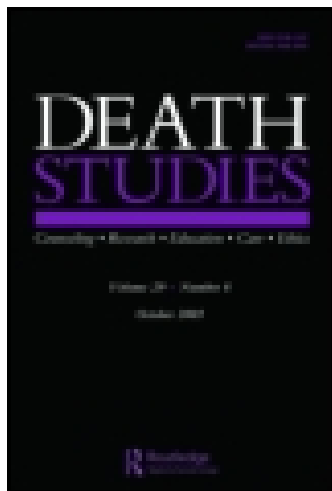


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Sara Santos^a, Rui C. Campos^b & Sofia Tavares^b

^a Portuguese Red Cross, Portugal

^b Department of Psychology and Research Center on Education and Psychology, University of Évora, Évora, Portugal

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Suicidal Ideation and Distress in Family Members Bereaved by Suicide in Portugal

Sara Santos

Portuguese Red Cross, Portugal

Rui C. Campos and Sofia Tavares

Department of Psychology and Research Center on Education and Psychology, University of Évora, Évora, Portugal

The present study assessed the impact of suicide and distress on suicidal ideation in a sample of 93 Portuguese family members bereaved by suicide. A control community sample of 102 adults also participated. After controlling for educational level, those bereaved by the suicide of a family member were found to have higher levels of suicidal ideation. Forty-two percent of family members had Suicide Ideation Questionnaire scores at or above the cutoff point. General distress, depression, anxiety, and hostility related to suicidal ideation, whereas time since suicide also interacted with general distress and depression in predicting suicidal ideation.

Exposure to suicide carries with it a number of adverse consequences (e.g., complicated grief, distress, depression, anxiety, posttraumatic stress disorders) with the increased likelihood for one's own suicide, being, perhaps, the most disturbing (Jordan & McIntosh, 2011a). In fact, several worldwide studies have reported that losing someone close to you to suicide increases the risk for both suicidal ideation and behavior. Crosby and Sacks (2002) reported that Americans who knew someone who had died by suicide in the previous year were more likely to report suicidal ideation and suicide plans and attempts. Hedstrom, Liu, and Nordvik (2008) found that Swedish men who were exposed to a suicide in their family or at the workplace were more likely to die by suicide. Rostila, Saarela, and Kawachi (2013) also found an increased risk of mortality by suicide among Swedish people who had experienced the death of a sibling by suicide.

In Denmark, a series of studies based on national health records illustrated a strong association between

a family history of suicide and current suicide (Agerbo, Nordentoft, & Mortensen, 2002; Qin, Agerbo, & Mortensen, 2003). De Leo and Heller (2008), using data from large-scale studies conducted in Australia and in several European countries, found that exposure to suicide increases the risk for suicide behavior and death by suicide, particularly in young people. Cerel and Roberts (2005) concluded that adolescents who have been exposed to family member suicide attempts and deaths are likely to engage in risk behaviors, to experience suicidal ideation, and to attempt to kill themselves. Research conducted with Micronesia citizens indicates that familiarity with suicide leads to an acceptance of the act by peers, who become prone to reproduce it (Rubinstein, 1983). In addition, several other studies (e.g., Agerbo et al., 2002; Cheng, Chen, Chen, & Jenkins, 2000; Kim et al., 2003; Kuramoto et al., 2010; Qin, Agerbo, & Mortensen, 2002; Runeson & Asberg, 2003) have demonstrated that suicide survivors (suicide bereaved individuals)—“someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person” (Jordan & McIntosh, 2011a, p. 7)—often exhibit a higher risk for suicide than the general population.

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Address correspondence to Rui C. Campos, Department of Psychology, University of Évora, Apartado 94, Évora 7002-554, Portugal. E-mail: rcampos@uevora.pt

Several researchers (e.g., Andriessen & Kryszynska, 2012; McIntosh & Jordan, 2011) have called for cross cultural research of the impact of suicide in terms of distress and risk in several specific subgroups of individuals bereaved by suicide based on categories such as family members bereaved by suicide. This is important because the way suicide is perceived socially and its consequences vary cross-culturally (Kaslow, Samples, Rhodes, & Gantt, 2011). In Portugal, to the best of our knowledge, no study has examined the impact of suicide on suicide risk of individuals bereaved by suicide, namely regarding the variables that might be related to suicidal ideation and risk, such as distress. Suicidal ideation is considered a key indicator of suicide risk (Ash, 2006; Bolognini, Plancherel, Laget, & Halfon, 2003; Bonner & Rich, 1987; Joiner et al., 2005; Linehan, 1981). Thus, identifying factors potentially contributing to suicidal ideation in family members bereaved by suicide is critical for the reduction and prevention of suicide thoughts and the transition from ideation to suicide (Kessler, Borges, & Walters, 1999; Mann et al., 2005).

In suicide bereaved samples, mental illness has been found to relate to suicide risk (e.g., Agerbo, Mortensen, Eriksson, Qin, & Westergaard-Nielsen, 2001; Agerbo et al., 2002; Fleischmann, Bertolote, Belfer, & Beautrais, 2005), and complicated grief and depression to increased likelihood of suicidal ideation (Mitchell, Kim, Prigerson, & Mortimer, 2005). However, the literature is scarce regarding the influence of other variables, namely other distress variables (e.g., anxiety) in suicidal ideation of individuals bereaved by suicide.

In clinical and nonclinical populations, extreme psychological distress has been considered a major risk factor for suicidal ideation (Rosenfeld, Breitbart, Krivo, & Chochinov, 2000) and psychological distress has been shown to make a large contribution to suicide behavior (e.g., Hirsch, Webb, & Jeglic, 2011; Kim et al., 2003; Lamis, Malone, Langhinrichsen-Rohling, & Elis, 2010; Martin, 1997; Overholser, Freheit, & DiFilippo, 1997; Youssef et al., 2004; Zayas, Hausmann-Stabile, & Kuhlberg, 2011). In the general population, suicidal ideation is related with psychiatric illness and depressive mood (Bae, Lee, Cho, Kim, Im, & Cho, 2013) and several empirical studies linked depression, anxiety, and hostility with suicidal ideation (e.g., Campos, Besser, & Blatt, 2012, 2013; Goldblatt, 2008; Lamis et al., 2010; Nepon, Belik, Bolton, & Sareen, 2010; Youssef et al., 2004).

In addition, demographic variables can provide a preliminary if crude assessment of suicide risk (Overholser, Braden, & Dieter, 2012). Being unmarried or a man is often believed to be related with suicide risk (e.g., McIntosh, Santos, Hubbard, & Overholser, 1994; Overholser et al., 2012; Qin et al., 2003). Being elderly has also been associated with suicide (Beautrais, 2001; Kposowa, 2000) as has being widowed (Borges, Angst,

Nock, Ruscio, & Kessler, 2006), separated, or divorced (Kposowa, 2000). It has also been reported that unemployment is a risk factor for suicide (Marmot, 2013; Mortensen, Agerbo, Erikson, Qin, & Westergaard-Nielsen, 2000; Koskinen et al., 2002; Platt, & Hawton, 2000; Qin et al., 2003) and that financial problems, which may be related to unemployment and low educational level, are mentioned by persons who have attempted suicide (Hall et al., 1999). In addition, the literature mentions that family members bereaved by suicide, namely spouses, present high levels of depression (Kessing, Agerbo, & Mortensen, 2003; Li & Zhang, 2010; Zhang, Tong, & Zhou, 2005), that the suicide of a younger relative may be associated with higher levels of distress (Séguin, Lesage, & Kiely, 1995), and that time elapsed since suicide predicts the presence of mental disorders (Saarinen, Hintikka, Lehtinen, Lönnqvist, & Viinamäki, 2002) and complicated grief (Newson et al., 2011; Piper, Ogrodniczuk, Azim, & Weideman, 2001) in suicide individuals bereaved by suicide, which can, in turn, be associated with suicide risk. Feigelman, Jordan, and Gorman (2008–2009) reported that a period of 3 to 5 years since the death usually marks the turning point leading to a decrease in grief pain, whereas Murphy, Johnson, Wu, Fan, and Lohan (2003) found that 3 to 4 years is the turning point in the acceptance of loss.

AIM OF THE STUDY

Despite the negative consequences of being confronted with a suicide in the family, individuals bereaved by suicide, namely individuals who lived with the deceased prior to the suicide, have received less attention in suicidology literature than other issues (Jordan & McMenamy, 2004; Jordan & McIntosh, 2011b). In Portugal, to the best of our knowledge, no other study has examined the impact of suicide on well-being and suicide risk of individuals bereaved by suicide. In addition, literature is scarce regarding the variables that might be related with suicidal ideation in individuals bereaved by suicide, namely distress variables, despite the fact that these variables have been studied in other populations.

The present article aims to assess suicidal ideation and its relationship to distress in Portuguese family members bereaved by suicide (household survivors) from the Alentejo, the Portuguese region with the highest rate of suicide in Portugal (National Institute of Statistics, 2013). A sample of family members bereaved by suicide was compared with a community control sample regarding suicidal ideation, and the impact of distress (general distress, depression, anxiety, and hostility) on suicidal ideation was tested within the sample of family members bereaved by suicide,

controlling for the effect of a pool of sociodemographic and suicide-related variables deemed important by previous literature.

We expected suicidal ideation to be stronger among family members bereaved by suicide relatively than in the community controls and distress to be related with suicidal ideation in family members bereaved by suicide, upon control for relevant sociodemographic and suicide-related variables.

METHOD

Samples and Procedures

Two samples participated in this study. An initial convenience sample of 120 family members bereaved by suicide (individuals who lived with the deceased prior to the suicide) living in the Alentejo Central region in Portugal was invited to participate. Twenty-seven people declined to participate resulting in a final sample of 93, comprising 62 (66.7%) female participants and 31 (33.3%) male participants; they ranged in age from 17 to 89 years ($M=52.6$; $SD=18.9$) and had a mean educational level of 7.0 years ($SD=5.5$) (see Table 1). The final sample of 93 bereaved participants and the group of 27 who declined to participate did not differ regarding the number of male and female individuals.

TABLE 1
Sociodemographic and Suicide Related Variables of the Family Members Bereaved by Suicide

Variables	N	%	M (SD)
Age			52.6 (18.9)
Education			7.0 (5.5)
Gender			
Male	31	33.3%	
Female	62	62.47%	
Marital status			
Married or living together	55	59.1%	
Not married	38	40.9%	
Employment status (working)			
Yes	43	46.2%	
No	50	53.8%	
Kinship			
Spouse	12	12.9%	
Brother	14	15.1%	
Children	42	45.2%	
Father or Mother	6	6.5%	
Grandchildren	10	10.8%	
Other	9	9.7%	
Time since the suicide			
Less than 3 years	20	21.5%	
More than 3 years	73	78.5%	
Recourse to professional assistance			
Yes	27	29.0%	
No	66	71.0%	
Age of deceased			53.2 (20.0)

The second sample was a convenience control community sample. The initial community sample comprised 120 participants but 18 preferred not to respond to the proposed measures, resulting in a final sample of 102 participants, also residing in the Alentejo Central region, which was 73 (71.4%) female and 29 (28.4%) male and ranged from 25 to 90 years of age ($M=48.6$; $SD=15.9$), with a mean educational level of 11.45 years ($SD=5.8$) (see Table 2).

The samples did not differ significantly regarding socio-demographic variables except for educational level ($t_{(192)}=5.5$, $p<.001$). Community participants ($M=11.5$, $SD=5.8$) had a significantly higher number of years of formal education than the family members bereaved by suicide ($M=7.0$, $SD=5.5$). Educational level was controlled when both groups were compared.

Participants were recruited in several community services such as Private Institutions of Social Solidarity (e.g., religious community centers; programs for health education in the community; food providing programs in the community) and city government services. Community participants were also recruited in public places like churches or shops. Each potential participant was personally contacted by Sara Santos and asked to take part in a study about the impact of suicide on the family. Potential bereaved participants were recruited by a “word of mouth” method. Potential community control participants were asked in the initial contact if they had already been exposed to a suicide of another person. If they responded affirmatively they were not accepted for participation (data collection). Participants gave written informed consent and were given the opportunity to discontinue their participation at any time. None of the participants chose to do so. Data were collected in individual sessions and met all the recommended ethical guidelines of the Portuguese Psychologists Board. Participants were neither paid nor compensated for their participation. When the participant had a low educational level or difficulties

TABLE 2
Sociodemographic and Suicide-Related Variables of the Community Controls

Variables	N	%	M (SD)
Age			48.6 (15.9)
Education			11.5 (5.8)
Gender			
Male	29	28.4%	
Female	73	31.6%	
Marital status			
Married or living together	53	52.0%	
Not married	49	48.0%	
Employment status (working)			
Yes	59	57.8%	
No	43	42.2%	

reading, items and questions were presented orally. Sessions took an average time of 27 min and were conducted by Sara Santos. All potential risk cases were referred to the Department of Psychiatry of Évora Hospital. Data collection took approximately 12 months.

Measures

Sociodemographic Questionnaire

Participants completed a questionnaire with socio-demographic and suicide-related information. Information gathered pertained to age, education, gender, marital status, employment status (working), kinship, time since the suicide (more or less than 3 years), recourse to professional assistance (the bereaved individual seek the assistance of a doctor or a psychologist following the suicide), and age of deceased (see Table 1). The community sample did not receive the suicide-related questions.

Suicide Ideation Questionnaire

Suicidal ideation was assessed with the Suicide Ideation Questionnaire (SIQ; Reynolds, 1988), a 30-item self-report measure. Items are scored in a 6-point Likert scale ranging from 0 (*I have never had this thought*) to 6 (*almost every day*), regarding suicidal ideation in the previous month. The psychometric properties of the SIQ are adequate and are available in the manual. A cutoff point of 41 was established (see Reynolds, 1988). The SIQ was adapted to Portuguese population by Ferreira and Castela (1999). The alpha for the Portuguese version (Ferreira & Castela, 1999) was .96. In the present study, alpha was .97.

Brief Symptom Inventory

General distress, depression, anxiety, and hostility were assessed with the Brief Symptom Inventory (BSI; Derogatis, 1993), a 53-item self-report inventory using a Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). It assesses nine psychopathology dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. It also produces three global indices, the Global Severity Index, the positive symptom total, and the Positive Symptom Distress Index (PSDI), which were developed to provide overall assessments of psychopathology or distress. We used only the depression, anxiety, and hostility scales, and the PSDI to assess general distress. PSDI was calculated by dividing the sum of all item values by the positive symptom total. Item 9, which assesses suicidal ideation, was removed from the computation of depression scale and the PSDI. The psychometric properties of the BSI are adequate

and are available in the manual (Derogatis, 1993). The BSI was adapted for the Portuguese population by Canavarro (2007). In the Portuguese version a score of ≥ 1.7 in the PSDI suggests emotional disturbance. Cronbach alphas for the Portuguese version (Canavarro, 2007) ranged between .62 and .80 for the nine symptom scales. In the present study, alpha values were .91 for the depression scale, .84 for the anxiety scale, and .75 for the hostility scale.

Data Analysis

We first compared family members bereaved by suicide and community controls regarding the number of cases scoring above the cut-off point in the SIQ using a χ^2 test. We also compared both samples regarding suicidal ideation using a *t* test, and while controlling for educational level, using a partial correlation.

Second, we related distress and suicidal ideation amongst the family members bereaved by suicide. The percentage of at-risk individuals bereaved by suicide (with a SIQ score equal to or above the cutoff point) who also scored a significant level of PSDI general distress (≥ 1.7 , the criterion adopted by Canavarro, 2007, for the Portuguese version of the BSI) was calculated. A χ^2 test then was used to compare the high- and low-risk individuals bereaved by suicide in regards to the number of cases scoring significantly for general distress.

We then explored the associations between scores on distress: general distress, depression, anxiety and hostility and scores on suicidal ideation, controlling for potentially significant sociodemographic variables. The correlations between distress, as assessed by the BSI scales, and PSDI and suicidal ideation, as assessed by the SIQ, were calculated to identify the significant univariate zero-order associations (see Table 3). Possible associations between a pool of nine relevant socio-demographic and suicide-related variables and suicidal ideation were also tested. Variables were age, education, gender, marital status, employment status (working or not working), spouse of the deceased, time since the

TABLE 3
Zero-Order Correlations Amongst Variables Studied

<i>Variables</i>	1	2	3	4	5	<i>M</i>	<i>SD</i>
Suicidal ideation							
1. SIQ score	—					42.53	41.68
Distress symptoms							
2. General distress	.75*	—				1.93	0.62
3. Depression	.77*	.87*	—			1.61	1.16
4. Anxiety	.69*	.77*	.74*	—		1.17	0.86
5. Hostility	.54*	.58*	.60*	.58*	—	1.03	0.76

Note. *N* = 93.

**p* < .001, two-tailed.

suicide (more or less than 3 years), recourse to professional assistance (consulting with a doctor or a psychologist following the suicide) and age of deceased. We also compared male and female bereaved participants regarding distress and suicidal ideation.

Because univariate zero-order correlations do not allow control for the effect of significant sociodemographic variables in the relation between distress and suicidal ideation and testing for a potential contribution of interactions between distress and sociodemographic variables, the multivariate technique of hierarchical multiple linear regression analysis was used. Significant sociodemographic variables were entered in a first step; each of the distress variables were entered in a second step and the interactions of each of the sociodemographic variables with each distress variable were entered in a third step. Variables were standardized prior to the computation of the product terms.

We examined the normality of residuals using the Kolmogorov-Smirnov Z test (K-S test). The results indicated that the distributions of residuals from the four regression analyses were relatively normal (p values $>.05$). Homoscedasticity was confirmed using the White test. We also examined multicollinearity between variables. Eigenvalues of the cross-products matrix, condition indexes along with variance inflation factors and tolerances from multicollinearity analyses indicated the absence of any multicollinearity.

RESULTS

Suicidal Ideation in Individuals Bereaved by Suicide and Controls

Forty-two percent of family members bereaved by suicide scored at or above the cutoff point in the SIQ, compared to just 5% of the community sample participants. The number of participants in either group scoring at or above the cut-off point in the SIQ was significantly different ($\chi^2 = 38.18, p < .001$). The bereavement group received a mean SIQ score ($M = 42.53, SD = 41.68$) significantly higher, $t_{(192)} = 6.33, p < .0001$, than that of the community group ($M = 14.0, SD = 17.46$). The partial correlation between group (family members bereaved by suicide coded as 1 versus community participants coded as -1) and suicidal ideation, controlling for educational level, was significant ($\beta = .39, p < .001$).

Suicidal Ideation and Distress in Individuals Bereaved by Suicide: Univariate and Bivariate Analysis

Ninety percent of at-risk individuals bereaved by suicide (scoring at or above the cut-off point in the SIQ) also had high levels of distress, according to the criteria

adopted by Canavarro (2007) for the Portuguese version of the BSI. Comparing the number of bereaved family members at risk for high distress with those not at risk, a significant difference was obtained ($\chi^2 = 19.49, p < .001$).

As can be seen in Table 3, the four distress variables tested correlated with suicidal ideation. A series of correlations also indicated significant association between age and suicidal ideation ($r = .29, p < .01$) and time elapsed since the suicide and suicidal ideation ($r = .26, p < .05$). Accordingly, subsequent analysis controlled for age and time since the suicide. Male and female participants did not significantly differ regarding general distress, $t_{(91)} = 1.74, ns$; depression, $t_{(91)} = 1.95, ns$; anxiety, $t_{(91)} = .85, ns$; hostility, $t_{(91)} = 1.47, ns$; and suicidal ideation, $t_{(91)} = .31, ns$.

Suicidal Ideation and Distress in Individuals Bereaved by Suicide: Multivariate Analysis

The results of the multivariate hierarchical multiple regression analyses are summarized in Table 4. In Step 1 we found that age ($\beta = .25, p < .05$) and time since suicide ($\beta = -.21, p < .05$) were associated with suicidal ideation. In Step 2, general distress ($\beta = .73, p < .001$), depression ($\beta = .73, p < .001$), anxiety ($\beta = .65, p < .001$), and hostility ($\beta = .59, p < .001$) were also associated with suicidal ideation. Finally in Step 3, Time Since the Suicide \times General Distress ($\beta = .22, p < .005$) and Time Since the Suicide \times Depression ($\beta = .18, p < .01$) were also significant. Figure 1A and 1B illustrates the significant interactions. As can be seen in Figure 1A and 1B, levels of general distress and depression are significantly associated with suicidal ideation scores as a function of time since the suicide, with significantly stronger associations as time since the loss grows long (more than 3 years).

DISCUSSION

The present study aimed to assess suicidal ideation and its relation to general distress, depression, anxiety, and hostility, in Portuguese family members bereaved by suicide. A community control sample was compared to one of family members bereaved by suicide and, after controlling for significant sociodemographic variables, the relation between distress and suicidal ideation was tested in the bereavement group.

Our findings showed that 42% of the Portuguese family members bereaved by suicide are at risk compared to just 5% of the community participants, which is a statistically significant and clinically substantial difference. Controlling for educational level, the samples differed significantly regarding suicidal ideation. These results

TABLE 4
Multivariate Hierarchical Multiple Regression of Suicidal Ideation

Predictors	R ²	ΔR ²	B	SE B	β	t/F	Overall F	df
Step 1	.13					6.54***	6.54***	2,90
Age			10.34	4.20	.25	2.48*		
Time			8.71	4.20	.21	2.08*		
Step 2	.57	+44%				91.95****	39.42****	1,89
General distress			30.40	3.17	.73	9.60****		
Step 3	.64	+7%				7.78***	30.33****	2,87
General Distress × Age			4.64	3.13	.10	1.48		
General Distress × Time			8.15	2.66	.22	3.07***		
Alt. Step 2	.51	+38%				112.84****	47.40****	1,89
Depression			30.32	2.85	.73	10.62****		
Alt. Step 3	.54	+3%				4.11*	32.06****	2,87
Depression × Age			1.23	3.08	.03	0.40		
Depression × Time			7.11	2.71	.18	2.62**		
Alt. Step 2	.62	+49%				69–53****	30.86****	1,89
Anxiety			26.98	3.24	.65	8.34****		
Alt. Step 3	.65	+3%				2.67	20.28****	2,87
Anxiety × Age			1.93	3.18	.05	.61		
Anxiety × Time			6.54	3.30	.16	1.98		
Alt. Step 2	.44	+31%				50.17***	23.47****	1,89
Hostility			24.43	3.45	.59	7.08****		
Alt. Step 3	.46	+2%				1.20	14.63****	2,87
Hostility × Age			1.37	3.83	.03	.36		
Hostility × Time			4.96	3.54	.12	1.40		

Note. $N=93$; ΔR^2 = increase in R^2 ; $t = t$ value associated with β ; $F = F$ value associated with the changes in R^2 .
* $p < .05$. ** $p < .01$. *** $p < .005$. **** $p < .001$, (two-tailed).

are consistent with the literature (e.g., Agerbo et al., 2002; Cheng et al., 2000; Kim et al., 2005; Kuramoto et al., 2010; Qin et al., 2002; Runeson & Asberg, 2003), which reports that individuals bereaved by suicide often exhibit an increased risk for suicide compared to the general population.

According to results, almost every family member bereaved by suicide who was at risk for suicide had high levels of distress. In fact, individuals bereaved by suicide have been characterized as a significantly distressed population with a high and persistent degree of psychological symptoms (Jordan, Feigelman, McMenamy, & Mitchell, 2011) and high rates of psychiatric disorders (Calhoun & Allen, 1991; Kessing et al., 2003; Mitchell, Sakraida, Kim, Bullian, & Chiappetta, 2009; Tsuchiya, Agerbo, & Mortensen, 2005). The results raise the urgent need for postvention in Portugal. *Postvention* refers to “those activities developed by, with or for individuals bereaved by suicide, in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behaviours” (Andriessen, 2009, p. 43). Unfortunately, the Portuguese National Suicide Prevention Plan has just begun implementation, and postvention is not yet a common clinical practice. In contrast, during recent decades, a number of countries, including the United States, the United Kingdom, Ireland, New Zealand, Australia, Sweden, Norway, and Flemish Belgium have developed and implemented

comprehensive suicide prevention programs and policies that encompass postvention strategies (Andriessen & Krysiniska, 2012).

According to our results, the four distress variables tested are related to suicidal ideation. This relationship has been observed in other clinical populations (e.g., Campos et al., 2012, 2013; Goldblatt, 2008; Lamis, et al., 2010; Nepon et al., 2010; Youssef et al., 2004) and in individuals bereaved by suicide, with other reports confirming that complicated grief and depression are related to suicidal ideation (Mitchell et al., 2005). Our findings reaffirm the need to intervene with individuals bereaved by suicide to reduce distress as well as suicidal ideation and risk. It is of great importance that individuals bereaved by suicide who are traumatized and feel distressed and unable to actively access public health services can benefit from an active postvention model (Campbell, Cataldie, McIntosh, & Millet, 2004) capable of proactively reaching new individuals bereaved by suicide and enabling them to access the services they need, when they need them. In fact, it is essential that postvention allow for “multiple points of access to multiple types of services” (Jordan et al., 2011, p. 129).

Our results demonstrate that age and time since the suicide are related to suicidal ideation. In fact, advanced age has been related to an increased risk of suicide (Beautrais, 2001; Kposowa, 2000). Furthermore,

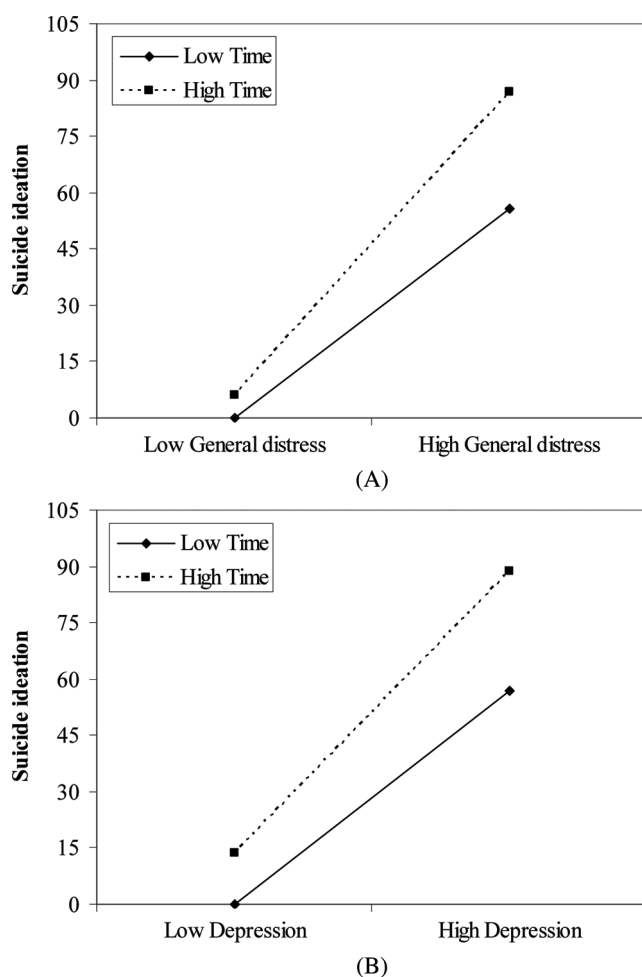


FIGURE 1 A: Interaction between general distress and time elapsed since suicide in the prediction of suicidal ideation. B: Interaction between depression and time elapsed since suicide in the prediction of suicidal ideation.

although some studies have suggested a decrease in the trauma of suicide over time (Li & Zhang, 2010), others have pointed out that time since suicide is predictive of the presence of complicated grief (Newson et al., 2011; Piper et al., 2001) and mental disorders (Saarinen et al., 2002) in individuals bereaved by suicide, which, in turn, may contribute to suicidal ideation (Mitchell et al., 2005). Some clinicians describe cases of individuals bereaved by suicide who are emotionally disturbed as long as 70 years after the event (e.g., Archibald, 2011).

We also observed that levels of general distress and depression are significantly associated with suicidal ideation as a function of time elapsed since the suicide, with significantly stronger associations with longer periods of time. This suggests that the relationship between distress and depression with suicidal ideation is stronger over time than it is at the 3-year mark. As time passes, distress may increase individuals' thoughts about death, thoughts that may be hypothetically associated with

fantasies or a wish to reencounter the deceased loved one. They may, in fact, be a way to cope with suffering that persists, at least in part, because of an inability to elaborate loss. In other words, thinking about death may be thinking of a way to be reunited with the deceased. Grinberg (2000) described several suicidal attitudes, one of which is identification with a loved one who has died by suicide. From our clinical practice, we can recall cases of older family members bereaved by suicide who, after the event, began to say for many years, that if distress were to become overwhelming, suicide would be an effective solution, so that "I would finally meet him [or her]." This finding may also relate to the stigma around suicide and individuals bereaved by suicide, described in the literature (e.g., Feigelman, Gorman, & Jordan, 2009; Jordan & McIntosh, 2011c). Individuals bereaved by suicide may withdraw from potentially supportive interactions with others, because of their belief that they will be negatively judged (Jordan et al., 2011). This can result in isolation, leading to distress and depression. The literature (e.g., Feigelman et al., 2009) shows that stigmatization interferes with suicide mourning and that these difficulties may place individuals bereaved by suicide at a greater risk for depression and suicidal ideation. Again, our results point to the need for postvention, even long after the suicide, and recall Shneidman's words (1969): "A benign community ought routinely to provide postventive mental health care for the survivor victims of suicidal deaths" (p. 22).

LIMITATIONS AND CONCLUSIONS

The present study has some limitations. The sample is heterogeneous, namely regarding age, and is not representative of Portuguese family members bereaved by suicide, because it is relatively small and was collected in just one Portuguese region. Other limitations are the cross sectional nature of the study and that time since suicide was not measured as a continuous variable. The quality of relationships beyond kinship relation was not assessed, which is another limitation. It is also possible that other variables in addition to distress are responsible for suicidal ideation, and that family members bereaved by suicide already experienced suicidal ideation before the suicide or that they were responding to other important issues that happened in the intervening years. Whatever the explanation, family members bereaved by suicide present a significantly higher level of suicidal ideation than the community controls. Future studies should address these issues in longitudinal designs with larger and more representative samples.

Despite these limitations, our results carry clinical implications because they confirm that family members bereaved by suicide are an at risk population that reports

high levels of suicidal ideation. These results remind us of the urgent need for postvention programs. Our findings also provide clinical indications for intervention with family members bereaved by suicide, particularly because they demonstrate that distress, depression, anxiety, and hostility are related with suicidal ideation. These factors should be the focus of intervention. Finally, our results are also important because they alert to the fact that time since suicide is a major risk factor, and hence there is a need for postvention that extends to those whose relatives' suicides are long past.

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