

Suicide Survivors' Perceptions of the Treating Clinician

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Seventy-one suicide survivors were surveyed about their perceptions of the clinicians who were treating their loved one at the time of death. Survivors provided information regarding their perceptions and attitudes toward clinician behaviors before and after the suicide and their perceptions of helpful and troubling aspects of clinician behaviors. Results indicated that survivors share a number of common opinions regarding the mental health care providers treating their loved ones. Several differences existed between survivors who consider lawsuits against mental health care providers versus those who do not. The implications of these findings for clinical practice, legal issues, surviving suicide, and future research are discussed.

Suicide can be devastating for family members left behind. Clinicians who have been treating the deceased at the time of death also suffer in the wake of a suicide (Jobes, Luoma, Hustead, & Mann, 2000). In 1999, there were over 29,000 suicides in the United States, making suicide the eleventh leading cause of death (Hoyert et al., 2001). Some estimates suggest that there may be as many as six to ten survivors (i.e., people closely im-

pacted by the suicide) for each suicide (Luukas & Seiden, 1997). Assuming six survivors per suicide, this amounts to a total of 186,000 new suicide survivors each year. Extrapolating from this estimate suggests that there are approximately 4.4 million American survivors of suicide since 1972 (Hoyert et al., 2001).

In terms of surviving clinicians, some estimates suggest that about one in five suicides, or 6,000 patients per year, were in treatment at the time of their death (Luoma, Pearson, & Martin, 2000). Moreover, research suggests that about half of psychiatrists and 20% of psychologists can expect to lose at least one patient to suicide over the course of their career (Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988).

Research indicates that compared to survivors of other deaths, suicide survivors may be subject to increased feelings of guilt, decreased amounts of social support, and increased needs to comprehend the death (Calhoun, Selby, & Selby, 1982). For mental health providers, suicide represents both a personal and professional crisis (Berman & Jobes, 1991; Litman, 1965), with reactions

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that include shock, anger, shame, and guilt (Hendin, Lipschitz, Maltsberger, Haas, & Wynecoop, 2000). It has been found that clinicians who have lost patients to suicide often face levels of grief comparable to people who have lost a family member (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; Litman, 1965).

Clinicians must also deal with very real professional concerns: family members' demands for answers, possible criticism by colleagues, fear of litigation, and feelings of inadequacy as a clinician (Hendin et al., 2000; Jobs & Maltsberger, 1995; Jones, 1987). In recent years, outpatient clinicians have witnessed a steady increase in suicide related malpractice claims (Jobs & Berman, 1993). Furthermore, at the very time when clinicians must face the challenges inherent in losing a patient to suicide, most mental health agencies and clinics do not have effective policies or guidelines to assist clinicians in dealing with survivors (Dunne, 1987). Clearly, simultaneously dealing with personal issues and emotionally bereft survivors can be a daunting task.

A number of authors have provided recommendations about how clinicians should behave toward the deceased's family in the aftermath of a patient suicide (Dunne, 1987). Usually these recommendations are based on first-hand experience and are often accompanied by personal accounts of losing patients to suicide. While extremely important, these accounts are limited in that often they do not contain any systematic description of how survivors perceive various types of therapist behavior. As yet, no empirical data speak to the issue of how clinicians are perceived as they deal with the family and friends of the deceased. Important questions remain regarding survivors' perceptions of helpful or troubling aspects of clinician behavior following such a loss. In addition, no one has systematically investigated what survivors believe would be helpful for clinicians to do after a loss. Thus, the purpose of this study was to specifically examine survivors' attitudes toward and perceptions of clinicians

who were treating their loved one at the time of death.

METHOD

The third author (E.D.) constructed a 5-page survey, which was inspired by discussion with members of the Task Force on Clinicians as Survivors of the American Association of Suicidology (AAS). The survey consisted primarily of multiple choice and yes/no questions, but also contained several open-ended questions. An initial draft was distributed to seven survivors who completed the survey and provided feedback to the author. A final draft was then created based on this feedback. The revised survey was distributed at several survivors of suicide national conventions. People who received copies of the survey were told to return it to their local survivor support groups and to distribute additional copies to members who fit study criteria. Thus, it is unclear how many eligible participants may have originally received the survey, therefore precluding an accurate estimate of the actual response rate.

RESULTS

A total of 73 surveys were returned; however, not every respondent answered all questions. Two surveys were excluded due to missing information about whether they had considered a lawsuit against clinicians, resulting in a total of 71 surveys.

Respondents

All respondents were relatives or friends of an individual who had died of suicide and who was also in treatment at the time of the suicide. Fifty-eight of the surveys contained demographic information. This group consisted of 15 men and 43 women, age 21–82 years ($M = 50.78$; $SD = 13.32$). Respondents identified the following relationships with their deceased loved one: 41%

identified themselves as “mother” of the deceased; 16% as “father,” 12% as “significant other,” 12% as “child,” 16% as “sibling,” and 3% as “other.” Of the 58 deceased, 37 were men and 21 were women, with an average age of 33.9 ($SD = 14.84$) (range 14–76). On average, surveys were completed four years ($M = 2.4$ years, range 14 days to 24 years) after the suicide. Fifty-six respondents indicated the profession of the deceased’s primary therapist: 57% were psychiatrists, 23% psychologists, 7% social workers, and 11% other type of mental health care provider.

Multiple-Choice Responses: Summary

For multiple-choice questions, percentages were calculated relative to the number of people who answered each question, rather than the total number of people. This was done because missing data was fairly common and we believed percentages of total numbers of responses would be misleading.

Information about Events Before the Suicide. The survey first asked survivors’ about their knowledge of their loved ones’ treatment and information about any contact they may have had with the clinician before the suicide. Ninety-four percent ($n = 67$) of respondents reported that they knew their loved one was in treatment, and 74% ($n = 50$) reported that they actually knew who the primary clinician was. Of those who knew who the clinician was, 68% ($n = 27$) believed the clinician would have welcomed contact. Seventy-one percent ($n = 47$) of respondents reported that they and/or a family member had attempted to contact the clinician before the death of their loved one. Of the 47 survivors who attempted to contact the clinician before the death, 79% ($n = 33$) were able to. Last contact, by the survivors, with the clinician averaged 14 days before the death ($n = 32$) with 50% within one week of the death. Only 11% ($n = 7$) of respondents reported that the clinician had contacted them or their family before the suicide. Eighty percent ($n = 56$) of respondents indicated that their loved one had been prescribed psychotropic medication at the time of death.

Information about Events After the Suicide. The survey next asked about survivors’ experiences with and impressions of the clinicians’ actions following the suicide. Only 39% ($n = 26$) of respondents reported that the clinician made contact with the family on his/her own after the death. Of those who were not contacted by the clinician, 74% ($n = 29$) attempted to contact the clinician themselves. Seventy-eight percent ($n = 55$) of respondents reported that they and/or other family members had some type of contact with the clinician after the death; of these, 62% ($n = 33$) reported having had a face-to-face meeting. Of those who had contact, 42% ($n = 18$) felt the clinician had not told them all they wanted to know, 48% ($n = 23$) felt the clinician was withholding information, and 40% ($n = 19$) reported their belief that clinicians held back information that may have been damaging to themselves. Sixty-four percent ($n = 41$) of respondents reported their belief that the clinician did not do all he or she could to save their loved one’s life, and 72% ($n = 41$) thought the clinician made mistakes while treating their loved one.

With regard to confidentiality, 23% ($n = 11$) of the respondents who actually had contact with the clinician reported that he or she stated that some information was confidential or privileged. In the total sample, 70% ($n = 47$) of respondents indicated a belief that the clinician should not be bound to confidentiality after the death of his/her client.

Twenty-two percent ($n = 14$) of respondents reported having invited the primary clinician to the funeral or memorial services. Regardless of invitation, in cases where the clinician did not attend, 44% ($n = 21$) would have wanted the clinician to attend. Results also showed that 56% ($n = 33$) of respondents believed the clinician grieved the loss of their loved one. Twelve percent ($n = 8$) of respondents were treated by the same clinician who had treated their loved one.

Thirty-four percent ($n = 24$) of respondents considered bringing a malpractice lawsuit against the treating clinician; of these,

57% ($n = 12$) actually consulted a lawyer about doing so. Twenty-three percent ($n = 5$) of these had actually brought a lawsuit; two had settled their suit by the time of the survey.

Open-Ended Responses: Summary

The survey contained four open-ended response sections. Forty-eight respondents answered the first question, 55 the second question, 49 the third question, and 51 the fourth question. While some respondents answered all four questions, other responses did not directly address the question. In many cases, respondents shared personal stories about their experiences with their loss, rather than directly answering the question. When possible, answers to the questions were coded out of these personal narratives. Some respondents offered multiple answers to each question. For each question, the authors examined responses and classified them into groups of similar answers. By classifying responses in this way, common themes emerged regarding survivors' impressions. When respondents gave answers that addressed multiple themes, answers were coded into all applicable categories. As a result, the number of respondents answering each question differs from the number of classified responses.

The first-open ended question asked respondents to describe mistakes they believed the primary clinician made while treating their loved one (Table 1). The most commonly reported mistake, appearing in 23% of responses, involved poor medication decisions. Examples of this type of answer included the belief that the clinician had prescribed the wrong dosage or wrong medication. The next most common mistake, clinicians not involving the family, was seen in 17% of responses. Fourteen percent of responses revealed that respondents believed that treatment was not aggressive enough and that the clinician did not take the possibility of suicide seriously.

The second question asked respondents to describe what was most helpful to them and their family with respect to the cli-

nician's behavior after the suicide (Table 2). Twenty-one percent of survivors' responses identified talking with the clinician about their loved ones' illness and/or treatment as helpful. Another 20% of responses indicated that "nothing" was helpful. Seventeen percent of responses revealed that the clinician offering his/her condolences was helpful. In addition, the clinician discussing his/her pain and sense of loss over the suicide was identified as helpful in 15% of responses.

Third, respondents were asked to describe what would have been helpful to them and their family with respect to the clinician's behavior after their loss (Table 2). The two most frequent responses revealed that survivors believed immediate contact with the clinician after the loss and disclosure of medical records would have been helpful (seen in 15% and 10% of responses, respectively).

Lastly, respondents were asked to describe how their attitudes and/or beliefs toward mental health care have changed, given their experiences (Table 3). Because many responses did not address the question, it was difficult to find common themes among the responses to this question. It appears likely that respondents had a difficult time understanding or answering this question. Most notable, 27% of responses revealed that survivors lost faith in the mental health care system after the suicide.

People Who Considered Malpractice Lawsuits Versus Those Who Did Not

A second analysis examined whether interactions with clinicians, characteristics of the deceased, or survivors' attitudes were associated with consideration of a malpractice lawsuit. Respondents' answers were divided into two groups depending on whether they had considered bringing a malpractice lawsuit against the clinician or whether they had not considered this course of action. A total of 24 respondents had considered filing a lawsuit against clinicians (34%), while 47 (66%) had not.

General Information. Respondents who considered malpractice lawsuits (RCMs) were

TABLE 1

Responses to the Question: "Do you believe the clinician made mistakes? If so, please describe." (N = 71)

<i>n</i>	(%) ^a	Responses
16	(23)	Medication decisions.
12	(17)	Clinician did not involve the family.
10	(14)	Treatment was not aggressive enough.
10	(14)	Clinician didn't take possibility of suicide seriously.
6	(8)	Release from hospital and/or treatment too soon.
4	(6)	ECT decisions.
4	(6)	Clinician did not consult with others.
3	(4)	Loved one "fooled" the clinician.
3	(4)	Clinician did not connect with the patient.
2	(3)	Misdiagnosis.
1	(1)	Clinician "ignored" a nurse's note.
1	(1)	Clinician did not allow review of medical records.
1	(1)	Clinician was overly optimistic.
1	(1)	Clinician didn't see loved one soon enough.
1	(1)	Clinician failed to review past history.

^anumber of responses / total number of respondents.

TABLE 2

Responses to Question A: "Please tell us what was most helpful to you and your family with respect to the clinician's behavior after your loss" and Question B: "Please tell us what would have been helpful to you and your family with respect to the clinician's behavior after your loss." (N = 71)

Question A		Question B		Responses
<i>n</i>	(%) ^a	<i>n</i>	(%) ^a	
15	(21)	11	(15)	Clinician making contact.
14	(20)	2	(3)	Nothing.
12	(17)	6	(8)	Clinician offering his/her condolences.
11	(15)	3	(4)	Clinician discussing his/her experience and sense of loss.
0	(0)	7	(10)	Clinician disclosing records and/or therapy information.
5	(7)	0	(0)	Clinician explaining loved one's illness and treatment.
2	(3)	1	(1)	Clinician stating that "it wasn't your fault."
2	(3)	0	(0)	Clinician offering treatment.
2	(3)	2	(3)	Clinician acknowledging mistakes.
2	(3)	2	(3)	Clinician offering referrals to support groups.
2	(3)	0	(0)	Clinician coming to the hospital.
0	(0)	2	(3)	Clinician educating family about suicide and grief issues.
0	(0)	2	(3)	Clinician follow up and/or contact after the death.
1	(1)	0	(0)	Clinician requesting toxicology report.
1	(1)	0	(0)	Clinician requesting picture of loved one.
1	(1)	0	(0)	Clinician thanking the family for contacting him/her.
0	(0)	1	(1)	Psychological autopsy.
0	(0)	1	(1)	Clinician not attending the funeral.

^anumber of responses / total number of respondents

TABLE 3

Responses to the Question: "Have your attitudes and/or beliefs toward mental health care changed given the experiences described above? If yes, please describe below." (N = 71)

<i>n</i>	(%) ^a	Responses
19	(27)	Lack of faith in clinicians/mental health care system.
5	(7)	Reform needed in the mental health system.
4	(6)	Good care depends on patients' honesty.
3	(4)	Greater understanding of clinical depression.
3	(4)	Assertiveness is needed with professionals.
2	(3)	Sense that clinicians are more concerned with money than patient's well-being.
1	(1)	Learned more about mental health system.
1	(1)	Anger toward mental health system.
1	(1)	Belief that clinicians withhold information to protect themselves.
1	(1)	Belief that clinicians are not aggressive enough.
1	(1)	Belief that clinicians try their best.
1	(1)	Belief that more education is needed for primary care physicians.
1	(1)	Belief that clinicians are arrogant.

^anumber of responses/total number of respondents

more likely to report a number of different interactions with and attitudes toward the clinicians of their loved ones than those respondents not considering a malpractice lawsuit (RNCMs). RCMs were less likely to know who the primary clinician was (50%, $n = 12$) before the death, $\chi^2(1) = 10.55$, $p < .01$, as compared to RNCMs (86%, $n = 38$). In our sample, lawsuits were more often considered for male than female suicides, $\chi^2(1) = 4.99$, $p < .05$). In addition, a trend suggested that psychiatrists were more likely to be considered for a lawsuit than were nonpsychiatrists, including social workers, psychologists, pastoral counselors, and others, $\chi^2(1) = 3.21$, $p = .073$.

Perceived Problems with Treatment and/or the Clinician. RCMs were more likely to believe that the clinician did not tell them what they wanted to know, $\chi^2(1) = 6.81$, $p = .05$, and that the clinician was withholding information, $\chi^2(1) = 7.71$, $p < .01$, especially information that might be damaging to the clinician, $\chi^2(1) = 6.62$, $p < .05$. Trends also suggested that RCMs were more likely to feel blamed by the clinician for the loss of their loved one, $\chi^2(1) = 3.56$, $p = .059$. Open-ended responses further highlighted differences between RNCM's and RCM's percep-

tions of helpful and/or nonhelpful clinician behaviors. Twenty-nine percent of RCM's responses indicated that the clinician making immediate contact would have been helpful after their loss as compared to 11% of RNCM's responses. RNCM's cited meeting with the clinician as most helpful more often than RCM's (23% versus 13%, respectively). Eleven percent of RNCM's responses indicated that the clinician explaining their loved one's illness and treatment was helpful as compared to 0% of RCM's responses. RCMs were also less likely to believe the clinician did all they could to help their loved one, $\chi^2(1) = 9.47$, $p < .01$. RCM's open-ended responses also reflected their belief that more could have been done in treatment. Other differences indicated RCM's cited mistakes, such as premature release from the hospital and failure to take the risk of suicide seriously, more often than RNCM's (seen in 17% of RCM's responses versus 2% and 9% of RNCM's responses, respectively.)

Grieving Issues. Results showed that RCMs were less likely to want the clinician to attend the funeral, $\chi^2(1) = 5.00$, $p = .05$, and that RCMs were less likely to see the clinician as grieving as compared to RNCMs, $\chi^2(1) = 11.69$, $p < .001$). Twenty-one percent

of RNCM's open-ended responses indicated that the clinician discussing his/her sense of loss after the death was most helpful as compared to 0% of RCM's responses.

DISCUSSION

This study represents an initial attempt at exploring survivors' perceptions of the clinicians treating their loved ones. Despite the relatively small scope of this survey effort, several valuable findings emerged from the data. In terms of patterns of contact between clinicians and survivors before and after the death, almost all survivors knew their loved one was in treatment, while a majority (74%) knew who the clinician was. Perhaps surprisingly, only 11% of the sample reported that the clinician attempted to contact them before the death. This suggests that clinicians may not be regularly contacting families of suicidal patients, a step commonly recommended by experts in the field (Berman & Jobes, 1991; Linehan, 1999; Sokol & Pfeffer, 1992). Our open-ended data also suggested that survivors regarded a clinician's failure to contact the family as particularly problematic; respondents cited not involving the family in the treatment as the second most frequent mistake that clinicians made. Data also highlight a discrepancy between survivors' desire for contact with the clinician after the death and clinicians' actual behaviors with regard to contact. Only 39% of survivors reported that the clinician had tried to contact the family after the suicide. However, it appears that most survivors wanted to speak to clinicians since 74% of those who were not contacted attempted to make contact (50% were successful).

A number of interesting trends raise a variety of questions as to how clinicians can best respond to survivors following the suicide of their loved one. First, the results of this study provide evidence that survivors share a number of common reactions following their loss. Perhaps most notable, the present data suggest that survivors value various types of contact with clinicians following

their loss. Respondents frequently regarded offers of sympathy, such as attendance at the funeral or expressions of condolence, as helpful. About half of respondents indicated that they would have wanted clinicians to attend the funeral. Given these findings, clinicians, unsure of how to handle the delicate issue of making condolence calls, attending funerals, or sending cards, should note the possible importance these actions may have for survivors during their time of grief.

Additionally, the present data indicate that meetings and open discussions about the clinicians' impressions of treatment are other types of contact survivors value. It is important to note, however, that contact alone does not ensure that survivors will regard clinicians positively: 78% of respondents reported having contact with the clinician following the suicide, yet as many as 48% of those who had contact believed the clinician held back information in order to protect themselves.

Several clear differences emerged between those survivors who considered bringing lawsuits against the clinician and those that did not. It is noteworthy that those survivors who did not consider bringing lawsuits tended to find meetings with the clinician as more meaningful and more often believed the clinician was being straightforward and open. In addition, clinicians who were seen as grieving the loss of the loved one and who openly answered survivors' questions and concerns regarding their loved ones' treatment were more likely to be part of the group that was not considered for lawsuits. Perhaps one interpretation of these results is that clinicians can act prudently and possibly reduce their risk of being the target of litigation by arranging phone calls or face-to-face meetings with survivors immediately following a patient's suicide. Another interpretation is that clinicians who (accurately) believed that survivors were more likely to sue, tended to respond defensively by not meeting with survivors and hiding information which might be damaging. Yet another interpretation is that angry, bereaved survivors who are considering lawsuits may be suspicious of the

clinician and may find little comfort in anything he or she has to say. Interestingly, those survivors who felt blamed by the clinician were more likely to consider bringing a lawsuit. Moreover, two survivors who did not consider lawsuits noted the importance of the clinician's statement that the suicide was not their fault. These results suggest that clinicians should be careful to avoid giving the impression of blaming the family for the suicide.

In the aftermath of a patient's suicide, clinicians are faced with the difficult choice of how best to respond to loved ones. Clearly, the decision of whether to contact survivors is a complicated one, in that clinicians must balance several conflicting demands: Clinicians must simultaneously manage their own grief and the grief of surviving loved ones while preserving their relationship to their deceased client and being cognizant of legal and ethical issues. Two forensic experts emphasize that from a risk management standpoint, clinicians who fail to engage in meaningful contact with survivors may indeed predispose themselves to wrongful death suits (E. Harris, personal communication, November 3, 2000; B. L. Welch, personal communication, October 16, 2000). While many attorneys are often inclined to discourage their clients from communicating with family members, "therapists do not have to engage in mea culpas on the one hand or be exceedingly defensive on the other," but rather "can express (their) anguish at not having been able to save the patient" (B. L. Welch, personal communication, October 16, 2000). Our data appear to be more in line with these experts' recommendations and highlight the possible importance of clinicians making appropriate and meaningful contact with survivors.

It is important to note several limitations to the present study. First, results should be interpreted cautiously because of the limited sample size. Unfortunately, the small sample size precluded more detailed analyses which could have examined several important questions. We were not able to investigate the impact of variation in the length

of time between death and reporting (ranging from 14 days to 24 years). Another aspect we were unable to explore was the differences in perceptions of the treating clinician either depending on the survivor's relationship to the deceased (e.g., parents vs. children or siblings) or whether or not the clinician had contacted the survivor before the death. In addition, because the study sample was not randomly selected from the population of survivors and response rates were not available, it is impossible to know how this sample may differ from the overall population of suicide survivors. Most of the respondents were people who were actively involved in some sort of suicide survivor organization. Future studies of this topic would want to use a sample that is more representative of the entire population of survivors to improve generalizability. Additionally, because it is possible that more than one family member completed the survey, some surveys may actually describe the same event. Data were also not available about the type of treatment survivors' loved ones were receiving at the time of the suicide. Future replications should consider examining possible differences in survivors' perceptions of the treating clinician and lawsuit consideration depending on the nature of the decedents' treatment (e.g., hospital versus outpatient). Lastly, a number of respondents did not fully complete the entire survey, which resulted in numerous incomplete surveys. It is possible that differences could exist between those respondents who completed the survey in its entirety and those who did not.

Every week in the United States, another 12 clinicians lose a patient to suicide and are placed in the position of having to deal with grieving suicide survivors with little information about how to handle the situation. It is vital that a better understanding of the issues facing both therapists and survivors is reached to better address the multitude of concerns suicide leaves in its wake. This study represents an initial attempt at exploring survivors' perceptions of the clinicians treating their loved ones. Further research can extend this line of work and continue to

investigate what kinds of clinician behaviors are most helpful and most troubling to grief stricken survivors. Such research may generate guidelines that clinicians can utilize to comfort and assist survivors as they navigate

through their tragic loss. Hopefully, findings may benefit both survivors who must face the suicide of their loved one and clinicians who must confront the personal and professional loss inherent in a patient's suicide.

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