Research

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EXPERIENCES OF HEALTH PROFESSIONALS WHO LOST PATIENTS TO SUICIDE: A QUALITATIVE STUDY

EXPERIÊNCIAS DE PROFISSIONAIS DE SAÚDE QUE PERDERAM PACIENTES POR SUICÍDIO: UM ESTUDO QUALITATIVO

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Abstract: The study aimed to explore and understand the experiences of healthcare professionals who have lost patients to suicide over the course of their careers, as well as the professional and personal repercussions of these losses. In-depth interviews were conducted with 13 professionals, and the data were subsequently analyzed using thematic analysis. The results revealed that losing a patient to suicide evokes a range of emotions, including sadness, guilt, helplessness, shame, fear, and shock. Factors that contributed to reframing this experience included seeking support from colleagues and revisiting the case with supervisors, engaging in psychotherapy, reflecting on the event, and maintaining contact with the patient's family members. A lack of contact with family members or a support network, as well as professional inexperience, were identified as factors that made coping with the experience more difficult. It is recommended that new public health policies and postvention actions be implemented and genuinely incorporated into national suicide prevention plans.

Keywords: Suicide; Tertiary prevention; Disenfranchised grief; Bereaved by suicide; Healthcare professionals.

Resumo: O estudo objetivou conhecer e compreender a experiência de profissionais de saúde que perderam pacientes ao longo da vida por suicídio e suas repercussões profissionais e pessoais. Foram entrevistados, em profundidade, 13 profissionais, empregando-se, posteriormente, a análise temática. Os resultados revelaram que perder um paciente por suicídio desperta emoções, como tristeza, culpa, impotência, vergonha, medo e choque. Os fatores que contribuíram para a ressignificação dessa vivência foram os seguintes entrar em contato com colegas e revisar o caso com supervisores, fazer psicoterapia, refletir sobre o ocorrido e manter contato com familiares do paciente. A falta de contato com familiares ou a rede de apoio e a inexperiência profissional foram sinalizadas como elementos que dificultaram lidar com a experiência. Sugere-se que novas políticas públicas de saúde e ações de posvenção sejam implementadas e, de fato, incorporadas aos planos nacionais de prevenção do suicídio.

Palavras-chave: Suicídio; Prevenção terciária; Luto contido; Enlutados por suicídio; Profissionais de saúde.

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1 Introduction

Suicide is among the leading causes of death worldwide, representing a complex and multifactorial phenomenon as well as a public health issue (Nie et al., 2021; Pontiggia et al., 2021). In 2019, more than one in every 100 deaths was due to suicide, with approximately 703,000 people dying by suicide globally, 77% of whom lived in low- and middle-income countries (World Health Organization [WHO], 2021). In Brazil, in 2019, there were 13,520 recorded cases (Brasil, 2021), which corresponds to about 37 deaths per day. Due to stigma, suicide is often reported as a death caused by other factors; therefore, these numbers are likely underestimated (WHO, 2021).

It is estimated that for every death by suicide, another 135 people are directly affected (Brasil, 2020). This group includes family members, friends, acquaintances, teachers, healthcare professionals, and other individuals who had contact with or felt connected to the person who died (Scavacini, 2018; Silva, 2015; WHO, 2014). The term "survivors bereaved by suicide" is used to refer to these individuals (Cook; Jordan; Moyer, 2015).

Losing a patient to suicide is considered an occupational hazard for mental health professionals (Malik; Gunn; Robertson, 2021), as it is one of the most challenging aspects of providing care in this field. It is important to note that the impact of caring for individuals at risk of suicide affects both the professional and personal lives of these practitioners (Rytterström *et al*. 2020). On a personal level, mental health professionals report strained relationships with family and friends, loss of self-esteem (Erbuto *et al*. 2021), decreased self-efficacy, a sense of responsibility for the patient's death (Qayyum *et al*. 2021), as well as feelings of guilt, shock, sadness, and anger (Sandford *et al*. 2020).

Evidence indicates that it is not uncommon for healthcare professionals, especially those working in mental health, to experience the loss of a patient by suicide (Malik *et al*. 2021). A study by Erbuto *et al*. (2021) involving professionals in this area found that more than one-third of participants had experienced the suicide of a patient during their careers. In another study conducted with 247 psychiatrists in Scotland, 67.61% reported having lost a patient to suicide, and among them, 47.37% had experienced more than one suicide (Alexander *et al*. 2000).

Individuals bereaved by suicide often face stigma and societal judgment, which intensifies their pain and can lead them to adopt a strong, positive attitude as a way to protect themselves and surviving family members (Goulah-Pabst, 2021). In such

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stigmatized situations, it is common for disenfranchised grief to occur, which is defined as grief that cannot be openly expressed or socially supported (Casellato, 2015). Many health professionals experience this type of bereavement when a patient dies by suicide, as they often face the fear of social judgment or feelings of guilt that may be perceived as a sign of professional and personal failure (Silva, 2015). These factors can lead professionals to silence their reactions to the event, making it more difficult to process their grief (Guedes, 2018). The impacts observed in professional practice include increased insecurity, caution, and defensiveness in managing suicide risk (Sandford et al., 2020).

Death by suicide is therefore a traumatic and highly emotional event (Roe; Smith, 2024). Not all professionals will feel bereaved, but they may experience stress reactions that range from normal intensity (Henry; Séguin; Drouin, 2004) to moderate or even traumatic levels (Silva, 2009). Suicide is also considered a violent death (Miller et al., 2021), due to how the body is found or the involvement of first responders, police officers, journalists, and firefighters, in addition to the legal investigation opened to determine the cause of death (Silva, 2015). These aspects contribute to the development of complicated grief, which involves a range of feelings such as sadness, guilt, anger, loneliness, hopelessness, rejection, failure, and self-scrutiny (Casellato, 2013; Goulah-Pabst, 2021; Malik *et al*. 2021).

However, experiencing the loss of a patient to suicide can also be an important learning factor, leading professionals to pay closer attention and apply greater rigor in assessing risk and intervening with patients who display suicidal behavior (Malik *et al*. 2021). Actions such as reviewing treatment approaches and investing in specialized training can help professionals reframe the experience as something constructive and growth-oriented, rather than purely tragic (Rothes; Henriques; Correia, 2013; Spiers *et al*. 2024).

To help professionals reframe their emotions and prevent long-term negative effects, it is essential that they have access to formal and informal support systems (Gulfi *et al*., 2016; Inostroza *et al*. 2024). These are known as “postvention strategies” (Pontiggia et al., 2021), defined as any intervention that occurs after a suicide with the aim of mitigating its impact on the bereaved (Fukumitsu *et al*. 2015), given that suicide bereavement can have a significant and lasting psychosocial impact, requiring appropriate psychosocial treatment (Pontiggia *et al*. 2021).

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In this context, in 2014, the World Health Organization (WHO) recognized postvention as a component of suicide prevention, acknowledging the importance of care and support for survivors bereaved by suicide (WHO, 2014). However, postvention studies remain limited (Scavacini; Meleiro, 2018), and there are but a few that specifically focus on psychologists, psychiatrists, and other health professionals who have lost patients to suicide (Cruz-Gaitán, 2020). Based on this, the present study aims to explore and understand the experience of health professionals who have lost patients to suicide over the course of their careers and the repercussions of this event on their professional and personal lives.

2 Method

2.1 Design and Participants

This study is characterized as exploratory, with a qualitative approach. A total of 13 health professionals participated, selected by convenience sampling. They were required to be over 18 years old and to have experienced the loss of patients to suicide during their professional practice. Table 1 presents the participants' characteristics, who ranged in age from 27 to 88 years, with the majority being women. The table shows a diversity of professions, with physicians and psychologists being the most represented. Most participants had lost more than one patient to suicide. The professionals worked in public or private institutions at the secondary or tertiary level in areas directly related to mental health care (e.g., Psychosocial Care Centers or psychiatric inpatient units) or in other health fields (e.g., clinical inpatient units or specialized departments such as pulmonology). At the time of the study, two participants were working independently in private practices.

Table 1: Participant Characteristics

Participants	Age	Sex	Profession	Employment type	Patients who died by suicide (n)	Most recent patient suicide (year)
1FPsic	35	F	Psychologist	Self-employed	1	2021
2MPsic	41	M	Psychologist	Public servant	1	2007
3FPsic	27	F	Psychologist	Public servant	2	2021
4MMed	88	M	Psychiatrist	Private sector	3	1990
5FEnf	34	F	Nurse	Public servant and private	5 or more	2019

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				sector		
6MMed	32	M	Psychiatrist	Public servant	1	2020
7FPsic	34	F	Psychologist	Self-employed	1	2021
8FPsic	37	F	Psychologist	Public servant	1	2015
9FEnf	56	F	Nurse	Public servant and private sector	5 or more	2010
10FPsic	42	F	Psychologist	Public servant	4	2019
11FMed	30	F	Psychiatrist	Private	1	2021
12MProf	44	M	Physical Education Professional	Public servant	5 or more	2015
13FTEnf	40	F	Nursing technician	Public servant	5 or more	2021

Note. F = Female, M = Male
Source: Research data

2.2 Research Instrument

A semi-structured interview was used as the research instrument. The interview guide had been previously tested and refined by two mental health professionals. The interview covered topics related to professional practice, the experience of losing a patient to suicide, knowledge about postvention, and work during the COVID-19 pandemic.

2.3 Data collection procedures

Participants were recruited through social media using the snowball sampling technique, whereby participants referred other potential participants for the study (Vinuto, 2014). Fifty individuals expressed interest and completed an online questionnaire developed by the authors to verify eligibility criteria, gather information to characterize the participants, and document their professional experience. Completing the instrument took approximately ten minutes on average. It also included questions to collect contact information for the invitation to the second stage, which was sent via WhatsApp and email. Of these respondents, 39 met the inclusion criteria, and 13 agreed to participate in the interviews.

The interviews were conducted online, via a virtual platform, between September and November 2021. All interviews were recorded for subsequent

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transcription and analysis. The interviewer arranged to be in a private setting for the interviews, and participants were asked to ensure they were in a similarly private setting. Anonymity was guaranteed, and the audio files were handled exclusively by the first author. The interviews lasted an average of 40 minutes and were conducted by the first author, a psychologist with specialization and experience in clinical practice and the field of suicide and self-harm. At this stage of the research, there were no withdrawals or refusals to participate. Following this stage, participants received the postvention booklet produced by the Vita Alere Institute by email, containing information on the concept of postvention, common feelings during the bereavement period, where to seek help, and general guidance for those bereaved by suicide (Scavacini et al., 2020).

2.4 Ethical Procedures

This study was approved by the Research Ethics Committee [name withheld to preserve blind review]. Prior to the interviews, participants agreed to the Informed Consent Form, which contained information about the research objectives, the risks and benefits of the study, as well as their right to receive support if needed.

2.5 Data Analysis Procedures

First, the audio recordings were transcribed. The transcripts were then sent to participants so they could verify the accuracy of the content and, if they wished, add any additional information. Next, the interviews were analyzed using thematic content analysis (Bardin, 2015). In the first stage, the first author conducted an initial, broad reading to skim the content and identify central ideas, which were organized into broad themes that emerged recurrently across the interviews. This initial theme organization was extensively discussed with the second author. Subsequent readings of the interviews and coded material were carried out to refine the categories and subcategories, redistribute excerpts, and incorporate new discussions and interpretations in collaboration with the second author. The third author was consulted in cases of disagreement and to help consolidate the final organization of the categories. The analysis was supported by NVivo software, version 10, and drew on discussions from national and international suicidology scholars and theorists (Gulfi *et al*., 2016; Scavacini, 2018; Silva, 2015). It also prioritized a reflexive approach to data interpretation, in which the researchers critically considered their own perspectives (Braun; Clarke, 2022).

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3 Results and Discussion

The interviews provided insights into the experiences of health professionals who have lost patients to suicide over the course of their careers, as well as the professional and personal repercussions of these events. Table 2 presents the resulting categories and subcategories, along with excerpts that illustrate the main themes.

Table 2: Categories, Subcategories, and Vignettes

Categories	**Illustrative vignette**	**Subcategories**
1. Feelings about the Experience and Its Repercussions	"I think the first impact is that avalanche of feelings, right? Sadness, wanting to understand what happened, trying to revisit whether there were any signs we missed, and maybe becoming a bit more concerned about the other patients we are also treating." (#8FPsic)	1.1. Impact on Professional Conduct
		1.2. Uncertainty and Doubts About Whether Something Different Could have Been Done
		1.3. Feelings
		1.4. Impact on Personal Life
2. Coping Strategies	"For me, these two things were fundamental: first, having a mindset that stopped me, like, 'calm down, you can't blame yourself for this, you know?' And second, the support network. People, at that moment, opened up their empathy, shared their life stories, you know? And they were highly empathetic with me." (#2MPsic).	2.1. What Helped Them Cope With the Experience?
		2.2. What Hindered Their Coping With the Experience?
		2.3. Did They Consider Leaving the Field or Profession?

Source: Research data

3.1 Feelings about the Experience and Its Repercussions

Losing a patient to suicide is an impactful experience in a professional's life. It brings about distressing emotions and leads to changes in clinical practice (Gulfi *et al*. 2016; Lyra *et al*. 2021; Rothes *et al*. 2013; Taib *et al*. 2024). The participants reported various impacts and feelings after losing a patient, with repercussions that affected not only their professional practice but also their personal lives.

In many accounts, an impact on professional conduct was evident—sometimes described as positive, sometimes negative. These findings are consistent with the study by Baldissera *et al*. (2018), which noted that although death is part of the daily routine for health professionals—especially in emergency and critical care—each professional copes with a patient's death in a different way.

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Among the repercussions, participants mentioned paying closer attention when assessing patients, becoming more cautious about sudden improvements, and feeling generally more vigilant—something that some considered a positive outcome: "I think I became more apprehensive; I think I became more careful. I think, on the one hand, that has a positive side, right? That I pay more attention now, you know?" (# 7FPsic) The literature supports this idea, indicating that after a patient's death, there may be an intensification of risk assessment and greater interest in issues related to suicide, such as more detailed session records and communication, a more cautious approach to patients at risk, and a stronger tendency to recommend hospitalization or collegial consultations (Erbuto *et al*. 2021).

One participant (#7FPsic) believed that when professionals work with many severe cases, they tend to become accustomed to this situation, which may contribute to lowering their level of alertness. However, the experience of losing a patient to suicide may cause them to become more vigilant once again. In this more cautious approach, contact with the healthcare team and other mental health specialists is an important strategy whenever any sign of risk is identified. In this sense, participants working in general healthcare reported reaching out to mental health professionals to carry out a more accurate assessment of the patient. They also described bringing more cases for discussion in team meetings, avoiding making decisions alone.

Right after the patient's death, professionals reported difficulties managing bureaucratic aspects of their practice, such as handling the deceased patient's medical records and dealing with the opening left in their schedule. At the same time, they struggled to understand what had happened and revisited their own conduct, as illustrated in the excerpt:

> The obsession with reviewing charts, reviewing what I did, reviewing step by step, reviewing what I said, what I didn't say, even wondering if I had the right expression on my face when I said it. You get like this, you know? My God, you feel responsible—how did I let this slip by? What was the sign they gave that I missed? (# 11FMed)

Some professionals reported making themselves more available to their patients, out of fear that something similar might happen again. With new patients, they imposed conditions for accepting similar profiles, such as requiring in-person psychiatric care to ensure that local hospitalization could be arranged if needed. This brought greater security to those who chose to continue working with patients presenting suicidal behavior. In contrast, some interviewees from the nursing and medical area did not perceive clear

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impacts on their professional practice: “I had already reflected on it, and by reflecting again, in that sense, it had no impact on my work—it had an impact on me personally.” (#4MMed)

Participants also described noticing changes in their relationships with their teams after the loss, often feeling more irritable and less patient with colleagues. Other participants did not feel motivated to work or to study the topic of suicide right after the incident: “I took about two weeks off from seeing patients, I didn’t see anyone.” (#11FMed); “I don’t know if it’s avoidance, if it’s denial, but I just don’t have the courage to get into it, to study it.” (#1FPsic)

On the other hand, some participants engaged in studying the topic further, seeking answers about management and self-knowledge, and becoming better prepared to talk about the subject. In addition, they noted greater investment from workplace managers in training and professional development, as well as more frequent team meetings that created space for open conversations. The literature highlights lack of preparedness and the absence of ongoing training for working with suicide as major challenges (Skehan *et al*. 2024; Zamineli de Lima *et al*. 2023). In this context, it is important to note that health professionals need ongoing training to develop and maintain suicide prevention and intervention practices. This can help them identify patients at risk, develop appropriate attitudes and emotional competencies, and strengthen their confidence when working with patients exhibiting suicidal behavior (Piccinini; Martins, 2021).

Most participants (9) expressed uncertainty and doubt about whether they could have done something differently, often re-examining their actions—an aspect consistent with the literature (Fukumitsu; Kovács, 2016): “We question ourselves whether the news was delivered in the best possible way for them, what else we could have done differently, or what other approaches we could have used with these patients.” (#5FEnf) More than half of the participants (7) were not sure whether the actions they chose contributed to the patient’s suicide. For example, #12MProf participated in transferring a patient to another unit just before their suicide attempt and was left wondering whether things would have been different had that decision not been made. Others questioned whether involuntary hospitalization might have been more appropriate, or whether more attentive listening and stronger family intervention could have led to a different outcome:

> So, I kept wondering about that. But on the other hand, I also thought: what if I hadn’t admitted him, and he had killed himself anyway? Had died by suicide

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> anyway? Maybe I'd feel even worse. So, I think… I think the admission was a necessary evil in this situation. (#6MMed)

Suicide is seen as a preventable act, which creates uncertainty about whether the professional's actions were appropriate and often leads to the search for a "guilty party" (Rothes *et al*. 2013). This tendency can make coping with grief more difficult. At the same time, healthcare professionals in general often lack the training and preparation needed to deal with suicide (Scavacini; Meleiro, 2018). When a patient dies by suicide, it is frequently perceived as a therapeutic failure (Silva, 2015). However, while it is possible to assess suicidal ideation and intent, it is not possible to predict whether a patient will ultimately take their own life. Accordingly, when professionals understood that there was no direct link between the patient's suicide and their own actions, this tended to lessen feelings of guilt and distress: "When someone is determined to commit suicide, they might be on medication, they might be seeing a psychologist, they might even be hospitalized with twenty-four-hour supervision—but if they want to do it, well…" (# 1FPsic) Five interviewees felt they had done everything possible within the circumstances and recognized the need to live with the feeling of powerlessness, as #2MPsic exemplified: "This is how I see it: 'look, I didn't commit any negligence,' you know?" (# 2MPsic)

Negative emotions have been highlighted in major studies on the impact of suicide on the bereaved (Kovács, 2010, 2011; Kreuz; Antoniassi, 2020; Rothes *et al*. 2013). In this regard, the professionals described a range of emotions they experienced immediately after the patient's death by suicide, including helplessness, shame, fear, shock, guilt, sadness, and longing: "When the news came that he had hanged himself, you feel really upset." (#10FPsic); "The fear is still terrifying—I'm still afraid every day, and I think I will be for the rest of my life." (#7FPsic) Several participants described the sense of helplessness as something internalized, a lasting result of the experience: "It's a very dark place because suicide leaves you in a limbo of powerlessness—it takes away all the answers." (#1FPsic); "Sometimes I still feel the same helplessness now that I felt back then." (#5FEnf). Participants also spoke about feelings of grief and longing, noting that this is a form of disenfranchised grief, and that not being able to talk about it was painful. One participant also described a sense of "disarray," of disorganization and emptiness, when seeing the patient's appointment slot and when interacting with the family:

> I felt so many things. I think seeing the name in my schedule… since I had two slots a week for each person, those slots stayed empty for a while. Then there were the conversations on my phone, talking to his brother, explaining what

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> was happening—so dealing with all of that was… I had to stay strong for a long time so I wouldn't show what I was feeling. But sometimes I do feel a bit of longing… everything feels a bit messy. (#3FPsic)

These findings align with Kovács's (2010) view on the difficulty health professionals can face in dealing with the pain of loss—and how it becomes even more painful to process when there is a strong bond with the patient. In these moments, professionals must confront feelings of failure and helplessness while experiencing a grief that cannot easily be shared, contributing to what is known as disenfranchised grief.

This experience of grief was tied to thoughts participants expressed, such as fearing they would lose patients if people found out what had happened, worrying they would be seen as incompetent or less respected, or feeling they wouldn't be understood by those who hadn't been through the same experience. Professionals also described feeling more depressed, hopeless, and questioning whether they should keep working with suicidal patients. These ideas echo other studies, such as Alexander *et al*. (2000) and Rothes *et al*. (2013).

> It's like this, look, it's really personal […] I thought I might even need to adjust something, take some kind of antidepressant or something, because I was really depressed, really—for about three weeks, really very depressed." (#11FMed)

> I remember I started feeling… I started getting depressed, I started feeling bad, you know? Feeling sad, feeling awful, feeling hopeless—and this event was one of those, among many others." (#2MPsic)

This difficult emotional experience also had an impact on the participants' personal lives, just as Malik *et al*. (2021) point out when they note that this experience can significantly affect professionals' lives. Participants who went through grief described how the loss affected their daily routines, such as no longer doing activities like going to the gym. For some, losing a patient to suicide—along with other stressful events—affected their quality of life, even if only temporarily:

> It was maybe just one more stressor, along with others that were already happening, that made me feel like that. I went through a period when I was really anxious, even had trouble sleeping. But I think it was actually more related to other things that were going on at the time. (#6MMed)

Most participants reported feeling more reflective for a few days after the death, trying to find an explanation for what had happened: "I thought about it all the time. I kept thinking about it constantly. All the time. I thought about it, but I didn't want to think about it, but it was kind of obsessive." (#11FMed) These accounts show how the loss affected participants' personal lives, as they were moved and felt pain for the patient and their family when faced with stories of suffering. On the other hand, the experience also

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prompted some interviewees to reflect on their own lives and search for new meaning, to think about their relationships, and to consider what they wanted to do to make their own lives feel worthwhile:

> Automatically, I ended up reflecting a lot about her life. Why did she have to... what was missing—was it a lack of a mother, a lack of relationships? I think it also made me more available, more attentive to the people around me […]. I ended up taking things easier—this was even reflected in my schedule, as I reduced my work hours a bit because I couldn't handle it all. I was really overwhelmed. (#1FPsic)

This process was accompanied by changes in behavior—for some, it meant placing greater value on family, life, and work; for others, it brought distance and loneliness: "I think that was the impact—I used to be more family-oriented, and now I'm more distant, more alone, more in my own corner, quiet. Like, I don't like to bother anyone [...] I'd rather be alone." (#9FEnf)

3. 2 Coping Strategies

Overall, participants reported various coping strategies and factors that they felt either helped or made it more difficult to deal with aspects of their professional and personal lives after losing a patient to suicide. They also spoke about thoughts of leaving the profession because of what happened and due to other challenges in the mental health field.

Among the aspects that helped them cope, nine participants mentioned sharing what happened with colleagues who had also experienced a patient's suicide, perceiving a non-judgmental attitude from others, and reviewing the case with supervisors. Critical review of the event is described in the literature as a factor that helps professionals better understand their responsibility and process the feelings and impacts of the experience (Henry *et al*. 2004). Seeking support—both from colleagues and family—combined with revisiting the case, were the most helpful resources used by professionals in a Portuguese study (Rothes *et al*. 2013). Participants felt deeply supported when colleagues also shared their own stories of losing patients to suicide, and when family members acknowledged the professional's grief. This connection and the empathy received from others validated their emotions and helped them cope better with the loss, as #2MPsic explains: "We talked in a group, right? Several people at the CAPS *(a Psychosocial Care Center)* told me they had also lost someone and that it was normal for us to feel guilty [...] it was really good because we talked with several professionals."

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Losing a patient to suicide has professional and personal consequences, making peer support essential. This contact with colleagues, along with professional case reviews, helps reduce inadequate reactions to suicide and can prevent long-term effects on clinical practice and the treatment of other patients (Alexander *et al*. 2000; Gulfi *et al*. 2016). Talking about suicide also helps break the taboo surrounding the topic and supports emotional recovery (Cruz-Gaitán, 2020). Participants also highlighted the importance of psychotherapy for reframing the loss and maintaining emotional stability—a finding also reported by Kershaw *et al*. (2024). Professionals viewed this treatment as a space free from judgment:

> I believe that those who care for others must also be cared for. We can't expect to help fix other people's lives if our own life is a mess. So, yeah… I think that was essential. The therapist being cared for. Being in therapy, because we deal with this all the time. (#11FMed)

Reflecting on what happened and identifying broader information about mental disorders were strategies mentioned by eight participants. In this sense, professionals said they tried not to dwell on self-blame but rather to accept that working with at-risk patients means being exposed to the possibility of losing a patient—especially for those working in mental health: "I also try not to keep beating myself up over something that, unfortunately, we can't control." (#5FEnf)

> We know we're exposed to this. And I think what helps is to focus on the cases we did manage to save—which are so many more. I think that's the motivation. We know we might not always be able to dissuade someone, but we also know that, in many success cases—let's call it that—people really do get better." (#8FPsic)

Another important point was the need to look at statistics on patients with mental disorders who die by suicide, to identify and understand the patient's specific characteristics and to acknowledge that those who work with severe cases will inevitably face the loss of at-risk patients at some point. Having this understanding helped reduce feelings of guilt. The length of the therapeutic relationship was also a factor professionals considered—they concluded that the shorter the bond, the less emotional impact the death of the patient had.

Other strategies, such as exercising, reading, praying, and having faith, came up in several participants' accounts as ways that helped them cope with the loss and reduce stress. Avoidant strategies were also mentioned, such as choosing not to think about what had happened and taking time off work to distance themselves from their routine. These participants understood that dealing with death was difficult and that not thinking about it could be protective at that moment, helping the pain ease in the long run.

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Other strategies included speaking with the patient's family, staying silent, and reflecting on the situation. Some participants shared that they made themselves available in case the family wanted to reach out, but this offer was not always taken up: "I always make myself available and wait—I leave the door open." (#9FEnf) One participant didn't see the family member because they didn't live in the same city. However, they mentioned that they would like to see the patient's mother if she ever came to town, as they had felt very supported by the mother when they received the news—and believed that this support had helped them cope with the situation. One participant said the patient left a letter, which brought them comfort and a sense of closure:

> The patient left me a message, which was to say thank you—really beautiful words. I think that helped me a lot, I think it was, yeah… it was one of the most important things, to be honest. And the family also treated me very well." (#11FMed)

Some participants attended the patient's funeral, a fact supported by Campbell and Fahy (2002, p. 46), who note that "psychiatrists should also seriously consider attending the patient's funeral. The funeral can be an important opportunity to grieve in a group setting." One participant who attended the funeral shared that doing so was a way to experience their grief: "During that time, I cried a lot. I even went to the funeral, talked with the family—so I had that mourning for myself" (#3FPsic).

Regarding aspects that hindered coping with the loss, three participants mentioned that contact with the patient's family made this process more difficult, as it brought them closer to painful news and repercussions of what had happened. However, one participant felt that not having more contact with the patient's family made it harder for them to process the loss, because they had made themselves available to meet with the patient's mother as a way to seek some kind of closure, but she never reached out. For this interviewee (#6MMed), not being able to share in and help hold her anguish made it more difficult to find that sense of closure. This feeling is in line with Fukumitsu and Kovács's (2016) view on the importance of taking an interest in and sharing the stories of other suicide survivors.

Not being able to share the experience with someone who had been through something similar was also mentioned by other participants when talking about their colleagues and team. In addition, blame and judgment from some coworkers, when they did occur, were experienced as factors that made dealing with the loss even harder: "So, at first, I got a bit of understanding from my colleagues on the day the person died, but after that there was a lot of pressure. [...] Judgments. (long sigh) [...] That's tough."

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(#3FPsic) In particular, this participant had to write the death report for the patient's suicide—something they emphasized was very difficult, since this report is not usually drafted by psychologists, and it meant their name would be on that document.

Personal experiences with suicide, loss, and grief can also influence how a professional deal with a patient's death (Kovács, 2010), as one participant explained:

> My father attempted suicide—using a firearm—but we managed to find out in time. Which is really hard, because, being a psychologist, I blamed myself. 'Why didn't I notice that my father wasn't okay?' I knew something wasn't right, I tried to get help, but he wouldn't accept it. [...] So the whole suicide issue really hit that nerve. [...] You can see yourself in it a bit. I think the first [patient suicides] were the hardest. (#10FPsic)

The participant's lack of professional experience at the time of the loss was also noted as a factor that made coping more difficult. One participant recalled that, early on, they were more afraid to discharge a patient who might need hospitalization, but now feels more confident—something echoed by two other participants who described feeling less anxious as their experience grew. Several participants emphasized that, early in their careers, there was a great desire to "save the world" (#5FEnf) and that, over time, they came to understand that this is not possible. In this way, greater professional experience can help in coping with loss and accepting the limits of their role.

Finally, having to continue their practice immediately after a suicide required significant effort from these professionals—and this was even harder for those who could not take time off in the first days: "What made it more difficult? Well, even though I didn't want to see anyone, I was still obligated to. Even though I didn't want to—I wanted some time to process all of it, I had to keep seeing patients" (#11FMed).

Not having a dedicated space in the workplace for listening and support after a patient's suicide is another factor that makes coping with the loss more difficult. The fact that suicide is so stigmatized and often viewed as a sign of clinical failure can prevent professionals from seeking help and can limit the development of appropriate postvention measures (Rothes *et al*. 2013). The stigma of failure can also keep professionals from using the experience as an opportunity for future learning (Spiers *et al*. 2024).

Although the decision to stop treating suicidal patients—or even to leave the profession altogether—remains underexplored, some research has shed light on this issue. While Gulfi *et al*. (2016) consider this tendency to be relatively rare, a study of 167 professionals who had lost a patient to suicide found that 15% of participants considered early retirement (Alexander *et al*. 2000). Another study of 141 professionals in Quebec found that 29% temporarily refused to treat suicidal patients, and 22% considered leaving

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the profession entirely after the loss (Henry *et al*. 2004). These findings are consistent with Cruz-Gaitán (2020), who also found that professionals may choose to see only patients without suicide risk—or even switch careers—because they no longer feel competent.

In this study, when asked directly, none of the participants stated that they had considered leaving the profession after losing a patient. However, over the course of the interviews, some did mention having questioned whether they would continue seeing patients at risk of suicide after experiencing such a loss. One participant reported that they had stopped accepting new patients with this profile, while three others described setting stricter criteria for accepting these cases. For one participant, the question of whether to continue treating patients at risk of suicide was a constant concern, and they used to think that if they ever lost a patient, they would leave the profession altogether:

> I always said that 'If one day someone dies on my watch, I think I'll quit my profession.' [...] Until you realize you're not God. And if the person is going to pass away, they will—but what matters is that you are very confident in your conduct so you don't feel guilty. [...] I think quitting is bad. No—you will grow, and know that you have helped many and can still help many more, by studying more and more, dedicating yourself more and more so that you build this confidence (#11FMed).

As this participant's account suggests, the experience of loss reframed the idea of leaving the profession as a coping mechanism, indicating that active and reflective engagement with the experience can bring a renewed sense of purpose.

4 Final Considerations

This study aimed to explore and understand the experience of health professionals who have lost patients to suicide over the course of their careers and the repercussions of this event on their professional and personal lives. The participants' accounts revealed that this experience has significant occupational and emotional impacts, highlighting the need for new public health policies and the effective implementation of postvention actions already foreseen in national plans.

It is crucial to discuss and incorporate postvention strategies not only at the individual level but also collectively within healthcare services—whether in the daily practice of teams or as part of training guidelines and institutional policies. At the collective level, important gaps were identified in the training and preparation of professionals to deal with risk situations and bereavement by suicide. These findings

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reinforce the importance of including suicidology in professional education to strengthen technical preparedness and reduce the stigma associated with this topic.

The findings discussed in this exploratory article are limited to the regional context represented by the participants—mostly women—selected by convenience sampling. Future research could deepen and broaden reflections on postvention among healthcare professionals by investigating how these processes unfold in different care settings through studies that combine extended observation and interviews.

In conclusion, the impact of suicide loss on healthcare professionals' well-being is also a way of caring for collective health. Strengthening support networks, reducing stigma, and investing in qualified training are important steps toward building more humane and sustainable practices. Likewise, it is essential that public policies and postvention actions are effectively incorporated into prevention plans, overcoming the persistent gap between official guidelines and their practical implementation in Brazil.

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