

## Clinical Trainees' Personal History of Suicidality and the Effects on Attitudes Towards Suicidal Patients

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Up to half of all individuals who completed suicide were in treatment at the time of death. Clinicians are thus uniquely positioned to help avert suicidal behavior, and the attitude of treating clinicians can greatly affect the quality of care of suicidal individuals. The goal of this study was to gain a preliminary understanding of how clinicians' own personal histories may impact their interactions with and attitudes towards suicidal patients. A questionnaire was distributed to clinical psychology trainees attending a voluntary 2-day workshop on working with suicidal crises. Questions assessed history of suicidality in self or close others, history of working with suicidal patients, attitudes towards suicidal patients, and attitudes towards preparedness and willingness to work with this population. Of 44 participants, 73% personally knew somebody who was suicidal, 59% had themselves experienced suicidal ideation, and 5% had an actual plan. Personal experiences with suicide were associated with increased stigmatizing attitudes, while specific education appeared to mitigate these negative feelings. Preliminary evidence is provided that indicates high levels of personal suicidal experiences in clinical trainees' histories which directly affect attitudes towards patients. It is suggested that specific education may increase students' preparedness and comfort in working with this vulnerable clinical population.

According to the National Center for Health Statistics, suicide is the second leading cause of death among adults aged 25 to 34 years in the United States (Nock, 2012). Additionally, the rates of suicide among Americans aged 35 to 64 increased by almost 30% between 1999 to 2010 (Centers for Disease Control and Prevention, 2013). Considering that more than 31,000 patients per year die from suicide while currently in treatment (up to half of all suicides; Fawcett, 1999; Hoyert, Heron, Murphy, & Kung, 2006), and that higher levels of involvement with mental health services is associated with a greater risk of completed suicide (Hjorthoj, Madsen, Agerbo, & Nordentoft, 2014), it is important for clinicians to have a better understanding of the variables that may impact treatment of suicidal patients. This includes clinicians' general attitudes towards and willingness to work with individuals who are suicidal.

The attitude of clinicians can greatly affect the quality of care of patients at risk of suicide (Sethi & Uppal, 2006). Whether it be unresolved issues from the clinician's past being triggered or realistic reactions to the patient's behaviors, the reactions of

clinicians towards patients may result in feelings of incompetence, hopelessness, demoralization, hostility, and/or withdrawal from emotional involvement with the client (McIntyre & Schwartz, 1998). This may set up a cycle of negative emotions and interactions between patient and clinician, resulting in unsuccessful and counterproductive treatment. Patients have much worse outcomes when they are treated by professionals who have pessimistic and discriminatory attitudes (Jorm, Korten, Jacomb, Christensen, & Henderson, 1999), and may have increased rates of self-harm and suicidal behavior (Hemmings, 1999). Focusing on the clinician's bias and attitude does not negate the effects of a patient's personality and maladaptive coping on outcomes. At the same time, it helps to develop a greater understanding of how therapist-related factors may operate within the treatment and, thus, impact outcomes.

Mental health professionals are more likely to have negative and stigmatizing attitudes towards mental illness and suicidal behavior than the general population (Henderson et al., 2014; Hugo, 2001; Jorm et al., 1999). This may be due to the mental health education system (Aydin, Yigit, Inandi, & Kirpinar, 2003; Nordt, Rossler, & Lauber, 2006), as well as the increased focus on biological defects rather than

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attribution of meaning (Read & Law, 1999). There is also some evidence that attitudes are likely to be shaped by clinicians' personal history with mental illness and suicide.

For instance, those who have experienced a patient's suicide are more likely to hospitalize suicidal patients, treat these patients with greater caution, and experience avoidance of or reluctance to treat depressed and/or suicidal patients in the future (Gulfi, Castelli Dransart, Heeb, & Gutjahr, 2010; Spiegelman & Werth, 2005). In addition, therapists surviving the death of a patient, especially therapists in training, often feel alone, unsupported, unprepared, ashamed, guilty, angry, and fearful of sharing their experience with supervisors and/or administrators (Grad & Michel, 2005; Spiegelman & Werth, 2005). However, the impact on clinicians is largely due to their own personal characteristics and previous life experiences (Alexander, Klein, Gray, & Eagles, 2000).

If clinicians' attitudes are largely shaped by personality and life experience, then it is plausible that students entering graduate training already manifest many of the perspectives that will shape their interactions with patients. It is important to understand, then, how education can affect change in any negative biases that might be shaped by one's personal experiences to help guide trainees to work effectively with vulnerable populations. While previous life experiences likely have the greatest impact on clinicians' attitudes and behaviors towards suicidal patients, studies examining clinicians' experiences with mental illness and suicide are limited and appear to be non-existent with regards to those in postgraduate training.

In a review of the few articles available, Kleespies et al. (2011) suggest that there appears to be evidence that the risk of suicide for psychologists is actually higher than the general population, as well as other similarly educated groups (e.g., Fussell & Bonney, 1990). A survey conducted in 1994 of 800 psychologists revealed that at least 61% had experienced clinical depression, 29% had felt suicidal at some point in their life, and 4% had actually attempted suicide (Pope & Tabachnick, 1994). These numbers have not improved in recent years; a survey of 1000 counseling psychologists conducted by Gilroy, Carroll, and Murra (2002) found that 62%

were currently depressed, and 42% had experienced suicidal ideation and/or behaviors. More disturbingly, it was found that 14% of those who were suicidal did not tell anybody, including their own therapist. This may not be surprising when it has been found that subjects consider depression in the therapist as a "personal flaw" that is not permitted (Deutsch, 1985, p. 312). In fact, Wood, Klein, Cross, Lammers, and Elliott (1985) found that only 55% of practitioners who responded that their depression affected their work actually sought help.

It is not surprising that psychologists may be more vulnerable to depression and suicide than the general population. Childhood trauma, maternal depression, and number of negative life events are common risk factors for depressive symptoms and suicidal ideation (Konick & Gutierrez, 2005; Wilcox et al., 2010). When compared with individuals of other professions, psychotherapists have been found to have a greater prevalence of childhood trauma and emotional neglect (Fussell & Bonney, 1990). Difficult experiences in one's family is thought to be particularly significant in an individual pursuing psychotherapy as a career, in that such a career choice might satisfy unmet needs (Strupp, 1973). Therapists are commonly thought of as 'wounded healers'; a concept that acknowledges the high rates of difficult life experiences individuals attracted to such a field have often faced (de Vries & Valadez, 2005).

Although it appears as though rates of experiences with suicide may not be uncommon in mental health professionals, there do not appear to be many empirical studies looking at how this personal history may affect attitudes. A study of non-mental health care professionals working in an emergency room in India concluded that internal conflicts over one's own suicidal proneness, in part, is positively correlated with avoidance of empathic closeness to suicidal patients, blaming of these patients and accusations of manipulation, and other negative attitudes that resulted in a low quality of care for these individuals (Sethi & Uppal, 2006). The lack of help-seeking in mental health professionals who are depressed (e.g., Wood et al., 1985) suggests that there is possibly a great deal of shame associated with one's own perceived weaknesses. In an account of her own struggle with mental illness, Sawyer (2011),

an esteemed psychologist at Yale University, states that the “prejudice that makes clinicians deny their own past or present need for psychotherapy affects our patients too” (p. 787). She urges professionals to open up communication about their own vulnerability and to not deny how personal experience can affect the treatment of patients. The effects of these personal struggles on the treatment of patients is not empirically known, but when looked at in the context of the previous studies cited, mental health professionals likely would have greater biases and more negative attitudes towards clients presenting with similar problems as themselves.

The following exploratory study used a researcher designed self-report questionnaire to gather information on rates of personal history of suicidal ideation, personal experiences of knowing individuals who were suicidal, and experiences working with suicidal patients for students attending a doctoral program in clinical psychology. Further, data were gathered on level of anxiety in working with suicidal patients, attitudes towards suicidal individuals, stigma associated with diagnosis, and willingness to work with patients who are suicidal. Personal history variables were examined relative to attitudes towards working with suicidal patients in their mental health career. It is hoped that this exploratory study can provide preliminary evidence for the rates of personal histories of suicidality, attitudes towards working with suicidal individuals, and any effects specific training might have on these attitudes among clinical psychology trainees.

## Methods

### Participants

A total of 52 participants attending the same clinical psychology doctoral program in the Northeastern United States attended the workshop. Of those, 44 (85%) completed the anonymous survey. Subjects from each of the first four years of the program participated; first year = 6 (14%), second year = 14 (32%), third year = 13 (30%), fourth year = 8 (18%), and no answer = 3 (7%). Participants were predominately female ( $N = 31$ ; 71%). No other demographic information was requested due to the sensitive nature of gathering personal data on students

who were in the company of faculty and peers. At the time of the study, the age range of graduate students was 21-60, but an age variable was not collected due to the identifying nature of those few individuals with an age older than 30.

### Measures

A 20-item questionnaire was constructed to obtain information regarding history of suicidality in self or close others, history of working with suicidal patients, and attitudes towards suicidal patients. The focus of the questionnaire was developed based on literature that provided evidence that, among clinicians, there is a prevalent view of suicidal patients as being manipulative and a burden on resources (Deans & Meocevic, 2006; Swain & Domino, 1985). This is particularly the case among clinical trainees (Jorm et al., 1999). Further, there is some evidence of an increase in negative attitudes based on personal history of suicidal ideation (Sethi & Uppal, 2006) or having experienced a patient's suicide (Gulfi et al., 2010; Spiegelman & Werth, 2005). Additional questions were developed using reformatted questions borrowing from The Mental Illness Clinicians' Attitudes Scale (MICA; Chronbach's  $\alpha = .79$ ; Kassam, Glozier, Leese, Henderson, & Thornicroft, 2010). The questionnaire developed was specific to students attending an elective two-day workshop offered by the graduate clinical psychology program, and was not validated or standardized. Many of these students were likely to have also attended a semester-long course focused on treatment of chronically suicidal and emotionally dysregulated patients, and questions were added in order to consider this variable. The full questionnaire is included in the appendix.

### Procedures

The questionnaire was distributed to students attending a two-day workshop on working with suicidal patients, which was provided by senior faculty. This voluntary workshop consisted of educational components that explained the motivations of chronically suicidal individuals, taught procedures and techniques for assessment, and described interventions used during crisis situations.

Students were informed that it was an anonymous survey, no identifying information was requested, and participation was completely voluntary. Institutional Review Board approval was obtained for both the pilot and reported studies. Answers to the questionnaires were entered into SPSS (version 18). All data was analyzed using *t*-test and ANOVA calculations, and no violations of normativity were found.

### Results

Of the 44 participants who completed the questionnaire, 26 (59%) had completed the previous course on specific treatment for chronically suicidal patients. Twenty-three participants (52%) had previous experience working with a suicidal patient, six (14%) had a patient threaten suicide, four (9%) had a patient attempt suicide, and two (5%) had a patient who completed suicide. Only 12 (27%) of the students had not known someone personally who was suicidal. Two (5%) had known somebody who had a specific plan, 12 (27%) knew somebody who threatened suicide, seven (16%) knew somebody who attempted suicide, and 11 (25%) knew somebody who completed suicide. The reported relationships of those who were personally known to be suicidal were: a family member ( $N = 11$ ; 25%), a friend ( $N = 12$ ; 27%), an acquaintance ( $N = 4$ ; 9%), and a close other ( $N = 3$ ; 7%).

Only 18 (41%) participants reported never having experienced any suicidal ideation themselves. Seven (16%) reported “maybe” having felt suicidal, 16 (36%) reported having only thought about it, and two (5%) reported having a specific plan. Participants reported being willing to tell a therapist if he or she was suicidal ( $M = 4.27$ ,  $SD = .95$ , with 1 = “strongly agree” to never tell a therapist and 5 = “strongly disagree” on a 5-point Likert scale), but were mostly unwilling to tell a peer ( $M = 2.98$ ,  $SD = 1.09$ , using the same 5-point Likert scale). Due to the disparity of balance between genders among this small sample, possible gender differences on the various measures were not considered informative and so are not reported here. Table 1 describes the frequency of suicidal experiences.

Although there was a small sample of participants, several significant differences did emerge. Table 2 describes the results of comparing attitudes towards

Table 1  
*Students' rates of experiences with suicide.*

	N (%)
Have you ever had a patient who was suicidal?	
Yes, they completed	2 (5)
Yes, they attempted	7 (17)
Yes, they threatened	2 (5)
Yes, they had a plan	4 (10)
No	27 (64)
Have you ever personally known somebody who was suicidal?	
Yes, they completed	15 (36)
Yes, they attempted	8 (19)
Yes, they threatened	7 (17)
Yes, they had a plan	1 (2)
No	11 (26)
Have you ever felt suicidal?	
Yes, I have attempted	0
Yes, I have had a plan	2 (5)
Yes, I have only thought about it	14 (33)
Maybe	6 (14)
No	19 (45)

and anxiety related to working with suicidal patients. Not all questions were answered by all participants. Twenty-six participants (59%) had received prior training on specific treatment for chronically suicidal patients. Those who received this previous training were significantly more likely than those who did not ( $N = 18$ ) to believe they had the adequate tools to treat suicidal patients,  $t(42) = 2.55$ ,  $p < .05$ , and to have more comfort in working with suicidal patients compared to others,  $t(42) = 2.53$ ,  $p < .05$ . After the 2-day workshop, participants had significantly more comfort in working with suicidal patients,  $t(49) = 2.45$ ,  $p < .05$ , and were significantly more likely to believe they had adequate tools to work with suicidal patients,  $t(49) = 3.48$ ,  $p < .01$ .

Those participants who had experienced any form of suicidal ideation ( $N = 22$ ) were significantly more likely than those who did not to consider diagnosis as a reason for characterizing an individual as manipulative, frustrating, and/or selfish,  $t(39) = 2.22$ ,  $p < .05$ . Similarly, those who did not have the previous course were also significantly more

Table 2

*Comparison of attitudes towards and anxiety related to working with suicidal patients between those with and without prior training and between those who have experienced suicidal ideation and those who have not.*

	Previous Training				Suicidal Ideation			
	With		Without		Personal experience		No	
	M	SD	M	SD	M	SD	M	SD
Adequate tools to treat suicidal patients <sup>a</sup>	3.19	.94	3.94*	.99	2.59	.91	2.37	.68
Comfort compared to other patients <sup>a</sup>	3.31	1.05	4.00*	.59	3.23	.97	3.32	.95
Would diagnosis influence attitudes? <sup>a</sup>	3.31	1.29	2.56*	.92	3.05	1.13	3.74*	.81

a = answers are based on a Likert scale (1 = *Completely*, 5 = *Not at all*); \*p < .05.

likely than those who had to consider individuals as manipulative, frustrating, and/or selfish based on diagnosis,  $t(42) = 2.13, p < .05$ . There was also a significant interaction effect between suicidal ideation and having had previous training on endorsement of suicidal patients as manipulative,  $F(1) = 4.10, p < .05$ , suggesting that education may mitigate the negative effects of personal suicidal ideation.

### Discussion

The results of this exploratory study appear to provide preliminary evidence for high rates of suicidality among mental health professionals in training, high frequency of having personal experiences with suicidal individuals, and possible negative effects of such experiences on attitudes towards suicidal patients. On a questionnaire that was given, during a program-sponsored workshop with faculty in attendance, 59% of participants reported having possibly felt suicidal at some point in their life, and 5% reported having had an actual plan; however, due to the nature of an in-person questionnaire given in front of faculty and peers, this may be an underestimate of the prevalence of suicidal ideation among trainees. According to their self-report, those trainees who did experience suicidal ideation were more likely to stigmatize suicidal individuals using diagnosis, possibly in an effort to differentiate suicidal individuals who are legitimately described according to stereotype and one's self. They also appeared to have more negative attitudes overall, although

this was not significant. Additionally, many of the participants were ambivalent towards or unwilling to tell a peer if they were suicidal, suggesting that there might be shame associated with personal suicidality.

Almost three-fourths (73%) of participants reported having known someone in their personal life who was suicidal, and 25% knew someone who completed suicide, most of whom were either family members or friends. Having known somebody who was suicidal is likely to have multiple effects; some may be more likely to avoid and stigmatize suicidal patients while others may be more empathic and more willing to work with suicidal patients. These tendencies may not be evident in this statistical analysis, but may be an area in which qualitative research could provide a better understanding.

Although there is some evidence that experiences with suicidal ideation is high among mental health professionals (e.g., Gilroy et al., 2002), there is only minimal empirical investigation of how clinician's personal history with suicide may affect attitudes towards suicidal patients. Previous studies have found some evidence that professionals working with suicidal patients may have increased pejorative and dismissing attitudes when they have a personal experience with suicide (Gulfi et al., 2010; Sethi & Uppal, 2006; Spiegelman & Werth, 2005). Unconscious projections of hatred and envy may be directed towards patients when a clinician has his or her own suicidal tendencies (Twemlow, 1997). These negative attitudes also tend to lead to worse outcomes (Jorm et al., 1999), including increased rates of

self-harm and suicidal behavior among patients (Hemmings, 1999).

Clinicians' personal histories can be associated with biases and avoidance when treating a patient with a similar history to one's self (Little & Hamby, 1999). Attempting to conceal and avoid painful experiences may impede emotional healing (Brewin, Dalgleish, & Joseph, 1996) and lead to shame (Platt & Freyd, 2012), externalization of blame, anger, hostility, and resentment (Sethi & Uppal, 2006; Tangney, Wagner, Fletcher, & Gramzow, 1992). It is hoped that this study may decrease some of that shame by reporting the high rates at which clinicians appear to experience suicidal ideation.

This study had several limitations. The sample size was small and consisted of a group of students attending the same program. The results may not be generalizable to students in other regions or of other disciplines, and also may not be descriptive of professionals once they begin their careers. A study comparing professionals' attitudes and experiences to those of trainees would help clarify how one's biases and behaviors change over time. The participants were all attendees at a voluntary workshop for working with suicidal individuals; those choosing to attend such a workshop could be more likely to have personal reasons for doing so. Future studies looking at effects of educational programs might benefit from comparing individuals who do and do not attend such programs to see if they differ on personal histories. The questionnaire was a self-report measure and may not accurately reflect the extent to which individuals have personally painful experiences or negative attitudes towards vulnerable individuals, particularly since it was given in front of other peers and faculty and the researcher personally knew many of the participants. The difficulty in obtaining information regarding professionals and trainees' personal histories may be a reason for the limited number of studies in this area. Further, this study was exploratory, attempting to contribute preliminary data for further research that is incredibly lacking, yet desperately needed. Lastly, the questionnaire used was not standardized or evaluated for construct validity or reliability. Future studies may use the findings of this exploration to create an instrument that is validated and standardized for greater accuracy and precision.

Although there is a high frequency of suicidal experiences among clinicians, it appears that education focused on a non-judgmental approach to working with suicidal individuals may buffer some of the negative effects these experiences might have. Several recent articles have emphasized the need for greater education of trainees both in understanding suicidal behavior and the need for dealing with one's own experiences (Kleespies et al., 2011; Rudd, Cukrowicz, & Bryan, 2008; Sawyer, 2011; Schoener, 1999; Sethi & Uppal, 2006). It is suggested that awareness of the effect of trainees' personal experiences on the treatment of patients (Kleespies, 1993), as well as the need for a greater understanding of patients' subjective experience are imperative in order to reduce stigma, bias, negative attitudes, poor quality of care, and resentment towards suicidal individuals (Kleespies et al., 2011; Sethi & Uppal, 2006; Spiegelman & Werth, 2005). The phenomenon of potential patient suicide and the effects of personal experience should be addressed during training in order to safeguard against some of the negative feelings and attitudes, as well as to increase awareness of one's own vulnerability to mental health issues (Middleton, 2008; Spiegelman & Werth, 2005).

Although further research needs to be conducted, the results of this study do suggest that personal experiences with suicide, both with self and other, may not be an uncommon phenomenon in individuals pursuing a career in the mental health field. Future studies should focus on larger populations, clinicians as well as trainees, the use of validated measures, and a control group to determine the level of effect of the educational process. Education may play a key role in mitigating any negative effects that one's personal history may have, and may increase student's preparedness and comfort in working with this vulnerable clinical population. Therefore, developing more focused educational programs that address clinicians' personal history and the impact on attitudes towards clients, as well as on teaching less stigmatizing approaches to working with this vulnerable population, are important directions for educators.

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### Appendix

1. What year are you
  - a. First year
  - b. Second year
  - c. Third year
  - d. Fourth year
  - e. Fifth year
2. Gender
  - a. Male
  - b. Female
3. Did you take the DBT course offered in the Fall of 2012?
  - a. Yes
  - b. No
4. Have you ever worked with a suicidal patient?
  - a. Yes
  - b. No
5. Do you feel comfortable working with a suicidal patient?
  - a. Completely
  - b. Mostly
  - c. Somewhat
  - d. A little
  - e. Not at all
6. Do you experience fear and/or anxiety in regards to working with a suicidal patient?
  - a. Completely
  - b. Mostly
  - c. Somewhat
  - d. A little
  - e. Not at all
7. Do you believe that you have the adequate tools necessary to assess and treat a suicidal patient?
  - a. Completely
  - b. Mostly
  - c. Somewhat
  - d. A little
  - e. Not at all
8. Have you ever had a patient attempt or commit suicide?
  - a. Yes, they completed
  - b. Yes, they attempted
  - c. Yes, they threatened
  - d. Yes, they had a plan
  - e. No
9. Have you ever personally known somebody who was suicidal?
  - a. Yes, they completed
  - b. Yes, they attempted
  - c. Yes, they threatened
  - d. Yes, they had a plan
  - e. No
10. If you answered yes to the previous question, was the person \_\_\_\_\_?
  - a. An acquaintance
  - b. A friend
  - c. Family member
  - d. Close other
  - e. N/A
11. Have you ever felt suicidal?
  - a. Yes, I have attempted
  - b. Yes, I have made a plan
  - c. Yes, I have only thought about it
  - d. Maybe
  - e. No
12. Are you currently in therapy?
  - a. Yes
  - b. No
13. If I were suicidal I would never tell a therapist
  - a. Strongly agree
  - b. Agree
  - c. Somewhat agree
  - d. Somewhat disagree
  - e. Strongly disagree
14. If I were suicidal, I would never admit it to my peers for fear of being treated differently
  - a. Strongly agree
  - b. Agree
  - c. Somewhat agree
  - d. Somewhat disagree
  - e. Strongly disagree
15. People who are suicidal can never recover enough to have a good quality of life
  - a. Strongly agree
  - b. Agree
  - c. Somewhat agree
  - d. Somewhat disagree
  - e. Strongly disagree
16. People who are suicidal are manipulative
  - a. Strongly agree
  - b. Agree
  - c. Somewhat agree
  - d. Somewhat disagree
  - e. Strongly disagree
17. People who are suicidal are frustrating
  - a. Strongly agree
  - b. Agree
  - c. Somewhat agree
  - d. Somewhat disagree
  - e. Strongly disagree
18. People who are suicidal are selfish
  - a. Strongly agree
  - b. Agree
  - c. Somewhat agree
  - d. Somewhat disagree
  - e. Strongly disagree
19. Would the patient's diagnosis influence your answers to the previous questions?
  - a. Definitely
  - b. Slightly
  - c. Maybe
  - d. Not really
  - e. Not at all
20. I feel as comfortable working with a person who is suicidal as I do a person with any other mental illness.
  - a. Strongly agree
  - b. Agree
  - c. Somewhat agree
  - d. Somewhat disagree
  - e. Strongly disagree