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Władysław Sterna

# SUICIDE AMONG PSYCHIATRISTS, PSYCHOLOGISTS AND PSYCHOTHERAPISTS

**psychiatrist's suicide**
**psychologist's suicide**
**postvention**

**Summary**

*Numerous publications deal with the problem of patient's suicide, attempts to understand its reasons, and methods to best help. There is far less written about the clinician's reaction to the death of his/her patient and its associated experiences. In the Polish literature, there is a lack of publications regarding the clinician's own suicide, its potential determinants, and causes, its impact on others, and its prevention. This article attempts to discuss the problem. At the outset, attention is drawn to the specific difficulties in experiencing this type of death by loved ones. It presents available data on suicide among psychiatrists, psychologists, and psychotherapists. Most publications note the increased risk of suicide in this professional group. Potential barriers to seeking adequate help are highlighted. The possible reactions of the professional community are discussed, as well as what happens to the patient after his therapist's suicide, which makes it much more difficult for the patient to continue seeking help. Finally, recommendations for clinician suicide prevention are presented, the most important of which is the introduction of discourse and training on the topic in the professional community.*

## Suicide as a kind of death

Suicide is rarely discussed in the public space, even though, as indicated by recent research conducted in the USA [1], almost 50% of the population will, at some point in their lives, be exposed to the suicide of someone they knew. The experience of loss after a suicide death and the process of mourning is unique because of several critical dimensions of this type of death: 1) ambiguity as to the will of the deceased; 2) the apparent possibility of avoiding death; 3) the stigmatization of suicide and 4) the traumatizing nature of death by choice [2]. In general perception, suicide is the decision of the deceased. However, after careful analysis of different cases, it can be concluded that the degree of involvement of "free will" and the complexity of decision-making-processes were different in each of them. Perceiving suicide as a free choice of the deceased complicates the process of mourning for other people, especially in terms of assigning meanings after death. Jordan [3] uses a very telling example here. If a loved one dies of cancer, it is perceived by the spouse as the loss of a cancer victim, and he or she rarely feels abandoned by the deceased. In the

case of suicide, many people feel abandoned or even rejected by the deceased due to his "decision". This perception of suicide leads to guilt over failure to keep the deceased alive or anger over their "desertion". Feelings of guilt and responsibility for suicidal death can be unintentionally compounded by suicide prevention programs that portray depression and suicide as treatable and preventable. Taking the example above, it is known that many cancer deaths are preventable, but it is also true that not all cancer deaths are preventable. Things are different in the case of suicide – relatives may believe that if some suicides can be prevented, it means that in the case of the death of a loved one, it was certainly possible; that it could have been prevented if someone (the deceased himself, a therapist, a close person) would have behaved differently. Feelings of guilt, shame, anger, and failure seem natural in this situation. The problem of stigmatization of suicide should be related to the history of the perception of this phenomenon. Until recently, most Western societies perceived it as the result of sinful behavior, characterological weakness, or even possession. Today, most people recognize that suicide results from psychological pain, but the stigma still extends to survivors who can be condemned and avoided in interpersonal contacts. Ambiguity in the perception of suicide leads to uncertainty about how the survivors should be perceived [3]. Should they be treated as someone who has inevitably lost someone with cancer? Or treat them as relatives of a person who has embarrassed the family (e.g., a drug dealer killed in a mafia feud)? Maybe, after all, survivors of suicide should be treated as those who are co-responsible for death and should bear some consequence (e.g., avoidance). At the end of this thread, it should be added that the very nature of suicide is traumatizing for the loved ones. Even if the chosen method of death was not violent (e.g., by drug abuse), it is perceived as a psychologically brutal attack against oneself and shared, social norms. This is even more so in cases of violent suicide. This violence is also a source of trauma for loved ones and grief.

## Suicide among psychiatrists

In January 2018, the Washington Post published a dramatic article by Pamela Wible [4], who, while attending the funeral of another doctor colleague who took his own life, started counting how many doctors she knew died in this way. She remembered leaving the service at 10, but at the time of publication, she already had 757 people on her record – becoming an informal information center on the subject. This article cannot be considered a scientific publication, but the research [5] shows that doctors as a professional group are a group of increased risk. This trend among physicians is maintained in many studies [6]. Not all medical specialties are at the same risk of suicide. Anaesthesiologists, psychiatrists, family physicians, and general surgeons are the specialties most burdened with this risk [7]. The high risk of suicide among anesthesiologists is explained by relatively easy access to potentially lethal drugs, frequent occupational burnout, heavy workload with a potential risk of harm to the patient, and low professional autonomy of this specialty. Psychiatrists are a professional group that is intuitively not in a particular suicide risk group. They have a good understanding of what leads to suicide; they have experience working with

suicidal patients; they are underestimated among other specialties but also appreciated by the importance of their profession; they also have the resources to get the best possible care for themselves [8].

There are few studies on psychiatric suicide rates and those that do show mixed results. Rose and Rosow [9] analyzed 48 physician suicides over three years and concluded that among physicians, it is psychiatrists who have the highest suicide rates. Ross [10], writing about the increased percentage of suicides among psychiatrists, indicates that the following popular theories try to explain this phenomenon: 1) people who specialize in psychiatry more often have mental disorders; 2) psychiatrists are more likely to suffer from affective disorders; 3) psychiatrists are more likely to think about suicide because they deal with suicides every day; 4) psychiatrists drink too much or have unstable relationships; 5) sychiatrists are too proud to have anyone around to talk to. Hawton [6] also indicates an increased risk of suicide among anaesthesiologists and psychiatrists, which is explained by the high stress level and dissatisfaction. Rich and Pitts [11], based on the analysis of 18,730 deaths of men and women, state that psychiatrists commit suicide twice as often as the general population ($p < 0.001$) and do not find such a relationship in any group of specialists. Freeman [12] reviewed the obituaries of the American Medical Association and found that the number of suicides among psychiatrists has been increasing over the last ten years. Ross [10] studied the percentage of suicides among psychiatrists for 75 years, stating that it is still increasing.

However, Blackly [13] and colleagues reported a percentage of suicides among psychiatrists similar to other specialties. Bergman [14] critically reviews the literature on this subject, pointing to significant research deficiencies. Bedeian comes to similar critical conclusions when analyzing the data based on which conclusions about psychiatrists were drawn [15].

## Suicide among psychologists and psychotherapists

Unfortunately, the knowledge of psychologists and other clinicians, whose professional experience is related to helping does not cause resistance to mental disorders or ensure optimal life functioning [16]. Of course, this does not question their ability to help, moreover, the concept of the "wounded healer," states that therapists are motivated to help others and have an increased capacity for empathy through painful life experiences that drive their sensitivity [17]. However, it is difficult to assess when this foundation of helping from a therapeutic tool becomes a harmful, problematic presence. Among the factors that may potentially affect the risk of suicide in the group of psychologists [18], there are such factors that may be recognized as profession-specific: difficulties associated with an intimate and confidential client/therapist relationship, which is not mutual; occupational isolation (private practice); difficulties in dealing with negative patient's behaviors such as aggressive and suicidal behavior; rapidly changing requirements in healthcare facilities; reduced supervision of individual work and increased time spent on administrative duties. These factors may be risk factors, but so far, this has not been demonstrated in studies. Zucker-

man [19] showed in her research that the following factors predispose a psychologist to suicide: suicides in family history, number of experienced life traumas, and general level of anxiety and depression throughout life – but these are not factors specific to psychologists.

The first, adequately designed study in the field of suicide rates in a group of psychologists, was the one held by American Psychological Association [20] over the years 1960-1969. This study compared suicide rates of psychologists vs. the general population according to standardized mortality rates subdivided by gender. Suicide rates in the group of male psychologists were comparable to the general population. However, the suicide rate in the group of female psychologists was almost three times higher than in the general population. The continuation of this study was an attempt to determine the causes of death of psychologists and members of the APA for the years 1981-1990 [21]. The study from this period did not confirm a higher number of suicides in this occupational group compared to the general population. The group of male psychologists even indicated a much lower frequency (7.8/100,000 to 24.9/100,000). The disadvantages of these two studies are: it is unclear how the cause of death was determined and that they included only APA-affiliated psychologists. In turn, the analysis of causes of death for the years 1984-1998 indicates a significant increase in the risk of death due to suicide among psychologists [22].

The APA website [23] states that even though the research results are different, one can find studies that worryingly indicate a higher risk of suicide among psychologists than in the general population. After several suicides of famous psychologists, the ad hoc committee formulated a report and recommendations in this regard, referring to APA research from 2009, according to which 40-60% of psychologists show some disturbance in professional functioning due to burnout, anxiety, or depression.

There are practically no studies on suicide among psychotherapists, and those available are outdated and methodologically incorrect. However, some authors attempted to discuss the present state of knowledge in the field [24]. They are critical of studies in which there was no difference in the group of men with the general population, while in the group of women, the risk of suicide was tripled. They indicate that precisely – the group of psychotherapists practicing in the profession should be enrolled on research, excluding those, employed at a university or in administrative positions because it does not give an idea of the actual extent of the phenomenon.

## Why?

When trying to understand an individual decision, we encounter numerous barriers in explaining the person's characteristics and the circumstances that could decide it. The reasons are probably multiple, but two groups of factors may be of the most significant importance: the work environment and the personal characteristics of the clinicians. Physicians work in a specific environment, struggle with conflicts with other physicians, have a deficit of teamwork, and often perform work mainly individually [25]. As a professional group, they are very often in contact with illness, suffering, and death and have to face "sudden bad news." Physicians' characteristics can also be a burden: perfectionism; obses-

sive attention to detail; an exaggerated sense of duty; an excessive sense of responsibility; the desire to please others. These features are rightly appreciated in professional work. However, at the same time, they increase the risk of experiencing stress and depression and result in remaining in a vicious circle without seeking help [26]. It may be added that physicians are likely to choose more effective methods of suicide and have greater access to potentially lethal agents.

It is difficult to answer why psychiatrists, psychologists, and psychotherapists commit suicide. A better question would be: 1) why professional skills are not enough to prevent one's suicide; 2) whether there may be any specificity in the profession of the helping person that undermines their professional competencies; 3) do professionals have unique barriers to seeking help? A complete answer to these questions would probably allow effective suicide prevention in these occupational groups, which is impossible with the current state of knowledge. Perhaps one of the reasons is the specific difficulties clinicians face in seeking help.

## Barriers to seeking help and undertaking interventions

Difficulties in using professional help by clinicians are manifold. In the APA study [23], the respondents mentioned several difficulties in seeking help: lack of time (61%); minimizing or denying problems (43%); privacy or confidentiality issues (43%); shame, guilt, or embarrassment (40%); lack of knowledge about available resources (31%); fear of losing professional status (29%); and insufficient social support (27%).

There are numerous barriers for mental health clinicians to seek help. Bright and Krahn [27] discuss each of them. Clinicians fear social stigmatization, so it is difficult for them to find another person in close proximity whom they can trust. They may also be afraid of disclosing medical data when applying for or renewing a license to practice. These concerns are not entirely unfounded, as one study [28] revealed that 69% of local medical licensing boards formulated at least one legally unacceptable question to the candidate regarding his mental health. On the other hand, some courts considered that such questions in the case of severe mental illnesses (BD, schizophrenia, paranoia) are admissible, as such severe mental disorders may be an obstacle to practicing the profession [29]. Psychiatrists may also self-treat their mood disorders instead of consulting another psychiatrist, which is not advisable.

The stigmatization of people with mental disorders is also experienced by mental health professionals (!). Therefore, seeking shelter in a professional role may be an attempt to compensate for the "weaknesses" of having the same problems as others. This defensive compensation may, in turn, lead to narcissistic ignorance, which is an expression of self-deception, making them even more vulnerable to further crises. In this way, a pathological dissociation occurs between the "public self" and the "private self" [30].

Clinicians seeking help for themselves may expect "special treatment", which may adversely affect the therapeutic process. Being a "special patient" actually seems to be a euphemism for "worst patient" because it involves receiving worse treatment and follow-up than

the rest. Similarly, self-diagnosis, self-prescription, obtaining "informal" but also infrequent consultations, and assuming the status of "VIP" are very common for doctors-as-patients. Threats related to the diagnosis and treatment of "special" patients may cause potential conflicts with staff and other patients; be associated with difficulties in giving control by the doctor-patient; the failure to give him accurate information about health or treatment – due to fear of being narcissistically hurt. Treatment providers may also underestimate the risk of suicide and may not make decisions about the hospitalization because patients-doctors know what keywords not to use to avoid hospitalization or to deny suicidal thoughts. The doctor and his family may deny his or her alcohol or substance abuse, avoid talking about suicidal thoughts or overlook essential symptoms not to stigmatize the patient.

## After a friend's suicide

Suicide always causes deep distress to those who remain. It is estimated that after one suicide death, there are six or more survivors [31]. Unlike other causes of death, those experiencing a loved one's suicide may feel isolated from the rest of the community or even family; they may feel stigmatized, and suicide may be perceived as an attack or rejection of them as a whole [32]. On the other hand, these people may blame themselves for not predicting death or failing to intervene effectively. After losing a significant other through suicide, it is expected to experience – in addition to pain and suffering – feelings of guilt and shame, accompanied by endless questions "Why?" [33]. Two emotions, shame and guilt, are harrowing and often experienced in a very complex or disguised way. Although they almost always appear together, it is worth distinguishing them [34]. Guilt stems from a moralizing, prohibitive conscience from transgressing specific rules or taboos. The roots of shame lie in the ego and stem from a feeling of inadequacy in meeting standards, and shame hides a feeling of weakness. Many feelings can overlap with shame – embarrassment (feeling of not being good enough); exposure to the public without consent (exposure to an unattained ideal); humiliation (loss of position, power, and dignity). A source of shame can also be self-awareness of one's actions or lack thereof – in the face that other people look at them critically. All these aspects of experiences can accompany clinicians when they experience a suicide of another clinician.

After the suicide of a psychiatrist or psychologist, many groups of people may be affected: family and friends; patients or clients; fellow professionals; trainees; local society. Edwin Shneidman [35] is the author of the term postvention, which includes activities that are helpful after experiencing the suicide of a loved one. It indicated that people who experienced the death of a loved one are more likely to develop suicidal thoughts or behaviors. Research shows that losing a partner or child causes a tremendous increase in the risk of suicide in a person exposed to loss [36]. Exposure to the suicide of any family member increases its risk at least 2-3 times [37], and even exposure to the suicide of a work colleague, increases 3.5 times the risk of suicidal thoughts or attempts in the future of the person exposed to them [38]. There are poignant descriptions of the experiences and coping of loved ones, such as the account of Sara Gorman, whose parents were both psychiatrists

and whose father, a professor of psychiatry, undertook a severe suicide attempt [39] after years of struggling with suicidal thoughts.

## An abandoned patient

One of the severe consequences of clinician suicide is the effect on the patient – it is surprising how rarely this topic is addressed in the literature. Definitely, this is a dramatic event in the patient's life and the loss of a supportive relationship. The therapeutic process in which both were involved is suddenly interrupted, and the patient is left alone with all the complicated feelings and thoughts. The sadness he/she experiences is compounded by the loss of faith in the „self-healing power" due to the therapist's failure. The therapist's suicide violates the essence of the therapeutic relationship, in which the patient can restructure and correct the experience of previous faulty relationships with others. The therapist's suicide may be perceived by the patient as abandonment and betrayal, especially if the patient has experienced other abandonment or loss in the past. This can be a severe disincentive to re-establishing a therapeutic relationship. It is experienced very intensely, even when the relationship with the clinician is almost exclusively about prescribing medications and having a short conversation [40].

There are few studies on patient responses to clinician suicide in the literature. Reynolds et al. [41] studied patients' reactions after the suicide of one of the therapists. The results of this study indicate that the initial patient's reactions were similar to those of bereavement after the loss of significant others. However, the study of this group also showed that patients have an increased risk of revealing pathological grief, difficulties entering subsequent therapeutic relationships, and increased acceptance of suicide as a solution to their problems. In this context, the clinician's suicide paves the way for the patient's behavior. Participants in this study also experienced intense feelings a year after the therapist's death – especially sadness, anger, and abandonment. The grieving process was much more complex because of the inability to give meaning or interpretation to the suicide. This was particularly important for people who were reluctant to continue therapy with another clinician and did not have the opportunity to work through the grief. In the study group, several patients, even after a year, did not accept the therapist's suicide as the cause of death and were convinced of other causes of death (murder). It seems that the search for facts that could refute the thesis about suicide serves to deny and prolongs the mourning process. Some patients felt left out and abandoned by the therapist's unilateral rupture of relationships because his/her suicide contradicted their importance as essential persons. A disturbing discovery of the researchers was that after the therapist's tragic departure, some patients accepted suicide as a possible solution to specific problems. A close relationship with the deceased could somehow instil in them the idea of suicide. However, it is not always the case that the loss of the clinician nullifies the effects obtained in the course of therapy and causes the patient to regress. There are descriptions of painful partings with a tragically deceased person, in which the patient closes the separation and even takes care of the internalized therapist [42].

Chiles [43] interviewed patients a year after the death of their psychotherapist and in this way he revealed three main themes. First, all patients described that they still have a strong emotional relationship with the psychotherapist, which is even stronger than it was, when she was alive. Chiles describes this as the patient's sense of omnipotence and elsewhere as an all-powerful responsibility. Treating this relationship as a continuation of therapy, patients had blocked negative feelings like anger and other transference-related feelings. None of them knew aspects of the therapist's private life and had no grounds to consider themselves as the person who contributed to her suicide. However, everyone had such feelings to varying degrees, and one of them even put it to the extreme – „I pulled the trigger." The second important thread was failures in continuing therapy with other people. Patients reacted differently: (1) remained without therapy, recognizing that if therapy does not help the therapist, it will not help them either; (2) were looking for someone like the deceased therapist, but they were disappointed; (3) tried to establish a relationship with a male therapist, then angrily devalued it; (4) expressed anger for various reasons at subsequent therapists, which was an unrecognized transfer of anger towards the deceased. Chiles emphasizes that when working with such a patient, one should start by explaining that they may be experiencing strong feelings towards him and should express them and that a clinician is open to cooperatively look for those emotions' sources. The third theme present in most patients was the problem of the therapist's fallibility and the curiosity about her life: what was it like, why did she kill herself, and what was done to help her? These questions are undoubted of a confidential and personal nature – the question remains whether patients, after the suicide of their therapist, should have an answer to them. Chiles argues that they should and that it should happen in the same manner as discussing the suicides of other people important to the patient – but of course, the decision should be made on an individual basis. A neutral therapist, privy to enough details, could discuss this with patients for their benefit.

The great challenge after a clinician's suicide is to mend the broken helping relationship, address the grieving process, and make patients want to trust therapy again and be able to work on the initial problem. After the suicide of a practicing clinician, his/her patients would need to be contacted. Unfortunately, it is not clear to whom this duty belongs and what scope of information it should provide to patients. There is also no explicit instruction on who should take over the possible database – in the case of doctors, their heirs hand over patient files to the Medical Chamber. In addition, such contact could be burdensome for people who themselves experience difficulties related to the departure of a colleague. There were cases described in which the deceased's family objected to disclosing information about the suicide, although the patients had already learned about it from the media [44]. Difficulties of this type have prompted recommendations to draw up a ‚professional will', which includes instructions and authorization for a designated clinician to act on their behalf in the event of sudden death [45]. In such a professional will, the clinician may indicate: a wish to transfer and retain confidential patient records; decisions about storing or destroying computer files; details about how to notify patients.

## Recommendations

Thinking about the future, it is worth sketching some recommendations aiming at reducing suicide rates among clinicians. Specific recommendations regarding activities that may reduce the risk of suicide in a group of psychologists were issued by the American Psychological Association [23]. Indeed, they can be extended to psychiatrists, psychotherapists, and nurses, and it is worth supplementing them with other, more up-to-date in Poland:

- Incorporating the topic of clinician suicides as a discourse topic. It is surprising and probably not accidental that this topic does not exist in Polish-language literature (collective repression?);
- inclusion in the professional training a suicide risk education not only for patients but also for other clinicians and themselves;
- self-therapy and supervision will, of course, would also be very helpful here;
- better training of professionals on possible signs of suicide and how to intervene with colleagues struggling;
- more emphasis on normalizing the challenges of being a clinician and supporting self-care strategies;
- providing information on suicides of clinicians on the model of websites developed, for example, for nurses [46];
- better education on postvention, i.e., what should be done after the suicide of a patient, but also of a colleague; support for everyone affected by the event and long-term support for those who may need it;
- promoting the possession of a professional will that can facilitate the handling of records and other issues in the event of death for any reason;
- conducting studies on the extent to which clinicians are at risk of suicide, taking into account certain factors of self-selection for the profession and specific working conditions factors, such as the intensive and isolated nature of work;
- development of recommendations for patients left after the clinician's suicide because in this group, the risk of complicated grief and suicide are significant (therapy, crisis interventions, support groups, sending letters with directions for support).

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Email address: wladster@kki.net.pl