Psychologist suicide: Practising what we preach

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How many psychologists or therapists have you heard of, or know, who have ended their own life? There are documented cases of psychologists who have done so, such as American psychologists Lawrence Kohlberg and Michael J. Mahoney, who died in 1984 and 2006 respectively (DeAngelis, 2011). On our own shores there have been psychologists such as Petruska Clarkson (Lees, 2006), who committed suicide in 2006, and Jon Driver just last year.

For some readers, discussing psychologist suicide may be painful: many of our readers will know and still grieve for a colleague, friend or mentor. Psychologist suicide can also be a delicate area to examine when considering the image the profession wishes to project; as many psychologists work with vulnerable individuals who may feel suicidal themselves, the notion that we are also vulnerable may be a difficult one to reconcile (Kleespies et al., 2011).

This article explores the limited literature available on psychologist suicide with a particular emphasis on those psychologists who have client care as a primary responsibility. I will argue that attention is needed in this underresearched area of psychology practice.

'Psychologist impairment'

'Psychologist impairment' has only very recently become an area of interest for research (Smith & Moss, 2009), and there are differences in opinion as to what 'impairment' actually refers to. Munsey (2006), for example, made the distinction between 'distress' and 'impairment', whereby distress is 'an experience of intense stress that is not readily resolved, affecting well-being and functioning, or disruption of thinking, mood and other health problems that intrude on professional functioning', while impairment refers to 'a condition that compromises the psychologist's professional functioning to a degree that may harm the client or make services ineffective' (p.35).

Others have found that working as a psychologist may increase distress through a variety of potential 'hazards', such as: 'negative client behaviours including suicidality or aggressiveness, professional and emotional isolation, lack of therapeutic success, and demanding paperwork and administration duties' (Norcross et al., 2007, p.37). Kleespies et al. (2011) spoke of other possible contributing factors to 'psychologist impairment' when they listed: 'pressures associated with managed care, rapidly shifting role demands in institutional and clinic settings, decreased individual control over work, and increased time needed for paperwork and/or administrative duties' (p.248); a description that is sure to strike a chord with many readers working in mental health services today. While I am not suggesting that there is a positive correlation between increased paperwork and suicidal behaviour, perhaps as psychologists we can become blind to our own signs of 'distress' and 'impairment', and there is a danger that the therapeutic interventions we use to work with our clients may not be as readily used on ourselves (e.g. Norcross, 2000).

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In conducting clinical work, psychologists are not only exposed to challenging material and behaviours from their clients, but are also under intense pressure to 'perform' (Sherman & Thelen, 1998), and when these factors are coupled with the psychologist's own possible disposition to mental health difficulties, particularly depression (e.g. Gilroy et al., 2002; Pope & Tabachnick, 1994), we can see how 'distress' and 'impairment' can result. Of course, it has often been argued in most therapeutic traditions that psychologists and therapists can make use of their own mental health as a foundation for their work (Deutsch, 1985; Sherman, 1996). Commonly known as the 'wounded healer' (e.g. Guggenbuhl-Craig, 1999), this notion states that 'therapists are both motivated to become healers and strengthened in their capacity to

> empathize with others by painful life experiences that fuel their vulnerability' (Wheeler, 2007, p.245).

However, there are questions regarding when this foundation shifts from a therapeutic tool to a more detrimental presence. As Good et al. (2009) point out, knowledge and experience about the assessment and treatment of mental health difficulties in others does not necessarily lead to immunity from your own mental health problems – or the ability to address them.


ANNA HEATH

Psychologist suicide

The literature on psychologist suicide is sparse. One of the earliest studies conducted on this topic was by Steppacher and Mausner (1973); they found that from 1960 to 1969 suicide rates amongst male psychologists were slightly below that of the general population, but that female psychologists had suicide rates nearly three times that of the general population. However, possible sampling and methodological errors, as well as the accuracy of using death certificates, has since called these results into question (Guy & Liaboe, 1985).

Phillips (1999) followed up the Steppacher and Mausner study and found that between the years of 1981 and 1990, the rate of suicide amongst psychologists was not above the national average. These results were in turn challenged by Kleespies et al. (2011), who questioned the generalisability of the findings presented by Phillips based on their sampling. Deutsch (1985) found that in a sample of 264 master's- and doctoral-level psychotherapists, 2 per cent reported a suicide attempt. Pope and Tabachnick (1994) found that out of 800 psychologists sampled, 29 per cent reported suicidal ideation and 4 per cent reported attempting suicide. Gilroy et al. (2002) surveyed 425 counselling psychologists' personal experiences with depression and found that 21 per cent reported passive suicidal ideation; 18 per cent suicidal ideation without a plan; 3 per cent suicidal ideation with a plan; and one individual attempted suicide. An American Psychological Association survey comprising phone interviews with colleagues of psychologists who ended their lives (cited in Kleespies et al., 2011) identified 14 cases of psychologist suicide, and although the authors remind us that the information is somewhat anecdotal, what they found particularly poignant was the extent of the emotional impact of their death on families, colleagues, students and, of course, clients (Chiles, 1974; Reynolds et al., 1997). They found that it took between one and two years for colleagues to make sense of and cope with their loss, and that many students and trainees started questioning their career choice because of the act. Most of the psychologists who ended their lives had substance misuse problems and/or depression; an interpersonal or professional loss preceded the suicide for many; and one was due to legal or ethical problems.

All of the above studies have been conducted in the United States; there are no studies that concern the UK, although there is more general research with health-related professions suggesting they have some of the highest suicides rates in the country (e.g. Meltzer et al., 2008; Stark et al., 2006). We cannot say with certainty, however, how common suicidal ideation and behaviour is amongst psychologists relative to other professions, as they are frequently omitted as an occupational category from epidemiological studies (Kleespies et al., 2011).

Barriers

What might the barriers be for future research on the topic of psychologist suicide? The first barrier might be the field of 'suicidology' itself, which has been accused of suffering from theoretical incohesiveness (De Leo et al., 2006; Rogers, 2001). This makes it difficult to 'map' a theory of suicide on to this topic; a number of theoretical proposals have been put forward and may be equally valid, for example psychodynamics (e.g. Huprich, 2004) and the stress-diathesis model (e.g. Rudd, 2000; Wenzel & Beck, 2008). New theoretical models of suicide are also attempting to redress this conflict (e.g. O'Connor, 2011).

In suicide research on the general population, underreporting and under-detection has made accurate suicide estimates difficult to verify (e.g. Nock et al., 2008). One would imagine that the same difficulties would apply to research on psychologist suicides. Suicide still carries with it great stigma (Sudak et al., 2008), and when taking into consideration the paucity of research examining psychologist suicide, it could be argued that stigma would be even greater amongst a professional group whose frequent contact with vulnerable clients means that they must be perceived as being 'up to the job' and not experiencing the same difficulties as the individuals they work with.

This burden weighs heavily, as highlighted in Smith and Moss (2009, p.4): 'In one study, researchers found that 85

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per cent of Division 29 (Psychotherapy) APA members surveyed believed working when too distressed to be effective is unethical. Despite this finding, this study also revealed that 60 per cent had done so (Pope et al., 1987)'. Pope and Tabachnick (1994) found that psychologists frequently withhold important clinical information from their own therapists, and one would assume from colleagues as well.

Others have suggested that psychologists see 'wellness and impairment in dangerous dualities' (Good et al., 2009, p.21). By this they mean that there is often a divide between 'us', the psychologists, and 'them', the clients – and that this can lead to a form of denial about the state of our own mental health, and indeed the mental health of our colleagues. Smith and Moss (2009) argued that we often provide care for others while we deny our own wants and needs; we are often at the forefront of others' torment, and connect with their depression and despair; much of our work may be performed in isolation where, because of pressures on services, we may have limited time with others and few individuals who thoroughly help us make sense of the difficult experiences of our clients, as well as our own. As Good et al. (2009) argued, however, our first barrier may be to overcome the potentially taboo nature of psychologist suicide, and to try and not see wellness and impairment as an 'us' and 'them' issue, but rather an issue of 'us and when'.

Conclusion

Kleespies et al. (2011) summarised that the findings on psychologist suicide are currently 'suggestive, albeit conflicting and flawed' (p.256), and should be interpreted with caution, and that further systematic review is needed. This echoes Guy and Liaboe's (1985) conclusions, when they stated:

> It is time to move beyond melodramatic proclamations to more refined research, identification, and treatment of the psychotherapists who are at risk of suicide. (pp.471-472)

Even though more than a quarter of a century has passed between these two suggestions, and though their calls for further research are exactly the same, there has been limited movement to address this.

Perhaps it would be important first to be able to determine the extent of psychologist suicide in the UK, and whether it indeed is greater than the general population. Kleespies et al. (2011) noted that research is needed to determine whether there are any differences between psychologists who have client care as a primary responsibility and those that do not (e.g. academic and research psychologists). Additional future research might also aim to examine the personal and professional barriers that might inhibit psychologists from being able to express that they are feeling suicidal.

Regardless of such results, we could suggest ways of increasing access to services for those psychologists who are experiencing suicidal ideation. DeAngelis (2011) suggested a number of actions that could be taken in order to address this gap, including incorporating suicide risk and prevention into postgraduate training; improving training of qualified professionals not only in managing suicidal behaviour with clients, but also in ways of intervening with colleagues who are experiencing difficulties; normalising the challenges of being a psychologist; and better education on post-ventions in case of a colleague's suicide. Finally, the author echoes the call for more research 'on whether psychologists are at unique risk for suicide given possible self-selection factors and factors specific to the therapy profession, such as the intense and isolated nature of the work' (p.19).

> "asking these questions of ourselves as a profession may be a good place to start"

Some may of course argue that psychologists are only human: why would they not have suicidal thoughts and in some cases act on them. Are we not stirring up difficult questions just for the sake of it? I would argue that psychologists can feel 'distressed' and 'impaired' and this can often be shared with managers, supervisors or personal therapists, but psychologists who feel suicidal should also have somewhere to turn without fear of recrimination. Psychologists also have an ethical duty, and they should certainly be able to exist in a professional environment where they feel they have the ability to acknowledge suicidal thoughts without being concerned about being judged by others. It might be that this is the greatest barrier and will prove incredibly difficult in practice because of the potential consequences for factors such as professional standing and future employment, amongst others. As has been found in previous research, one of the most common reasons for psychologists and therapists to not admit depression or suicidal thoughts is a fear of professional censure (e.g. Deutsch, 1985; O'Connor, 2001).

There is no doubt that this is a complex and sensitive topic; however, as psychologists, we are often in the habit of asking difficult and probing questions of our clients about suicidal ideation, and we hope that by doing so our clients can be open with us in the interest of their well-being, perhaps asking these questions of ourselves as a profession may be a good place to start (Schoener, 1999).

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