Brazilian Journal of Psychiatry
bjp
Revista Brasileira de Psiquiatria

Braz J Psychiatry. 2023 Jan-Feb;45(1):62-70
doi:10.47626/1516-4446-2022-2617
Brazilian Psychiatric Association

REVIEW ARTICLE

Bittersweet transformative experiences in professionals working with suicidal patients: a meta-synthesis

Natália Gallo Mendes **Ferracioli**,[1] Elaine Campos Guijarro **Rodrigues**,[1] Manoel Antônio dos **Santos**[2]

[1]*Programa de Pós-Graduação em Psicologia, Faculdade de Filosofia, Ciências e Letras de Ribeirão Preto (FFCLRP), Universidade de São Paulo (USP), Ribeirão Preto, SP, Brazil.* [2]*Departamento de Psicologia, FFCLRP, USP, Ribeirão Preto, SP, Brazil.*

Objectives: To synthesize and reinterpret findings from primary qualitative studies on the emotional experience of health care professionals working with mental health and mental health professionals providing care for people with suicidal behavior.
Methods: We conducted a systematic review of the literature with the SPIDER structured search strategy in six databases (PubMed, Web of Science, Scopus, PsycINFO, CINAHL, and LILACS). A meta-synthesis was performed with data from qualitative studies published between 2005 and 2021. Two independent reviewers screened and assessed the articles. They evaluated methodological quality of included articles, extracted data, and performed the thematic synthesis.
Results: Of 852 articles, 21 met the inclusion/exclusion criteria and were synthesized. The meta-synthesis revealed three descriptive themes: coping with adverse experiences; coming across fortunate experiences; professional-personal implications. Based on these descriptive themes, we elaborated the analytical theme: bittersweet experiences of personal and professional transformation.
Conclusions: Mental health professionals working with people manifesting suicidal behaviors must cope with complex emotional experiences that involve controversial and ambivalent feelings. Such feelings have repercussions that may transform personal and professional life. The present results are useful for the development and implementation of interventions that promote better overall mental health outcomes for healthcare providers.
Registration number: PROSPERO CRD42021257237.

Keywords: Mental health services; suicide; suicidal ideations; health personnel; literature review

Introduction

Suicide is a public health problem with serious consequences for families and communities facing this experience, which challenges the limits of the human condition.[1] Each year, more than 700,000 suicides occur worldwide,[2] a number that is possibly underestimated since many suicide attempts are not accounted for – due to the difficulties in confirming suicidal intent, underreporting, and the taboo and stigma surrounding the issue.[3,4] It is estimated that the number of suicide attempts is 10 to 20 times greater than the recorded number of suicides,[5,6] demonstrating a complex scenario.

Suicidal behavior is a multifactorial and multi-determined phenomenon.[7,8] Therefore, the care of people who experience this situation must be approached from a multiprofessional and interdisciplinary perspective, covering the various levels of care.[1] Care usually involves mental health professionals, such as psychiatrists, psychologists, psychoanalysts, counselors, therapists, and social workers, in addition to health professionals such as nurses and nursing assistants/technicians, physicians, and community health workers, among others.

Because of its radical nature, suicide is one of the most challenging human experiences known to psychology.[9] Patients with suicidal behavior often elicit extreme and controversial feelings in health care professionals, which may affect the quality of the relationship they establish.[10-12] As health care professionals are strongly committed to the preservation of life and the restoration of mental health, individuals who attempt against their own physical integrity may be seen as a potential threat and even as offensive to life as a value, assaulting professional dignity and hurting susceptibilities, devotions, and expectations.[5] For this reason, patients with suicidal potential are often rejected by health care teams, treated with open or veiled hostility and stigmatizing attitudes.[11,13]

Even empathy towards the psychological suffering of others may represent a risk, to the extent that professionals experience the pain of their patients so intimately that they become disconnected from their own emotional

Correspondence: Natália Gallo Mendes Ferracioli, Av. Bandeirantes, 3900, Monte Alegre, CEP 14040-901, Ribeirão Preto, SP, Brazil.
E-mail: nataliagmendes@hotmail.com
Submitted Apr 01 2022, accepted Jul 15 2022.

How to cite this article: Ferracioli NGM, Rodrigues ECG, Santos MA. Bittersweet transformative experiences in professionals working with suicidal patients: a meta-synthesis. Braz J Psychiatry. 2023;45:62-70. http://doi.org/10.47626/1516-4446-2022-2617

pain,[14] while confronting their own existential questions[10] and experiences of mourning in situations of death by suicide.[15] All this can overwhelm the professional with saturated feelings and toxic aspects that, over time, deeply penetrate their personality in a kind of "psychic intoxication."[16]

Much of the literature focusing on the professional practice of mental health personnel working with patients who present suicidal behavior has investigated practical aspects involving risk assessment, management, and conduct. In addition, empirical studies, theoretical studies, and experience reports have been published with a focus on emotional impacts of working with suicidal behavior demands. Nevertheless, systematic assessments of the literature are lacking: only one systematic literature review about the impact on mental health practitioners of the death of a patient by suicide[17] and one constructivist-inspired meta-synthesis addressing the perceptions of paramedics and emergency department staff about the care and assistance provided to people who self-injure[18] were retrieved in a literature search. Thus, considering this gap, the present study aims to synthesize and reinterpret findings from previous qualitative studies on the emotional experience of health care professionals working with mental health and mental health professionals in assisting people experiencing suicidal behavior.

Methods

Design

The present systematic review and meta-synthesis integrates qualitative findings to enable new interpretations and provide a comprehensive description – greater than the mere sum of parts – of an event or experience. The objective is to reflect and go beyond descriptions and summary presentations of unlinked resources.[19,20] Rather, the contributions of the research are discussed and evaluated to shed light on methodological and theoretical improvements, gaps, weak points, and issues that still need discussion.[21]

We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) recommendations.[22-24] The protocol was registered in PROSPERO, the international prospective register of systematic reviews[25] (CRD42021257237). The Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) guide was used to report the essential elements to be covered in a qualitative evidence synthesis.[26]

A meta-synthesis was performed according to the following steps: 1) definition of the research question; 2) elaboration of the search strategy; 3) systematic literature search and selection of the articles to be analyzed; 4) methodological evaluation of the selected articles; 5) extraction of data from the articles; 6) elaboration of qualitative synthesis. The goal was to produce a new analysis based on the integration of selected qualitative findings.[20] Since this is a review of published studies, submission to and approval by a research ethics committee was not required.

Research question and search strategy

We formulated the following guiding question: What qualitative evidence is available about the feelings, attitudes, and reactions of mental health professionals in caring for people with suicidal behavior? Some examples of these feelings, attitudes and reactions are anger, guilt, fear, empathy, compassion and avoidant behaviors, among others. The chosen search strategy was structured by the SPIDER tool (Sample, Phenomenon of Interest, Design, Evaluation, Research type), suitable for qualitative and mixed methods research, making it possible to perform a sensitive search due to the refinement of the strategy components[27] (Box S1, available as online-only supplementary material).

The literature search was conducted in six databases: LILACS, PsycINFO, PubMed, CINAHL, Scopus, and Web of Science from inception to December 31, 2021. No date restrictions were applied. The databases were selected based on examination of other systematic reviews and meta-syntheses and considering the specificities of the databases, which collect the international production in the health sciences and, more specifically, in the mental health area, contemplating peer-reviewed technical-scientific documents. The search terms and keywords were adapted for each database (Health Science Descriptors [DeCS], APA Thesaurus, CINAHL Subject Headings, Medical Subject Headings [MeSH] and respective entry terms]. Also, they were grouped and combined using the Boolean operators AND/OR and adjusted for each database.

Eligibility criteria

The following criteria were applied for inclusion of studies in this review: i) primary qualitative studies, published in Portuguese, English, or Spanish, without date restrictions; ii) focus on the emotional experience of mental health professionals or health professionals in general who work in contexts of mental health, trained or undergoing training, to care for individuals with suicidal behavior.

For the meta-synthesis, the following were not included: i) quantitative, mixed, secondary, or review studies; ii) grey literature, not peer-reviewed; iii) letters to the editor, editorials, opinion essays, guidelines, and abstracts published in scientific proceedings; iv) studies that describe protocols for the care of patients with suicidal behavior without addressing the emotional experience of health care workers.

Study selection

Two independent authors (NGMF and ECGR), with expertise in systematic reviews, simultaneously screened all references in the six databases using the search strategies described earlier. Software Rayyan® for systematic reviews[28] was used to organize, find and delete duplicates, and classify the articles according to the previously established criteria. Both authors determined eligibility based on title and/or abstract. Any study addressing preventive and/or management strategies to

handle mental health issues in health professionals caring for people with suicidal behavior was considered for inclusion. The Kappa index[29] was calculated to evaluate the interjudge consensus and check the consistency and validity of the selection of articles. The result of 0.84 indicates almost perfect agreement among the researchers.

A total of 852 studies were retrieved from the six selected databases, of which 90 were excluded because they were duplicates. Reviewers then read the titles and abstracts of the articles independently, applying the inclusion and exclusion criteria. At this stage, 726 references were excluded, and 36 were selected to for full text reading. In addition, one report was included by hand search of the reference lists in other articles, totaling 37 articles for full text review. A third reviewer (MAS) discussed any disagreements between researchers, and a final decision was made. Articles that did not meet eligibility criteria were excluded. Finally, 21 articles met the eligibility criteria. The selection process and the reasons for exclusion are described in the flowchart developed according to PRISMA guidelines[22] (Figure 1). The two reviewers read the selected articles in full (NGMF and ECGR). A standardized form was used for data extraction and analysis.

Data analysis

Both researchers (NGMF and ECGR) independently analyzed the data focusing on the eligibility criteria. The qualitative data analysis of results was performed in three stages, using thematic synthesis[30]: i) reading the selected studies aiming at the identification and creation of codes (line by line coding) related to the objectives of the thematic synthesis. As codes were created, the subsequent studies were coded into the pre-existing codes and

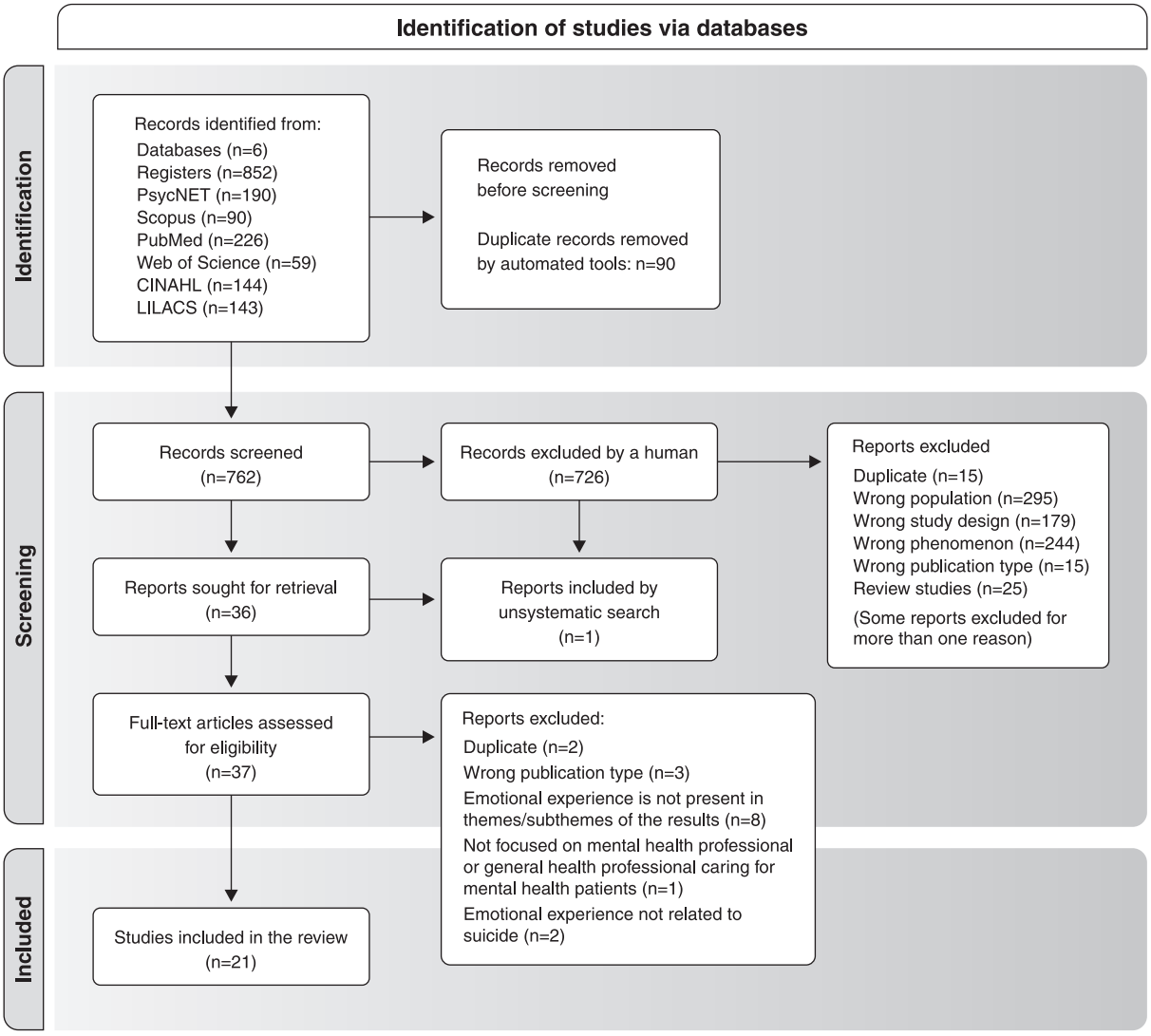

Figure 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram of study selection process.

new codes were added when necessary; ii) from an inductive analysis, systematic grouping of codes by related areas, to construct descriptive themes; iii) development of the analytical theme. In thematic synthesis, while the elaboration of descriptive themes remains "close" to the primary studies, the analytical theme represents a stage of interpretation in which reviewers "go beyond" the descriptive themes and generate new interpretative constructs, explanations, or hypotheses.

QDA Miner Lite software was used for coding and data management. The use of data analysis software allows researchers to engage in analytical practices that overcome the limits of manual techniques, making their processes more transparent.[31] The two reviewers (NGMF and ECGR) jointly conducted the data analysis and synthesis, which was ultimately discussed and validated by the research team, an expert in this type of analysis (MAS).

Results

Characterization of the studies and population included

The following variables were extracted: first author, year of publication, country where the research was developed, study objective, design, data collection procedures and data analysis methods, number and characteristics of participants (Table S1, available as online-only supplementary material).

The 21 articles included in this meta-synthesis were published between 2005 and 2021 and are derived from studies conducted in 10 different countries: Belgium (n=1),[32] Brazil (n=4),[33-36] Ireland (n=3),[37-39] Norway (n=3),[40-42] Peru (n=1),[43] Slovenia (n=1),[44] South Africa (n=1),[45] Sweden (n=3),[46-48] Taiwan (n=2),[49,50] and United States of America (n=2).[51,52] The studies used a variety of theoretical and methodological approaches: phenomenology (n=6),[36,40,41,43,48,51] phenomenography (n=1),[46] social constructionism (n=1),[39] symbolic interactionism (n=1),[35] and ethnography (n=1).[50] Eleven studies did not specify the theoretical framework adopted, providing only a generic statement of being a qualitative study in addition to the method or technique used for data analysis, predominantly grounded theory (n=7).[32,35,38,39,44,49,51]

Data were collected through individual interviews (n=12),[36-42,44,46-49] focus group (n=1),[34] self-administered questionnaire (n=1),[52] combination of interviews and field notes (n=3),[32,45,51] combination of individual interview and participant observation (n=1),[50] combination of individual interview, group, and datasheet (n=1),[43] and combination of individual interview and sociodemographic questionnaire (n=2).[33,35]

The overall set of 21 studies comprised 435 participants from different fields of knowledge and specialties: nurses, assistant nurses, and undergraduate nursing students (n=10),[32,35,37,38,40,42,47-50] psychologists and psychotherapists (n=5),[33,36,39,43,44] social workers (n=2),[51,52] and physicians (n=1)[41]; in some studies, the sample included practitioners from the aforementioned professions as well as psychiatrists (n=3).[34,45,46] The work contexts included psychiatry and mental health in psychiatric and general hospitals, inpatient and outpatient clinics (n=8),[32,40-42,46-48,50] family health strategy unit (n=1),[34] suicide intervention service (n=1),[39] emergency service (n=1),[35] clinical psychology (n=1),[36] clinical psychiatry (n=1),[49] community services (n=1),[37] and studies carried out in more than one context (n=2).[38,51] Some studies did not specify the context of professional practice, or only provided information about the public and/or private nature of the service (n=5).[33,43-45,52] Regarding professional experience, the sample included from undergraduate students having their first contact with mental health patients to health professionals with 35 years of experience.

Methodological quality assessment

The Critical Appraisal Skills Programme (CASP Qualitative Checklist)[53] was used to assess the quality and internal validity of the articles. This tool allows agile assessment of all types of qualitative data. It consists of 10 questions about: specification of objectives, appropriateness of qualitative methodology, study design, sampling strategy, data collection, reflexivity (considerations about the relationship between researcher and participants), ethical considerations, rigor of data analysis, clarity of results presentation, and significance of the research. Any disagreement between the researchers regarding the CASP checklist was again discussed with a third reviewer (MAS).

All studies clearly reported their objectives, had an appropriate qualitative methodology, adequacy of study design, data collection and analysis, clarity in the presentation of results, and significant contributions to the field of study. However, some items of the CASP (Box S2, available as online-only supplementary material) were not covered in some of the articles, namely: the relationship between researcher and participants was not made explicit in seven studies,[33,34,36,38,41,43] ethical considerations were partially reported in two studies,[43,51] and the recruitment strategy was not mentioned in one study.[36]

Synthesis of the findings

The thematic synthesis of the findings of the 21 studies included in this meta-synthesis produced 35 codes, which were grouped into three descriptive themes: i) coping with adverse experiences; ii) coming across fortunate experiences; iii) professional-personal implications. Based on these descriptive themes, the following analytical theme was proposed: bittersweet experiences of personal and professional transformation (Box S3, available as online-only supplementary material).

Descriptive theme 1: coping with adverse experiences

The results show that working with patients who present any element of suicidal behavior (ideation, attempts, or death by suicide) is emotionally impacting and intense, with high potential to elicit negative reactions (distress). Professionals are exposed to disruptive experiences and feelings in their practice,[32-43,45,47-52] as reported by a

psychotherapist participating in one of the studies: ''[...] I have not been able to sleep at night fearing that they will commit suicide with an overdose or by cutting themselves or finally doing the final act [...] It had me quite worried, totally took my affections, my thoughts, logically I had to resort to more help [...] I could see, I could breathe this boy's anguish, I could feel his despair'' (our own translation) (p. 75).[43]

In almost all the studies, the professionals reported feeling confused, disorganized, numb or awkward,[32-37,40-48,51,52] and they often perceived themselves as limited, powerless, frustrated, helpless, and hopeless[32-35,37,40,42-46,48-52] when coming across a suicidal patient, usually because they felt unprepared and insufficiently trained. The following interview excerpts expose such situations: ''There are cases that we have no idea where to start, others that we don't know what to say to them anymore, that we don't have the ability to offer what they need'' (our own translation) (mental healthcare professional) (p. 10)[34]; ''As a person, as a human being, what makes it difficult is, I know for example that I'm actually powerless to whatever the client feels'' (counselor) (p. 42).[45]

Feelings of rage, anger, irritation, and betrayal[35,40,41,43,50-52] were also reported both towards the patient and other members of the support team: ''I was pissed [at the clients]; felt like why the hell couldn't they have called me? Why couldn't they have talked to me? Why couldn't they have reached out to me? Why couldn't they have reached out to [their] family? They have not thought to turn to me?'' (clinical social worker) (p. 332)[51]; ''I felt that my being on vacation was negligent, and that made me angry. I became angry with the psychiatrist for not doing more. I was shocked at the rapid deterioration and angry that I did not see it coming'' (social worker) (p. 204).[52] Anger was also expressed over the immediate effects and disorder triggered by a patient's suicide, once the professional has to make practical arrangements, like rescheduling or dropping appointments: ''So when it happens, it's a pain in the butt. Because everything else has to work around it'' (clinical social worker) (p. 332).[51]

In this sense, we identified the occurrence of condemnatory and discriminatory attitudes towards patients[35] on the part of some professionals, to the extent that those who attempt or wish to make an attempt to end their own lives may be perceived as hurting the dignity of a professional dedicated to promoting health, triggering numerous adverse feelings in these caretakers, as already described. The report of nurses/nursing assistants/technicians[35] explains the indignation of health providers: ''There are so many sick people trying to survive and these patients trying to die. They don't value life'' (p. 348).

It is important to emphasize that the emotional experiences contemplated up to this point of the analysis encompass experiences that occur both before (when there is ideation or even suicide attempt), and after death by suicide. There are also experiences of fear and apprehension that the patient will carry out their plans,[35-47,49,51,52] which cause worries and concerns.[32,34-39,43-45,47,49,52] These concerns are related in part to the social image of these professionals who ''cannot'' prevent their patients from committing suicide. They fear that their credibility will be demoralized. In other words, they worry about how they would be judged by their peers (other health professionals) and the patients' relatives: ''I was afraid I might say the wrong thing when I talked to him. Like, if I used the wrong words and made him feel upset, it would be all my fault'' (nursing student)[49] (p. 528); ''I kept arranging a thousand excuses [not to receive the patient], then I stopped and said 'wait a minute, what is my fear?'. The fear is actually the person trying to commit suicide there with me, is that I have to save his life'' (our own translation) (psychologist)[36] (p. 912); ''Did the family think I did the right thing or think I'm stupid? I was just so stunned and worried what people thought'' (clinical social worker) (p. 334).[51]

Anxiety,[32,38,40,42,44,45,50-52] discomfort,[32,35,38,40,41,47] and anguish[43,47] were recurrent feelings, leading professionals to consider their work around suicidal behaviors difficult, challenging and complex,[32,34,35,39,40,44,45,47,49] as well as highly tiring and devitalizing[35,39,40,43,45,46,49-52]: ''[...] [death] is present all the time [...] After the sessions they leave you, not dead, but inert [...]'' (our own translation) (psychotherapist) (p. 75).[43]

The first experience with death by suicide can have a devastating effect on the professional's psyche. The feelings reported by professionals after the suicide of a patient encompass primarily guilt and self-blame[33-35,37,38,40,42-48,50-52]: ''I felt very guilty, I was the one who let the patient out'' (mental healthcare professional) (p. 46).[46] A large proportion of professionals also described feeling depressed, sad, upset, and entering into a grieving process[33,35,37,40,44-46,48,51,52]: ''It was both frustrating and, well, sad'' (psychiatric nurse/assistant nurse) (p. 1627)[48]; ''I could not control my crying. I mean, I was grief-stricken'' (clinical social worker) (p. 332).[51]

Some professionals also reported experiencing trauma and shock,[35,37,46,50-52] surprise and unawareness,[37,51] intrusion, invasion, and exposure,[43,47,51,52] loneliness and isolation,[37,43,47,51] disappointment,[35,45,51,52] and pain, both emotional and physical.[43,46] Such experiences are made explicit in powerful accounts that denote experiences of psychic suffering: ''Perhaps this was the most traumatizing experience in 20 years as a therapist and supervisor'' (social worker) (p. 206)[52]; ''The night he died, I got deathly ill; I had to go to the emergency room. I thought I was having a heart attack'' (clinical social worker) (p. 332).[51] Reactions such as denial and disbelief[37,51,52] and shame[51] were also expressed by professionals. Others reported experiencing emotional emptiness and nothingness.[48,50-52]

Descriptive theme 2: coming across fortunate experiences

Despite the undeniable psychological distress underlying the adverse experiences reported in the previous theme, the present study also found reports of fortunate experiences by mental health professionals working with patients with suicidal behavior. Empathy,

compassion, respect, altruism, and patience were some of the positive feelings expressed by professionals.[32,34,35,37,39-41,44,46,48-50]: "I think now I understand others better" (physician) (p. 7)[41]; "[…] conveying closeness is important, seeking attunement, showing that I understand that struggling with these [suicidal] thoughts must be very difficult for them... I think you should be able to allow yourself to be touched in a genuine way. But not in a way that knocks you down [...] That you listen carefully to your patient but also reflect about what these interactions do to yourself" (psychiatric nurse) (p. 3073)[32]; "Before I'd cared for suicidal patients, I felt they were so stupid. After I cared for them for a while I came to understand [...] I learned I could demonstrate empathy for her suicidal behavior" (nursing student) (p. 530-531).[49]

Of course, these experiences do not occur in isolation and exclusively. They are always permeated by suffering and described less frequently. Nevertheless, one study[39] points out that, despite the fatigue, working with patients with suicidal behavior involves a deep level of care, compassion, with an emotional intensity that leads to a loving connection and empathy with the patient: "Ultimately, you know, unconditional love is being offered from one human being to another. That's what we are on a base level and they can feel that and they can connect with that" (therapist) (p. 814).

Those fortunate feelings may appear both before and after the patient's death by suicide. There are also reports of relief following the suicide, possibly linked to two central motives: ending chronic and persistent suffering – as is evident in this psychiatric nurse's speech – "He found peace. I think he is better now because worse is not possible" (p. 1628)[48]; and moving beyond a painful demand, since the professional was already exhausted from dealing with it – "[…] a little relief, because you may have been so tired and so angry at times too" (p. 33).[40]

Moreover, numerous professionals report fortunate experiences of feeling capable and self-confident,[32,35,38,41,44,46,47,49,51,52] as well as hopeful[43] and relieved[32,39] as they realize that their interventions had positive effects and that they were successful in providing mental health care and in preventing suicide, as their patients improve: "There are a lot of things I can do to prevent suicide" (physician) (p. 5)[41]; "It's a satisfaction that we have the opportunity to help them" (nurse/nurse assisting/technician) (p. 348).[35] Even in cases of death by suicide, some professionals claim to feel grateful for what they learned from their patients for the opportunity to enrich their professional experiences: "I'm quite grateful to them, they use their lives to write textbooks and tell us about it" (psychiatric nurse) (p. 1400).[50] A sense of reconciliation and self-justification relatively to the situation is also reported[37,38,51,52]: "I have acknowledged that I can not possibly save all my clients. I try to do my best always and be on top of things" (social worker) (p. 207).[52]

Descriptive theme 3: professional-personal implications

The studies evidenced that experiencing all the emotional intensity previously described entails that mental health professionals will not come out unharmed from the experience of caring for people with suicidal behavior. This has serious implications for both professional and personal life. Not by chance, one of the aspects most frequently reported in the studies included in this meta-synthesis is the need to mediate boundaries, especially those between work and the existence of professionals as individuals, in an attempt to clearly demarcate the type of relationship professionals will establish with such patients.[34,38,40-51] These boundaries are often blurred and confused due to over-identification with the patients' suffering, as the following reports demonstrate: "I try not to make it affect me, but I know I bring it home" (clinical social worker)[51] (p. 336); "I myself have to go through my own desire to live or not to live. We never do this once and for all. My own attitude about life is activated every time I meet a suicidal patient" (psychiatric nurse) (p. 522).[42]

The responsibility for making correct decisions in the management of patients with suicide risk and, consequently, providing the necessary care when a life is hanging by a thread emerge in the studies as important professional implications.[32,35-41,44,45,47,51,52] In turn, other elements that impact professional performance are set into motion, such as avoidant behaviors concerning meeting these demands,[35-37,44-46,50-52] as well as the urge for therapeutic connection in order to enable and facilitate an effective work.[32,36,39] The following excerpts exemplify that: "I think the issue of responsibility is one that always comes up. [...] It's on you [the decision's], on you" (clinical social worker) (p. 334)[51]; "Some people try to escape. Some professionals arrange a thousand excuses not to go attend" (nurse/assistant/technician) (p. 349)[35]; "[...] I kept finding a thousand excuses [not to receive the patient]" (our own translation) (psychologist) (p. 912).[36]

In this sense, one of the elements most insistently referred to by professionals as fundamental for intervention in the context of suicide risk is self-care. It evidences the need to continuously rethink their positions, to have moments and spaces to debrief, and to take care of their psychological health by through psychotherapy and regular supervision with other mental health professionals. This basic care ensures spaces for reflection on one's own feelings and emotions aroused by work to reduce personal vulnerability. Self-care allows professionals to renew their strength and share the burden of care, expanding the opportunities for reflection on cases involving suicidal behavior and their appropriate management[32,34,37-41,43-47,49-51]: "[…] it's nice to have someone to offload that onto, you know, and to not judge you, or to reassure you, or very often to help you understand what it was in that patient that made you feel so upset" (psychiatrist) (p. 43)[45]; "To exchange experiences with colleagues has been rewarding" (physician) (p. 5)[41]; "I knew that I had a supervisor, that I have my own personal therapy, through which I was processing it. That was very helpful for me" (therapist) (p. 983).[44]

Finally, when death by suicide does unfortunately occur, some professionals report the implication of learning from that event. This may promote both technical and personal development as it triggers reflections on life and adjustments in practice.[37,38,50-52] The report of a

clinical social worker is an example: "I made some changes, thinking, 'well, you know, I would never have guessed that he would do this'. So I started asking kids more questions because we social workers often assume that if they don't say anything they're okay" (p. 336).[51] Some professionals feel so impacted that they even modify their work contexts and make concrete changes in their lives: "I did not want this type of life dealing with these clients; this is why I'm getting out of private practice after working for so many years with severely disturbed mental health clients. I still want to stay within social work, but not as a private therapist; Well, it was out of that that I moved to another state" (p. 335).

Analytical theme: bittersweet experiences of personal and professional transformation

Consistent with the highlighted findings, this analytical theme demonstrates that mental health professionals working with people who manifest suicidal ideation or who attempt and/or die by suicide experience the most diverse feelings. Such feelings encompass both painful (bitter) and satisfying (sweet) experiences, a mix that triggers emotions that affect the psychological balance of professionals. Repeated exposure to situations of suicidal behavior has significant consequences for both personal life and professional performance: "When you see or experience persons at risk for suicide, you feel frightened, shaken up and you start to reflect on your own beliefs about life" (psychiatric nurse) (p. 523)[42]. "When you see that it [intervention with suicidal patients] helps, it gives more confidence" (physician) (p. 13).[41]

Discussion

In this review, we synthesized qualitative evidence about the emotional experience of mental health professionals caring for people with suicidal behavior. Three descriptive themes were elaborated that show considerable emotional intensity arising from working with this demand, ranging from adverse experiences to fortunate experiences, with potential implications and transformation of both personal and professional aspects.

The literature indicates that controversial and ambivalent feelings are part of the performance of mental health professionals dedicated to the management of people who present suicidal potential,[3,10-13] which was largely corroborated by the findings of this meta-synthesis. The implications for practice shown in the present study are also evidenced by the literature, given that emotional experiences impact the way health professionals manage and relate to patients with suicidal behavior.[3,5,11-13,17,54]

An empirical study conducted with a sample of 242 Portuguese physicians (general practitioners and psychiatrists) and psychologists described the impact of a patient's death by suicide.[55] The findings revealed emotional distress, worry, doubt, fear, frustration, shock, surprise, anxiety, and increased insecurity as predominant feelings. The most frequent reactions encompassed increased attention, vigilance, and rigor in patient assessment and interventions. In addition, professionals reported supervision, case review, and contact with colleagues as the main resources used for support. The authors concluded that a patient's suicide generates considerable emotional and professional impact and constitutes a source of learning and professional development when there is a favorable social support network. Similar results were reported by a recent systematic review about the impact on mental health practitioners of the death of a patient by suicide,[17] which showed that the most common personal reactions included guilt, shock, sadness, anger and blame, in addition to increased caution and defensiveness in the management of suicide risk. The study concludes that losing a patient to suicide can have significant personal and professional impact on mental health professionals. Such findings fully converge with the conclusions of this meta-synthesis.

Another relevant point made by a Norwegian study[12] is that therapists, especially psychiatrists and psychologists, are often torn between performing adequate suicide risk assessment, categorizing mental disorders, and assuming a more empathic position. Out of a defensive need, professionals may adopt a more detached position to the detriment of a real connection with suicidal patients, which can have negative consequences for both the professional and the patient. To avoid this, it is important to get deep into this dense field of human experience without losing boundaries, which requires keeping pathological identification under control.

The emphasis usually given to the technical part of the management of patients with suicidal behavior is a bias in the training of these professionals. Such training may contribute to the difficulties faced by mental health professionals in terms of emotional management, since little attention is given to subjective aspects that need to be processed by health workers, such as countertransference.[5,10,17] Authors argue that mental health professionals should ideally be able to develop a dual role of conducting appropriate technical assessments while being available and open to welcoming the patient's impactful narrative.[12,54]

It is important to note that not all professionals experience the adverse work-related aspects of suicidal behavior. Often this translates into professional stiffness, with some professionals reporting to feel so affected that they develop avoidance behaviors and sometimes even modify their careers to no longer meet this type of demand.[51] Conversely, our meta-synthesis evidenced that working with people with suicidal behavior may also be enriching and provide an opportunity for reflection about existential issues, such as the meaning of life,[10,50] thus favorably influencing professional development and self-confidence.[32,41,44,46,47,49,50,52]

It has also been widely described that the personal impacts of the intense emotions experienced by mental health professionals[10,14,16,17] tend to intensify in the absence of the social support by peers and lack spaces for decompression. As a result, professionals become overwhelmed with toxic emotions and identified with patients' painful experiences. Thus, the importance of caring for oneself while caring for others[14,16] is reiterated, as well as the importance of the professional having

access to a consistent psychosocial network and being supported by personal psychotherapy, supervision, teammates, family, and friends.[17,32,34,39-41,43,44,47,49] Also underscored is the importance of multiprofessional and interdisciplinary work in addressing suicidal behavior, as it brings potential benefits to both patients and professionals.[1,3]

Among the limitations of present study is the small number of countries covered, preventing extrapolation of the conclusions across cultures. Furthermore, not all studies contributed to the construction of all codes, and some contributed more than others, rendering the reliability of each code different. As a strength of this meta-synthesis, we highlight the wide variety of professional specialties and contexts contemplated by the included studies, even though the lack of a study focusing specifically on psychiatrists is an important gap in the literature, considering that psychiatric care is a key piece in the clinical and scientific approach to suicide.

About the implications for clinical practice, the importance of investing in basic and continued training for adequate qualification of mental health professionals for the management of suicidal behavior is evident. Multidisciplinary work environments also confer greater security to work with this demand and its sensitive issues. Besides, professionals must have space for self-care, including access to personal psychotherapy, moments for leisure and family life, as well as institutional devices for decompression, such as supervisions, team meetings, and implementation of interdisciplinary interventions. So, it is clear that both the educational and healthcare systems need to enable professionals to develop socioemotional skills to deal with suffering, by incorporating changes that take into account the psychological distress routinely faced by mental health professionals.

This meta-synthesis articulated and integrated evidence from studies addressing the experiences and perceptions of mental health professionals in their work with people who have thought about, attempted, or died by suicide. The synthesis enhance the findings of the primary studies, giving emphasis and relevance to the emotional and practical implications of dealing with suicide, a singular demand of mental health environments. We conclude that this experience is complex and multifaceted. It involves controversial and ambivalent feelings and experiences, which inevitably have consequences and transform personal and professional life. Our findings support the systematization of mental health interventions and may serve as the basis for the development of recommendations for the prevention or management of mental health issues by mental health practitioners, governmental leaders, and educators worldwide.

Acknowledgements

This study was supported by a Research Productivity Grant from Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq) and Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES).

Disclosure

The authors report no conflicts of interest.

References

1 Santeiro TV, Leite RFD, Rocha GMA. Suicide and social media: dialogue with clinical psychologists. Psicol Clinica. 2020;32:535-56.
2 World Health Organization. Suicide [Internet]. 2021 Jun 17. https://www.who.int/news-room/fact-sheets/detail/suicide
3 Fukumitsu KO. The psychotherapist facing suicide behavior. Psicol USP. 2014;25:270-5.
4 Schmidt B, Gabarra LM, Gonçalves JR. Psychological intervention in terminality and death: experience report. Paideia (Ribeirao Preto). 2011;21:423-30.
5 Botega NJ. Crise suicida: avaliação e manejo. Porto Alegre: Artmed; 2015.
6 Ferreira Jr A. O comportamento suicida no Brasil e no mundo. Rev Bras Psicol. 2015;02:15-28.
7 Cassorla RMS. Suicídio: fatores inconscientes e aspectos socioculturais. São Paulo: Blucher; 2017.
8 Ferracioli NGM, Oliveira WA, Oliveira-Cardoso EA, Corradi-Webster CM, Risk EN, Santos MA. Suicide behavior: life and death paradox in the midst of the COVID-19 pandemic. Estud Interdiscip Psicol. 2021;12:75-98.
9 Ferracioli NGM, Cardoso EAO, Vedana KGG, Pillon SC, Miasso AI, Souza J, et al. Os bastidores psíquicos do suicídio: uma compreensão psicanalítica. Vínculo. 2019;16:17-28.
10 Carlén P, Bengtsson A. Suicidal patients as experienced by psychiatric nurses in inpatient care. Int J Ment Health Nurs. 2007;16:257-65.
11 Slaven J, Kisely S. Staff perceptions of care for deliberate self-harm patients in rural Western Australia: a qualitative study. Aust J Rural Health. 2002;10:233-8.
12 Hagen J, Hjelmeland H, Knizek BL. Connecting with suicidal patients in psychiatric wards: therapist challenges. Death Stud. 2017;41:360-7.
13 Granek L, Nakash O, Shapira S, Ariad S, Ben-David MA. Oncologists, oncology nurses and oncology social workers experiences with suicide: impact on patient care. Psychosoc Oncol. 2020;38:543-56.
14 Arantes ACQ. A morte é um dia que vale a pena viver. Rio de Janeiro: Casa da Palavra; 2016.
15 Bulcão RSL. The therapist is affected: hermeneutics as a clinical position. Rev Latinoam Psicopatol Fundam. 2013;16:147-53.
16 Areco FS, Ferracioli NGM, Lisboa BB. Saúde mental do professional de saúde: o autocuidado como pilar fundamental. In: Andrade CJ, editor. Saúde mental e trabalho: temas emergentes na contemporaneidade. Curitiba: CRV; 2018. p. 113-24.
17 Sandford DM, Kirtley OJ, Thwaites R, O'Connor RC. The impact on mental health practitioners of the death of a patient by suicide: a systematic review. Clin Psychol Psychother. 2020;28:261-94.
18 Rees N, Rapport F, Snooks H. Perceptions of paramedics and emergency staff about the care they provide to people who self-harm: constructivist metasynthesis of the qualitative literature. J Psychosom Res. 2015;78:529-35.
19 Methley AM, Campbell S, Chew-Graham C, McNally R, Cheraghi-Sohi S. PICO, PICOS and SPIDER: a comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. BMC Health Serv Res. 2014;14:579.
20 Sandelowski M, Barroso J. Handbook for synthesizing qualitative research. New York: Springer Publishing Company; 2007.
21 Vosgerau DSR, Romanowski JP. Review studies: conceptual and methodological implications. Rev Dialogo Educ. 2014;14:165-89.
22 Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ. 2021;372:n71.
23 Liberati A, Altman DG, Tetzlaff J, Mulrow C, Gøtzsche PC, Ioannidis JPA, et al. The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate healthcare interventions: explanation and elaboration. BMJ. 2009;339:b2700.
24 Moher D, Liberati A, Tetzlaff J, Altman DG. Prisma Group. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. PLoS Med. 2009;6:e1000097.

25 National Institute for Health Research. PROSPERO: international prospective register of systematic reviews [Internet]. [cited 2022 Mar 15]. http://www.crd.york.ac.uk/prospero/
26 Tong A, Flemming K, McInnes E, Oliver S, Craig J. Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. BMC Med Res Methodol. 2012;12:181.
27 Cooke A, Smith D, Booth A. Beyond PICO: the SPIDER tool for qualitative evidence synthesis. Qual Health Res. 2012;22:1435-43.
28 Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan – a web and mobile app for systematic reviews. Syst Rev. 2016;5:210.
29 Viera AJ, Garrett JM. Understanding interobserver agreement: the kappa statistic. Fam Med. 2005;37:360-3.
30 Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Med Res Methodol. 2008;8:45.
31 Woods M, Paulus T, Atkins DP, Macklin R. Advancing qualitative research using qualitative data analysis software (QDAS)? Reviewing potential versus practice in published studies using ATLAS.ti and NVivo, 1994-2013. Soc Sci Comput Rev. 2015;34:597-617.
32 Vandewalle J, Deproost E, Goossens P, Verfaillie J, Debyser B, Beeckman D, et al. The working alliance with people experiencing suicidal ideation: a qualitative study of nurses' perspectives. J Adv Nurs. 2020;76:3069-81.
33 Malgarezi VA, Borowski SB, Cesconetto RAZ, Whachholz T. Psychologists' perceptions regarding suicide: qualitative research from Santa Catarina Southern scenario. Rev Psicol Saude. 2019;12:169-79.
34 Ferreira GS, Fajardo AP, Mello ED. Possibilidades de abordagem do tema do suicídio na Estratégia Saúde da Família. Physis. 2019;29: e290413.
35 Vedana KGG, Magrini DF, Miasso AI, Zanetti ACG, Souza J, Borges TL. Emergency nursing experiences in assisting people with suicidal behavior: a grounded theory study. Arch Psychiatr Nurs. 2017;31: 345-51.
36 Zana ARO, Kovács MJ. The psychologist and the care of patients with suicidal ideation or attempt. Estud Pesqui Psicol. 2013;13: 897-921.
37 Morrissey J, Higgins A. "When my worse fear happened": mental health nurses' responses to the death of a client through suicide. J Psychiatr Ment Health Nurs. 2021;28:804-14.
38 Morrissey J, Higgins A. "Attenuating Anxieties": a grounded theory study of mental health nurses' responses to clients with suicidal behaviour. J Clin Nurs. 2019;28:947-958.
39 Aherne C, Coughlan B, Surgenor P. Therapists' perspectives on suicide: a conceptual model of connectedness. Psychother Res. 2018;28:803-19.
40 Hagen J, Knizek BL, Hjelmeland H. Mental health nurses' experiences of caring for suicidal patients in psychiatric wards: an emotional endeavor. Arch Psychiatr Nurs. 2017;31:31-7.
41 Høifødt TS, Talseth AG, Olstad R. A qualitative study of the learning processes in young physicians treating suicidal patients: from insecurity to personal pattern knowledge and self-confidence. BMC Med Educ. 2007;7:21.
42 Gilje F, Talseth AG, Norberg A. Psychiatric nurses' response to suicidal psychiatric inpatients: struggling with self and sufferer. J Psychiatr Ment Health Nurs. 2005;12:519-26.
43 Callirgos XU. Meanings of suicide in a group of psychoanalytic psychotherapists. Pensam Psicol. 2018;16:69-81.
44 Podlogar T, Poštuvan V, De Leo D, Žvelc G. The model of dynamic balance in therapists' experiences and views on working with suicidal clients: a qualitative study. Clin Psychol Psychother. 2020; 27:977-87.
45 Goldstone D, Bantjes J. Mental health care providers talk about their experiences preventing suicide in people with substance use disorders in South Africa: implications for clinical practice. Int J Psychiatry Clin Pract. 2019;23:40-8.
46 Rytterström P, Ovox SM, Wärdig R, Hultsjö S. Impact of suicide on health professionals in psychiatric care mental healthcare professionals' perceptions of suicide during ongoing psychiatric care and its impacts on their continued care work. Int J Ment Health Nurs. 2020;29:982-91.
47 Jansson L, Graneheim UH. Nurses' experiences of assessing suicide risk in specialised mental health outpatient care in rural areas. Issues Ment Health Nurs. 2018;39:554-60.
48 Hultsjö S, Wärdig R, Rytterström P. The borderline between life and death: mental healthcare professionals' experience of why patients commit suicide during ongoing care. J Clin Nurs. 2019; 28:1623-32.
49 Sun F-K, Long A, Chiang C-Y, Wu M-K, Yao YC. The psychological processes voiced by nursing students when caring for suicidal patients during their psychiatric clinical practicum: a qualitative study. J Clin Nurs. 2019;29:525-34.
50 Tzeng WC, Yang CI, Tzeng NS, Ma HS, Chen L. The inner door: toward an understanding of suicidal patients. J Clin Nurs. 2010;19: 1396-404.
51 Ting L, Sanders S, Jacobson JM, Power JR. Dealing with the aftermath: a qualitative analysis of mental health social workers' reactions after a client suicide. Soc Work. 2006;51:329-41.
52 Sanders S, Frey JJ, Ting L. Reactions of mental health social workers following a client suicide completion: a qualitative investigation. Omega (Westport). 2005;51:197-216.
53 Critical Appraisal Skills Programme. CASP checklist: 10-questions to help you make sense of qualitative research [Internet]. https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf
54 Michel K, Valach L. The narrative interview with the suicidal patient. In: Michel K, Jobes DA, editors. Building a therapeutic alliance with the suicidal patient. Washington: American Psychological Association; 2011. p. 63-80.
55 Rothes I, Henriques MR, Correia RS. Patient suicide: the experience of Portuguese doctors and psychologists. Rev Port Saude Publica. 2013;31:193-203.