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SUPPORT GROUP FOR SUICIDE SURVIVORS

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ABSTRACT. Suicide can be understood as the undesirable outcome resulting from a complex interaction of factors, and its outcome generates intense impacts on the family and society as a whole. Considering that for each suicide about 100 people are affected, even so, these receive little or no support, and still, that mourning/grief for suicide has specificities that can complicate the process; the action of the intervention after a suicide is amplified as essential. This article describes and bases the process of construction and management, through a voluntary initiative of Psychology professionals, a support group for suicide survivors / bereaved in the city of Maringá, PR/Brazil, started in September 2016 and maintained monthly and free participation. The support groups represent fundamental resources of emotional support in the posvention, being considered space of listening, recognition, legitimation and support to people mourning/grief or intensely impacted by suicide, thus making it possible to construct meanings for loss and an adaptation to the ongoing process of re-signification.

Keywords: Grief; suicide posvention; support group.

GRUPO DE APOIO PARA SOBREVIVENTES DO SUICÍDIO

RESUMO. O suicídio pode ser compreendido como o desfecho decorrente de uma complexa interação de fatores e, seu resultado gera intensos impactos na família e em toda sociedade. Considerando-se que para cada suicídio estima-se que cerca de 100 pessoas sejam afetadas, recebendo pouco ou nenhum suporte, e que o luto por suicídio tem especificidades que podem complicar o processo; a tarefa da intervenção após um suicídio se amplia como imprescindível. Este artigo descreve e fundamenta o processo de construção e manejo por iniciativa voluntária de profissionais da psicologia, de um grupo de apoio para sobreviventes/enlutados pelo suicídio na cidade de Maringá-PR, iniciado em setembro de 2016, com frequência mensal e gratuidade na participação. Os grupos de apoio representam recursos fundamentais de suporte emocional na posvenção, sendo considerados como espaço de escuta, reconhecimentos, legitimação e apoio a pessoas enlutadas ou intensamente impactadas pelo suicídio, assim, possibilitando a construção de sentidos para a perda e uma adaptação ao processo continuado de ressignificação.
Palavras-chave: Luto; posvenção do suicídio; grupo de apoio.

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GRUPO DE APOYO PARA SOBREVIVIENTES DEL SUICIDIO

RESUMEN. El suicidio puede ser comprendido como el desenlace indeseable resultante de una compleja interacción de factores y su resultado genera intensos impactos en la familia y toda sociedad. Considerando que para cada suicidio cerca de 100 personas son afectadas, aún así, éstas reciben poco o ningún soporte, y aún, que luto por suicidio tiene especificidades que pueden complicar el processo; la acción de la intervención después de un suicidio se amplía como imprescindible. Este artículo describe y fundamenta el proceso de construcción y manejo, por iniciativa voluntaria de profesionales de la Psicología, de un grupo de apoyo para sobrevivientes / enlutados del suicidio en la ciudad de Maringá-PR/Brasil, iniciado en septiembre de 2016 y mantenido con frecuencia mensual y gratuidad en la participación. Los grupos de apoyo representan recursos fundamentales de soporte emocional en la *posvention*, siendo considerados como espacio de escucha, reconocimiento, legimitación y apoyo a personas enlutadas o intensamente impactadas por el suicídio, así, posibilitando la construcción de sentidos para la pérdida y una adaptación al proceso continuado de resignificación.

Palabras clave: Duelo; *posvention* del suicidio; grupo de apoio.

Introduction

> […] he was destitute of all, even going into death in a last fatigue that struck him […]. He was going to overthink with what did not exist for the rest of his days, as a disease that was not seen. It was a disease that came out in his words (Mãe, 2016, p. 22).

When a person tries to take his/her own life, he/she establishes an uncomfortable and feared issue, breaks a barrier and opens up a recurring question regarding the reasons that lead a person to want to cease to exist, to annihilate him/herself.

Although there are several speculations, it is difficult to achieve complete clarity about such a complex phenomenon. However, suicide can be understood as an extreme way of dealing with pain, despair and hopelessness in the face of life (Núcleo de Estudo de Prevenção do Suicídio [NEPS] & Centro Antiveneno da Bahia [Ciave], 2017). For this reason, suicide reveals the pain of existing and, when it becomes unbearable, the individual, wishing to get rid of intense suffering, for various reasons and complex factors that interact together, may end up killing him/herself.

According to the Associação Brasileira de Psiquiatria [ABP] (2014, p. 7), suicide can be defined as "[…] a deliberate act performed by the individual him/herself, whose intention is death, consciously and intentionally, even if ambivalent, using a means that he/she believes to be lethal".

Suicidal behavior encompasses a *continuum* of behaviors that range from suicidal ideation (thinking, idea and desire to kill yourself), which may (or may not) evolve into the threat, plan and/or attempt of suicide until death, and such behavior is associated with different degrees of lethal intention and knowledge of the true reason for this act on the part of the person who practices it (ABP, 2014).

According to the Organização Mundial da Saúde [OMS] (2000), suicide can be understood as a result of a complex interaction of biological, genetic, psychological, social, cultural and environmental factors. Thus, suicidal behavior becomes a complex and multidetermined phenomenon, dealing with the "[…] outcome of a series of factors that accumulate in the individual's history, which cannot be considered in a causal and simplistic way only to certain specific events in the individual's life. It is the final consequence of a process" (ABP, 2014, p. 10).

As it is a process, then, there is no way to establish definitive causes or motives for suicide. However, according to ABP (2014), it is possible to identify risk factors, and the main are: 1. Previous suicide attempts, which increases the risk about 5 times; 2. Mental illness (including depression, bipolar disorder, alcoholism and abuse/addiction to other drugs and personality disorders and schizophrenia) undiagnosed or untreated (undertreated); 3. Access to lethal means. It is important to pay attention to them, as they are parameters that, if checked, added and evaluated accurately, can be indicative for taking effective preventive or support measures.

Fukumitsu et al. (2015, p. 49) describes other risk factors for suicidal behavior, including "[…] states of irritable or depressed mood, prolonged periods of isolation, hostility with family and friends, withdrawal from school or significant drop in school performance, behaviors such as substance abuse (alcohol and drugs), physical violence, reckless sexual activity and running away from home".

Protective factors are those which, in turn, involve all those circumstances, characteristics, contexts, relationships and situations considered as healthy and positive by the individuals, which can constitute barriers to the suicidal act; and may include

> High self-esteem, good family support, well-established social ties with family and friends, religiosity regardless of religious affiliation and reason for living, absence of mental illness, being employed, having children at home, sense of responsibility, with the family, desired and planned pregnancy, positive adaptability; problem solving capacity and positive therapeutic relationship, as well as access to mental health services and care (ABP, 2014, p. 24).

It is important to highlight that both protection and risk factors are variable and the assessment must consider the meaning that each individual gives to the experience of that particular factor, according to the whole sociocultural context, risk perception, age, gender, personality structure and personal values. Even though there are apparent and stable protection factors, they alone do not guarantee the complete extinction of the risk.

Suicides are preceded by important warning signs, such as verbal and/or behavioral signs, which, however, are not always noticed by the family or the environment. However, there are also suicides that are committed in an impulsive manner (NEPS & Ciave, 2017) and, thus, apparently there are no manifestations of such signs. According to Scavacini (2017, p. 49), we must pay attention to the fact that "[…] the signs can be verbal or behavioral […]", and are not always clear, making sense only after the act. For Fukumitsu and Kovács (2015, p. 42) "[…] there are several types of suicide - the planned ones, the impulsive ones, the ones that gave no clue and the ones that indicated that death could happen".

For this reason, it is understood that a risk assessment should be conducted in an attentive and individualized manner by health professionals trained in the phenomenon, including the perception of human suffering in its different manifestations and, then, the construction of an adequate safety plan, when the risk is detected.

Suicide is a serious public health problem, considering that its mortality has increased by about 60% in recent years. The report published by the World Health Organization (OMS, 2014) presented an epidemiological mapping of this phenomenon for 172 countries from

2002 to 2012, and it was identified that suicide is among the 3 main causes of death of people in the 15 to 44 year old age group, exceeding the number of deaths from violence or war together. Every 45 seconds, die, in the world, a person for this reason, while in Brazil, one person dies every 40 minutes. In this context, Brazil is the eighth country in absolute number of deaths by suicide, as it becomes even more worrying considering that while the world average remains stable over the years, in Brazil the percentage has been increasing more and more.

With regard specifically to the reality of the municipality of Maringá, State of Paraná, in 2016, according to epidemiological data from the Municipal Health Secretariat, 369 cases of self-inflicted violence, that is, suicidal ideation and/or attempted suicide, that of these 135 (37%) were men and 234 (63%) women. Regarding suicide deaths reported in the municipality, in 2016, 18 deaths were reported, 11 of which were men and 7 were women. This was the scenario in 2016, in which the work of the Support Group for Suicide Survivors began in the municipality.

Epidemiological data from 2017 refer to an increase in cases, since 576 cases of self-inflicted violence were reported, 160 (28%) of which were men and 416 (72%) were women; 27 deaths are reported, 20 (74%) men and 7 (26%) women. However, it is estimated that such numbers exceed up to 10 times what was reported due to issues related to underreporting.

Bereavement

> [...] because death never replies, not because she doesn't want to, but because she doesn't know what to say in the face of the greatest of human sorrows (Saramago, 2005, p. 15).

We share the statement that the death of someone loved or significant is one of the most painful experiences faced by a human being (Ferro, 2014). As a result of the death or loss event, we experience a set of responses or reactions considered as universal, normal, expected and adaptive, which vary according to the parameters of each society/culture.

Thus, bereavement is the normal response to the breaking of a bond, in which there was an affective investment between the mourner and the person who is gone. Not only do we react only to the loss of a person, but it is possible to have an answer to any type of loss that involves something or someone significant (Bowlby, 1997; Parkes, 1998), as there may be regret in the face of different types of loss, including loss of status, bond, person, animal, job, location, ideal. Therefore, it is considered as a dynamic process, constituting a subjective experience endowed with meaning, inserted in a culture and multidetermined. For this reason, although it is a universal response and anchored in culture, the way in which each person experiences bereavement is unique, as well as the bond that was broken (Franco, 2010).

It is worth mentioning that, even when the loss is due to the death of a loved one, thus establishing a concrete and physical break in the relationship, we must also carefully consider the symbolic dimension of this break. What exactly does it mean to think about such breaks? After the loss, the mourner experiences, in a very particular and singular way, many changes related to the social, family, economic environment (Braz & Franco, 2017), thus, reality presents a new context of life where the person who has gone will not return and whoever remained will experience life, routine, work, relationships, in short, his/her own existence in the face of that definitive absence.

According to researchers on the topic (Franco, 2010; Barbosa, 2010; Franco, 2002; Braz & Franco, 2017), the perception of the entire grieving process must consider several factors that interact with each other. Didactically, the authors list: 1. The meaning and/or function of a certain person, animal or thing that has been lost; 2. The type of relationship and bond established between the person who is gone and the person(s) who remained; 3. The age of the deceased in relation to the age of who remained; 4. The type of death (announced, accidental or unexpected, by suicide); 5. If there is a body for the funeral rituals significant to the family and if it was possible to perform them; 6. If there are vital/normative crises experienced by the mourner; 7. How was the experience (more or less close, support network, conflicts) during the breaking process.

Mourning, for most people, is integrated in a way that allows adaptation to the world and to life without the deceased person. With the elaboration process and the time of each individual, the absence is recognized and the survivor can think about the deceased without feeling completely overwhelmed by the pain or emotions that he/she cannot deal with, he/she can resume activities, reexperience comfortable and loving feelings, develop skills to look at him/herself and the world in order to integrate the loss (Ferro, 2014). However, for some people, this process does not shift to integration, causing functional, occupational and daily difficulties; greater emotional difficulties, comorbidities, depressive disorder, post-traumatic stress, worse physical health and suicidal ideation - such experiences can be configured in what is defined as complicated grief (Young et al., 2012 apud Ferro, 2014).

Bereavement for suicide

In the world, every 40 seconds a person dies by suicide and, every three seconds, a person tries to take his/her own life. Brazil is the eighth country in absolute number of suicides, with 11,821 deaths recorded in 2012, about 30 per day, of which 9,198 men and 2,623 women. Between 2000 and 2012, there was a 10.4% increase in the number of deaths, with an increase of more than 30% in young people. We must pay attention to the underreported numbers, even so, in Brazil, every 45 minutes a person kills him/herself (ABP, 2014; WHO, 2014).

Thinking about the fact that for each suicide death about 6 people are affected (ABP, 2014), we must take into account that in Brazil alone there are at least a hundred people a day impacted by the suicide of a family member or someone very next. For Young et al. (2012 apud Ferro, 2014), the number of survivors can range from 6 to 14 people. Anyway, the number seems to be even greater when estimating the number of members affected in a family (parents, children, grandparents, siblings, uncles, cousins) or, for example, in a classroom with about 50 students and teachers, or even, when suicide occurs in the workplace, among health teams and other patients or in public environments. Thus, according to data from the National Action Alliance for Suicide Prevention (2015, apud Fukumitsu, 2019), each suicide death impacts 115 people.

Given this context, the question becomes necessary: what kind of support do the bereaved by suicide have access to?

We are facing a type of loss with specificities that are often invisible and neglected, as survivors/bereaved receive little or no care for their grief, according to research by Johns Hopkins University and Karolinska Institute (2010) presented by Pitman (2016).

The suicide of a family member or friend can have an intense and often devastating impact on those emotionally close (Jordan & McIntosh, 2011 apud Cook, Jordan, & Moyer, 2015). It is well established that exposure to suicide death can be a significant risk factor for

the development of many negative consequences in the mourner, including an increased risk of suicide ((Pittman, Osborn, King, & Erlangsen, 2014 apud Cook et al., 2015).

International literature contains several terms to describe who goes through a suicide loss, including 'survivor, suicide survivor, survivor of suicide, survivor after suicide, suicide loss survivor, bereaved by suicide, bereaved through suicide'. The term survivor has different meanings in different countries and contexts (Andriessen, Krysinska, & Grad , 2017, p. 05). The National Action Alliance for Suicide Prevention (NAASP) uses the terminology 'Survivors of Suicide Loss' (Cook et al., 2015).

If the consensus for the terminology is not unanimous, for Andriessen (2009, p. 43), there is also no consensus in the definition, because losing a significant person does not necessarily mean that that person was loved. In this sense, the author refers, for example, about

> […] a train driver who involuntarily becomes an instrument in the suicide of a person who is standing on the tracks. In this case, the person who died by suicide and the survivor are probably not even known. However, the latter could be traumatized by suicide and then be called a survivor.

However, we will use the term 'survivor' as a term used to designate those who are bereaved or strongly impacted by suicide and whose life is strongly altered because of the loss (Andriessen, 2009; Jordan & McIntosh, 2011 apud Cook et al., 2015).

The bereaved population is admittedly vulnerable, requiring serious ethical care in relation to management and research (Franco, Tinoco, & Mazorra, 2017). Those bereaved by suicide, specifically due to the characteristics of the type of death, may experience the experience of bereavement as something silent, hidden, prohibited.

Suicide is considered a type of violent, unexpected and traumatic death, widely stigmatized and subjected to intense social judgment, thus implementing risk factors for survivors, especially for those who witness the scene and start to remember the facts and images, or even , for those who are involved with intimate inquiries about the reasons or need to respond publicly about the (im)probable reasons for that death. Thus, such a process is unique, since the very nature of the type of death affects the experience of bereavement (Cook et al., 2015).

In this sense, for Gleich (2017), it is not possible to formulate an answer that includes some universality in the decisions that precede the suicidal act. For the author, there is a question that maybe will never be answered: 'why?', even though there are letters or notes, the absence of answers implies the burden of guilt.

According to Pires (2014, p. 231), "[…] the loss of a significant person by violent death [...] is a disruptive and shocking experience, which has a character of unpredictability and a different complexity from the loss by natural death". Faced with such a context, for the bereaved person, death occurs as a result of an intentional human action (suicide), which reinforces the belief that this death should not have happened. This type of death is generally in the public domain and the bereaved person is exposed to the curiosity of the media and those around them - resulting in an invasion of intimacy and privacy. All "[…] this plot can influence the bereavement process, resulting in distrust, greater difficulty in seeking help, and social isolation" (Pires, 2014, p. 231).

There are stressors very intensely present in the mourning for suicide that can be configured as characteristics of this type of bereavement, thus, increasing the possibility of complications. Cândido (2011, p. 98) points out "[…] feelings of guilt, shame, anger, feeling of anguish or lack of existential meaning, feeling of stigmatization, lack of support or understanding from others, as well as a greater tendency towards isolation". The author also

presents the occurrence of anxious and depressive disorders, ideations and suicidal behavior, psychosocial and family difficulties already present in the dynamics of these bereaved family members, before the death.

NAASP research also reiterates suicide as a shocking event that causes disbelief, guilt and self-guilt, shame, feelings of abandonment and rejection, anger, fear, relief, increased risk of suicide and the constant question 'Why?'. Still, factors such as the ambiguity surrounding the decision to die; suicide is characterized as preventable in the population; suicide is stigmatized and traumatic, are listed by Cook et al. (2015).

Other important factors that surround death by suicide and affect the bereaved survivor are researched by Silva (2015) and concern the taboo that, in these cases, turns out to favor the pact of silence and the crystallization of a family secret, or even, damaging or preventing the practice of funeral rituals depending on how the body looks after the act (often mutilated, requiring sealed urns) and also questions of a religious nature, as it is considered a sinful act.

It is necessary to consider that people bereaved by suicide are potentially affected by three types of trauma, according to Cook et al. (2015). Being them, psychological trauma, when they reflect or reconstruct the trajectory of psychological pain that the deceased person went through; direct exposure to the suicide scene, when they witness the act or find the body; and the imagined exposure, when they consider a mental image of what happened or the suffering that the person went through when dying or before the act (Cook et al., 2015).

For Nakagima et al.. (2012 apud Ferro, 2014, p. 247), the prevalence of complicated mourning increases when the cause of death is suicide, due to factors such as "[…] lack of preparation for death (unexpected death), difficulty in assigning meaning/explanation to suicide, and various social stressors". Thus, some important signs that grief may become complicated should be noted, as in these cases, the survivor support group may not be the most suitable resource. Important signs such as: intrusive and persistent thinking, separation anxiety, prolonged disbelief, grief that lasts a long time and causes dysfunctions in the individual's life, impairing his/her activities; they should be used as a warning for a possible complicated grief - and in these cases, the conduct is the referral to a specialized evaluation.

Postvention

> And as hopes have this fate to be fulfilled, to be born from one another, that's why, despite so many disappointments, they are not over yet in the world [...] you put the meanings you wanted in words that after all had others senses [...] (Saramago, 2005, p. 151).

Postvention is defined as the set of interventions performed in the post or after a (self)destructive or traumatic event. In general, it would be everything related to the necessary care for bereaved by someone who took his/her own life, in order to reduce the traumatic effects (Ferro, 2014; Scavacini, 2017; Shneidman, 1993 apud Cândido, 2011).

Authors also define postvention as the follow-up of those people who attempted suicide, but did not obtain the death result. In this sense, Andriessen (2009, p. 43) literally quotes the designation of Shneidman (1969, p. 19), when he coined the term postvention as being "[…] the useful activities that occur after a stressful or dangerous situation". Specifically, "[…] activities that occur after a suicidal event" (p. 22), which may be after a behavior that resulted in suicide or an attempt. Thus, posvention is understood as a

specialized intervention on the family members and friends of the person who died by suicide, in order to help resolving the grieving process, including discouraging eventual suicidal ideas or tendencies, thus caring for survivors of a suicide is a way of preventing other self-inflicted deaths/prevention for future generations (Scavacini, 2017).

In posvention, conducts, actions, skills and strategies are undertaken for the management and care of those who attempted suicide or those mourning the death of those who committed suicide. For Roy (2013), the objectives of posvention are, in general, to mitigate the impacts associated with suicide. Specifically, it would be to reduce the effects of temporary stress or post-traumatic stress disorders, alleviate the impacts of the crisis, favor mourning by preventing the development of complicated grief and, transversely, prevent the contagion effect. For this reason, Roy points out that psychosocial intervention programs in posvention should have as essential principles the promotion of a sense of security by offering techniques that help to reduce anxiety, reinforce a sense of personal and collective competence, stimulate social support, attachment and hope.

There are different types of intervention recommended and developed in the posvention. Psychological autopsy, mutual aid or support groups, individual psychotherapy are presented as resources (Ferro, 2014). An important task in posvention includes training and/or support for local teams that intervene shortly after a suicide, including first responders, firefighters and other professionals who work in crisis situations (Berman et al., 2006 apud Bteshe, 2013). There are also other community responses to suicide management, often referred to as 'posvention responses', which aim to promote recovery after suicide and prevent further suicide deaths (Andriessen, 2009).

For Andriessen (2009), even though the effectiveness of posvention is not fully verifiable, the author states that in the posvention programs, the survivors are actively involved and contribute to a better understanding of suicide and its prevention. Thus, all suicidology without the involvement of survivors is considered a bad suicidology, just as a suicide prevention without survivors would be considered a bad prevention. Since survivors are a risk group for suicide and, simultaneously, are involved in suicide prevention, posvention or post-intervention is an "[…] integral and indispensable preventive part of a suicide prevention program, that is, posvention is prevention" (Andriessen, 2009, p. 46).

Objective

The general objective of the study was to describe the process of constructing and managing a support group for suicide survivors in the city of Maringá, State of Paraná, and specifically, to theoretically substantiate the group's purpose as a space for exchange and support to face this type of grief, according to the synthetic cut of the authors' perceptions.

Methodological Path

The groups are organized as follows: it is a monthly meeting (except between December and February of each year), open to the entire community of survivors, including those grieving suicide (eventually accepting survivors of the suicide attempt), free, without prior registration, without religious connotation. The group lasts approximately 02:30hs, with the main objective of support and psychoeducation. However, even open to the participation of people of all ages, it is clear that the group is not prepared to serve children.

The meetings are disseminated through free social media and verbally in meetings with the community and held in a space provided in a private practice. The initiative is

planned and conducted by 2 professionals, who authored this text, who have a degree in Psychology (1999 and 2005), one of them having a PhD in Clinical Psychology from PUCS-SP and the other, PhD student in Psychology at UEM-PR, both with clinical and academic experience in Suicide Prevention and Posvention, supported by training in Suicidology, and currently specialization from Institute Vita Alere-SP and other national and international courses on the subject.

As for the procedures, the support groups are led by professionals with the limited function of listening, directing, clarifying, embracing and psychoeducation. Even so, the activities, frequency and adjustments for group functioning are discussed and defined with all members at each meeting.

The theoretical framework that grounds the support for bereaved people is based on the approach of studies, research and interventions in the grieving process advocated by Franco (2010) and Parkes (1998).

Support group for suicide survivors

> [...] because on the sorrow of each were celebrated, in some way, the availability increasingly aware of friendship [...]. Trust was already the answer (Mãe, 2016, p. 103).

Contextually, our experience with support groups for survivors of suicide in the city of Maringá, State of Paraná, is a voluntary professional initiative, initiated on the occasion of the Yellow September Campaign[4] in 2016 as one of the activities planned for the awareness and prevention of suicide.

Faced with the question: 'Is the person who attempted suicide also called a survivor?', we rely on the performance of Almeida, Scavacini and Silva (2016), whose initial proposal for the holding of the First National Meeting of Suicide Survivors was to receive bereaved by suicide, so they could talk about the loss experience. During the organization, the coordinators of the meeting received applications from another category of survivors: those who attempted suicide and survived, indicating an understanding of the term survivor in another sense. Even in the face of theoretical controversy, because the nomenclature 'Survivor' does not apply to the person who tried and did not obtain the death result, these people were supported in that group. With the perception of the importance of caring for bereaved survivors and survivors of the suicide attempt, in the categories receiving support and sharing experiences, they held a meeting and it was possible to deal with both demands positively. For this reason, our support group in Maringá also received, but not exclusively, people who made suicide attempts.

Technically, it is a support group, differing from a self-help group in several aspects. According to the instructions in the guide entitled Preventing Suicide - How to start a survivors' group (World Health Organization [WHO], 2000), self-help groups are composed of people directly and personally affected by a specific issue, condition or concern, in this case, bereaved by suicide are the ones who conduct the activities and priorities of the group, and the members who lead and make decisions in/by the group.

The support groups, since their beginning, received a very variable number of participants at each meeting, being possible to estimate an average of 3 to 8 people - some meetings did not have any participant making the group unfeasible, and other meetings with up to 15 people present. For this reason, it was a challenge, initially, the fact that, despite being free and open to the community of bereaved by suicide, the adhesions were still small

[4] September 10th is officially World Suicide Prevention Day (www.abp.org.br).

compared to the number of survivors in the region of Maringá. Perhaps the difficulty in recognizing or exposing the history of loss in front of people, until then, strangers, was an impeding factor for many to access the group. As an initiative to remedy this situation, we expanded the disclosure, in addition to free social media, also contacting health professionals who could refer their bereaved patients to participate in the group. We understand that this initiative made it possible for more information about the survivor's grief to reach professionals and they became partners in spreading the existence and format of this support group.

For this reason, informing the community, students and professionals, through lectures, training and participation in the local media, about the process of bereavement by suicide was a concomitant task, and very necessary, since it provided space for doubts to be discussed breaking the prejudice that silences the expression of sorrow.

As for the participants, a recurring perception in the groups was the most frequent participation of women. Being a panorama the participation of men (parents who lost children), the other participants being daughters of deceased mothers, mothers and stepmother of deceased children, friends, sisters, accompanying family members and one woman with suicide attempts. The ages ranged from 18 to 50 years.

The central reason that motivated them to join a support group was precisely the expectation of receiving some kind of support and finding resonance or answers for what they were experiencing.

Discussion

The accomplishment of these support groups has shown that they are important resources for accessing, rescuing and embracing people in times of vulnerability, providing recognition and legitimacy to the suffering they are facing. In this sense, the group can provide space for active listening to content surrounded by taboo and, until then, silenced or rejected by society, family and, often, by the individual him/herself. Considering the difficulty in asking for help, which many bereaved people have due to the strong stigma that marks and labels suicide, the provision of a welcoming space for the expression of feelings provides for the rescue of the bond and the offer of a secure basis for legitimizing the suffering.

However, although the support group is an available resource, it is important to note that other resources can be presented and validated as consolation and seek help. Walsh e McGoldrick (1998) highlight that family support, the presence of friends, religion, contact with nature, literature, music and films can be sources of inspiration, relief and closeness after a loss. In the support group, this type of conduct is encouraged, allowing participants to express their alternatives and ways to manage life in the face of such a difficult loss.

Davel and Silva (2014, p. 114), when referring to their experience at the Instituto de Apoio a Perdas Irreparáveis (API), affirm that the group's purpose is to facilitate the grieving process through sharing. This occurs "[…] to the extent that the externalization conversations between the members make it possible to visualize the different ways of understanding and experiencing the problems resulting from the losses that affect their lives".

We understand that support groups allow a context where the emotional experience can be perceived as something acceptable, which is why it is manifested and integrated into the meeting, after all, all participants identify themselves in the same type of traumatic loss. Thus, as stated by Yalom (2006), therapeutic factors such as instillation of hope,

universality, information sharing, altruism, corrective review, development of socialization techniques, imitative behavior, interpersonal learning, group cohesion, catharsis, existential factors, can be the basis for the changes and serve to shape the group's experience, maximizing its effectiveness.

Therefore, it is identified the expression of the facts that involve the entire occurrence of suicide and, consequently, aspects of the mourner's relationship with the deceased. In this sense, we agree that the reports in the group "[…] bring out the images, the significant memories of the deceased and their forms of relationship" (Davel & Silva, 2014, p. 114).

In our experience of support group meetings, participants reported aspects about the occurrence of the loss. Detailing how, when, under what circumstances the loss materialized allows the group an access to painful content, making participants relive the impact of the news or images of the death. In these cases, the impact experienced by the survivor who finds the body is even more significant, the images are considered traumatic and tend to remain or return frequently to remembrance. In repetition, the content of the traumatic scene is reported in subsequent meetings when a participant feels embraced and decides to detail about what happened, rescuing the feelings of this confrontation with the disconcerting reality that the image causes/represents.

Although this opportunity to tell about the occurrence of the loss is extremely painful, finding in pairs a look of understanding and legitimation can be a facilitator in the process of resignificating the scene and the content of that event.

The participants' report mentions the establishment of a safe space for reporting the difficulty of accepting a death by suicide. Factors such as 'time to grieve and understand the loss' need support to be authorized. For the participants, the inaccuracy or inexistence of motives or perceptible signs, considered definitive and concrete for the suicide of their loved ones, is a recurring point. The feeling of guilt for not having noticed the signs is mixed with the feeling of anger towards the person who did not show concrete signs or was not able to ask for help clearly.

In this type of group, support is accessible to the bereaved people through sharing. The use of psychoeducational methods helps to recognize the reactions experienced in themselves and in peers, making sure that what they feel is shared or is anchored also in the experience of other grievers - even when hostile feelings arise, which would not find resonance in other media. In the group, faced with stories of losses, the exchanged experiences are approached by psychologists in order to gradually clarify and allow the correction of misconceptions that can implement guilt, impotence and other complications. Still, the narrative of the facts, received without judgment in the support of this group, can provide relief from anxiety, allowing the mourner to make his/her resignifications and connections - aided in the whole process by the professional support present.

Thus, we understand that the support group is, indeed, a space for welcoming and sharing these pains, with the purpose of recovering the confidence strongly shaken by the violent loss. In these groups, the mourners are received and invited to start a gradual course, respecting their rhythm, time and possibilities of giving new meaning to sorrow. Resignification involves joining fragments by removing them from hidden places, breaking silences and secrets, keeping an eye on oneself and the relationships, allowing the group to approach and assist in creating or strengthening bonds and serve as a support network in this such a delicate moment.

Final considerations

> Whoever elected the search cannot deny the crossing (Rosa, 1986, p. 12).

Groups are an important resource of support and embracement, since few actions of posvention are carried out in our region and survivors often have a limited or none support network and start to deal individually or in isolation with the vulnerabilities of this process.

Contextually, sharing about the experience of a tearing pain, marked in the real of the flesh, visceral, finds refuge in the other narratives of the group, but also in the looks and gestures, in the speechless, in the silence. They are stories of pain that affect family, friends, community and an entire society; making some live the loss devastatingly.

The support group shelters each individual in its particular and unique sorrow, but also brings together the mutual recognition of collective pain. The narratives, touching each participant in its own way, according to their possibilities of speech and listening, allow for empathy, emotion, care, support, compassion to emerge, but they also anchor a secure link for the identification of ambiguous feelings, where anger, sadness and guilt can be expressed. In such a way, the participants are welcomed by the respect they build together, seeking some cohesion, without judgments.

The real and brutal sorrow finds in the group an encounter with several possibilities of interpretation; thus, it receives care, dressing, driving. The process allows, among the participants, a connection through the pain that, when recognized and renewed, gradually finds a place; allowing the expansion of the senses and an adaptation in a continuous process of resignification.

In this sense, adaptation, as stated by Walsh and McGoldrick (1998), does not mean elaboration, in the sense of a complete and definitive acceptance of the loss, but the discovery of ways to put the loss in perspective and move on.

Therefore, an important principle that we keep is precisely the absolute respect for the feelings expressed in the group, as we understand that bereavement can be welcomed, allowing him/herself to be cared for in his/her suffering. Even so, it is important to consider that the loss is for everyone, and it will be forever. And about this one, only knows who feels. As Guimarães Rosa (1986) writes, one feeling belongs to the one who feels it, but the other belongs to whoever feels.

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