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RESEARCH

Experiencing suicide in the family: from mourning to the quest for overcoming

Vivenciando o suicídio na família: do luto à busca pela superação

Vivenciando el suicidio en la familia: del luto a la búsqueda por la superación

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ABSTRACT

Objective: to understand the family's experience of losing a family member by suicide. **Method:** study with qualitative approach with reference of the Constructivist Grounded Theory. The theoretical sample consisted of 20 participants, among health professionals and family members of people who committed suicide. Data were collected through intensive and coded interviews from initial and focused coding. **Results:** three categories were obtained: *Being in a "state of shock"*; *Living with the suffering and effects of the loss of the family member*; and, *Rebuilding life*. From the articulation of these categories emerged the phenomenon: "Experiencing the loss of a family member by suicide: from mourning to the quest for overcoming". **Final considerations:** each category represents a stage in the family's experience of losing a family member by suicide. The results provide support for suicide prevention and postvention actions developed by health professionals.
Descriptors: Mental Health; Suicide; Family; Family Relations; Nursing.

RESUMO

Objetivo: compreender a vivência da família ao perder um familiar por suicídio. **Método:** estudo com abordagem qualitativa com referencial da Teoria Fundamentada nos Dados construtivista. A amostragem teórica foi composta por 20 participantes, entre profissionais de saúde e familiares de pessoas que cometeram suicídio. Os dados foram coletados por meio de entrevistas intensivas e codificadas a partir de codificação inicial e focalizada. **Resultados:** foram obtidas três categorias: *Entrando em "estado de choque"*; *Convivendo com o sofrimento e as repercussões da perda do familiar*; e, *Reconstruindo a vida*. Da articulação dessas categorias, emergiu o fenômeno: "Vivenciando a perda de um familiar por suicídio: do luto à busca pela superação". **Considerações finais:** cada categoria representa um estágio da vivência da família ao perder um familiar por suicídio. Os resultados fornecem subsídios para ações de prevenção e posvenção do suicídio desenvolvidas por profissionais de saúde.
Descritores: Saúde Mental; Suicídio; Família; Relações Familiares; Enfermagem.

RESUMEN

Objetivo: comprender la vivencia de la familia al perder un familiar por suicidio. **Método:** estudio con abordaje cualitativo con referencial de la Teoría Fundamentada en los Datos constructivistas. El muestreo teórico fue compuesta por 20 participantes, entre profesionales de salud y familiares de personas que cometieron suicidio. Los datos fueron recolectados por medio de entrevistas intensivas y codificadas a partir de codificación inicial y focalizada. **Resultados:** se obtuvieron tres categorías: *Entrando en "estado de choque"*; *Conviviendo con el sufrimiento y las repercusiones de la pérdida del familiar*; y *Reconstruyendo la vida*. De la articulación de esas categorías, emergió el fenómeno: "Vivenciando la pérdida de un familiar por suicidio: del luto a la búsqueda por la superación". **Consideraciones finales:** cada categoría representa una etapa de la vivencia de la familia al perder un familiar por suicidio. Los resultados proporcionan subsidios para acciones de prevención y posesión del suicidio desarrolladas por profesionales de la salud.
Descriptores: Salud Mental; Suicidio; Familia; Relaciones Familiares; Enfermería.

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INTRODUCTION

Suicide is the act of intentionally causing one's own death. It is a multifactorial phenomenon, which may be related to mental disorders, such as depression, bipolar disorder, alcoholism, substance abuse/dependence, and schizophrenia. Hanging, firearm, poisoning, smoke/fire poisoning, and falling from height are the main means used by people to commit suicide[1-2].

Suicide is one of the ten leading causes of death in the world, especially among teenagers and adults. It is recognized by the World Health Organization (WHO) and the Ministry of Health (MS- *Ministério da Saúde*) as a serious public health problem because, according to estimates, more than one million people commit suicide each year in the world, suicide occurs every 40 seconds[3]. Approximately 75% of the cases occur in low- and middle-income countries, with Brazil accounting for the eighth largest number of suicides in the Americas, with an average of 5.7 deaths per 100,000 inhabitants, being the third cause of deaths due to external causes in the country[4].

In view of these statistics, knowing how to suicide occurs is of great relevance, aiming to prevent the incidence of suicide deaths, as well as to raise the awareness of the population that the topic needs to be more discussed and no longer faced with prejudice[5]. For this, important actions of health education shall de developed, like the elaboration of national and local strategies of prevention, making the population aware about the detection and early initiation of treatment when there is occurrence of mental disorders, great responsible for the occurrence of suicidal acts[1].

With the increase in suicide rates, the number of bereaved who need to have their expanded care also increases, since self-inflicted death generates suffering in those who stayed and have experienced suicide effects[6]. The focus of suicide in the family group tries to understand the intensity and amplitude of this act in the life of the people, being the group that suffers most of the effects of several natures, which can last for a lifetime[2]. In addition, suicide also often generates disruption in the family context[7].

As suicidal behavior cannot be reduced to simplistic explanations, the process of mourning cannot be attributed to a single understanding. Mourning for suicide encompasses many dimensions, and the way of dealing with it depends primarily on the interrelationships of the bereaved. Among the aspects that influence the process of mourning, the form of death (sudden or violent), the proximity of the relationship with the lost person, and the historical antecedents and personality and social characteristics[6].

In this context, the term "postvention" has recently been introduced, which refers to prevention, mourning and activities after the loss by suicide. It involves the development of actions to mitigate the loss of suicide and the prevention of the suffering of the next generations[6]. For this, it is important that nurses and health professionals be able to approach suicide in a broad and unbiased way[2,8], including postvention activities in the family group.

However, the search for Brazilian scientific research on suicide in the Latin American Literature on Health Sciences (LILACS), Nursing Database (BDENF), Virtual Health Library (VHL), Scientific Electronic Library Online (SciELO) and the National Library of Medicine (Pubmed) shows that there is little scientific production on suicide mourning, since studies on risk factors and the role of health professionals prevail[6,8-11]. Therefore, it is necessary to advance the understanding of how families experience the loss of a member by suicide, aiming at the development of interventions by health professionals to host, promote postvention and mental health of these family members[9].

Thus, considering that the literature on the subject is still incipient and that the understanding of the experience of bereaved family members can contribute to the practice of nursing and health professionals in this care area, interest arose for the accomplishment of the present study, whose guiding question was: how does the family experience the loss of a family member by suicide?

OBJECTIVE

To understand the family's experience of losing a family member by suicide.

METHOD

Ethical aspects

Ethical aspects were respected in accordance with Resolution 466 of the National Health Council (*Conselho Nacional de Saúde*)[12]. The study was approved by the Research Ethics Committee of the *Centro Universitário Barriga Verde*. The interviews were agreed by the participants by signing the Informed Consent Term, after explaining the objectives and method of the study. The statements obtained were identified with the letter "P" for professionals and "F" for family members, associated with numbers according to the order of interviews. It should be noted that the sample groups were foreseen in the authorization granted by the Ethics Committee.

It is important to mention that, considering the subject addressed, some participants were emotionally affected during the interviews. In these cases, they were offered psychological care in their reference unit.

Type of study

This is a study of qualitative approach and with the theoretical-methodological framework of the constructivist perspective of the Grounded Theory[13].

Study setting

The study setting was a municipality in the south of Santa Catarina state, with a population of approximately 30,000 inhabitants; there are nine Family Health Strategies (FHS), a Family Health Support Center (*Núcleo de Apoio Saúde da Família*), a Psychosocial Care Center (CAPS- *Centro de Atenção Psicossocial*), a Maternal and Child Health Service, a reference unit for Men's Health, a Community Polyclinic (*Policlínica de Atendimento Municipal*), and a Hospital General with 84 beds, which also has emergency service.

In 2015, the municipality had 6.9 deaths per suicide per 100,000 inhabitants, which corresponds to a higher index at the national level. Data from the Brazilian Mortality Information System (*SIM*) indicate the occurrence of 5.4 deaths per 100,000 inhabitants in Brazil and 9.3 deaths per 100,000 inhabitants in the State of Santa Catarina in the same year[14].

Collection and data organization

As recommended by the Grounded Theory, the study participants were enrolled from the study through theoretical sampling, which consists of the inclusion of different subjects to refine and increase the categories throughout the study[13]. The theoretical sample of the study was composed of 20 participants, organized into three sample groups, defined from the circularity of the data and in the constant comparative method[13].

The first sample group (P1-P9) was composed of nine professionals from the FHS, four nurses and five physicians. The objective of data collection with this group was to know the care provided by FHS professionals to family members of people who committed suicide. Data collection started with the FHS, considering its role as a gateway to the *SUS* (Brazilian Unified Health System) care. From the data collection with the 1st sample group, it was hypothesized that *CAPS* is the reference for the care and follow-up of family members of suicidal patients in the city. In order to continue the research, the second sample group (P10-P13) was composed of four *CAPS* professionals: a nurse, a psychologist, a psychiatrist, and a social worker. It was sought to know how it is the care to the family members of suicidal patients in the *CAPS* and the professionals' perception about the coping mechanisms developed by the families in the face of the loss of a family member by suicide. Finally, the third sample group (F14-F20) was composed of seven family members of people who committed suicide: three children, one wife, one aunt, one sister and one mother.

The inclusion criterion for the 1st and 2nd sample group was professional experience in the care of family members of people who committed suicide or patients with suicidal risk. The inclusion criteria for the 3rd sample group were to have a family bond with someone who committed suicide and to reside in the municipality where the research was carried out. It should be emphasized that there were no refusals or withdrawals among the research participants. The size of the theoretical sampling was determined by the theoretical saturation, that is, from the repetition of the data before the evidence already collected for the theoretical construction of the research[13].

Data were collected through an intensive interview[13] during the second half of 2016, after a pilot test. The interviews were conducted at the participants' preference sites, recorded by electronic audio device and transcribed in full. The interviews were conducted individually by the first author of this article, who at the time of data collection, was a nursing academic and a research group participant. The interviewer had no previous relationship with the participants. The FHS nurses assisted in the identification of family members interviewed. The initial contact with the family members was given through Community Health Agents. The average duration of the interviews was 35 minutes.

The questions asked to the professionals were about the care given to family members of people who committed suicide. The issues addressed to the family members sought to explore the meaning of suicide and how it impacted the family environment, as well as coping and/or overcoming strategies developed by the family.

Data analysis

The initial and focused coding steps were used to analyze the data. The initial coding consists of dividing and naming each segment of data into codes that express the meanings present in the respondents' speeches. In the focused coding, the most significant or frequent initial codes were classified, integrated, synthesized and organized into subcategories and categories until the phenomena or the key family member category of the research was obtained. The phenomenon is the key idea upon which a set of actions or interactions is conducted by people[13]. The NVIVO®11 software was used to organize and categorize the data.

The coding was performed by the same researcher who conducted the interviews. During the data analysis process, the research team met to discuss coding and contribute to the organization of subcategories and categories. At the end, the analytical process and the results were submitted to the validation of two researchers with experience in the use of the Grounded Theory.

RESULTS

Regarding the profile of the participants, the 13 health professionals were between 28 and 58 years of age, nine were female, and with professional experience ranging from four months to 12 years. In addition, five had specialization in the area of health, two of them in the area of mental health. The seven family members had different links with the people who committed suicide (children, wife, aunt, sister and mother). Six were female and were between the ages of 24 and 51 years. The family suicide time ranged from four months to 11 years.

The three categories and their subcategories that emerged from the analysis of the data are presented in Chart 1. From the interconnection of the categories, the phenomenon "Experiencing the loss of a family member by suicide: from mourning to the quest for overcoming" was obtained. The following describes each of the categories.

Chart 1 – Categories, subcategories and study phenomenon

Phenomenon	Category	Subcategory
Experiencing the loss of a family member by suicide: from mourning to the quest for overcoming	Being in a "state of shock"	Feeling difficult to deal with loss
		Despair for suicide
		Having doubts about the veracity of the suicide act

To be continued

Chart 1 (concluded)

Phenomenon	Category	Subcategory
Experiencing the loss of a family member by suicide: from mourning to the quest for overcoming	Living with the suffering and effects of the loss of the family member	Remembering the image of the dead person
		Suffering the judgment of society
		Bearing the "guilt"
		Facing financial problems
		Causing family disruption
		Developing Mental Disorders
	Rebuilding life	Relying on God
		Highlighting support from friends and support from health professionals
		Strengthening family unity
		Deciding to move

Being in a "state of shock"

Receiving the news of a family member's death is a difficult and painful time, but when it is caused by a suicidal act, it becomes even more shocking. Family members at the first moment are in a "state of shock", despairing of the news. Suicide is an act of surprise to family members, because even though they knew that their loved one had suicidal ideation, they did not expect they killed themselves.

> *It's despairing, I've lost my father, I've lost my mother, I felt bad, but my brother's suicide was horrible, it seems like my world fell apart, we didn't know what to think, we didn't know what to say, it was a very horrible thing, terrible feeling.* (F3)

> *The family is knocked off its feet, I don't know if I can use this word, the family gets very depressed, especially the father, mother, brother, so it's very difficult for the family* [...]. (F1)

Family members face difficulties in dealing with this sudden loss and seek answers to what has happened. Despair takes over this tragic moment, mainly because most of the cases do not have a single and sufficient justification for the act. Thus, family members present difficulties in dealing with this type of death, arriving to question the veracity of the self-harm. In an eagerness to justify death, they initially believe that death may have occurred through murder rather than suicide.

> *We have a patient who lost her only child by suicide, but she doesn't accept suicide. She thinks she was murdered, but it was suicide.* (P13)

> [...] *I haven't realized, at first I thought someone had done it, I dug up all this and I couldn't accept it.* (F3)

> *The family tries to find explanations, reasons, but surely will never find the answer 100% because the person who did it is gone. But the main reason for the family is to dig up answer.* (P2)

Living with the suffering and effects of the loss of the family member

After the initial "state of shock", the family members go to a second moment that is of coexistence with the suffering and effects of the suicide in the life of the family. Suicide leaves traces difficult to forget, and becomes a trauma for the family. The family member who finds the body presents difficulties in overcoming and forgetting such a scene. The image of the dead person permeates the mind of the family member constantly, causing anguish and suffering.

> *When I remember him, everything comes in my mind. He always wore a red sweatshirt and jeans shorts* [...]. *When that movie comes in my mind it makes me sad and I get really bad.* (F1)

> *I had a hard time trying to forget it, because I saw him hanged, they didn't take the body without someone from the family helping, and I felt really disturbed afterwards.* (F3)

> *I don't even like to remember, it brings me more sad memories and longing* [...]. *Still the memories come in my thoughts.* (F6)

In addition to coping with mourning over the death of a loved one, family members need to deal with the demands and judgments of society. Just as family members seek answers to suicide, society in some way needs explanations and makes hasty judgments. Thus, at the same time that family members are judged by society, they feel guilty for not having been able to avoid death.

> *Society judges any form of behavior, there will always be people criticizing and saying that they* [family] *didn't do what was necessary.* (P13)

> *And the family suffers prejudice. Why did the person do it? Why hasn't anybody from the family cared for him?* (P3)

> *Because we didn't seek a quicker resource or didn't give the attention he deserved, I think there has been a bit of carelessness on our part, on my family's part.* (F1)

> *I could have done more for him. Because I didn't realize he was in a situation like this..* (F3)

Financial problems were among the factors related to suicide. In addition to family members losing someone who, most of the time contributed to the family's livelihood, still had to deal with the financial debt left by those who committed suicide. This fact, coupled with the complexity surrounding suicide, has generated, in most cases, disruption within the family. The family felt lost in this setting, which negatively affected the family dynamics.

> *The difficulty is in paying rent, paying for energy bills, water bills, and so on.* (F2)

> *And it causes disorders in the family environment as a domino effect for everyone even for the strongest people in the family; it actually ends up with the family being independent of the person.* (P1)

> *In relation to the change in the family environment and the family structure, which certainly changes when one has a suicide, a whole family disruption occurs.* (P2)

The suffering caused by suicide can become a risk factor for the healthy living of family members who followed this process. The emergence of mental disorders after experiencing the death of a family member by suicide proved to be common and constant among the family members interviewed, due to the difficulty in overcoming and accepting self-inflicted death.

> *I got depressed, didn't feel like doing anything, didn't feel like leaving the bed, my wish when I woke up in the morning was to stay there.* (F3)

> *When I'm home I hardly talk, I'm quiet, I don't like speaking. I've changed a lot after this* [suicide] *happened, I'm not living. It seems I'm wandering.* (F5)

Rebuilding Life

During the process of mourning by suicide, family members sought help to ease suffering and rebuilding life. One of the main strategies cited by family members was to cling to God, so that faith proved to be a strong ally in the recovery process. Family members also stressed the importance of support from neighbors and friends. It was also mentioned the relevance of support given by health professionals, especially the psychologist. In contrast, some family members preferred to isolate themselves.

> *God helps to overcome this moment, if God does not help I do not know what would happen to me today, every day I pray, I ask God to give me strength, to try to get up.* (F3)

> *We had a lot of help from neighbors, close people, friends and psychologist, my mother needed a lot of help, even for work because she wouldn't be able to do it alone so we had a lot of help, the biggest help came from family, friends and neighbors.* (F1)

> *In relation to the family, we had one or two cases of patients who committed suicide in the community, at the time I worked. The family didn't come to look for us; we only knew about the fact because of the community.* (P2)

As they passed through this moment of disruption, all family members felt fragile and needed to support each other to rebuild the family structure and continue with their life. The change of approach was one of the strategies cited to overcome this disruption, especially when suicide occurred in the same residence. Leaving behind the city and the house where you lived with the loved one has proved to be a factor that softens the pain.

> *I believe what happened has united the family even more; now we no longer have father and mother, so we have become closer to each other.* (F2)

> *So, it is not easy for you to live in the place where that happened* [...]. *Look, it is a passage of our lives, after that my life changed, I came here and I started a new and totally different life from I had there.* (F4)

> *My husband and I moved to a new house, we left the house because we still felt a lot his presence.* (F5)

> *We had to move, we didn't stay there anymore,* [...] *we thought it would be better for everyone to leave and live in a different and calmer way. I think that was the main change of life.* (F1)

From the articulation of categories and subcategories, coupled with the reflective thought of what is happening in the event studied, the phenomenon was obtained: "Experiencing the loss of a family member by suicide: from mourning to the quest for overcoming". The flowchart presented in Figure 1 represents the interaction of the categories with the phenomenon.

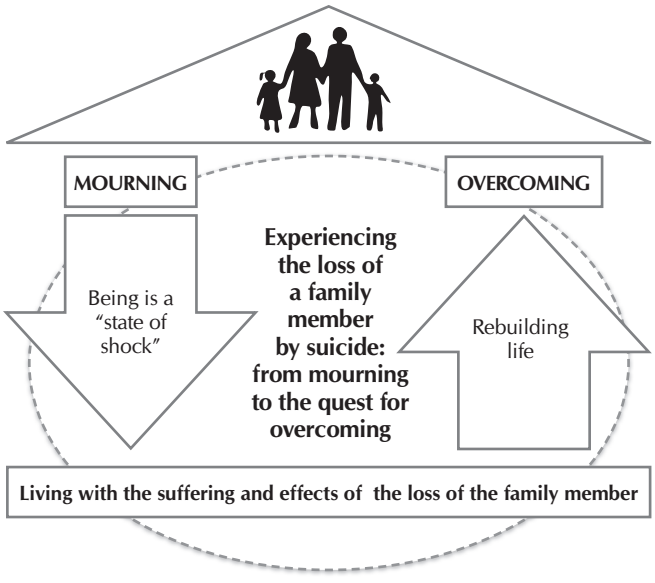

Figure 1 – Representative flowchart of the phenomenon and its categories

DISCUSSION

From the results of the study, it was possible to understand the experience of the family in the face of the loss of a family member by suicide. It can be said that this experience is a process marked initially by an acute emotional reaction, followed by a stage of acceptance, in which the family develop strategies to deal with the absence of the family member and gradually seek to rebuild life. Throughout this process, between difficulties and emotional stress, the need for reorganization of family structure and relationships was evidenced in the research.

The impact of sudden death as a result of suicide is a fact that causes functional changes in a family system, because they severely disrupt their balance without having a concrete understanding of the situation[14-17]. The loss of a loved one is psychologically traumatic and can result in an imbalance between body and mind of the person experiencing this situation. Thus, mourning represents an exit from the state of health and well-being, resulting in an important psychosocial transition, whose impact spreads in all human areas, such as: cognitive, emotional, physical, religious, family and cultural, fruit of a painful experience manifested by the breaking of a sentimental bond[15].

In the initial moment of mourning, it was noticed, as evidenced in the first category, that some family members did not initially believe that the death would have occurred through suicide and they considered the possibility of a murder as a hypothesis that seemed to be less painful. Similarly, a study in Denmark has pointed out that the consequences of suicide are classified as a state of doubt, horror and panic, followed by feelings of powerlessness because they do not allow family members to avoid events[7].

The absence of a family member due to suicide death favors the development of mental sorrows that may persist throughout life. Similarly, a study carried out in Colombia showed that death by suicide implies the formation of a deep and painful feeling among close family members or friends, turning into a phase that is initially marked by tensions, contradictions and the search for answers by the act, and that later, it favors the experimentation of an approximation and familiar union[17].

Family members classified the marks of suicide cases as ineligible for family memory, necessitating adaptation to live with the memories and the image of the dead person. It is common for family members to show signs of flashbacks, nightmares and intrusive images of the event, without having control of these manifestations, invading the mental field unexpectedly, especially during sleep in the form of nightmares. This can result in distress and despair, evidencing the need for professional help to overcome the situation[6].

Not only was the sense of loss to be faced by family members, they also had to face the judgment of society as presented in the second category of this study. The people who make up the social network of the bereaved feel embarrassed, have a certain prejudice regarding this way of dying and in the attempt to seek answers, end up criticizing the family members for not having observed or avoided suicide[14-16].

The death of a family member by suicide brings the loss of part of a hierarchically organized collective structure to the family environment, which generates the need for a reorganization of the system, which varies according to the context and the characteristics of the family members. In this sense, it is common the appearance of financial problems, as evidenced in the present study. The onset of financial difficulties occurs mainly when the suicidal family member is responsible for all or most of the family's livelihood[14-15].

How survivors will respond to the changes that come with suicide in their family environment will be paramount for healthy adaptation and recovery. In line with the results of the present study, a study carried out in Portugal also showed that the family member suffers from the loss of a loved one by suicide, with a high probability of developing disorders such as general suffering, depression, anxiety and hostility, leading to also develop ideation and risk for committing suicide[18]. Sometimes family members do not establish a direct relationship between the loss and the appearance of symptoms in one of their members, either by denial of the act, by the diversity of the feelings involved and the fragile approach related to the theme[19]. This shows that the family after the suicide becomes frayed, weakened and weakened. In addition, they develop a sense of guilt for not being able to avoid what happened, as verified in the second category of this research.

Guilt is a feeling that manifests itself in the majority of death row bereaved family members of suicide victims. Family members, especially the suicidal parents, are often responsible for the attitude of the person and for not taking any action to help and avoid suicide[14]. This feeling, when exacerbated, can manifest as a predictor for the development of difficulties to overcome the act of suicide committed by his family member, bringing consequences that culminate in the family environment as a whole[20].

Overcoming the challenges of suicide within the family context is paramount for rebuilding a healthy life. Supporting oneself in faith and in God presents itself as an essential factor for overcoming the suffering experienced, as evidenced in the third category of this study. These results corroborate the findings of an earlier research that also evidenced religious faith as an ally in the search for understanding suicide, alleviating its suffering and aiding in the pursuit of a higher purpose[19]. The religious attitude orientates the daily life of the family, favoring the development of a positive and reflective attitude that helps in overcoming the situations experienced with suicide[16].

In an attempt to overcome and rebuild themselves amidst the difficulties and conflicts arising from suicide, family members seek psychological support and the help of professionals to better cope with these conflicting situations, as evidenced in the results of the present research. In the treatment of family members who are victims of suicide, it is necessary to welcome the bereaved, directing the work forces to the impact of the situation, respecting their uniqueness and adopting the practice of open and sincere communication, so that all bereaved can give meaning to their loss and can continue with their lives[6,18]. In this same line of thought, American researchers point out that listening to the anguish and feelings of the bereaved family contributes to the treatment and recovery of their mental health[21].

In the results of the study, the change of residence by family members was also evidenced as a strategy to avoid suicide-related memories. It is known that suicides that have been consummated in the family's own residence show a situation

of sadness and difficulty of adaptation in an even healthier way. In addition, there is often a popular belief that it was a "cursed" house because of the self-destruction of the suicide and the family in his own home[19].

It is important that family members are supported by health and nursing professionals in the quest for a new environment to rebuild their lives, adapting to the changes and difficulties experienced with the death of the family member. Thus, the need for a qualified training with the capacity to identify suicidal behavior at all levels of health care, preventing the anticipation of the end of life, as well as to improve the family situation after an episode of suicide, including postvention actions[6,22].

Study limitations

The results of the study come from a single setting and should be generalized with caution, considering the methodological characteristics of the research and multiple nuances of the problem investigated. Thus, the need for new studies in other contexts and with other approaches that contribute to the understanding of a subject as complex as the suicide mourning.

Contributions to the sectors of nursing, health or public policy

The results of this study could help health professionals in the planning of care and assistance to the family that experiences mourning for the self-inflicted death of one of its components. In this context, the importance of the nurse's role as a professional committed to the integral care of the human being is highlighted, in the development of action and care strategies aimed at the prevention of mental health promotion and mainly, postvention. The research also contributes to the spread of the term "postvention", which is still little known and used in Brazil. Finally, it is pointed out the relevance of the inclusion of an increasingly broad approach to the subject of suicide in the training of nurses and health professionals.

FINAL CONSIDERATIONS

The findings of this study showed that the family experience of losing a family member by suicide passes through three stages represented by the categories: *Being in a "state of shock"*; *Living with the suffering and effects of the loss of the family member*; and, *Rebuilding life*. From the articulation between these categories, we obtained the phenomenon "Experiencing the loss of a family member by suicide: from mourning to the quest for overcoming".

It was concluded that, faced with a suicide case in the family, family members initially face difficulties in accepting and dealing with such loss. After that, family members gradually develop strategies to cope with the suffering and effects of the loss of the family member. Among these strategies were the valorization of faith in God and the search for the support of one's family, friends and neighbors. Also highlighted was the search for professional help, especially in the face of the emergence of mental disorders. From this, family members begin the process of reconstruction of life, seeking to overcome the suffering of the abrupt loss of a family member by suicide.

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