resources, is a link to resources for clinician-survivors. Clinicians who contact me often gingerly express their desire for support, understandably fearing an amplification of shame they already are carrying. Shame demolishes a person's sense of self. Shame isolates and evicts us from our relational home.

Some studies have explored the ubiquitousness with which clinician-survivors are met with judgment and shaming from colleagues. It has been found that clinicians who have not experienced a suicide loss professionally or personally are more likely to assume that there must have been something the treating clinician had done wrong. One way to understand this is to consider the nature of trauma.

People involved in the traumatic event, either directly or indirectly (hearing of it, etc.), hold parts of the experience and defend against the emotional enormity of it. Blame, shame, grandiosity, omnipotence, and guilt are often convoluted in the mix. Unbearable feelings are projected or disavowed. Most of us "know" this, but when we are in the midst of it ourselves we can forget.

Before I entered my contact information on the clinician-survivor network, I carefully considered this act—a public acknowledgment of an aspect of my history. Before I agreed to write this article, which is drawn from a public presentation I gave to two different professional organizations, I considered how my history in print felt quite different than speaking it. I sensed the risk I felt in both instances. For me the risk is primarily located in relationship to colleagues unfamiliar with suicide loss. My feeling of risk among the professional community is not singular —it is cited repeatedly as a way that therapists feel shame for their grief in relation to patients generally, and most especially the shame felt when a patient completes suicide.

Coming out, so to speak, on the website and in this article are acts of advocacy for other therapists in a direct way, and ultimately also, I believe, advocacy for patients. Coming out in these ways are antidotes to shame as well, although revealing oneself carries with it a chance of being judged or shamed. Hiding when feeling shame, after all, is a protective solution to those risks—albeit risks that are generalized. Two anecdotes may elucidate.

When a psychologist-colleague found out that I publicly acknowledged my identity as a suicide survivor, he questioned me. He wondered if I were exposing something that "should" be hidden. His sense of hiding was initially justified by the importance of neutral stance and limited self-disclosure. With further exploration between us, however, my colleague came to realize that he felt anxious and even dissociated when hearing about my experiences. His shaming reaction toward me was a coping mechanism for his anxieties.

Another colleague responded quite differently to finding out about my public acknowledgment as a suicide survivor. Her response: There but before the grace of God go I. She too felt anxious hearing my experience, but she remained in communion with me. She shared her anxiety and her wishful fantasy that she would never experience this kind of trauma. Through our discussion, we created a relational home for one another.

In therapy, we create, with our patients, a relational home. While this home is focused on the patient's needs, it is irrevocably the particular home we live in with our patient. That home continues to live inside of the therapist-survivor after the patient dies. In Trauma and Human Existence: Autobiographical, Psychoanalytic, and Philosophical Reflections (2007), Robert Stolorow writes, "The mangling and the darkness can be enduringly borne, not in solitude, but in relational contexts of deep emotional attunement and understanding." The loss of a patient or a loved one by suicide is unfathomable, though we know it happens. It is nothing short of a cataclysmic trauma, one that is enormous to digest. The impact of it on clinicians has been compared to the traumatic loss of a parent. It is a leveling experience for it takes us out of our protected role as therapist and throws us into the most humble, bare experience of our own humanity.

Brian, the psychiatrist, only learned of my family history after Jill's death. He wondered, "Perhaps there is some unconscious way Jill knew you could make meaning of and bear her death." It is curious whatever Jill may have implicitly known of me—but ultimately that is something I will never know. Importantly, it was not lost on me, her therapist, the relevance of the place she chose to die. What it meant to her, what she communicated to me in her final message, and what she communicated in her choice of place. It was not lost on me, her therapist, the layered meanings in the timing of death. The curious exploration of these among other unspoken aspects of our work together was what I gave voice to in my year of kept appointments. A year of rediscovering meaning. A year of regaining clarity, ground, and clinical voice. A year of examining the soul of the process between us, and what lived on within me.

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Following is a list of readings and resources for clinicians and clinician-survivors who wish to learn more about, and seek support for, the grief of losing a client to suicide.

The clinician-survivor network of the American Association of Suicidiology provides consultation, resources, support, and education to mental health professionals in the aftermath of suicide loss, personally and/or professionally. The website includes nationwide clinicians available as resources, as well as an extensive bibliography.

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