Impact of suicide of the elderly on their families

Impacto do suicídio da pessoa idosa em suas famílias

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Abstract *The scope of this paper is an analysis of suicide of elderly people and the impact on the dynamics of their families is presented. The method used is of the qualitative research type known as psychosocial autopsy and is based on interviews with the family members of 51 elderly people who committed suicide in 10 Brazilian cities. The study in these cities was defined by epidemiological research that revealed the relevance of this phenomenon. Many themes were analyzed in the investigation. However, this text focuses on how the families coped with the death of the elderly person, their impressions regarding the act, and the repercussions on family members and the social network. Pursuant to a comprehensive analysis of the testimonies, the following nuclei of significance were revealed: feelings of guilt for the act; social isolation and its manifestations on health; social stigma and prejudice; prospects of overcoming family suffering; anger and feelings of the improbability of the act; and care for the family members. The families manifested suffering, sadness, and perplexity at the death of the elderly person, which influences and has repercussions on their dynamics and at an individual level. Such consequences are different in each area researched depending on the experiences the family has had with acts of this nature.*

Key words *Suicide, The elderly, Family*

Resumo *Apresenta-se uma análise sobre o impacto do suicídio de idosos, na dinâmica de suas famílias. O artigo é fruto de um tipo de pesquisa qualitativa a que se denomina autópsia psicossocial e está baseado em entrevistas com familiares de 51 idosos suicidas de 10 cidades brasileiras. O estudo nessas localidades foi definido por levantamento epidemiológico que revelou a relevância do fenômeno. Foram vários os temas analisados na investigação. Mas este texto se debruça sobre como a família enfrentou a morte da pessoa idosa, suas impressões sobre o ato e as repercussões nos seus membros e na rede social. A partir da análise compreensiva dos depoimentos, foram construídos os seguintes núcleos de sentido: culpa pelo ato, isolamento social e suas manifestações na saúde, estigma e preconceito social, sofrimento familiar e perspectivas de superação, raiva e crença na improbabilidade do ato e atenção aos familiares. As famílias manifestaram sofrimento, tristeza e perplexidade pela morte do idoso, o que influi e tem repercussões na sua dinâmica e no âmbito individual. Tais consequências são diferenciadas nos locais pesquisados e dependendo das experiências da família com atos dessa natureza.*

Palavras-chave *Suicídio, Idoso, Família*

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Introduction

This study focuses on the analysis of the impact caused by the suicide of elderly people on their families. It is part of a national project called *Is it possible to prevent the anticipation of the end? Suicide among the elderly in Brazil and possibilities of action by the Health Sector.*

The decision to focus on families was a result of our accumulated experiences as health professionals, which indicate that suicide has life-changing impacts on the social groups that are closer to the individuals that commit it. Of such groups, the family is under the strongest long-term effects of several kinds. For instance, during a research about the subject in the city of Rio de Janeiro we interviewed a woman whose father had killed himself thirty years ago. She was able to describe the facts and circumstances, still fresh in her memory, and all the suffering experienced by her family since then. She also mentioned that her mother had attempted to terminate her own life several times after the suicide of her husband[1]. Understanding the intensity and breadth of these impacts is of utmost importance in designing family care programs, which, so far, has not been taken into account by health[2] and social assistance services. Indeed, after a non-systematized review carried out on February 23, 2012, an intersection of the descriptors "health services for the elderly, suicide, family and autopsy" on the Medline and PubMed databases indicated twelve related articles. After analyzing their titles and abstracts, we found that only six referred to suicide and health services. There was not, however, a correlation between "impact on the family" and "suicide among the elderly", which is a flaw in the elaboration of this knowledge for scientific purposes.

A myriad of feelings, such as guilt, inexplicable feelings, questions without any logical answer and a strong social stigma descend over and haunt the family members of suicidal individuals. These feelings need to be expressed, for as Mitty and Flores[3] put it, it is *a reality no one will cross unharmed* (pg.162).

In the polarized construction between investigation and explanation we were able to grasp the meaning of this myriad of feelings as *pain that manifests itself through the symptoms displayed by the subject and the insistence on maintaining social bonds.*[4] Therefore, this article, by presenting the results of the impact of suicide of elderly individuals on their family members, raises questions and sets the grounds for a discussion that is still scarce in literature and in the consciousness of society[2].

We worked with the concepts of "family dynamics" and "family structure" to understand the forms of relation adopted by this social group when experiencing suicide. Bronfman[5] defines family dynamics as *conducts and actions reported by an established normativity that permeates the daily lives of the members of the group. This dynamics is defined by the interactions and connections between the members, and is limited by the material conditions in which the family lives*. We can conceptualize the term *family structure* as an *organized pattern where family members interact*[6].

From this perspective, we understand that rules, functions, attributions and roles distributed and performed within the family group are incorporated by each one, by opposition or similarity. The identifications that occur in this dynamics are reproduced in broader social relations and in the different manifestation of affections and emotions, which is peculiar in primary relations.

The complexity of the subject "suicide and family dynamics" implies a qualitative approach based on the triangulation of theoretical anthropological and psychological perspectives. To triangulate theories is to recognize fundamental elements in the comprehension and analysis of experiences described by family members, such as: contexts in which the facts occur; and directions and relations among the several aspects, psychic, social and cultural, found in the contexts; the rupture of a linear and reductionist vision of cause and effect; and opening up the complexity of the meanings of the phenomena.

From this more encompassing perspective, we intend to analyze the impacts of the suicide of elderly individuals on the dynamics of their families, with special emphasis to those that live in the countryside and rural areas.

Durkheim[7] defined suicide as any case of death that results directly or indirectly from a positive or negative act, carried out by the victim himself, knowing that it will produce this result. The same author highlighted that this fact can only be explained by an analysis of the society where the suicidal individuals live, and not by a simple interpretation of what occurred with the individual. We agree with the author about suicide being social in nature, however we disagree with the thought that the individual and his micro-universe have no importance in this equation. We understand suicide as a personal decision loaded with social significance. According to Shneidman[8], suicide is understood as a conscious act of self-annihilation, as a "state of multidimensional restlessness" experienced by a subject

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in a state of vulnerability that perceives the problem and defines that the best solution for it is self-extermination.

Methodological trajectory

This study is based on stories told by family members of elderly individuals, collected by means of what we call psychosocial autopsies. The classic term that defines the method to explain and understand suicides is "psychological autopsy", created by Shneidamn[8]. We, however, decided to adapt it to "psychosocial autopsy", to provide relevance to the overlapping between the psychological and subjective perspectives. The decision to interview family members resulted from the understanding that family stories are important if one wishes to understand the environment where the suicide occurred, and to show the debris relatives are left with after the fatal event. In this regard, a person who takes his own life is the co-author of the narratives constructed during his own existence, and the impact of his acts will continue to exist through time[9].

Through a psychosocial autopsy, we attempt to learn and understand, among other aspects, about the micro-social aspects that involve the family and community environments of suicidal individuals, especially after their self-termination[10].

This study is based on information provided by family members of suicidal elderly individuals from cities located in five different regions of Brazil: North (Manaus), Northeast (Teresina, Tauá and Fortaleza), Midwest (Campo Grande and Dourados), Southeast (Campos dos Goytacazes) and South (São Lourenço do Sul, Candelária and Venâncio Aires).

For the purposes of this study, the regions above presented the highest suicide rates. Their inhabitants work with tobacco and sugar cane cultivation, cattle herds, oil exploration and mining, with some being located close to indigenous tribes.

In compliance with the guidelines of scientific literature, interviews were conducted on average two years after the suicide, in order to preserve the emotional aspects of family members, knowing that revisiting memories can be painful and bring strong emotions to the surface.

Contact with family members obeyed a certain logistic, involving Forensic Medicine Institutes, State and Municipal Health Secretariats, basic care health services, especially the Family Health Strategy (ESF), Psychosocial Care Centers (CAPs), Police Stations and Health Surveillance Services, which provided us with forensic reports, police reports and lists containing the names, addresses, and family members responsible for the elderly person who committed suicide. The selection obeyed the following criteria: method used; accessibility; sex; age; year when the event occurred; and availability of the family.

Telephone contact was made with the families to schedule visits. In some cases, the contact was intermediated by Community Health Agents (ESF), which were extremely helpful in locating some families. In other cases, contact was made directly by the researchers.

Of the total number of families selected, ten were not located; eight refused to be interviewed, stating that they were not ready to speak about the subject; one agreed to participate, but did not show up for the interview. Most families were happy and thankful for the opportunity to verbalize and elaborate their memories with the support of researchers. Literature indicates that families involved in the context of a suicidal crisis need help to reconstruct themselves, through a system that provides them with support and protection[10]. Obviously, the interviews had no therapeutic purpose, but several people said it was the first time somebody was available to listen to them speak about something so painful.

One key informant was responsible for the construction and annotation of the story of life of the person who committed suicide: self-portrait, way of life, mental states, impressions about the act, atmosphere of the suicide, repercussions on the family and behavior of the social and family networks. Other family members attending the meetings added important information as well.

The questions included in the collection form, standardized for the national survey, were inspired by Shneidman[11], who combines the testimonials of family members, friends and professionals who witnessed a case of suicide and develops different explanations about: What happened? Why did it happen? Could the self-annihilation have been avoided? For him, the success of these autopsies does not lie in providing a unified perspective about the case, but rather in providing different viewpoints about it.

Most of the interviews occurred with the presence of more than one family member, lasted on average 60 minutes, in a location provided by the family (porches, living rooms, sheds, kitchens and restaurants). Eighty-two people were interviewed, of which fifty-three women and twenty-nine men.

The conversations were recorded, except for five interviews that were hand-written by request

of families that were uncomfortable with the recorder. We were careful about preserving peculiarities, describing emotions and indicating pauses due to overwhelming feelings. The recorded interviews were transcribed in full, and the hand written information was organized immediately after the interviews. Afterwards, the collected data were compiled and organized into categories, resulting in relevant structures that became topics for analysis. The discussion about the findings combines literature about the subject, the empirical data collected and comprehensive and interpretative inferences.

The project that led to this article was approved by the Committee on Ethics and Research of the National School of Public Health, FIOCRUZ, and all the participants signed a Term of Free and Informed Consent (TCLE). The recommendations and ethical aspects were respected and family members that demonstrated relational conflicts were referred to reference services.

Results and Discussion

The educational level of the families interviewed ranged from college-level to no education. Their occupations were diverse, such as: public servants, employees of private companies, farmers, self-employed professionals (carpenters, masons, shoemakers, mechanics, truck driver, street vendors) and rural workers. Most lived in the rural area, or the deceased elderly individual came from those areas. Their predominant religion was Catholic, even though some would describe themselves as spiritists, evangelic, or devoid of any type of creed. The relatives of these individuals usually comprised large families. We found families composed of 5 to 15 siblings.

The impacts of the suicide of an elderly person on their families was approached by means of the following analytical categories, or cores of meaning, extracted from the comprehensive analysis of psychosocial autopsies[12]: "feeling of guilt about the suicide", "social isolation and its impacts on health", "stigma", "social prejudice", "disbelief in the unlikeliness of the act", "rage", "family suffering", "perspective of recovering", and family care".

These categories will be presented to show how the process of self-inflicted death interferes in both the structure and dynamics of families, producing a recursive causation. Feelings are mixed in the reports of family members, comprising both a universe of suffering and pain, and possibilities of reorganizing and recovering individuals and families. The feeling of guilt for the suicide, along with the rage for not having believed, above all, that it could happen, are mixed with the social isolation that many surrender themselves to, thus impairing their recovery and their emotional health. Additionally, in the cases reported, the constant questioning, perplexity and accusations are mixed in the family and social psychological sphere[13].

Feeling of guilt for the suicide of an elderly family member

Among the vast array of manifestations and verbalizations of families, the feeling of self-reproach is always the first to emerge, whether explicit or veiled - in testimonials permeated with emotion, weeping or compunctious silence -, or in the transfer of one's own feeling of guilt to somebody else. In an incoherence between facts and feelings, we verified that all the elderly individuals that had committed suicide and whose story we had access to, relied on the constant and careful support and presence of family members close to them. Providing such care was frequently the responsibility of women: wives, daughters or daughters-in-law: *I started to feel guilty. The psychologist said I should not, that these things happen no matter what you do* (daughter; North region). *I feel guilty for not being careful enough at that moment. The funeral was terribly sad, it was pouring down* (widow; South region). And less elaborate among family members that had close emotional ties with the deceased, as they believe they could have *done more than they did*. This is a recurring idea and many say that even though they were present, they could have been closer, more careful and more perceptive.

In some families, guilt does not translate feelings of rage or indignation; it is a projection of other explanations, such as why the children were not at home at the moment of the suicide - *everybody feels guilty for not being there when it happened* (grandson; Northeast region) - or because they notice that they did not give the necessary attention to certain dialogues or episodes that suggested that the elderly family member wished to die.

Social isolation and its manifestations on health

Social isolation and its manifestations on the health of family members appears on some dia-

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logues, especially through a manifestation of attachment to the physical environment where suicide was committed, or through some symptom of psychic suffering; "she was beginning to feel depressed" (daughter referring to her mother; Northeast region). Such statements are accompanied by lack of hope and enthusiasm, sadness and no desire to leave the house: "I have never been able to enjoy life again." (Widow; South region).

Some family members interviewed are taking psychiatric medications or on psychotherapy, but have not established any direct relation between their loss and the onset of symptoms, and have not noticed that the treatment they are submitting themselves to intends to contribute to their recovering from the trauma caused by the suicide. Such situation can be observed in an interview where the daughter-in-law does not establish any relation between the suicide of an elderly family member and the psychiatric isolation of her husband, choosing to ascribe the problem to too much work. It should be clarified that the use of psychiatric medications by the family is not always related to the suicide of a family member.

He [son] *cannot sleep. He has been on sedatives for two or three years now, but I think it is because we work too much. He cannot sleep without the pills* (daughter-in-law; South region).

One can assume that many family members do not perceive that one of their relatives has become ill due to a denial of the act, to the myriad feelings involved, and to the weak and fragile approach of health professionals to the subject, when it exists.

Being closed in on oneself, a characteristic of social isolation, is an element that facilitates the onset of illnesses, especially those related to the psychic suffering caused by suicide. The feeling that many people have when sharing their pain with their families - since they do not have any specialized support - is that it does not decrease with suffering, but rather gets multiplied and intensified.

During the first few days she [the mother] *was in such grief, she would not even talk. Many things have changed in our lives. Now I have this problem, I do not feel like going out, I do not even like to talk about my father's death* (daughter; Northeast region).

The lack of reciprocity in the dialogues and social isolation emerge as coadjuvants in the impoverishment of possibilities for the recognition of the other. Movements towards autonomy, towards going out looking for some emotional compensation, are felt by the bereaved and they withdraw, as if this were a disloyalty to the invisible bonds connecting them to the person who committed suicide[13].

Families going through a situation of loss, as is the case with suicide, tend to develop feelings related to unquestionable loyalty or extreme independence. In the first case, some members stand out for their dedication and for taking responsibility for the problems, whereas others will move away from their families or from outstanding emotional and practical matters. The belief is that the person considered disloyal will completely replace family ties with others that are transient and foreign. On the other hand, those that remain loyal and are aware of the after-death problems of their beloved ones believe it would be impossible to replace the lost relationships, and socially isolate themselves in a confusion of psychologically sick feelings, or drown themselves in suffering[13].

A very common situation in cases of suicide is related to the location where the suicide occurred, one that can be called *the myth of the cursed house*. This belief will guide family relations after the event, becoming integrated to the perceptive context of the family, and therefore realigns the internal modalities of family relations, reorganizing new schemes of reference, as expressed in the following speech:

After my father died, my mother sold the house. She would not live there anymore. I also left the place, moved to another neighborhood. I never go there, only if I really need to. I could not enter the house; the memory was always there. My mother also moved, now she lives in another neighborhood with my brother (daughter; Southeast region).

One son cut down the tree from which his father hanged himself. As a result, the house and its surroundings no longer represent a cozy home, but rather but threatening environment. Thus, for some families it is important to distance themselves both in space and time, so they can reorganize and restructure themselves.

The myth of the "cursed house" appeared in several reports, such as the testimonial of this widow who perhaps tried to sooth her incommensurable suffering by telling us about the fact:

People are afraid of the house. They say it carries his memories, and suffer because of that. But we have to be here every day! Dear, if there are any ghosts here I have to learn to deal with them (wife; North region).

Stigma, social prejudice and belief in the unlikelihood of the act

The feeling of shame related to the suicide of a family member is mentioned in literature as the most predominant feeling among families, due to the stigma and social prejudice associated to suicide. Shame usually comes as a consequence of elements external to the family, such as the reaction of friends and neighbors, who distance themselves. Such attitudes both interfere in the interpersonal relations between bereaved family members and may exaggerate conflicts within the family[13], such as indicated by the following statements: *People said we were to blame, that we had abandoned him, had not taken care of him* (son; South region); or even:

I spent many sleepless nights, spent one year hiding from people. Friends wanted to help, but I was hiding in shame. Now this is all gone, but I am still reluctant to leave the house (daughter; Northeast region)

External attitudes, especially those of old friends and neighbors, will often times contribute to reorganizing the behavior and discourse of family members about the suicide. Some of the interviewees mentioned children or other relatives who supposedly knew the reasons that had led to the suicide, but would keep this information to themselves, in such a way that an eloquent silence of reprimands and finger pointing would predominate. One lady finished her interview referring to the difficulties that her family members were facing when trying to understand and overcome by themselves the death of their father, burying with him many pains and sorrows: *it is best to bury what happened with him* (daughter; Northeast region).

The belief that in reality the suicide would not occur, in spite of implied attempts made by almost all elderly individuals to indicate that they would kill themselves, is another reason for suffering and guilt. The testimonials below indicate that many families minimized or even overlooked the signs, maybe as a result of the influence of the social discourse that conceives the aging process as a disposable period of life.

He had given away all his new clothes, and when I had to prepare the body (dress it up for the funeral)*, where were they? I did not find any. He had taken me to the bank, opened an account under my name, and transferred all his money to it. He was always saying: I am not fit for anything, I am only fit to die* (daughter, Southeast region).

Other examples show how family members were not aware of the fact that the repeated indications that their family members were giving up on life, signs of isolation and sadness, should not be treated as normal, but rather as requests of help against abandonment and feelings of uselessness.

On his birthday celebrations he would say: what's the purpose of all this? I am going to die anyway. He would always ask his grandchildren to buy poison, or a rope for him to hang himself. He would ask for a knife, he was always giving hints. He told my mother to take care of herself and not do anything crazy (daughter; Southeast region).

One aspect that has also been analyzed in other cultures is the fact that usually adults and youngsters do not believe when the elderly say that they are going to commit suicide. This is also compatible with the usual idea that "people who want to commit suicide will not say so", something that family members will often repeat; or that the elderly give indications that they wish to commit suicide as a form of manipulation[13].

Rage and family suffering

Rage is one of the most commonly manifested reactions of families when facing the suicide of one of its elderly members. People usually consider the act as a manifestation of aggression and contempt, as ungratefulness or even betrayal against the care received by the person. Below are some expressions of this feeling:

Even now, I still ask myself [and feel angry about it]*: Why? How? What happened? Sometimes I am in the kitchen and I start thinking, how? I am on the verge of going mad!* (daughter; Southeast region).

I am still unable to deal with this, after forty years together... I gave him my hand; I was his friend, his partner, his wife. I feel betrayed by everything he did to me (widow; Southeast region).

Many relatives feel that death is a rejection against them, which also impairs their self-esteem and leads to feelings of rage. As indicated by Lindemann & Greer[14] "To be bereft by self-imposed death is to be rejected". The feeling that family members demonstrate after the suicide is that the person who committed it did not think much of his family, and thus took his own life, leaving everybody perplexed, guilty, shamed and distressed.

As if that were not enough, he shames us now at the last moment. My brother, brother-in-law and sister were summoned [to testify]. *Afterwards somebody came, somebody from an agency for the*

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defense of the elderly came to visit and to know what had happened, because it was not common for an elderly person from a stable family to commit suicide (daughter; North region).

We found that the feeling of rage was very intense among elderly women who had survived their husbands. Bowlby[15] mentions that rage is a common characteristic among widows above age 60 who experience unexpected losses. He explains that this feeling is part of the process of bereavement and is not an abnormality, unless it triggers other problems.

We also came across another form of expression of rage: indifference, which refuses to acknowledge that the other person is worthy of attention and care. Such was the case with family members that refused to go to the funerals of their suicidal relatives, or others that, in spite of having gone to the funeral, maintained a certain irreverence for the person who took his own life.

Anguish is a manifestation commonly found among the family members of elderly who commit suicide. The suffering experienced due to sudden loss is seen by them as a huge grief in their lives, like a pain that haunts them everywhere, all the time, and that can linger for years on end, depending on the intensity of the ties existing between children, parents and grandchildren before the suicide. This anguish persists if there is no narrative to provide support to individual and group progress. We found, for instance, the case of a daughter that killed herself after the death of her father, as she could not bear the massive loss. Obviously, there were other aggravating factors involved, but the suicide of her father was the triggering factor.

In some cases, children are left with the responsibility to pay for the debts of the person who committed suicide - in cases where financial problems are allegedly one of the reasons for the suicide. Usually, these problems are solved with the sale of family assets. This, in turn, leads to an intensification of conflicts, affecting not only the dynamics of the family, but also the subjectivity of each member, leading to the fear of financial charges and to conflict when it comes to electing who is going to be responsible for the consequences of the debts. In several of the families in which this problem occurred, we found a strong feeling of rage towards both the deceased and his descendants.

We also found that suicide has a repercussion on the mental health of the closest family members, especially on the most vulnerable ones, who find it difficult to adapt themselves to adverse situations:

The impact on the family was gigantic. We could not eat for more than a week. I still miss him, remember him every day. Ever since he retired we started seeing him more frequently, but he never gave a hint, nothing (daughter, Northeast region).

H has a son with depression from his second marriage; he was crazy for his father. He developed this depression after the tragedy but will not treat it. He is a young, handsome, twenty-year-old young man. (sister, Northeast region).

Recovery and family care

Writers like Montalbán[16], Herrera[17] and Martine & Parra[18] comment on and reiterate what we observed: suicide is a stress factor for the family in general, and leads to a disorganization of its members. The degree in which this disorganization manifests itself depends, above all, on the level of cohesion and emotional ties between the relatives. Some of them may have strength and maturity enough to offer attention to the most affected members, reducing that disorganization and its most dramatic expressions. We observed that family members who live close to their elderly tend to be the most visibly affected, but many of them are also those who promote processes of recovery among siblings, children and grandchildren. Many families stated that religion gave them the strength to overcome the pain and the suffering, as shown below:

I choose to believe he did it out of love for me, and leave what I do not understand to God. One thing happened, I was lying on the bedroom floor and I felt like he was there. I saw him, but could not find the strength to wake up. I felt his hand on my back: Easy, easy, I am well. I was relieved! (son; North region)

In this case, the son used his mystical-religious experience as an instrument of re-signification, which helped him understand his father's act as an act of love, and therefore harmonize his suffering with the search for a higher, integrating purpose. What is inexplicable in the material world is transferred to the spiritual plane, where answers are unnecessary, since according to the perspective of the son, albeit paradoxically, the suicide was a design of God.

Authors like Martinez & Parra[18], Conwell and col[19] and Luoma et al.[20] in their studies about access to the elderly in risk situations confirm that two-thirds or more of the elderly who committed suicide, most of whom with symptomatic disorders, were under the treatment of primary care services between thirty days and half a week before the act.

Some family members stated very emphatically in their interviews that they feel that the health sector and the religious groups provide little or no support the families: *more attention to the families, more religious support* (son; Southeast region). Even though primary care services seemed to be the most adequate in providing preventative support, health professionals still have not expanded individual and medical care to encompass the needs of the family, respect the relations between generations, and implement health-promoting, life-maintaining actions.

According to this perspective, the deployment of the guiding principles of intersectorality and the inclusion of actions with the power to minimize the lack of harmony in families must be discussed by the health sector. For that purpose, it is of the utmost importance that the Family Health Strategy be implemented as a state policy, for one of its most unique principles consists of "embracing" the family as the core of its activities, and supporting it in all the episodes that may affect physical and mental integrity, or possibly preventing them. *I think we need support, somebody to talk to* (wife; Northeast region).

We have no health services close by, everything is very far. Everything is difficult; in a case like this, at least the family should be provided with support. We hardly ever see a health professional here, we do not have support, nobody to talk to, not even a word of comfort. It is hard, very hard, we are not asking for too much, just one visit would do (daughter; Northeast region).

One may suppose that the daughter's declaration stating she is *not asking for too much, just one visit would do* verifies that the program is overlooking some crucial issues that are not among the most common health problems that deeply affect the families who experience them, as is the case with the suicide of a family member. The proposal of such care, however, is expressed in the official documents of primary health care: to implement intersectorality and its structuring pillars, such as providing shelter, integrality, longitudinal care, humanization, and improved access. According to our understanding, however, provisions set forth in writing will only become a reality if there is awareness of certain issues, and diagnosis to demonstrate and contextualize them.

Conclusions

In complete agreement with experienced authors[19,21], we consider that the most adequate measures for reducing suicide among the elderly are strategies to prevent the onset of the suicidal state. Therefore, interventions by the health sector and by various modalities and scopes of social assistance may be efficient in protecting these individuals and in making their lives useful and healthy.

When a death by suicide occurs, however, discussing what could have been done does not lead anywhere, and families are left with perplexed, grieving and suffering. Over the course of this study, we verified that in most cases, instead of joining forces and providing mutual support, family members will distance themselves from each other, especially when there are economic and financial conflicts involved. In these cases, the frailest members tend to develop physical and mental health problems, loss of concentration, deprivation of sleep, and become socially isolated. The memories of the suicide haunt them like a ghost, destroying their plans. Very frequently, the partner, the children and even the grandchildren descend into grief and sadness, not finding the strength to resurface. The feeling of guilt for the death of the elderly member, among other reasons for not having believed that the suicide would occur, the social isolation, the distancing of friends and neighbors, are the causes of a suffering that can last for many years and have unpredictable consequences if the family group is not given adequate support.

We understand that our role, considering what was exposed above, is to suggest health system interventions and social assistance actions to help families minimize the negative effects, both relational and psychological. This requires seeing them as a multidimensional unity, and offering social and psychological support. Such support cannot be improvised. In addition to sensibility and compassion, it requires a solid educational background and a planned proposal for group and individual intervention. Professionals with adequate training are able to approach these families and establish a conversation that will help them take a step forward towards overcoming the traumatic event.

Many families, assailed by guilt or shame, refuse help immediately after the suicide. To many of them, not talking to strangers - even though they may be health and social assistance professionals - may be a way to defend themselves from pain, and to survive public humiliation. Strategies are required to overcome this barrier and to assist the group and people individually, as provided for by the WHO[22]. It is in this process that

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professionals can help clarify myths about suicide and reinterpret experiences, helping people give meaning to their suffering and deconstruct beliefs that create anguish in the family by putting them in a moral dilemma, as instigated by some religions that considers suicide an anathema. *Bereaved individuals have fantasies about how death is going to affect them in the future, and exploring ways to deal with this reality minimizes the impact of the loss*[13]. Therefore, one needs to avoid approaching families in an isolated or out-of-context manner, especially in cases where relational conflicts are intense and family members are unable to find mutual support for their suffering. When this occurs, it is important to involve actors with ties to the family of the deceased, but who are not at the core of collective suffering, as is the case with neighbors and friends.

In order to provide care to the families of elderly individuals who committed suicide one needs, above all, to know their peculiarities. In view of such a complex problem, we all know that every case is different, and a standard recipe cannot be applied to issues that affect personally each one of the individuals as well as the whole group. Unfortunately, our study indicates that this type of care does not exist, and that families tend to solve - or not - their problems by themselves, as they usually do not get any support from the community either. The taboo of suicide is very much present, and the family members of the person who commits it are often discriminated, and even feared, by neighbors and friends.

In conclusion, professionals need to be present in such a way that is sympathetic, humane and technical, and not limited to one visit or consultation. This is what the interviewed families demand, and what became evident through the testimonials that comprise this study.

Collaborators

Figueiredo AEB, Silva RM, Mangas R, Gutierrez DMD and Sousa GS contributed to data collection and analysis, and to the elaboration of this article. Vieira LJES and Furtado HMJ participated in the elaboration of the text and in data analysis.

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