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Experiências traumáticas de pessoas enlutadas por suicídio de alguém próximo: um estudo qualitativo

Porto Alegre
2020

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Dissertação apresentada como requisito parcial para a obtenção do título de Mestre em Psiquiatria e Ciências do Comportamento, à Universidade Federal do Rio Grande do Sul, Programa de Pós-Graduação em Psiquiatria e Ciências do Comportamento.

Orientador: Prof. Dr. Pedro Vieira da Silva Magalhães

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JÚLIA CAMARGO CONTESSA

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Porto Alegre, _____ de _____ de 2020.

A Comissão Examinadora, abaixo assinada, aprova a Dissertação "Experiências traumáticas de pessoas enlutadas por suicídio de alguém próximo: um estudo qualitativo", elaborada por Júlia Camargo Contessa, como requisito parcial para a obtenção do Grau de Mestre em Psiquiatria e Ciências do Comportamento.

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Prof. Dr. Pedro Vieira da Silva Magalhães - Orientador

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RESUMO

Introdução: A exposição ao suicídio é um evento violento e inesperado, capaz de provocar trauma nas pessoas a ele submetidas, em especial, aos familiares de quem cometeu suicídio. Existem estudos que demonstram elementos de trauma nessa população, além de prejuízo na saúde física e mental. Contudo, apesar dessas evidências, há a necessidade de conhecer a experiência de trauma pela perspectiva dos próprios sujeitos para desenvolver tratamento/assistência mais eficazes e para construir estratégias para auxiliar logo após a perda e em longo prazo. **Objetivo:** O objetivo deste estudo foi investigar as experiências de trauma de familiares de pessoas que morreram por suicídio. **Método:** A partir de uma abordagem qualitativa procura-se compreender como as pessoas vivenciam o evento de trauma, e os significados que dão a essas experiências. Devido à parceria do Hospital de Clínicas de Porto Alegre com o Instituto Geral de Perícias do Rio Grande do Sul, foi possível o acesso a familiares de indivíduos que passaram por essa situação, uma vez que, logo após o suicídio, o corpo é encaminhado para necropsia. A equipe de pesquisa utilizou essa oportunidade para contato inicial, esclarecimento e convite sobre a pesquisa. Com isso, na presente pesquisa foram incluídos familiares de indivíduos que cometeram suicídio e que aceitaram participar das entrevistas. Esses indivíduos participaram de uma entrevista semiestruturada organizada em áreas temáticas destinadas a apreender a experiência decorrente da exposição de um familiar ao suicídio e suas consequências do seu próprio ponto de vista. A análise de dados foi realizada através da análise de conteúdo de Bardin. **Resultados:** Foram feitas 37 entrevistas no total. Destas, quatro entrevistas foram realizadas com dois membros da família na mesma entrevista (ou seja, 41 participantes). As análises geraram dois temas: encontrar o corpo do suicida e reações ao suicídio. Este segundo tema, por sua vez, foi subdividido em seis subtemas. Estes seis subtemas são os seguintes: reações; memórias; impacto no indivíduo; saúde física; impacto social e familiar; e enfrentamento e busca de sentido. **Conclusões:** São relatados de forma vívida a surpresa e o choque tanto relacionados ao encontro do corpo no local do suicídio, quanto ao recebimento da notícia. São relatos de experiências que possivelmente são sintomas relacionados ao trauma. Isso faz com que essa experiência cause prejuízo a saúde mental e física. Assim, é imprescindível que os clínicos sejam

capacitados a identificar as demandas e formas de tratamentos adequados para essa população. Os modelos pós-intervenção após o suicídio devem incorporar tais achados e investigar o trauma de forma consistente.

Palavras-chave: Exposição ao suicídio. Trauma. Estudo qualitativo.

ABSTRACT

Introduction: Exposure to suicide is a violent and unexpected event, capable of causing trauma to people subjected to it, especially to the family members of the suicided. There are studies that demonstrate elements of trauma in this population, in addition to impairment in physical and mental health. However, despite such evidence, there is the need to acknowledge the experience of trauma from the perspective of the subjects themselves in order to develop more effective treatments/assistance and to build strategies to assist, either shorthly after the loss and in the long term. **Objective:** The objective of this research was to investigate the trauma experiences of family members of people who died by suicide. **Methods:** From a qualitative approach, the research seeks to comprehend how people experience the event of this trauma, and the signification they give to these experiences. Due to the partnership between the Hospital de Clínicas de Porto Alegre and the Instituto-Geral de Perícias do Rio Grande do Sul, it was possible to access family members of individuals who went through this situation, since, right after suicide, the body is sent to necropsy. The research team used this opportunity for initial contact, clarification and invitation to the research. Thus, in this research were included relatives of individuals who committed suicide and agreed to participate in the interviews. These individuals participated in a semi-structured interview organized in thematic areas designed to apprehend the resulting experience of exposure of a family member to suicide and its consequences, from their point of view. Data analysis was performed using Bardin's content analysis. **Results:** A total of 37 interviews were conducted. Of these, 4 interviews were conducted with two family members in the same interview (totaling 41 interviewees). Content analysis suggested two core themes: finding the body at the suicide site and reactions to suicide. The second theme was divided into six subthemes. These six subthemes are: reactions; memories; impact on the individual; physical health; social and family impact, and coping and meaning making. **Conclusion:** The surprise and shock regarding both the finding of the body at the suicide site, and receiving the news, are vividly reported. Throughout the interviews are experiences that are possibly symptoms related to trauma. This entails damage to mental and physical health. Thus, it is essential that

clinicians receive training to identify the demands, and forms of treatment suitable for this population. After suicide Post-intervention models should incorporate such findings and investigate trauma in a consistent manner.

Keywords: Exposure to suicide. Trauma. Qualitative study.

Sumário

1. INTRODUÇÃO

A exposição a um suicídio é um evento comum durante a vida. Entre familiares, a estimativa é que entre 3 e 5% de exposição, com 1% expostos no último ano (1). Quando o suicídio acontece, ele impacta e se torna doloroso para familiares, amigos, colegas e outras pessoas na comunidade em geral, não apenas a pessoas próximas de quem cometeu suicídio. Entre o grupo de pessoas expostas ao suicídio, nota-se que os mais afetados e enlutados por mais tempo, são os familiares e amigos mais próximos. Para os familiares próximos, existe a necessidade de enfrentar o luto e diversos problemas psicossociais, o que faz essa população se apresentar mais vulnerável a ter risco de suicídio. Em relação a essa forma de morte, o suicídio é considerado uma morte violenta e imprevisível para os que estão ao redor (2,3).

Mortes violentas e inesperadas vêm sendo recentemente investigadas como eventos capazes de provocar trauma, o que tem sido denominado luto traumático (4). A morte violenta causa surpresa e prejuízo na saúde mental para os familiares. Como possível consequência aparece a dificuldade para a elaboração do luto, o que pode contribuir para o desenvolvimento do transtorno de estresse pós-traumático (5).

Quando ocorre um fato na vida de um indivíduo que seja incontrolável, inesperado e que cause uma percepção negativa de experiência, pode ser produzido um evento traumático. Acontecimentos que podem causar dores psíquicas e/ou físicas ou até mesmo a morte são potencialmente traumáticos, apesar da singularidade de cada um. A exposição a esses eventos pode causar potenciais prejuízos na saúde mental e/ou física (6).

Considerando eventos potencialmente traumáticos, na Austrália, foi realizado um estudo em uma comunidade rural com amostra de 623 indivíduos. Observou-se que, em um grupo de 305 pessoas em que ocorrida a morte inesperada de um familiar, 107 (35,1%) apresentou associação com transtorno de estresse pós-traumático. Testemunhar dano, morte e a visão de cadáver foram relatados por 208 pessoas desta amostra, com 75 (36,1%) apresentando associação com transtorno de estresse pós-traumático (7).

Investigação comparando grupos de enlutados por cônjuge, os dividindo em morte natural inesperada e morte violenta (acidentes, homicídios e suicídios), verificou que a morte violenta pode causar mais sintomas pós-traumáticos e persistência de depressão do que morte natural inesperada. Este estudo mostra que esse tipo de perda

causa sintomas de tristeza acima do normal, causando um evento traumático, o que pode produzir o transtorno de estresse pós-traumático (8).

Além de trazer prejuízos à saúde mental, o evento traumático compromete a saúde física. Estudo transversal realizado entre 14 países para investigar associação entre eventos traumáticos e doenças físicas encontrou risco elevado de saúde física associado com exposição a um ou mais eventos traumáticos (9).

Sobre a saúde mental e física após a exposição ao suicídio, foi realizado estudo na Irlanda com 18 familiares de indivíduos que cometeram suicídio. Ressalta-se que a maioria dos familiares apresentou complicações psicossomáticas, na saúde física e saúde mental meses após a morte. Questões como perda de energia, dores persistentes no peito, falta de ar, dores físicas, hipertensão, diabetes e diverticulite apareceram na saúde física. Sobre experiências imediatas seguidas do suicídio, incluem-se náusea, vomito, falta de ar, dormência, perda de memória, dores físicas e insônia. Em relação à saúde mental, diversos participantes trazem pesadelos e visões do falecido, perda de apetite, náuseas devido aos flashbacks de achar o corpo e sentimentos de depressão e desanimo. Encontrar o corpo do indivíduo que cometeu suicídio aparenta causar mais sintomas severos relacionados a trauma, como depressão, ansiedade, ataque de pânico, transtorno de estresse pós-traumático, pensamentos e tentativas de suicídio. Imagens intrusivas sobre a forma da morte apareceram não apenas para quem encontrou o corpo, mas também para aqueles que foram notificados da forma da morte (10).

Existem outras evidências semelhantes às citadas acima. Estudo de caso referente a uma esposa que perdeu o parceiro de forma inesperada por suicídio e o encontrou enforcado, verificou a presença de sintomas persistentes, como dores de cabeça, insônia, humor depressivo, ataque de ansiedade, dificuldade no trabalho e pensamentos obsessivos e intrusivos após a morte do parceiro. Foi possível preencher critérios para transtorno de estresse pós-traumático, pois além dos outros sintomas, existia o sentimento de estar revivendo a situação, comportamentos relacionados a evitação, hipervigilância, com memórias repetitivas e intrusivas (11). Para o familiar que encontra o corpo, pode haver sintomas de estresse pós-traumático, como lembranças da vivência (*flashbacks*) e pesadelos, criando dificuldade para esquecer a cena (12,13).

O sentimento dos familiares é de que o evento poderia ter tomado um curso diferente e não ter tomado à proporção de suicídio. Com todos esses pontos acima mencionados, o ato suicida tem o potencial de trazer para os familiares diversos

sentimentos, por exemplo, culpa, desespero, tristeza, isolamento, ressentimento, raiva, choque, desamparo, agitação, ideação e tentativa de suicídio (11–19).

Entre outros aspectos dolorosos, se encontra o estigma social ao redor da forma da morte, fatores financeiros, conflitos familiares, mudanças e inversão de papéis na dinâmica familiar, rotina e mudanças de endereço. Entre os familiares, existe a dificuldade de comunicar-se entre si sobre a dor que sente em relação à perda do falecido (13,14,17,19).

O suicídio ainda pode impactar o vínculo entre familiar e suicida, já que o familiar pode ter sentimentos de abandono, raiva e rejeição. A forma da morte, muitas vezes, convola-se na questão mais importante da vida do suicida, de maneira a fazer com que os familiares esqueçam a sua história de vida e a sua personalidade. Passa a ser necessário para o familiar compreender os motivos da atitude final do suicida, sendo difícil pensar em outros aspectos (20).

Sobreviventes de suicídio demonstram estar abertos a expressar os seus sentimentos, compreender melhor a experiência, buscar respostas e melhor entendimento dos motivos que levaram ao suicídio, assim como se manter mais estável. Para encontrar estas soluções, existe necessidade de escutar o que estes familiares necessitam dizer (21).

Para isso, a pesquisa segue a metodologia qualitativa com entrevistas semiestruturadas. As abordagens qualitativas são especialmente interessantes porque permite capturar a experiência dos participantes, seus significados e entender a perspectiva deles. Através desse método, é possível compreender como as pessoas experimentam os eventos e os significados que eles dão a essas experiências (22).

2. JUSTIFICATIVA

O entendimento da experiência do familiar em relação ao estressor, consequências, saúde mental e rede de apoio pode ajudar a conhecer a experiência após a exposição do evento traumático. O conhecimento destes aspectos é relevante, já que a exposição a suicídio pode causar sofrimento psíquico e talvez novos suicídios. Conhecer desde a perspectiva dos próprios sujeitos fornece dados culturalmente adequados capazes de auxiliar no desenho de tratamentos/assistência mais personalizados e construir estratégias para auxiliar logo após a perda e em longo prazo, portanto, mais eficazes.

3. OBJETIVOS

3.1 OBJETIVO GERAL

A fim de contribuir com o conhecimento do fenômeno traumático após a exposição ao suicídio, buscamos neste trabalho investigar em profundidade as experiências de trauma de familiares de pessoas que morreram por suicídio.

3.2 OBJETIVOS ESPECÍFICOS

- Descrever a experiência de trauma relacionado à exposição ao suicídio e as modificações decorrentes após a experiência;
- Descrever a reação inicial fisiológica e psíquica do familiar;
- Conhecer a percepção e sentimentos do familiar em relação ao estressor e à pessoa que cometeu suicídio;
- Investigar como o familiar exposto ao estressor percebe o meio social após o evento traumático;
- Descrever experiências particulares em relação a encontrar o corpo.

4. MÉTODO

4.1 DESENHO

Este é um estudo qualitativo com entrevistas semiestruturadas em profundidade. A pesquisa qualitativa procura identificar a realidade do sujeito e aprofundar os significados da experiência. As abordagens qualitativas são especialmente interessantes porque permite capturar a experiência dos participantes, seus significados e entender a perspectiva deles. Através desse método, é possível compreender como as pessoas experimentam os eventos e os significados que elas dão a essas experiências (22). Diversos estudos internacionais, com abordagem qualitativa, pesquisam a experiência de trauma em familiares de indivíduos que cometeram suicídio utilizando este método (17,23,24).

A análise de dados foi realizada através da análise de conteúdo de Bardin. A escolha dessa análise foi com o objetivo de explorar, aprofundar e verificar questões sobre um determinado tema. Isso pode ser realizado através de diversos meios de comunicação em que as mensagens subjacentes não foram aprofundadas o suficiente. É um método empírico e que utiliza procedimentos para decifrar a mensagem e o seu significado. A análise é temática e deve se obter inferência da mensagem obtida na entrevista a ser explorada em busca de sentido (25).

4.2 INSTRUMENTO

A entrevista ocorreu no mesmo momento em que os familiares eram entrevistados para outras questões de pesquisa, como por exemplo a autópsia psicológica, sendo toda a entrevista realizada por profissionais de saúde mental. A equipe já possuía experiência e treinamento no processo desde 2012. O método de coleta foi através de entrevista em profundidade semiestruturada, organizada em áreas temáticas destinadas a apreender a experiência decorrente da exposição ao suicídio. A entrevista era semiestruturada para permitir que, ao mesmo tempo em que o pesquisador

procurou questões que considera essencial, o participante se expresse de modo a manter a sua singularidade (26).

Através da entrevista, foi investigada a experiência traumática do familiar exposto ao estressor. O objetivo principal desse recurso era oferecer um espaço de escuta, acolhimento e coleta de informações para se descobrir questões decorrentes ao suicídio. As entrevistadoras eram psicólogas treinadas para aplicar a entrevista, mantendo-se neutras, favorecendo um ambiente acolhedor e com o discurso o mais profundo possível. Também possuíam experiência em estudos qualitativos.

4.3 AMOSTRA

Este estudo está dentro da linha de pesquisa "Avaliação de parâmetros bioquímicos e moleculares do encéfalo e suas correlações clínicas em indivíduos que cometeram suicídio". Esta linha de pesquisa estuda o suicídio através da análise de encéfalo de indivíduos que cometeram o suicídio entre 18-60 anos de idade. A autorização para a doação do encéfalo para pesquisa é solicitada aos familiares responsáveis legais no momento dos procedimentos de necropsia. Estes familiares também são convidados a participarem de entrevistas qualitativas de autópsia psicológica e de investigação do processo de luto após 2 meses da abordagem inicial.

Na presente pesquisa foram incluídos familiares de indivíduos que cometeram suicídio e que aceitaram participar das entrevistas. Foi selecionado este perfil de participante por eles serem capazes de fornecer informações detalhadas sobre a exposição ao trauma. Assim, a amostra é um conjunto de pessoas que passaram por essa experiência e que foram representantes desse universo, expressando através da entrevista a sua realidade (27).

Além da importância de selecionar uma amostra adequada que represente o objetivo de pesquisa, foi relevante selecionar um local que permitiu acesso a este conjunto de indivíduos (27). Portanto, os familiares foram convidados a participar do projeto no Instituto Geral de Perícia IGP- RS. Este local foi selecionado porque o Hospital de Clínicas de Porto Alegre já detém parceria com o Instituto Geral de Perícias do Rio Grande do Sul (IGP-RS), o que permite acesso a voluntários que passaram por essa situação, uma vez que, logo após o suicídio, o corpo é encaminhado para necropsia. Com isto, os familiares têm a necessidade de ir a esta instituição após acontecer o

evento traumático. A pesquisadora utilizou essa oportunidade para contato inicial, esclarecimento e convite sobre a pesquisa.

4.4 PROCEDIMENTOS

Os familiares que aceitaram compor o grupo de pesquisa foram convidados a participar das entrevistas após o mínimo de dois meses depois do suicídio. A equipe entrou em contato com o familiar por telefone para esclarecer que o objetivo é investigar a experiência traumática até aquele momento. As entrevistas foram realizadas por via telefônica ou agendadas conforme disponibilidade da equipe e de sala no Centro de Pesquisa do Hospital de Clínicas de Porto Alegre, tomando os cuidados de privacidade.

No início, o familiar pode esclarecer as suas dúvidas em relação à pesquisa. O pesquisador explicou como seria a entrevista e solicitou a autorização para a gravação. Também foi obtida a assinatura do termo de consentimento após o voluntário compreender o processo e aceitar a participar. Após o término da entrevista, o pesquisador questionou novamente se o familiar aceitava manter sua autorização para utilização dos dados da entrevista para a pesquisa. Foi esclarecido aos familiares que suas informações seriam preservadas através do sigilo.

4.5 ANÁLISE DOS DADOS

As entrevistas foram gravadas e transcritas. O material foi organizado para a análise através das seguintes etapas: pré-análise; exploração do material; inferência e interpretação dos resultados (25).

O processo da pré-análise organiza o material. Deve se realizar intuições e ter ideias iniciais para um plano posterior de análise que pode ser flexível para captar novos elementos. Assim, foram escolhidas as entrevistas para a análise que eram relacionadas aos objetivos para o processo final. A pesquisadora manteve uma posição e leitura aberta para conhecer melhor as ideias que percorriam os entrevistados, e diante disso, aos poucos constatar todos os elementos que consistiam na temática (25).

Após esse processo, torna-se necessário explorar o material por meio da codificação. Esta técnica de operações transformou a entrevista para representar o

conteúdo e características da experiência de trauma. Foi feito cortes sobre as entrevistas para categorizar o conteúdo de trauma (25).

A seguir, efetivaram-se categorias de agrupamento sobre a experiência de trauma. Em cada categoria, foram reunidos elementos com características semelhantes dos discursos dos familiares. O título das categorias reflete o conjunto de elementos (25).

Após classificar as categorias, foram feitas inferências a partir dos objetivos para interpretar o material. Por meio das entrevistas, os familiares trazem a mensagem, e diante disso, se interpreta o significado de como foi à experiência de trauma (25). É importante que a amostra ofereça informações de forma profunda para ser realizada a saturação de dados por meio das entrevistas. A saturação ocorreu quando o pesquisador encontrou nas entrevistas elementos semelhantes. Isto significa que aquele objetivo foi saturado e que não foi necessário realizar mais entrevistas para responder à questão de pesquisa (28).

4.6 ASPECTOS ÉTICOS

A abordagem dos indivíduos foi feita por profissionais qualificados e preparados para lidar com entrevistas, assim como temas que proporcionam sofrimento a saúde mental. A abordagem de aspectos éticos foi realizada através do termo de consentimento informado. Além de oferecer o consentimento através da assinatura de um termo, os participantes consentiam verbalmente após o fim da entrevista.

O projeto foi aprovado pelo Comitê de Ética e Pesquisa do Hospital de Clínicas de Porto Alegre (HCPA). Devido à situação delicada de luto e possível trauma, quando a equipe percebia sofrimento psíquico do familiar, era oferecido e orientado para o familiar atendimento gratuito pelo programa NET Trauma oferecido pelo HCPA. Esta assistência era disponibilizada ao familiar mesmo com a recusa do consentimento e participação da pesquisa.

5. RESULTADOS: ARTIGO

5.1 ARTIGO SUBMETIDO À REVISTA "DEATH STUDIES"

A qualitative study on traumatic experiences of suicide survivors

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ABSTRACT

Exposure to suicide of a loved one can be a traumatic experience. The objective of this research was to investigate the experiences of suicide survivors related to trauma. This is a qualitative study with semi-structured interviews. Data presented here was obtained from 41 participants. The interviewees' perception was that suicide brought harm, symptoms and suffering. Traumatic experiences can begin immediately after the event, with many reporting symptoms lasting many months and persistent impact, both personal and to the family. Postvention models after suicide should incorporate such findings, and investigate trauma consistently.

Keywords: trauma; suicide; qualitative study

Introduction

Exposure to the suicide of a close one is a common life event. Among family members only, three to five percent are exposed, with 1% exposed in the previous year (Andriessen, Rahman, Draper, Dudley and Mitchell, 2017). Suicide can be traumatic due to the violent and unpredictable quality of the death, with many survivors going on to suffer from a form of traumatic grief (Public Health England, 2015; Andriessen and Krysinska, 2012; Shear, Zuckoff, Frank, 2001).

Grief experienced by suicide survivors can be qualitatively distinct from grief after non-violent death; guilt, confusion, rejection, shame and anger can add to the bereavement process. Violent (Tal Young, Iglewicz, Glorioso, Lanouette, Seay,

Ilapakurti and Zisook, 2012) deaths can cause more post-traumatic symptoms and depression than unexpected natural deaths (Kaltman and Bonanno, 2003), although there is significant variability owing to sampling and methodology (Sveen and Walby, 2008). Traumatically bereaved families can have suicidal ideation irrespective of type of loss (Williams, Eddinger, Rynearson and Rheingold, 2018). There are suggestions that violent loss can lead to prolonged grief and then to post-traumatic symptoms, and that this is not always reported or treated. Perceived unexpectedness and shock have been shown to lead to distress and dissociation, which can lead to grief and trauma symptoms (Boelen, 2015; Sanford, Cerel, McGann and Maple, 2016; Jordan, 2020). For the family member who finds the body, there may be added symptoms of post-traumatic stress, such as intrusive memories of the experience (flashbacks) (Botega, 2015; Dutra, Preis, Caetano, Santos and Lessa, 2018; Padoan, Cardoso, Martini, Farias, Contessa and Magalhães, 2019).

Family members report difficulty communicating the pain they feel in relation to the loss (Dutra, Preis, Caetano, Santos and Lessa, 2018; Castelli Dransart, 2017; Peters, Cunningham, Murphy and Jackson, 2016; Ross, Kõlves, and De Leo, 2019). Suicide is stigmatized, and the feeling of being unable to talk about the death because of other discomfort can be a barrier towards the healing process. Family members also often strive with understanding reasons for suicide (Jordan, 2009). There may be perceived abandonment and rejection, as they see the suicide as an act of personal responsibility that could potentially have been prevented (Tal Young, Iglewicz, Glorioso, Lanouette, Seay, Ilapakurti and Zisook, 2012).

While there is a debate on how particular the grief process is following suicide, qualitative studies can help in the understanding of underlying themes and processes. Qualitative studies on grief related to suicide are sparse, usually not focusing on

traumatic aspects of the death (Shields, Kavanagh, Russo, 2017). The objective of this research was to investigate the trauma experiences of family members of people who died by suicide in depth. We sought to investigate those experiences related to trauma, with emphases on experiences related to the initial reaction to the trauma, perceptions of the trauma, aroused feelings and consequences for the social environment resulting from the suicide.

Methods

Design

This is a qualitative study; semi-structured in-depth interviews were used to gather information. The method has been widely used to understand the experience of suicide survivors (Ross, 2018; Peters, 2016; Lee, 2019). Bardin's content analysis was used to explore the data (Bardin, 2009). In this kind of thematic analysis, the researcher strives to understand what structures or models latent in the participant discourse.

Data collection

We employed semi-structured interviews to investigate traumatic experiences of family members exposed to suicide. The interview was semi-structured to allow the participants to express themselves, while the researcher also looked for relevant issues (Minayo, 2010). The interviewers explored exposure to suicide as a traumatic phenomenon, especially the experience of finding the body, physical and psychological reactions to the exposure, impact on the individual, perception, feelings and changes aroused by the experience. Interviewers used an interview guide designed by the authors, containing prompts to the themes described above.

The data presented here is a section of a broader protocol. Female psychologists (JCC and CSP) with training at master's or doctoral level and clinical experience conducted all interviews. Interviewers underwent a complete training procedure held by bioethics and mental health advisors and has been working closely with bereaved families since 2012. Interviewers had to subject their practice to a critical examination of values and posture in order to help unpack assumptions they could have brought to the field, identifying how personal contexts might shape results and interactions. The data presented here was collected between 2013 and 2019.

Sampling

This paper reports on family members and close relatives of people who died by suicide. Briefly, participants were approached immediately after the suicide and invited to participate in the study; they could consent to donate the deceased person's brain for neurobiological research and also participate in a psychological autopsy and qualitative research protocol at least 2 months after the initial approach (Padoan, Cardoso, Martini, Farias, Contessa and Magalhães, 2019; Longaray, Padoan, Goi, da Fonseca, Vieira, Oliveira, Kapczinski, Magalhães, 2017; Padoan, Garcia, Rodrigues, Patusco, Atz, Kapczinski, Goldim, Magalhães, 2017). There were no further inclusion or exclusion criteria other than those of the brain donation protocol; participants could also refuse to donate and participate in the interview. All participants had a close relationship with those who died by suicide (table).

Procedure

Family members were first approached to participate in the project at the coroner's office (Instituto-Geral de Perícias IGP-RS). Those who agreed to participate were invited to the interviews after a minimum of two months after the suicide. We had access to 71 families that were approached for the larger study into suicide and agreed to receive a telephone call to schedule this research interview. From those 71 families, 37 agreed to schedule this interview and completed the research interview protocol. One family agreed to schedule the interview but missed the appointment. During research data collection, we attempted to reschedule the interview but there was no answer to our telephone calls. Eight families refused to participate in the interview alleging they were not interested. We were not able to reach 26 families: 20 did not answered the call and six gave invalid phone numbers.

The interviews were preferably conducted in person (21 of 37), but some were conducted by telephone (16 of 37) at the request of family members. In-person interviews occurred in a specialized clinical research facility at the University Hospital. We conducted the interviews within one single appointment of about 150 minutes face-to-face and about 80 minutes when we used telephone calls.

Analysis

The interviews were recorded and transcribed. Interviewers had a research protocol into which they were able to take field notes on impressions and feelings aroused by the conversation and emotional state of the informants. Analysis was conducted by a pair of researchers (CP; JCC) and coding matrices were discussed in group meetings in all phases of the coding process.

Analysis was performed with the help of the NVivo program (QSR International Pty LTD 2010). The material was organized for analysis through the following steps: pre-analysis; exploration of the material; inference and interpretation of results (Bardin, 2009). After this process, the material was explored through coding. Next, experiences were categorized; from the categories, elements with similar characteristics were gathered. After classifying the categories and according to study objectives, inferences and interpretations were made. The meaning of the trauma experience was assigned according to the categories provided by thematic analysis (Bardin, 2009). Data saturation was the criterion employed to end data collection and no further interviews were conducted (Guest, Bunce and Johnson, 2006). We report the findings according to current COREQ guidelines.

Ethical aspects

All participants signed an informed consent form, and verbally confirmed consent after the interview ended. The institution's Research Ethics Committee approved the project. Due to the delicate situation of mourning and possible trauma, specialized trauma focused treatment was offered at no cost for families whenever necessary at the institution's outpatient clinic. This was available to the family member independently of consent to participate in the research protocol.

Results

We conducted 37 interviews; four interviews were conducted with two family members at the same appointment (that is, 41 participants). Interviews were conducted a median of 6 months after the suicide; seventy-eight percent of interviewees were women, 18 of those were either wives, sisters or mothers; median age for the sample was 47 (see Table). The experience of trauma associated with suicide was present in the discourse of many of the interviewees. Content analysis suggested two core themes, finding the body at the suicide site and reactions to suicide. We further subdivided the second theme into six subthemes. We termed these six subthemes related to reactions to suicide as reactions; memories; impact on the individual; physical health; social and family impact; and coping and meaning making.

Finding the body

Family members reported detailed descriptions in terms of the scene, their emotions, actions and memories about the event. The experience was intensely described as "hell", attributed to the shock of finding the body and what surrounded the scene of death, the presence of police and curious passersby. Family members talk about the immediate social surroundings. When faced with the suicide, they report a difficulty in believing the death really occurred and often seek help from police officers, emergency services and other family members to assist in possible resuscitation. Among this, there are also efforts to prevent other family members from seeing the scene.

These narratives have a description of the complete scenario, attitudes towards the scene and feelings aroused by it. The family members mentioned painful emotions, such as shock, despair and disbelief at the scene. Attempts to revive the suicidal person

were also reported, indicating difficulty in perceiving or understanding that the person was deceased.

(F 1)- The day that it happened, that he hanged himself, my grandson found him. They called me, I arrived there and the kids were trying to revive him. They took him out, broke the rope, and dropped him on the floor. They started doing CPR. Only when I got in there, I was shocked, you know. I just said to the boys "there is no use in doing this massage anymore, because he is not alive". Because in his neck, there was a mark, it was up there, the spot where the blood circulation stopped.

(F 31)- It was terrible, incomprehensible. The pain was hard, you know. In fact, I kind of didn't, I didn't admit that she was, she was, that she was already dead. I called 911, the paramedics came. For me, she was still... I couldn't see it at the time. For me she was still breathing. But she did it in the bathroom, with a rope and that was it.

(F 5)- I saw her hanging. But I didn't know for how long she was there. I didn't want to accept that. I thought that as a health professional, I could do something. I tried to take the rope off, but I couldn't do it. My son took a knife and cut it out, and when it fell off, I took the rope away and started doing CPR. And she was cold. And I said to him "call 911 to help me". They arrived and pronounced it: "she is dead". I got desperate, I panicked. She was my only daughter.

(F 1)- And I was there screaming in that courtyard. People started to show, lots of people, lots of people, cars up there, you know, cars. And I worried about my daughter because she was at work, she didn't know about it yet. How am I going to warn her about it now? How will I tell my daughter that?

(F 31)- And he was at the house with her. I was sleeping, saw nothing. When I got there in the morning, I found her... And he, I asked my mother to get him out of there, so that he wouldn't see this whole sequence of scenes that are very dreadful for anyone, especially for him. That was it.

Immediate reactions

Regarding the initial reaction to the suicide, there were feelings like shock, anger, shame and guilt. It becomes difficult to accept the event and whether the death is real.

(F 4)- It is very difficult to receive news. When it happened, my brother and I took care of all the errands, paperwork, and I was still having a hard time to believe he had done it. And I was in disbelief until we were at the coroner's office, when we had to identify the body. That was when I realized it. I can't describe it, it's a very bad situation

(F 8)- Even if you know it happened, you think it will be… It's like I told you about the impact, the shock... For you to accept it like this on the spot... In my whole life I'll think it's unacceptable. But being hit with this news like that, right on the spot. It is much worse!

(F 18)- I still do not believe it somehow. It's like he's alive, out there. So, this is something that worries you.

Memories and avoidance

Family members report having persistent intrusive memories and thoughts about the deceased. They also report experiencing the dead loved one, such as seeing them, hearing them, talking and having dreams about the person coming back to life. Consequently, they describe all kinds of efforts to avoid those disturbing experiences,

trying very hard not to think about the death and the deceased, as well as avoiding places and routines that are associated to the deceased. The memories are described as sad and painful.

(F 34)- "I want to see if I can get a medical leave due to this persisting memories. It is not something fleeting for me, it is very much present in my day-to-day routine ... It´s like all the time, you know? It comes all the time, all the time, all the time, all the time. Every hour, every second, you know? When I go to the bathroom sometimes, I get scared to go to the bathroom alone, you know? Then my hands get all sweaty, my feet sweat... "

(F 3)- Because of the trauma, I am always very anxious ... Because it is something that cannot be forgotten, right? You keep on having these thoughts about him, about his death, and all this keeps on coming back to you...

Impact on the individual – grief and depressive symptoms

After suicide, family members mention loss of interest, negative beliefs about themselves and the world, suicidal thoughts, depression, anxiety, isolation, crying, panic, anger and guilt.

(F 5)- I don't feel like getting out of bed anymore. I don't feel like working anymore. I come to work counting the hours for me to go home. I lost the joy in things. I don't celebrate anything else. I don't feel like celebrating birthdays, Christmas, new year. Nothing. Nothing else interests me, nothing more. I don't like to go out, I don't like to talk. People irritate me. It's like I hate life. I fret about everything. I get irritated by everything. Sometimes I don't even want to be talked to, I just want to be quiet. I just want to be in a corner alone. Isolated.

(F 24)- But several times it crossed my mind that I could do the same crazy thing as him. I won't deny it. I go out on the streets and look at cars and think "if I throw myself there in front of a car, I will be with him"

(F 31)- Well, it's about mixed feelings. We feel guilty, because we should have done more. We feel frustrated because what we did was not enough to keep her here with us. You even have a feeling of anger towards the person: why did you do that? It is a very complicated thing to express, everything that happens, everything that afflicts us. In fact, I can compare it to an earthquake that happens within your life, and you have to rebuild so many things after that. It is very heartbreaking.

Physical health

Participants report that, after the suicide, they noticed changes in general health. In the first days after the event there is insomnia, hypertension, nausea, shortness of breath and palpitations. Among the symptoms that persist, there are difficulties in sleep and weight control.

(F 11)- "I gained 22 lb. I lost focus on things like that, mainly in relation to my weight and such."

(F 28)- "I got really sick... I got sick, I used to pass out, feel dizzy, couldn't eat, vomiting a lot... Early on, I couldn't eat and vomited a lot. But now I'm anxious so I eat a lot."

(F 5)- "On the day she died I took about 20 pills of valium. And I didn't even fell asleep. I didn't sleep for two days. Everyone says they don't know how I made it. That valium makes you sleep for days. Not to me. It just calmed me down, made me dazed. As if... As if it wasn´t quite happening. Like it was a dream. And I was going to wake up. Many,

many times I say to myself: "This is just a nightmare." I'm going to wake up. And none of this really happened."

Social and family impact

Family members describe stigma and prejudice. There is difficulty talking about the form of death and the feeling of lack of understanding and empathy in relation to the event. Among the survivors, quarrels, disagreements, disunity, guilt as an attempt to blame someone in the family for the suicide, concern for other family members after the event and threats of suicide are common.

(F 20)- "Because we feel ashamed, you know, to tell what happened. At first, when asked about how my brother died, I used to tell people that it was sudden death. Because people get horrified, you know. And then I wonder... The priest from our town, when he heard it was suicide, he said: "Oh, what a horror." Just like that, right to my face. He didn't know that I was his sister. "Oh, what a horror, why did he do that?" Yes, I also ask myself why he did it. But you know what? He did it, and that's not what I wanted for him. That's not what I wanted to hear from him also. You know?"

(F 21)- "Well, working also upset me because people didn't ask me anything, but they looked at me in a certain way. They changed their way around me. I felt I had to smile, I had to appreciate it. If they said" hi ", then I had to respond. But all I wanted was to be left alone… And even today it still bothers me. So much so that today it happened there at work and I couldn't stand it, you know, I cried all day. Bad luck. "

(F 29)- "I can't go to their house. No way I will go there. Every time I see my sister and my brother-in-law... Because from my point of view, they were the main culprits for this to have happened. "

(F 2)- Only 28 days after my brother died by suicide, my other brother also tried to kill himself. The family was very upset after the suicide, very shaken. (...) So I don't know what went on in his head. But after that one was found dead, everybody retreated from family gatherings. So he kind of convinced himself about a conspiracy theory against him."

Coping and meaning making

Participants discussed how life changed after suicide. There appears pain, suffering and the search for reasons for the suicide that accompany the family members' daily lives. Families bring up how much more painful it is to lose someone by suicide than by any other form of death. Over time, the thoughts of family members remain the same, as if it were not possible to elaborate on the sadness of losing a loved one by suicide. There are many unanswered questions about the suicide that torment survivors.

(F 7)- "My mother died seven months ago and I haven't yet absorbed this story, I haven't digested it... I don't know how to live without her... I miss her so much because she listened to me, she took care of me ... "

(F 29)- "And now I very much miss him, miss him a lot and I practically do not to believe what happened. It is very difficult. Very difficult. Unbelievable. Sometimes I stop and I ponder about it and it still seems that it did not happen. I thought that a year later I'll be better. I think it may never come to terms. "

(F 11)- "What most revolts me is not the suicide itself, it is not knowing why. Because she did not have depression, she was a very happy person, who loved helping others.

But a suicide will stay with us for the rest of our lives! And our lives became hell after that.

Discussion

The participants reported here several trauma-related experiences after suicide. Among the themes emerging from their discourse, there was an immediate reaction of shock and disbelief, distressing re-experiencing and avoidance and sadness, anger and guilt. There was a perception of stigma and increasing difficulty counting on others for support, and attempts to hide the manner of death. Another theme was finding the body on the scene after the suicide, described as shocking and disturbing, made worse by the lack of privacy and scrutiny by police and other onlookers. Traumatic experiences can begin immediately after the event, with many reporting symptoms lasting months and persistent impact, both personal and to the family.

A recent systematic review was only able to unearth 11 studies on the general experience of suicide grief. They suggest three common themes from these studies, feelings, meaning and context of bereavement (Shields, Kavanagh, Russo, 2017). Our analysis clearly touches on the first theme. We confirm that themes related to intense distress related to trauma appear in the first months after suicide. After suicide, participants reported a wide range of symptoms, such as loss of interest, negative beliefs about themselves and the world, suicidal thoughts and attempts, symptoms such as depression, anxiety, isolation, crying, panic, anger and remorse.

We add to these findings the presence of traumatic elements (disturbing intrusive memories, guilt, negative feelings, avoidance, anger), that can act to perpetuate this pathological cycle. The immediate moment after death was reported as the most difficult and painful for family members. Case studies on the experience of survivors have reported the presence of traumatic symptoms, such as flashbacks, depressed mood, anxiety attack, guilt and intense suffering (Padoan, Cardoso, Martini, Farias, Contessa and Magalhães, 2019; Roston, 2017; Kawashima and Kawano, 2017). People close to

the deceased can carry emotions such as shock, guilt, flashbacks, nightmares, avoidance, hypervigilance, repetitive memories and the feeling of reliving the event that becomes common in these people's lives, as we report here. The fear that another suicide by someone close to them could occur was another disturbing consequence for the survivors, associated with hypervigilance, anxiety and difficulty in having positive feelings.

Immediate experiences after suicide can include affective, trauma-like and somatic symptoms. In this study, immediate reactions after the suicide of a relative were despair, shock, confusion, pain, guilt, anger and denial, with doubts about the reasons for the suicide and the form of death, as previously described (Dutra, Preis, Caetano, Santos and Lessa, 2018; Lindqvist, Johansson, Karlsson, 2008; Adams, Hawgood, Bundock and Kõlves, 2019; Ross, Kõlves, and De Leo, 2019). Neurovegetative and somatic symptoms were also frequently reported, with insomnia most prominent in the first days after the suicide. Other studies corroborate psychosomatic complications for family members after exposure to suicide. Loss of energy, persistent chest pain, shortness of breath, physical pain, hypertension, diabetes and diverticulitis appeared in physical health. (Spillane, Matvienko-Sikar, Larkin, et al, 2018). As a result, survivors of a suicide loss end up seeking general practitioners. Thus, it is essential for health professionals - and not just mental health professionals - to be able to identify the demands and appropriate treatment for this population (Nic an Fhailí, Flynn, Dowling, 2016).

In relation to the suicide scene, previous qualitative studies show that finding the body can produce despair (Padoan, Cardoso, Martini, Farias, Contessa and Magalhães, 2019). There is difficulty in forgetting the scene, which passes through the mind frequently, causing much suffering (Dutra, Preis, Caetano, Santos and Lessa, 2018). The

theme of finding discovering the body has been much discussed, as well as to reasons for possibly "staging" this act, and qualitative research has been called for (see Lester, for instance) (Lester, 2015). Data on the effects of finding the body are surprisingly spare. While there are interesting discussions focused mainly on whether "viewing" the body in formal settings after violent death can have beneficial effects, (Omerov, Steineck, Nyberg, Runeson, Nyberg, 2014) this is an obviously different from unwittingly discovering a loved one's body. A quantitative analysis on Swedish parents who lost a child to suicide did not find any signs that trauma symptoms were more prevalent in parents who encountered their children's body. Although relevant because of sample size and representativeness, the report is solely based on parents' reports collected 2 to 5 years after suicide. (Omerov, Pettersen, Titelman, Nyberg, Steineck, Dyregrov, Nyberg, 2017). These two factors could make it difficult to extrapolate to other samples and situations. Discovering the body here has been described as a horror; disfiguration was vividly mentioned as were attempts at resuscitation. The whole scene presented an overwhelming emotional challenge, as the situation was difficult to grasp, attracted many people and at the same time there was the impulse to hide it from other family members. Coupled with the immediate description of shock, sleeplessness and anxiety, it is hard not to see the whole sequence as contributing to the trauma of suicide loss.

Stigmatization was another phenomenon reported as painful by the participants. Qualitative studies reveal that families perceive a weak support network and find it difficult to talk openly about feelings after death (Peters, Cunningham, Murphy and Jackson, 2016; Azorina, Morant, Nessa, Stevenson, Osborn, King, and Pitman, 2019; Ross, Kõlves, and De Leo, 2019). This creates difficulties for family members to discuss the matter and seek treatment when necessary (Ross, Kõlves, and De Leo,

2019). Telling other family members and society about suicide is difficult, and families report feeling the necessity to omit the manner of death, which can cause difficulties at the time of the farewell (Tzeng, Su, Tzeng, Yeh, Chen, and Chen, 2010). Different types of need for social assistance are perceived, such as initial help, guidance on services, practical support, support group, information, locating clinical assistance for the grieving process and support from people close to the grieving process. (Ross, Kõlves, and De Leo, 2019).

This study aimed to explore trauma related phenomena after exposure to suicide. The research did not aim to assess the diagnosis of PTSD or other psychiatric disorders, but rather to capture the experience of exposure to this form of trauma. Qualitative studies are also not intended to generate results that are generalizable to the entire population, but rather to explore themes that must be further developed. The population of origin for the study was the one that originally participated in a study of brain tissue donation for research. Whether those who were not approached or did not want to participate in any way in the study would bring different or contradictory themes is not possible to define. These results need to be tested in the general population, with the aim of expanding knowledge and determining whether these traumatic phenomena after suicide exposure can occur on a larger scale. Further qualitative studies on family members exposed to suicide are necessary to advance our knowledge on the consequences of this traumatic event for the survivors. Through this, it is possible to identify the needs of this population to formulate treatment strategies that are issue targeted and culturally oriented.

While there has been some qualitative investigation on suicide grief, the specific focus on trauma is novel in this report. Among the themes explored here, the surprise and shock both related to finding the body at the scene of the suicide and receiving the

news of it are vividly reported. These are reports of experiences that are possibly symptoms related to trauma and are reported as traumatic by the survivors interviewed. Postvention models after suicide should incorporate such findings, and investigate trauma consistently.

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Table 1. Characteristics of included participants.

Participant	Gender	Age	Months since suicide	Kinship
1	Woman	58	6	Mother
2	Man	58	4	Father
3	Woman	16	4	Sister
4	Woman	30	14	Daughter
5	Man	75	4	Grandfather
6	Woman	50	13	Mother
7	Man	55	12	Father
8	Woman	47	6	Niece
9	Woman	48	7	Wife
10	Woman	53	13	Wife
11	Woman	56	14	Mother
12	Woman	32	12	Daughter-in-law
13	Woman	25	6	Granddaughter
14	Man	39	2	Ex-husband
15	Woman	23	11	Daughter
16	Man	60	3	Father
17	Woman	33	12	Daughter-in-law
18	Woman	63	3	Wife
19	Woman	53	3	Sister
20	Man	52	3	Father
21	Woman	19	3	Sister
22	Woman	50	5	Sister
23	Woman	59	2	Mother
24	Woman	57	6	Niece
25	Woman	52	12	Spouse
26	Woman	55	7	Wife
27	Man	61	12	Son
28	Woman	32	12	Granddaughter
29	Man	44	3	Ex-husband
30	Woman	67	10	Mother
31	Woman	27	12	Cousin
32	Woman	46	12	Aunt
33	Woman	28	3	Sister
34	Woman	47	12	Sister
35	Woman	33	5	Niece
36	Woman	47	4	Wife
37	Woman	38	8	Daughter
38	Man	43	8	Son
39	Woman	53	2	Aunt
40	Woman	28	2	Sister
41	Woman	34	3	Wife

6. CONSIDERAÇÕES FINAIS

Este estudo teve como objetivo explorar fenômenos relacionados ao trauma após a exposição ao suicídio. A pesquisa não teve como objetivo avaliar o diagnóstico de transtorno de estresse pós-traumático ou outros transtornos psiquiátricos, mas sim captar profundamente a experiência de exposição a essa forma de trauma. Os estudos qualitativos também não se destinam a gerar resultados generalizáveis para toda a população, mas sim a explorar temas que devem ser aprofundados. A população de origem do estudo foi aquela que originalmente participou de um estudo de doação de tecido cerebral para pesquisa. Não é possível definir se aqueles que não foram abordados ou não quiseram participar de alguma forma do estudo trariam temas diferentes ou contraditórios. Esses resultados precisam ser testados na população em geral, com o objetivo de ampliar o conhecimento e determinar se esses fenômenos traumáticos após a exposição ao suicídio podem ocorrer em maior escala.

Embora ocorra atualmente investigação qualitativa sobre o luto por suicídio, o foco específico no trauma é novo neste relatório. As pessoas expostas ao suicídio, em especial, familiares próximos, devido as circunstâncias, como nível de exposição, violência e imprevisibilidade relatam de forma vívida a surpresa e o choque tanto relacionados ao encontro do corpo no local do suicídio, quanto ao recebimento da notícia. São relatos de experiências que possivelmente são sintomas relacionados ao trauma. Diversos fatores de caráter social, como estigma, falta de respostas positivas de apoio e isolamento, podem contribuir para manter esses sintomas. Apesar da ocorrência de tratamento, a ausência da compreensão sobre a exposição ao suicídio como um evento traumático pode dificultar o auxílio oferecido aos familiares.

Devido a essas circunstâncias, mais estudos qualitativos sobre familiares expostos ao suicídio são necessários para avançar nosso conhecimento sobre as consequências desse evento traumático para os sobreviventes. Por intermédio destes estudos, é possível identificar as necessidades dessa população para formular estratégias de tratamento que sejam temáticas e orientadas culturalmente.

Consoante mostrado, a experiência de um evento traumático pode causar prejuízo a saúde mental e física. Entre os expostos ao suicídio, pode causar tentativas e comportamentos suicidas. Assim, é imprescindível que os clínicos sejam capacitados a identificar as demandas e formas de tratamentos adequados para essa população. Os

modelos pós-intervenção após o suicídio devem incorporar tais achados e investigar o trauma de forma consistente.

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APÊNDICES

APÊNDICE A: ROTEIRO DE ENTREVISTA

ANEXOS

ANEXO A: CONSOLIDATED CRITERIA FOR REPORTING QUALITATIVE STUDIES (COREQ)

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

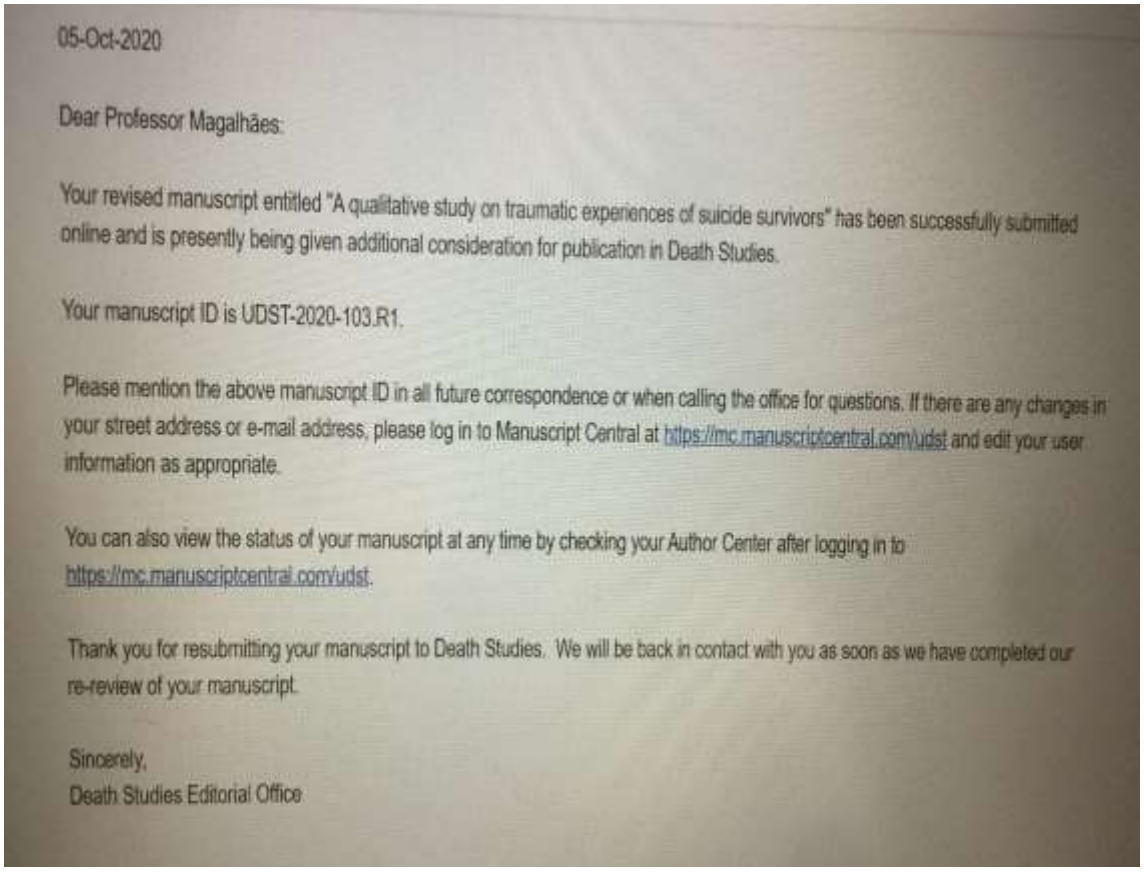
Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	Methods
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	Methods
3. Occupation	What was their occupation at the time of the study?	Methods
4. Gender	Was the researcher male or female?	Methods
5. Experience and training	What experience or training did the researcher have?	Methods
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Methods
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Methods
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Methods
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Methods
Participant selection		

10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Methods
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Methods
12. Sample size	How many participants were in the study?	Methods
13. Non-participation	How many people refused to participate or dropped out? Reasons?	Methods
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	Methods
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	Methods
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Table 1
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Methods
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	Methods
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Methods
20. Field notes	Were field notes made during and/or after the inter view or focus group?	Methods
21. Duration	What was the duration of the inter views or focus group?	Methods
22. Data saturation	Was data saturation discussed?	Methods
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	Methods
25. Description of the coding tree	Did authors provide a description of the coding tree?	Methods
26. Derivation of themes	Were themes identified in advance or derived from the data?	Methods
27. Software	What software, if applicable, was used to manage the data?	Methods
28. Participant checking	Did participants provide feedback on the findings?	N/A
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant	OK

	number	
30. Data and findings consistent	Was there consistency between the data presented and the findings?	OK
31. Clarity of major themes	Were major themes clearly presented in the findings?	OK
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	OK

ANEXO B: CARTA DE SUBMISSÃO DO ARTIGO



05-Oct-2020

Dear Professor Magalhães:

Your revised manuscript entitled "A qualitative study on traumatic experiences of suicide survivors" has been successfully submitted online and is presently being given additional consideration for publication in Death Studies.

Your manuscript ID is UDST-2020-103.R1.

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