Impact of Patient Suicide on Mental Health Professionals

Shipra Singh, MD; Nitin B. Raut, MD; Akansha Bhardwaj, MD; and Yogender Malik, MD, DNB

Abstract

Objective: To explore the effect of a patient's suicide on mental health professionals (MHPs), the perceived psychological and professional impacts, the support MHPs require versus actually receive, and their views on training that is provided to cope with such incidents.

Methods: A mixed-methods approach was used. An online survey was conducted from September to October 2023. The validated semistructured questionnaire was open for 8 weeks and covered demographics, details of incidents, emotional and professional impacts, and support systems. Responses were analyzed using descriptive statistics and thematic analysis to derive insights from qualitative data.

Results: Among 96 responses, 51% had treated patients who died by suicide. These patients were mostly males, primarily diagnosed with psychotic or affective disorders. Of the MHP respondents, 76.6% experienced suicide of a patient after completing their training. Around one-third reported moderate-to-extreme emotional impact of the incident, with sadness, regret, and guilt being common responses. Support-seeking behaviors were common with 52.2% of respondents finding support from colleagues, family, or professional communities helpful, but formal training on managing patient suicide was found to be lacking.

Conclusion: Patient suicide can impact MHPs, affecting emotional well-being, professional identity, and personal life, emphasizing the importance of establishing a supportive environment, incorporating enhanced training into psychiatry programs, and encouraging open dialog.

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Author affiliations are listed at the end of this article.

Suicide is a prominent global health and social issue, with an estimated 800,000 people dying due to suicide annually. For every suicide, approximately 6–20 people (usually family members and acquaintances) are adversely affected.[1,2]

For mental health professionals (MHPs), the tragedy of a patient's suicide is likely to be experienced at some point in their careers, evoking intense emotional distress comparable to that of a family member.[3–5] MHPs have higher exposure to suicide than the general public, including the bereaved family members and friends, primarily due to the nature of their work, which often involves forming close therapeutic alliances with individuals who may be at high risk of suicide.[6,7] Despite their pivotal role, the impact of patient suicide exposure on MHPs remains an underexplored area.

These incidents may trigger a range of emotional and behavioral responses such as sadness, shock, guilt, fear, persistent low mood, distress, and diminished self-confidence, often accompanied by feelings of professional inadequacy. Some clinicians report fear of litigation and consider leaving the profession. Personal lives may also be affected, with increased irritability and reduced ability to manage home responsibilities.[8–10] Professionally, MHPs may question their identity, feel incompetent, fear treating suicidal patients, and worry about legal or public consequences.[10–14] These experiences can lead to changes in practice—either positive, such as increased vigilance and collaboration, or negative, such as defensive approaches or avoidance of high-risk patients.[11,12,14]

Seemingly, there is limited emphasis on patient suicide–related training in psychiatry residency and mental health education. Research indicates that many MHPs feel inadequately prepared to handle emotional and professional repercussions of a patient's suicide, leaving them feeling isolated and ill-equipped to navigate such distressing events.[15]

Recognizing and understanding the impact of such an event are necessary precursors to identifying how best to support health professionals who experience it. Hence, this study explores the impact of patient suicide on MHPs and assesses the availability and utilization of formal and informal social support systems by MHPs at

Clinical Points

- Patient suicide can cause lasting emotional and professional distress in mental health professionals (MHPs) due to their unique relationship with the patient.
- Confidential peer support and structured debriefing can ease guilt and reduce burnout in MHPs.
- Integrating structured modules in psychiatry training programs focusing on the emotional aftermath, legal implications, coping strategies, and support pathways after patient suicide through workshops or reflective spaces may help build preparedness and resilience.

the time of a patient's suicide. It also aims to investigate the perception about training required for dealing with such incidents.

METHODS

Study Design

The study utilized a mixed-methods approach involving a survey administered to MHPs through various social media networks, including WhatsApp and email, using Google Forms. Institutional ethics committee approval was received. Along with a link to the Google form, information outlining the aims and objectives of the study was provided. Clicking the link and responding to the survey was considered as providing consent. The online questionnaire was live for 8 weeks (September to October 2023), and a reminder was sent to participants after 3 weeks. Once completed, a new or alternative questionnaire could not be sent by the same participant.

The study included doctors (comprising postgraduate students, senior residents, senior faculty, and private practitioners in psychiatry), psychologists, psychiatric social workers (encompassing trainees and faculty), and mental health nurses working or practicing in India. The minimum sample size was 100 (calculated by formula $4\ pq/d^2$, where $p = 50\%$, $q = 50\%$, and $d = 20\%$ of p). However, only 96 responses were received after the second reminder. The final analysis was conducted with the achieved sample. Purposive sampling was used.

A semistructured questionnaire was developed, based on existing literature, and validated by 2 experienced professionals (A.B., C.B.). The questionnaire comprised 6 sections: (1) demographic factors, (2) details of the incident, (3) the effect of the incident on the psychiatrist, (4) the support received, (5) the support required, and (6) the perception about training required to deal with such incidents. MHPs who had not experienced a patient suicide were instructed to skip directly to section 5 after completing section 1. The questions were presented in multiple-choice format, Likert scales, or as short open-ended responses. Anonymity was ensured at all levels. Only the study investigators had access to the data, and caution was taken to exclude any possible personal identifiers from the data and the results.

Statistical Analysis

The data were coded, tabulated, saved, and stored securely in Google Sheets. Descriptive tools such as frequency counts and percentages were used to summarize qualitative variables using Microsoft Excel software. Thematic analysis was employed to interpret the qualitative data derived from responses to 4 specific open-ended questions:

1. "What type of emotions did you experience and to what extent? What made you feel that way?"
2. "Looking back, do you think the suicide of your patient could have been prevented? What do you think could have been done?"
3. "Was there anything that helped you cope with the situation and how?"
4. "Was there anything that made your coping with the situation difficult and how?"

The analysis was conducted collaboratively by the authors using the thematic analysis framework by Braun and Clarke,[16] ensuring a rigorous and unbiased examination of qualitative data. Independent review of all responses was completed to gain a thorough understanding of the data, and then data were coded and specific themes were identified from specific segments.[16] These themes were refined and validated through discussions and revisiting the data to ensure comprehensiveness and accuracy. The thematic analysis resulted in integrating the themes into the overall study findings, with each theme detailed and supported by direct excerpts from respondents to illustrate and substantiate the analysis.

RESULTS

Demographic and Professional Details

The demographic and professional details of the 96 respondents are provided in Table 1. The details of the incident were explored and are tabulated in Table 2.

Impact on Emotional Well-Being

With regard to assessing the effect of the incident on emotional well-being, around one-third of the participants had a moderate-to-extreme effect. Sadness was the most common emotion felt, followed by regret and guilt. These effects were majorly perceived up to 1 month (46.8%). However, around one-fourth of respondents reported ongoing effects up to 6 months or longer, and 8.5% considered changing their career path as a

Table 1.
Demographic Details of the Participants

Characteristic	Had not experienced a patient's death by suicide, % (N = 49)	Had experienced a patient's death by suicide, % (N = 47)
Sex		
Female	61.20	63.80
Male	38.80	36.20
Age, y		
≤35	53.10	76.60
>35	46.90	23.40
Profession		
Clinical psychologist	4.10	4.30
Clinical psychology trainee	. . .	2.10
Psychiatric social work trainee	. . .	2.10
Psychiatric social worker	4.10	10.60
Psychiatrist	81.60	55.30
Psychiatry postgraduate	10.20	25.50
Experience, y		
≤5	34.70	59.60
6–10	28.60	19.10
>10	36.70	21.30
Setting of work		
Academic institution	61.20	83.00
Nonteaching hospital	12.20	8.50
Individual practitioner	26.50	8.50
Area of specialty		
Child and adolescent	12.20	2.10
Deaddiction	6.10	6.40
General	77.60	83.00
Geriatric	. . .	2.10
Other	4.10	6.40
Age group working with		
Adult	89.80	95.70
Child and adolescent	10.20	2.10
Geriatric	. . .	2.10

Table 2.
Details of the Incident of Patient Suicide

Characteristic	N (%)
Sex of the patient	
Male	35 (74.5)
Female	12 (25.5)
Age of the patient, y	
<20	6 (12.8)
21–40	32 (68.1)
41–60	9 (19.1)
>60	0
When did this incident happen? (most recent incident if it has happened more than once)	
Within last 6 mo	4 (8.5)
Between 6 and 18 mo ago	16 (34.0)
Between 18 mo and 3 y ago	6 (12.8)
Between 3 and 5 y ago	12 (25.5)
Over 5 y ago	9 (19.1)
When in your career did this happen?	
During training	11 (23.4)
After completing training	36 (76.6)
Where did the incident happen?	
In hospital setting	7 (14.9)
Patient's home	31 (66.0)
Patient's workplace	0
Other	9 (19.1)
Diagnosis of the patient (*ICD-10*)	
F10–F19	7 (14.9)
F20–F29	20 (42.6)
F30–F39	14 (29.8)
F40–F48	5 (10.6)
F60–F69	5 (10.6)
F90–F98	1 (2.1)
F99	1 (2.1)
For how long was the patient following up with you?	
≤1 mo	13 (27.7)
1–6 mo	17 (36.2)
7–12 mo	6 (12.8)
>1 y	11 (23.4)
How was the patient following up with you?	
Regular	15 (32.0)
Irregular	32 (68.0)
Were you involved in any inquiry or legal issues following the patient's suicide?	
No	43 (91.5)
Yes	4 (8.5)

consequence. Only 27.7% were mildly comfortable in discussing the incident and its impact with colleagues, and 89.4% believed that the incident could have been prevented. The majority of respondents reported that they received adequate support from family, friends, and colleagues. However, support from the hospital/organization they were working with was largely lacking (Table 3).

Thematic Analysis of the Open-Ended Questions

"What type of emotions did you experience and to what extent? What made you feel that way?"

The responses showed that 34.6% of MHPs focused on the themes of sense of responsibility and guilt along with reflection on treatment and care. Subthemes of guilt involved personal accountability ("felt responsible"), unexpected outcome ("I did not anticipate it. Though I know I am not guilty, still feel guilty for not knowing and helping."), and professional guilt ("Sad that he did not share the suicidal ideation with me during consultation."). Additionally, 35% of participants felt improvement was needed in communication and monitoring and direct intervention, suggesting that stronger vigilance and proactive measures could have potentially changed the outcomes (Table 4).

"Looking back, do you think the suicide of your patient could have been prevented? What do you think could have been done?"

The participants provided insights on potential interventions. Communication and monitoring improvements were frequently mentioned, including the need for assertiveness with management ("I should have been more assertive with the management") and ensuring regular follow-ups ("Regular follow-ups, warning signs should have been explained to family"). For direct intervention, suggestions ranged from the judicious use of restraints ("We could have saved him if

Table 3.

Effect of the Incident on the Mental Health Provider and Support Received (N = 47)

Questions	Responses[a]				
	Not at all	To some extent	Mild	Moderate	Extreme
To what extent did this incident affect your emotional well-being?	1 (2.1)	8 (17)	23 (48.9)	13 (27.7)	2 (4.3)
What type of emotions did you experience and to what extent?					
Shame	31	8	6	2	0
Sadness	2	9	14	17	5
Anger	18	11	9	6	3
Contempt	32	8	6	0	1
Fury	31	8	5	3	0
Regret	8	12	12	12	3
Paranoia	41	5	1	0	0
Guilt	14	11	11	9	2
How long did you perceive this effect?					
<1 wk			14 (29.8)		
1 wk–1 mo			22 (46.8)		
Up to 6 mo			8 (17.0)		
More than 6 mo			3 (6.4)		
Did you ever consider or act in any way to change your career path as a consequence of a patient's suicide?					
No			43 (91.5)		
Yes			4 (8.5)		
How comfortable were you in discussing the incident and its impact with your fellow colleagues?					
Not at all			6 (12.8)		
To some extent			7 (14.9)		
Mild			13 (27.7)		
Moderate			12 (25.5)		
Extreme			9 (19.1)		
Looking back, do you think the suicide of your patient could have been prevented?					
No			5 (10.6)		
Yes			42 (89.4)		
	None	**Minimal**	**Moderate**	**Adequate/as expected**	
To what extent did you receive support from the following in relation to the incident in question?					
Hospital/organization you were working with	19	9	10	9	
Colleagues	12	9	9	17	
Family	7	15	7	19	
Friends	10	7	11	19	

[a]Values are presented as n (%) or n.

chemical and mechanical restraints were used judiciously.") to stronger insistence on hospital admission ("More insistence on his admission to the hospital"). The role of support systems was also underscored, with many emphasizing the need for greater family involvement and education ("Told parents with more impact about the need for close monitoring"), indicating that a comprehensive, multifaceted approach may be key in preventing such tragedies.

Coping With the Incident

"Was there anything that helped you cope with the situation and how?"

Of the respondents, 52.2% reported that support seeking helped them cope with the situation. Colleague support was emphasized in comments like "Speaking with colleagues, talking to our team who treated the patient" Family support also played a significant role, as one noted, "Discussed it with my wife. She is also a psychiatrist." Additionally, professional community support ("Talking to friends who are mental health professionals") and seeking professional help ("Supervision and personal therapy helped") were valuable. In personal reflections, professionals acknowledged their limitations ("My understanding that I am a professional and not God") and engaged in positive reframing ("Such incidents are part of the profession, we need to learn to tackle these issues in a positive way."). Coping strategies varied from distraction ("Involving myself in work") to spiritual engagement ("Spiritual beliefs and motivation"). External validation, such as feedback from patients' families ("Her husband and daughter reached out to me and were very thankful

Table 4.
Thematic Analysis of Open-Ended Questions Regarding Perceived Emotions

Major theme	Subtheme	Excerpts	Total responses
Question: What type of emotions did you experience and to what extent-In relation to this question, what made you feel that way?			
Sense of responsibility and guilt	Personal accountability	"Felt responsible" "My staff nurse's child"	5
	Unexpected outcome	"I did not anticipate it. Though I know I am not guilty, still feel guilty for not knowing and helping"	1
	Professional guilt	"Sad that he did not share the suicidal ideation with me during consultation"	3
Reflection on treatment and care	Perceived helplessness	"Nothing could be done to ensure follow up, so felt helpless in that sense" "The patient did not in any way give previously during treatment any suicidal thoughts in spite of repeated inquiry"	3
	Hindsight and regret	"We could have saved him if chemical and mechanical restraints were used judiciously" "Maybe I could have done something more than what I did to prevent his death"	5
	Focus on psychoeducation	"He was voicing suicidal ideation and still his family did not contact any mental health professional"	1
Impact of the loss	Emotional response to loss	"Sadness about the life lost and anger about how management blamed psychiatrist in particular"	2
Adaptive coping	Compartmentalization	"Keeping professional life and personal life completely detached"	1
Insights on practice improvement	Vigilance and prevention	"More vigilant"	2
	Acceptance of clinical challenges	"She was a case of untreated paranoid schizophrenia since age 18 years" "The patient did not in any way give previously during treatment any suicidal thoughts in spite of repeated inquiry"	3
Question: Looking back, do you think the suicide of your patient could have been prevented? In relation to this question, what do you think could have been done?			
Communication and monitoring	Assertiveness with management	"I should have been more assertive with the management"	**1**
	Regular follow-ups	"Regular follow ups," "Followed up, warning signs should have been explained to family," "Frequent follow ups, change of medications"	**3**
	Stronger vigilance and checking on patient absences	"More surveillance," "Stronger vigilance," "Checked about not showing up on first drop out appointment, intimate her friend overseas who would check with me sometimes about her well-being"	**3**
Direct intervention	Use of restraints	"We could have saved him if chemical and mechanical restraints were used judiciously"	**1**
	Insistence on hospital admission	"More insistence on his admission to the hospital," "Admission," "I could have been more persistent with the patient to remain admitted,"	**3**
	Aggressive management and treatment adjustments	"Admission and aggressive management," "Better pharmacotherapy and structured counseling," "Could add a mood stabilizer"	**3**
Support systems	Family care and involvement	"Family care and involvement," "Include family in caregiving and supervision," "If he was given support by his family as instructed during follow-up sessions"	**3**
	Enhancing communication with family	"Told parents with more impact about need of close monitoring," "If the parents had listened," "Proper clarification, psychoeducation, and counseling of the patient and family could have prevented the incident"	**3**

for what I had done for the patients."), also provided comfort (Table 5).

"Was there anything that made your coping with the situation difficult and how?"

Almost half (48.4%) responded that nothing specific made coping difficult, while the other half felt that emotional impact and professional challenges made the coping difficult. Regarding the kind of support, services, and help that would be required by a MHP to deal with patient suicide, confidential advice from a senior clinician or a confidential reflective practice group were suggested by nearly half of the participants (53.1% and 46.9%, respectively) (Table 6).

"How should the training in relation to dealing with death of a patient by suicide be incorporated in psychiatry residency?"

Around 80% responded that this topic should be included in the curriculum for postgraduate training, workshops and seminars. Approximately 15% responded that trainees should be taught the coping methods neccesary in dealing with such circumstances.

Table 5.
Thematic Analysis of Questions Regarding Coping With Patient Suicide

Major theme	Subtheme	Excerpts	Total responses
Question: Was there anything that helped you cope with the situation and how?			
Support seeking	Colleague support	"Speaking with colleagues, talking to our team who treated the patient," "Communicating with my colleagues and trainees regarding what precautions we should take"	8
	Family support	"Discussed it with my wife. She is also a psychiatrist"	1
	Professional community support	"Talking to friends who are mental health professionals"	2
	Professional help	"Supervision and personal therapy helped"	1
Personal reflections	Recognition of limitation	"My understanding that I am a professional and not God"	1
	Positive reframing	"Such incidents are part of the profession; we need to learn to tackle these issues in a positive way"	1
	Introspection	"Own introspection"	2
	Acceptance	"Yes, talked to a senior who said that it happens in a psychiatrist's career, and one can't prevent all suicides"	1
Coping strategies	Distraction	"Involving myself in work"	1
	Enhanced vigilance	"More meticulous towards commanding hallucinations patients"	2
	Endurance Coping	"Time"	1
	Spiritual engagement	"Spiritual beliefs and motivation"	1
External validation and reassurances	Feedback from patients' families	"Her husband and daughter reached out to me and were very thankful for what I had done for the patient"	1
Question: Was there anything that made coping difficult and how?			
Emotional impact	Guilt	"Guilt," "Feeling I could have saved him," I felt incompetent and discussion over the case was avoided by fellow colleagues, made me feel more guilty"	**3**
	Negative external feedback	"Occasional comments of peers," "Negative reaction of family members by reinforcing the guilt"	**2**
Professional challenges	Work disruptions	"My work pattern involves me traveling overseas a few times a year. I worry every time I go overseas, and I get memories of the patient"	**1**
	Systemic and administrative issues	"Top management was stuck up on technical details rather than circumstantial evidence," "The continuing administrative apathy"	**2**
	Unexpected clinical outcome	"The suddenness. He was better, then acted out"	**1**
External feedback from families	Feedback from families	"Families' noncooperation"	**2**
Continued exposure to stressors	Regular exposure to risk	"My career as a psychiatrist which brings me in regular contact with suicidal patients, now I am more cautious and insistent"	**1**
	Returning to work	"Going back to the same workplace and exposing myself to challenging patients"	**1**
Social perception	Professional stigmatization	"Self-inflicted stigmatization with the profession along with high societal expectations of not allowing this to happen with psychiatry as a profession"	**1**
Perceived support	Support received	"I think I received adequate support," "Poor social support"	**2**
No difficulty	. . .	"Nothing," "No," Not really," None," Nil," "NA"	**15**

DISCUSSION

The current study presents a comprehensive look into the impact of patient suicide on MHPs, especially psychiatrists and psychiatry trainees. The demographic profile showed a predominance of female respondents, and psychiatrists formed the largest professional group. The demographics closely align with those observed in the study by Gulfi et al,[17] wherein 54.4% of participants were female and the majority were psychiatrists (74.8%).

Patient suicide was not an uncommon experience, as 51% of participants confirmed that they had a patient under their treatment who had died by suicide, consistent with findings from Ruskin et al[18] and Chemtob et al,[5] wherein around half of the MHPs had encountered such an incident. A larger study by Castelli et al[19] found a slightly higher prevalence (58%) among institutional MHPs.

Regarding the details of the incident, the majority of the patients were male and aged between 20 and 40 years, with the predominant diagnosis being psychotic illnesses, followed by affective disorders. These findings were similar to those of Pieters et al,[20] in which the majority of patients were male, younger than 40 years, and diagnosed with depressive psychotic disorder.

It was found that, 76.6% of respondents experienced the suicide of a patient after completing their training, which contrasts with another study[20] in which the majority (78%) encountered such incidents during their training period. Ruskin et al[18] reported that 31% of

Table 6.

Support and Training Required to Cope With Patient Suicide (N = 96)

Questions	Responses, n (%)
What kind of support/services/help would a mental health professional in this situation require?	
A senior clinician to give confidential advice and support	51 (53.1)
Support for the formal processes following a patient's suicide	30 (31.3)
A confidential reflective practice group or space specifically for processing the effects of a patient suicide	45 (46.9)
Help in communicating or meeting the family/friends of the patient who has died	39 (40.6)
Information about resources for families affected by suicide	24 (25)
Access to a general reflective practice	18 (18.8)
Organized peer support	43 (44.8)
A training session about this topic	36 (37.5)
Information about support for the community	17 (17.7)
Workshop to share experiences	28 (29.2)
Counseling and therapy	29 (30.2)
None	0
How important is educating trainees about dealing with death of a patient by suicide (even if there hasn't been any during their training period)?	
To some extent	0
Mild	0
Moderate	19 (19.8)
Extreme	77 (80.2)
How effectively is this training imparted (in Indian settings) per your experience?	
Not at all	25 (26)
To some extent	38 (39.6)
Mild	18 (18.8)
Moderate	4 (4.2)
Extreme	11 (11.5)

respondents had experienced the suicide of a patient while they were still in training. Though there is a dearth of literature for comparison, this difference might also reflect variations between institutional settings and private practice. In institutional settings, the support systems and supervision available during training could dilute the immediate impact of patient suicides, whereas in private practice where professionals practice with higher autonomy, the burden of such incidents may be more intensely felt after training is completed. Most of the time (66%), the incident occurred in the patient's home, which contrasts with the findings of Pieters et al,[20] in which 68% (n = 54) were inpatients. This suggests that suicide occurring outside of controlled environments like hospitals might reflect challenges in post-discharge care and the need for stronger follow-up and community-based support systems; 21% of the patients were following up for 3 months or less and ~68% had irregular follow ups. Gulfi et al[17] reported more intense reactions observed among professionals who felt responsible for and close to the deceased patient. This may be related to the duration of the therapy and to the fact that MHPs were still in contact with the patient at the time of suicide and felt that their relationship was intense.[17]

Approximately one-third of participants reported a moderate-to-severe impact on their emotional well-being, with sadness being the most commonly reported emotion, followed by feelings of regret and guilt. These feelings persisted for a while, with 17% reporting that they experienced these effects for as long as 6 months, and some of them even considered changing their career path as a consequence of this incident. These results mirror findings from Ruskin et al,[18] wherein 71% felt helpless, 55% experienced horror, and 44% experienced anxiety. Literature reviews by Lafayette and Stern[21] and Foley and Kelly[3] support the notion that MHP reactions to patient suicide can be profound and long-lasting, resembling grief responses and, in some cases, posttraumatic stress symptoms. These experiences may also lead to defensive clinical practices, including more conservative risk assessments and increased documentation.

Comfort with discussing the incident was limited, with only 27.7% feeling mildly comfortable sharing it with colleagues. This finding echoes that of Ruskin et al,[18] where 27% of participants reported being unable to seek help, reflecting the stigma or discomfort around addressing such distressing professional events.

Qualitative data analysis revealed that 34.6% of responses centered on a sense of responsibility and guilt, along with reflections on the treatment and care

provided. Guilt was categorized into subthemes such as personal accountability, unexpected outcomes, and professional guilt, emphasizing a belief that the suicide represented a failure on their part. This aligns with Ting et al,[22] who noted that many MHPs view patient suicide as evidence of professional inadequacy. About 35% of participants felt that better communication, monitoring, and direct intervention could have prevented the suicide, including being more assertive about hospitalization, judicious use of restraints, and ensuring regular follow-up. Chemtob et al[5] found that younger age and less training were associated with greater emotional impact, suggesting trainees may be more vulnerable.

Professionally, such incidents often lead to significant changes in clinical practice, including increased documentation, lower thresholds for hospitalization, and more defensive therapeutic decisions.[8,9] Coping strategies were varied: 52.2% relied on support seeking through colleagues, family, or the professional community. Others employed personal reflections, distraction, enhanced vigilance, or spiritual beliefs. These findings are consistent with Pieters et al,[20] who emphasized the role of supervisory and peer support. Some professionals felt isolated, underscoring the importance of accessible institutional support. Gulfi et al[17] similarly found that those who had sufficient support experienced less distress and fewer professional disruptions. Ting et al[22] also emphasized the protective role of professional support in such contexts.

All respondents in our study agreed on the importance of training in managing the impact of patient suicide, but only 11.5% felt that existing training in India was extremely effective. Pieters et al[20] similarly reported that despite the frequency of such incidents, less than half of professionals had received formal training. Only a small percentage had been taught to cope with the psychological and professional consequences of a patient's suicide. Globally, studies show that only 20%–25% of psychiatry trainees receive adequate education in this domain.[3,23,24]

Those who did receive post-suicide management training found it helpful, mirroring the positive reception of such programs in studies from other countries.[5,9] Given the emotional and professional ramifications of patient suicide, these findings strongly advocate for integration of structured and mandatory training on the topic in postgraduate psychiatry curricula. Formal programs could offer not only preventive frameworks but also crucial support mechanisms for navigating the aftermath, ultimately safeguarding the well-being of MHPs and improving patient care.

CONCLUSION

The suicide of a patient has a profound impact on MHPs, affecting their emotional well-being, professional identity, and susceptibility to burnout, while also posing potential legal challenges. Creating supportive workplace environments and strong professional networks is crucial in addressing these challenges. Psychiatry training programs should incorporate education on coping mechanisms and burnout prevention, while fostering open discussions among peers. These initiatives can strengthen MHPs' resilience and enhance the quality of mental health care. However, this study has certain limitations, including a small sample size, unequal representation of different MHP groups, and potential recall bias due to its retrospective design. Future research may explore the long-term psychological and professional impact of patient suicide on MHPs. Studies with larger, more representative samples can help identify group-specific needs and coping mechanisms. Prospective, longitudinal designs would provide deeper insight into recovery trajectories. Additionally, evaluating the effectiveness of structured support programs and resilience-building interventions can inform best practices. Exploring cultural, institutional, and systemic factors influencing MHP responses to patient suicide will also be crucial in developing tailored, evidence-based strategies to support their well-being and professional functioning.

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Author Affiliations: Institute of Human Behaviour and Allied Sciences, Delhi, India (Singh); Lady Hardinge Medical College, Delhi, India (Raut); All India Institute of Medical Sciences, Delhi, India (Bhardwaj); Pt. B.D. Sharma UHS, Rohtak, India (Malik).

Corresponding Author: Yogender Malik, MD, DNB, Pt. B.D. Sharma UHS, Rohtak, India (yogendermalik187@gmail.com).

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