Suicide bereavement and complicated grief

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Losing a loved to suicide is one is one of life's most painful experiences. The feelings of loss, sadness, and loneliness experienced after any death of a loved one are often magnified in suicide survivors by feelings of guilt, confusion, rejection, shame, anger, and the effects of stigma and trauma. Furthermore, survivors of suicide loss are at higher risk of developing major depression, post-traumatic stress disorder, and suicidal behaviors, as well as a prolonged form of grief called complicated grief. Added to the burden is the substantial stigma, which can keep survivors away from much needed support and healing resources. Thus, survivors may require unique supportive measures and targeted treatment to cope with their loss. After a brief description of the epidemiology and circumstances of suicide, we review the current state of research on suicide bereavement, complicated grief in suicide survivors, and grief treatment for survivors of suicide.

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Introduction

Nearly 1 million people die by suicide globally each year.[1] Suicide is one of the top ten leading causes of death across all age groups. Worldwide, suicide ranks among the three leading causes of death among adolescents and young adults. During 2008-2009, 8.3 million people over age 18 in the United States (3.7% of the adult US population) reported having suicidal thoughts in the last year, and approximately 1 million people (0.5% of the adult US population) reported having made a suicide attempt in the last year. There were just under 37 000 reported deaths by suicide (completed suicides) during the same time period, and almost 20 times that number of emergency room visits after nonfatal suicide attempts.[2] Rates of suicidal thoughts and behaviors vary by age, gender, occupation, region, ethnicity, and time of year. According to a 2011 report[2] released by the CDC, in 2008, the highest prevalence of suicidal thoughts, plans, and attempts among those surveyed in the US was reported

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by adults aged 18 to 29 years, non-Hispanic white males, people who were unemployed, and people with less than a high school education. There were no reported differences in the rates of suicide attempts by geographical region, though people living in the Midwest region of the US were most likely to have made a suicide plan in the last year, and those in the Midwest and Western region of the US reported the highest prevalence of suicidal ideation. While rates of completed suicides tend to be higher among men than women and higher among middle aged or older adults than among younger people, rates of nonfatal suicidal behavior are higher among females and adolescents and young adults.[1]

The most commonly employed methods of suicide are by gunshot, hanging, drug overdose or other poisoning, jumping, asphyxiation, vehicular impact, drowning, exsanguination, and electrocution. There are other indirect methods some attempters may employ, such as behaving recklessly or not taking vitally required medications. Many suicides go unreported, as it can be difficult to identify indirect suicide attempts as suicide, and even some of the more direct methods of suicide may not be clearly identifiable attempts. For example, drug overdoses or vehicular impact attempts are more passive methods, and it may be difficult to determine whether an event was an attempt or accident. Conversely, accidental drug overdoses can often be confused with suicide attempts. If the deceased left behind a note or told someone about their plans or intent to take their own life, this can help those left behind, the suicide survivors, to distinguish between an attempt and an accident, but often no such explanation exists.

Nearly 90% of all suicides are associated with a diagnosable mental health or substance-abuse disorder.[3] The underlying vulnerability of suicidal behavior is the subject of intense research scrutiny, and includes biological, social, and psychological underpinnings.[4-8] While depression and bipolar disorder are the most common disorders among people who attempt suicide, suicide attempters may also suffer from substance abuse disorders, other psychiatric disorders such as schizophrenia, and may feel that suicide is the only way to end an unbearable pain they may be feeling as the result of their mental illness, trauma, or a significant loss, rejection, or disappointment. Additionally, a past history of suicide attempts is the best predictor for future attempts.[9] Common themes among suicide attempters are feelings of hopelessness, despair, and isolation from family and friends. Despite loved ones' and professionals' best efforts to support them in their suffering, suicide attempters are often unable to think clearly and rationally through their pain.

It is estimated that 85% of people in the United States will know someone personally who has completed suicide.[3] For each suicide completed, at least 6 loved ones are directly affected by the death.[10] While not everyone exposed to a suicide will be acutely affected by the death,[11] this is likely an underestimation as reported figures may not account for the emergency responders, health care providers, coworkers, and acquaintances also affected by the suicide. That said, individuals most closely related to the deceased are usually those most adversely affected by the death.[7,12]

Grief reactions and characteristics

Grief is the universal, instinctual and adaptive reaction to the loss of a loved one. It can be subcategorized as *acute grief*, which is the initial painful response, *integrated grief*, which is the ongoing, attenuated adaptation to the death of a loved one, and finally *complicated grief* (CG), which is sometimes labeled as prolonged, unresolved, or traumatic grief. CG references acute grief that remains persistent and intense and does not transition into integrated grief.

Acute grief

After the death of a loved one, regardless of the cause of death, bereaved individuals may experience intense and distressing emotions. Immediately following the death, bereaved individuals often experience feelings of numbness, shock, and denial. For some, this denial is adaptive as it provides a brief respite from the pain, allowing time and energy to accept the death and to deal with practical implications: interacting with the coroner's office, planning a funeral, doing what is necessary for children or others affected by the loss and settling the estate of the deceased. But, for most, the pain cannot be put off indefinably. It may not be until days, weeks, or even months following the death that the reality is fully comprehended, both cognitively and emotionally, and the intense feelings of sadness, longing, and emptiness may not peak until after that recognition sets in. Indeed, grief has been described as one of the most painful experiences an individual ever faces. Shock, anguish, loss,

anger, guilt, regret, anxiety, fear, intrusive images, depersonalization, feeling overwhelmed, loneliness, unhappiness, and depression are just some of the feeling states often described.

Feelings of anguish and despair may initially seem ever-present but soon they occur predominantly in waves or bursts—the so-called pangs of grief—brought on by concrete reminders of or discussions about the deceased. Once the reality of the loss begins to sink in, over time, the waves become less intense and less frequent. For most bereaved persons, these feelings gradually diminish in intensity, allowing the individual to accept the loss and re-establish emotional balance. The person knows what the loss has meant to them but they begin to shift attention to the world around them.

Integrated grief

Under most circumstances, acute grief instinctively transitions to integrated grief within several months. However, as described later, this period may be substantially extended for those who have lost a loved one to suicide. The hallmarks of "healing" from the death of a loved one are the ability of the bereaved to recognize that they have grieved, to be able to think of the deceased with equanimity, to return to work, to re-experience pleasure, and to be able to seek the companionship and love of others.[13-15] For many, new capacities, wisdom, unrecognized strengths, new and meaningful relationships, and broader perspectives emerge in the aftermath of loss. However, a small percentage of individuals are not able to come to such a resolution and go on to develop a "complicated grief" reaction.[16]

Complicated grief

CG is a bereavement reaction in which acute grief is prolonged, causing distress and interfering with functioning. The bereaved may feel longing and yearning that does not substantially abate with time and may experience difficulty re-establishing a meaningful life without the person who died. The pain of the loss stays fresh and healing does not occur. The bereaved person feels stuck; time moves forward but the intense grief remains. Symptoms include recurrent and intense pangs of grief and a preoccupation with the person who died mixed with avoidance of reminders of the loss. The bereaved may have recurrent intrusive images of the death, while positive memories may be blocked or interpreted as sad, or experienced in prolonged states of reverie that interfere with daily activities. Life might feel so empty and the yearning may be so strong that the bereaved may also feel a strong desire to join their loved one, leading to suicidal thoughts and behaviors. Alternatively, the pain from the loss may be so intense that their own death may feel like the only possible outlet of relief.

Some reports suggest that as many as 10% to 20% of bereaved individuals develop CG.[17,18] Notably, survivors of suicide loss are at higher risk of developing CG.[11,19] CG is associated with poor functional, psychological, and physical outcomes. Individuals with CG often have impairments in their daily functioning, occupational functioning, and social functioning.[20-23] They have increased rates of psychiatric comorbidity,[19,24-26] including higher rates of comorbid major depression and post-traumatic stress disorder (PTSD). Furthermore, individuals with CG are at higher risk for suicidal ideation and behavior.[27-32] Additionally, CG is associated with poor physical health outcomes.[33,34] Overall, untreated CG results in suffering, impairment, and poor health outcomes, and will persist indefinitely without treatment.

Bereavement after suicide

Suicide survivors often face unique challenges that differ from those who have been bereaved by other types of death. In addition to the inevitable grief, sadness, and disbelief typical of all grief, overwhelming guilt, confusion, rejection, shame, and anger are also often prominent.[11,35] These painful experiences may be further complicated by the effects of stigma[36,37] and trauma.[38] For these reasons, grief experienced by suicide survivors may be qualitatively different than grief after other causes of death. Thus, while Sveen and Walby[39] found no significant differences in rates of comorbid psychiatric disorders and suicidality among suicide bereaved individuals compared with other bereaved individuals across 41 studies, they did find higher incidences of rejection, blaming, shame, stigma, and the need to conceal the cause of death among those bereaved by suicide as compared with other causes of death.

As outlined by Jordan,[11] certain characteristics of suicide bereavement that are qualitatively different from other forms of bereavement may lead to delays in survivors' healing.

Need to understand, guilt, and responsibility

Most suicide survivors are plagued by the need to make sense of the death and to understand why the suicide completers made the decision to end their life. A message left by the deceased might help the survivors understand why their loved one decided to take his or her own life. Even with such explanations there are often still unanswered questions survivors feel they are left to untangle, including their own role in the sequence of events.

Another common response to a loved one's suicide is an overestimation of one's own responsibility, as well as guilt for not having been able to do more to prevent such an outcome. Survivors are often unaware of the many factors that contributed to the suicide, and in retrospect see things they may have not been aware of before the event. Survivors will often replay events up to the last moments of their loved ones' lives, digging for clues and warnings that they blame themselves for not noticing or taking seriously enough. They might recall past disagreements or arguments, plans not fulfilled, calls not returned, words not said, and ruminate on how if only they had done or said something differently, maybe the outcome would have been different.

Parents who have lost a child to suicide can be especially afflicted with feelings of guilt and responsibility.[40] Parents who have lost a child to suicide report more guilt, shame, and shock than spouses and children.[41] They often think "If only I had not lost my temper" or "If only I had been around more." The death of child is arguably the most difficult type of loss a person can experience,[17] particularly when the death is by suicide. Parents feel responsible for their children, especially when the deceased child is young. Indeed, age of the suicide deceased has been found to be one of the most important factors predicting intensity of grief.[42]

While guilt is not a grief response specific to death by suicide, it is not uncommon for a survivor to view the suicide as an event that can be prevented. Therefore, it is easy for survivors to get caught up in self-blame.[37] Understanding that most suicide completers were battling a psychiatric illness when they died helps some survivors make sense of the death and can decrease self-blame.

Rejection, perceived abandonment, and anger

Survivors of suicide may feel rejected or abandoned by the deceased because they see the deceased as choosing to give up and leave their loved ones behind. They are often left feeling bewildered, wondering why their relationship with the person was not enough to keep them from taking their lives.[43] One survivor told us that when she had shared her own suicidal ideation with her sister, her sister made her promise to never act upon her suicidal thoughts. When her sister took her own life, this survivor not only felt abandoned, but she also felt deceived. She felt angry about this perceived deception, she felt angry for being left behind to deal with life's stresses without her sister, and she felt angry that her sister put her and her family through the pain of dealing with her death by suicide. She was now alone.

Suicide bereaved spouses often struggle because the marriage may be the most intimate relationship an individual ever experiences, and to be left by a self-inflicted death can feel like the ultimate form of rejection.[44] Children who lose their parents to suicide are left to feel that the person whom they count on the most for the most basic needs has abandoned them.[45,46] Results of one study suggest that children whose parents completed suicide and had an alcohol-use disorder were less likely to feel guilty or abandoned, and suicide bereaved spouses whose partners had an alcohol-use disorder were more likely to react with anger than other suicide bereaved spouses.[47]

Anger is a common emotion among many survivors of suicide. It can be experienced as anger at the person who died, at themselves, at other family members or acquaintances, at providers, at God, or at the world in general. Often survivors feel angry at themselves for feeling angry, as they also recognize that the deceased was suffering greatly when deciding to die. Survivors may also feel angry towards other family members or mental health providers for not doing more to prevent the death and angry towards the deceased for not seeking help. A few survivors told us that their loved ones took their lives after a shameful behavior was revealed and/or in the midst of strained relationships. Survivors under these circumstances often feel anger at the deceased for depriving them of the opportunity to work through the difficult time or for not taking responsibility for their behavior.

Stigma

Unlike other modes of death, suicide is stigmatized, despite recent valiant strides to destigmatize mental illness and suicide. Many bereaved individuals report that

it can be difficult to talk to others about their loss because others often feel uncomfortable talking about the suicide. This can leave the bereaved feeling isolated.[48] The feeling of being unable to talk about the death is often compounded by the perceived need to conceal the cause of death. At times, other people's belief systems, including that of the survivors themselves, can be a barrier to accepting the death and a deterrent to talking about it. When coping with a loss, people often turn to religion for comfort and guidance. A challenge for some survivors is that several religions impose shameful restrictions on the grief rituals for those who have been bereaved by suicide. Suicide survivors face additional logistical barriers when handling the deceased's business after a suicide, as most insurance policies even have clauses with built-in stigma.[49] Despite alarmingly high rates of suicides in the United States military, it was only until very recently (July 6, 2011) that the United States Government began to honorably acknowledge the bereaved after a military suicide, as is done for other deaths that occur in combat zones. For many people, talking about their loved ones is vital for their recovery from their loss. The stigma of suicide poses a barrier to the healing process.[37]

Trauma

Survivors of suicide are more likely than other bereaved individuals to develop symptoms of PTSD.[50] The majority of suicide methods involve considerable bodily damage. Occasionally, survivors are witnesses to the final act, or the first to discover the dead body. Those left to find the deceased's body struggle to get the gruesome images of out of their minds.[51] In such circumstances, traumatic distress, marked by fear, horror, vulnerability, and disintegration of cognitive assumptions ensues. One survivor told us the poignant story of her boyfriend, who immediately after a breakup, climbed to a nearby bridge and leaped to his death while she looked on in horror. Not unexpectedly, her grief was replete with such trauma symptoms as preoccupation with reminders, terror-filled recollections, avoidance of high places, and other reminders. After a death by suicide, themes of violence, victimization, and volition (ie, the choice of death over life, as in the case of suicide) are common and may be intermixed with other aspects of grief. Disbelief, despair, anxiety symptoms, preoccupation with the deceased and the circumstances of the death, withdrawal, hyperarousal, and dysphoria are more intense and more prolonged than they are under nontraumatic circumstances.[52]

Suicide risk in survivors

Suicide and mental illness runs in families, likely a result of both heritability and environmental factors.[7,8] Survivors of suicide may be left to struggle with their own suicidal ideation, while seeing that the deceased escaped the anguish and put an end to their suffering. Despite the fact that the suicide bereaved intimately understand the intense pain and suffering experienced by all those who survive a suicide loss, survivors are at higher risk themselves for suicidal ideation and behavior than are other bereaved individuals.[53,54] Crosby and Sacks[55] reported that people who had known someone who died by suicide in the last year were 1.6 times more likely to have suicidal thoughts, 2.9 times more likely to have a plan for suicide, and 3.7 times more likely to have made a suicide attempt themselves. The pain of dealing with the loss of a loved one by suicide coupled with shame, rejection, anger, perceived responsibility, and other risk factors, can be too much to bear, and to some, suicide seems like the only way to end the pain. Some may feel closer to their loved one by taking their life in the same way. Indeed, a survivor told us of how her mother's death by suicide was so difficult to bear for her sister who, like her father, also struggled with bipolar disorder, that her sister completed suicide in the exact same way the following year, on the same date, at the same time. Finally, as with other types of losses, yearning for a loved one can be so intense, that the desire to join the loved one in death can be overwhelming.

Complicated grief in survivors of suicide

While research results are mixed regarding whether grief differs by mode of death,[43] data suggest that the incidence of CG is high among survivors of suicide, as survivors of suicide loss are at higher risk of developing CG.[11,19] Specifically, Mitchell and colleagues[57] reported that the rate of CG was 43% among their pilot study population of 60 Caucasian, Christian, employed, mostly female suicide bereaved participants grieving a total of 16 deaths collectively. This is at least double the rates of up to 10% to 20% of CG reported in the general population.[17,18] Further, Mitchell and colleagues report that

suicide survivors closely related to the deceased experience rates of complicated grief at twice the level as friends, coworkers, and relatives (57% to 80% vs 14% to 28%).

Individuals from that same sample who developed CG were almost 10 times more likely to have reported suicidal ideation 1 month after the death of their loved ones, controlling for depression.[30] In another sample of participants with CG, suicide bereaved participants reported twice the rate of recurrent and current depression compared with other bereaved individuals, reported higher rates of suicidal ideation before the death, and were at least as likely to report suicidal ideation since the death as other bereaved participants suffering from complicated grief.[58] Finally, Latham and Prigerson found that CG is associated with higher levels of suicidal ideation independent of PTSD and depression.[29]

One study[49] suggests that 3 to 5 years is the time point at which grief after a suicide loss begins to integrate, raising the question of how the time frame used in discussions of normal and integrated grief applies to grief after suicide, and therefore what is the "normal" timeline for grief after suicide. That said, in at least one sample studied,[59] symptoms of traumatic grief 6 months after a peer suicide predicted the onset of depression or PTSD at subsequent timepoints. Therefore, it is important for clinicians to know how to identify traumatic grief in order to provide appropriate support and treatment when needed.

Treatment

Considering that grief is a normal, adaptive response to loss, noncomplicated grief that is not comorbid with depression does not warrant any formal intervention in most circumstances. However, in light of the above delineated stigma, anger, and guilt associated with suicide loss, reassurance, support, and information provided by family, friends, and, sometimes, clergy is often not available or sufficient for survivors of suicide loss. Although there exists a paucity of treatment studies in survivors of suicide,[60] most experts agree that: (i) initial attention should be focused on traumatic distress; (ii) self-help support groups can be beneficial; and (iii) there is a role for both pharmacotherapy and psychotherapy in those already showing adverse mental health effects or at high risk for severe and persistent difficulties.[37,61]

Support groups

While few survivors seek help,[62] many survivors who attend support groups find them to be at least moderately helpful,[63] particularly survivors who either do not have adequate social support in the family or immediate community, or who are unable to access friends or acquaintances because of stigma or other roadblocks.[64] For many survivors, participation in support groups is felt to be their only access to people who they feel can understand them, or the only place where their feelings are acceptable, thus providing them with their only means of catharsis. The universality of their experiences provides great reassurance that they are not alone in their feelings and that others have faced similar experiences and have come out not only intact but often stronger. The bonds that develop among people can be very strong as they join a club whose "dues" are high and as they offer each other mutual support. Through such supports, individuals may receive helpful suggestions for taking care of real-life obligations such as dealing with estates and legal issues: talking to others, including children; developing fitting memorials for the deceased; coping with holidays and special events; and setting realistic goals for one's new life which now has such a huge and unfillable void.

Common components of successful support groups include providing accurate information, permission to grieve, normalization of affects and behaviors that may be totally out of keeping with the person's usual state, and most important, conveying to survivors that they are not alone. Often it is helpful to see others who have "survived" the suicides of their own loved ones, and eventually it may even be helpful to have the opportunity to help others. Support groups that are relatively homogeneous (eg, suicide survivors rather than any bereaved, or those who have lost children rather than other losses) are often the most helpful.[35] Survivors of suicide loss groups may also be particularly effective for children who have lost a parent or family member by suicide.[61]

Survivors can locate support groups on Web sites belonging to groups such as the American Foundation for Suicide Prevention (AFSP) and the American Association of Suicidology (AAS) which host directories of over 400 suicide support groups throughout the United States. To locate support groups worldwide, survivors can visit the Web site of the the International Association for Suicide Prevention (IASP), an organi-

zation officially affiliated with the World Health Organization. With membership in over 50 countries across the globe, the IASP postvention (suicide bereavement) taskforce offers a multitude of resources to survivors including survivor guides, 24/7 helplines for people of all age groups including child survivors, and does so in multiple languages. Some survivors are wary of groups and may prefer individual counseling or family therapy, indeed suicide has a profound effect on the entire family,[11,37] or even Web-based support groups or bibliotherapy.[64-67] These same organizations also sponsor organized survivors' events such as suicide prevention walks and survivors of suicide days, but too few people know about the events and some may find it difficult to go to their first event unless they go with support of a friend of a family member. Many survivors who attend these events extol their benefits and comment on the sense of belonging, of being part of a larger community, and of nonjudgmental acceptance that they experience.

Suicide bereavement comorbid with depression or post-traumatic stress disorder

For survivors whose loss has triggered a depressive episode or PTSD, support groups often are not enough. Many clinicians avoid prescribing medication or formal psychotherapy even in the face of a full major depressive syndrome or PTSD, falsely rationalizing that depressive and trauma symptoms are normal in the face of loss and that treatment might "interfere" with the grieving process. But studies have shown that appropriate treatment for these symptoms is indicated and efficacious.[68-70] Thus, if a suicide survivor is experiencing a Major Depressive Disorder (MDD) or PTSD, the clinician should consider medications and/or psychotherapy as indicated for these clinical conditions.

Clinicians often are unclear as to both if, and when, to initiate treatment. As in other, non-bereavement instances of MDD, the decision rests on various factors, including the severity, intensity, and pervasiveness of symptoms, comorbidities, past history of MDD, previous outcomes to treatments, safety, and patient preferences. A second decision point regards how to treat comorbid psychiatric conditions. At present, there is no single form of psychotherapy and/or antidepressant medication ready to be hailed as the treatment of first choice for MDD or PTSD in the context of suicide bereavement.[15] However, there is no reason to suspect that psychotherapy should not be as effective, either alone or in combination with medications, as it is in other, non-bereavement or non-suicide-related instances of MDD or PTSD. Meanwhile, several studies document the effectiveness of antidepressant medications for bereavement-related depression.[68-74] All classes of antidepressant medications are about equally effective, but differences in their side effect profiles usually dictate which medication is best suited for an individual patient. The authors recommend following American Psychiatric Association Treatment Guidelines[75] for the treatment of depression and PTSD and providing an integrative approach based on the individual's needs, resources and availability of treatment, that incorporates support, education, cognitive and interpersonal techniques, psychodynamic principles, grief-specific strategies, bright light, exercise, and cutting-edge medication management.[76]

Suicide bereavement and complicated grief

As previously outlined, survivors of suicide loss are at increased risk of developing CG. Without treatment, CG symptoms follow an unrelenting course. The effectiveness and role of pharmacologic management of CG are not yet established, but the literature suggests preliminary promise for the use of bupropion[69] and escitalopram.[77,78]

Although not specific to suicide bereavement, studies support the use of cognitive behavioral therapy (CBT),[79,80] time-limited interpretive group therapy,[81,82] and complicated grief therapy[83] for the treatment of CG. Complicated grief treatment (CGT) is a modification of interpersonal psychotherapy, adding elements of cognitive behavioral therapy, exposure, gestalt, and motivational interviewing. The basic principle underlying CGT is that acute grief will transition instinctively to integrated grief if the complications of the grief are addressed and the natural mourning process is supported. Each session includes loss-focused grief work as well as restoration-focused attention. The loss-focused grief work aids the bereaved in accepting the loss, talking about the death and surrounding events, starting to take pleasure and comfort in memories of the loved one, and feeling a deep sense of connection with the deceased. It uses imagery and other exercises that resemble exposure techniques coupled with cognitive restructuring. The restoration-focused work helps the person become free to pursue personal goals, engage in meaningful relationships with others, and experience satisfaction and enjoyment.

Studies support the robust efficacy of CGT for the treatment of complicated grief, even in situations of great severity, chronicity, and comorbidity.[83-85]

When complicated grief occurs in the context of suicide bereavement, the psychiatric and psychological literature provide few, if any, empirically based guidelines.[62,86] It is not unlikely that the CGT described above may be beneficial for many suicide survivors with CG, but the therapy may need to be modified to provide more emphasis on the recurrent themes of suicide bereavement: the quest to understand why, guilt, rejection, shame, anger, and stigma. The role of medications is not at all clear, but since there is some evidence that medications may be of benefit in non-suicide-related CG, pharmacotherapy may also be helpful to suicide survivors with CG. Since CG often co-occurs with MDD and PTSD, attention to these disorders may also be necessary; for example, depression focused psychotherapy, antidepressant medication, and prolonged exposure[51] may be indicated in specific situations as an adjunct to CGT, as an alternative to CGT, or if therapy does not result in an optimal outcome. While research suggests that it is the exposure component of CGT that is the essence of its effectiveness,[87] whether or not this level of exposure therapy is sufficient to treat suicide survivors with or without CG and/or PTSD remains to be explored. More research on the needs of suicide survivors, including individualized treatment approaches for unique patient profiles, is badly needed.[60]

Conclusions

Suicide survivors face unique challenges that can impede the normal grieving process, putting survivors at increased risk for developing complicated grief, concurrent depression, PTSD, and suicidal ideation. If left untreated, these conditions can lead to prolonged suffering, impaired functioning, negative health outcomes, and can even be fatal. Because of the stigma associated with suicide, survivors may feel they are unable to secure enough support from friends or family, but may benefit from attending support groups with other survivors who uniquely share their experiences and offer a haven for survivors to feel understood. Because suicide survivors are at higher risk for developing PTSD and complicated grief and may be more susceptible to depression, it is important for survivors and clinicians to be mindful of and address troubling symptoms should they occur. Treatment should include the best combinations of education, psychotherapy, and pharmacotherapy, often with a focus on depression, guilt, and trauma. While the field of suicide bereavement research is growing, there remains a need for more knowledge on the psychological sequelae of suicide bereavement and its treatment in general, and particularly among the elderly, those with pre-existing mental illnesses, men, and minorities.[88] ❑

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Duelo complicado tras la pérdida de un cercano que se ha suicidado

El perder a un ser amado por suicidio es una de las experiencias más dolorosas de la vida. Los sentimientos de pérdida, tristeza y soledad experimentados después de cualquier muerte de un ser querido a menudo se amplían en los sobrevivientes de suicidas con sentimientos de culpa, confusión, rechazo, vergüenza e ira, y también con los efectos del estigma y del trauma. Además, los sobrevivientes de pérdidas por suicidio tienen un alto riesgo de desarrollar depresión mayor, trastorno por estrés postraumático y conductas suicidas, como también una forma prolongada de duelo llamada duelo complicado. Añadido al peso que esto implica está el importante estigma, el cual puede mantener a los deudos alejados de la tan necesaria ayuda y de los recursos curativos. Por lo tanto los deudos pueden requerir de medidas de soporte especiales y de un tratamiento particular para afrontar sus pérdidas. Después de una breve descripción de la epidemiología y de las circunstancias del suicidio se revisa el estado actual de la investigación en el duelo por suicidio, el duelo complicado en deudos de suicidas y el tratamiento del duelo en sobrevivientes de suicidas.

Deuil compliqué après la perte d'un proche par suicide

Perdre un être aimé par suicide est l'une des expériences les plus douloureuses de la vie. Les sentiments de perte, de tristesse et de solitude ressentis après la perte d'un être cher sont souvent amplifiés, chez les survivants d'un suicidé, par des sentiments de culpabilité, de confusion, de refus, de honte, de peur et les effets du stigmate et du traumatisme. Les survivants à une perte par suicide ont en outre un risque plus élevé de développer une dépression majeure, un état de stress post-traumatique et des comportements suicidaires, ainsi qu'une douleur morale prolongée appelée deuil compliqué. Le stigmate considérable qui s'ajoute au fardeau initial peut éloigner les survivants du soutien nécessaire et des possibilités de guérison. Les survivants ont donc besoin de mesures de soutien particulières et d'un traitement ciblé pour faire face à leur perte. Après une brève description de l'épidémiologie et des circonstances du suicide, nous analysons l'état actuel de la recherche sur le deuil après un suicide, sur la douleur morale compliquée et son traitement chez ceux qui survivent au suicide d'un proche.

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