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ON THE IMPACT OF SUICIDE AND ACCEPTING IT IN THE THERAPEUTIC PROCESS

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suicide
family therapy
shame

Summary

The article addresses the experience of traumatic loss related to the suicidal death of a loved one, as well as working with this experience in family therapy. It pays particular attention to the role of shame, guilt, the recurring question of why, as well as the potential disruption of family bonds. The text is casuistic and descriptive in nature. An analysis of fragments of therapeutic sessions with families after the suicidal death of a child was conducted, and reference was made to literature from the field of attachment theory and research on shame in the context of loss and grief.

A child's suicide causes parents to question their parental competence, challenges their previous identity, and creates a risk of harm within family bonds. Shame often becomes a central experience that hinders communication and the grieving process, which prevents the repair of bonds and the gradual reformulation of one's identity. The therapeutic process allows for the gradual breaking through of shame, which, when hidden, causes isolation, and enables the sharing of emotions and the joint search for meaning in the face of the mystery of loss.

Therapy for traumatic loss requires the therapist to create a space in which it is possible to express thoughts and feelings that may be blocked due to shame, taboo, or the desire for mutual protection. The therapy focuses on working with guilt, reframing meanings, and maintaining bonds.

Introduction

This article focuses on two central aspects of family experience following the suicide of a child. The first concerns the suddenness and existential impact of the loss, while the second examines how therapeutic conversations can help family members gradually shift their attention from the violence and incomprehensibility of the death toward the meaning of the deceased person's life.

The suddenness of suicide profoundly disrupts the continuity of the survivors' world and their sense of self. To illustrate this experience, we draw on material from the initial

therapy sessions of two families shortly after the suicide of a child. These clinical encounters offer insight into an experience that often exceeds the explanatory power of established psychological theories and psychotherapeutic models. For this reason, we also turn to poetry, which, in our view, more directly captures the collapse of the survivors' previous world and the painful absence of an answer to the persistent question: Why?

In the second part of the article, we present material from a later stage of therapy with a third family following the suicide of a child. This clinical example illustrates how recalling moments from the child's life during therapy can gradually counterbalance the overwhelming images of the death itself.

Background

Bereavement following suicide involves not only the relational pain of losing a loved one but also the challenge of coping with a profoundly traumatic event characterized by suddenness, violence, and psychological shock [1]. Grief is a complex psychological and existential process shaped by the nature of the loss, the circumstances surrounding the death, and the individual resources of the bereaved person.

One factor that may complicate grieving is the sudden and unexpected nature of the death, which abruptly disrupts the continuity of the relationship and leaves no opportunity for psychological preparation [1]. The violent circumstances surrounding suicide often prolong the initial state of shock and make it particularly difficult to accept the reality of the loss.

A further challenge arises from the traumatic nature of suicide itself. The suicidal death of a loved one represents not only a profound interpersonal loss but also a traumatic event capable of undermining fundamental assumptions about the self, other people, and the world [1]. Bereaved family members frequently experience intrusive memories, nightmares, and a persistent need to reconstruct the circumstances surrounding the death. Daily life becomes dominated by recurring questions: Why did this happen? Could I have prevented it? Am I in some way responsible? Such questions often develop into persistent moral self-blame. In our therapeutic work with families, we frequently observe impaired emotional and cognitive integration resulting from the coexistence of grief and post-traumatic stress reactions.

The grieving process may be further complicated by religious and cultural attitudes toward suicide, which often intensify social stigma [2]. Jordan and McIntosh [3] describe suicide bereavement as "not fully sanctioned" grief because social stigma frequently limits both its public expression and the availability of community support. Bereaved individuals commonly experience profound shame and may conceal the circumstances of the death from others. The resulting burden of carrying a family secret can deepen isolation and diminish the family's capacity to adapt to the loss.

Feelings of guilt and shame therefore become central themes in therapeutic work with families bereaved by suicide. Providing opportunities for these experiences to be openly acknowledged and discussed is of considerable therapeutic importance. Research indicates that 42% of individuals bereaved by suicide report high levels of shame, while 22% acknowledge experiencing suicidal thoughts themselves [4]. These challenges are

particularly pronounced following the suicide of a child, which profoundly disrupts the expected order of life and the parents' fundamental assumptions about their role. Parents often experience intense emotional suffering [5], accompanied by the painful conviction that they have failed in their primary responsibility to protect their child. Many are left struggling with profound questions about the meaning of suffering and the possibility of continuing life after such a loss [1].

The uncertainty surrounding a child's motives and mental state frequently becomes an additional source of suffering. Incomplete knowledge about the events leading to the suicide leaves parents unable to reconstruct what happened or to answer the persistent question of *why* in a way that offers genuine psychological relief.

According to Stroebe and Schut's Dual Process Model [6], grieving involves an ongoing oscillation between confronting the loss and engaging in activities that restore everyday functioning. This movement between loss-oriented and restoration-oriented coping is essential for healthy adaptation. In clinical practice, one often observes a gradual extension of periods devoted to re-engaging with everyday life. Following the suicide of a child, however, therapy must address not only grief and the continuing relationship with the deceased but also trauma-related symptoms, experiences of social stigma, and disruptions to parental identity.

The suicide of a loved one can profoundly disrupt both the survivor's sense of self and their sense of the world's predictability. It may temporarily impair relationships with surviving family members while simultaneously disrupting the internal relationship with the deceased. Bowlby's attachment theory provides a useful framework for understanding these experiences. Human beings possess an innate need to form secure attachment relationships. When caregivers respond consistently to a child's needs, the child develops confidence that support will be available during times of distress. Conversely, repeated failures of responsiveness contribute to insecurity, feelings of abandonment, and changes in attachment strategies designed to protect the individual within close relationships [7]. Such experiences may culminate in what Johnson and colleagues describe as an attachment injury [8].

Within this perspective, suicidal thoughts and behaviour may be understood as a form of interpersonal communication [9], conveying experiences of unbearable disconnection, rejection, or abandonment. For surviving family members, the news of a loved one's suicide often represents an overwhelming experience of relational rupture [10]. Such trauma may fundamentally undermine confidence in the stability of close relationships and even alter one's relationship with oneself. In this sense, suicide strikes simultaneously at both attachment and identity. The full impact of this psychological "blow" often cannot be understood immediately. The following clinical examples, drawn from the early therapy sessions of two families shortly after the suicide of a child, illustrate the depth and complexity of this experience.

Therapeutic contexts of work with families

The beginning: The world after the blow

A middle-aged man telephoned the therapist in tears. When she asked what had happened, he replied, "Our daughter is dead. She threw herself under a train." The therapist listened quietly for a moment before asking, "How old was your daughter?" After answering, the father asked, "Can you help us?" At that moment, the therapist did not know how to respond. Instead, she offered the family an appointment, providing the date, the office address, and her telephone number. When she entered the therapy room the following day, the family was already waiting. Their younger daughter had drawn a house on the whiteboard. The therapist began talking with her, asking whether it was their house, whether they lived in a house or an apartment, whether they had a balcony, and who the figures standing on the balcony were. The girl replied that they were strangers. The father then joined the conversation. "We have an apartment in City X because the girls go to school here, and we usually spend weekends at our house in the countryside." The therapist noticed that he was speaking in the present tense. Turning to the younger daughter, she asked, "Do you have your own room?" The girl replied, "I shared a room with my sister." This was the first time the therapist noticed the family shifting into the past tense. Looking gently at the younger daughter, she said, "I understand that you're all here today because something very frightening has happened." Silence followed. Every member of the family lowered their eyes. Turning to the parents, the therapist continued, "I understand that you've spoken with your younger daughter about her sister's death." The father answered mechanically, his words coming with visible effort. "We told her that her sister is with the angels." After another long silence, the therapist encouraged him to continue. He added, "We told her that something terrible had happened, and that she is with the angels." The therapist turned to the girl. "Your parents told you." The girl sat hunched over, silently nodding. "You're very sad, aren't you?" the therapist asked. The girl nodded more emphatically. "Because you shared a room with A.?" Again, she nodded. Another long silence followed. The therapist looked toward the parents. "When... when did it happen?" The mother answered almost inaudibly, "The day before yesterday." The father added in a whisper, "On Tuesday." The therapist repeated softly, "On Tuesday." "Tuesday evening," the father continued. The younger daughter then said, "I think it was more at night." The therapist looked at her. "At night?" "Yes," the girl replied. "It was already dark."

Step by step, the therapist approached the moment at which, for this family, their world had come to an end. As the family members stared at the floor, she imagined that images were passing through their minds—perhaps the same unbearable image returning again and again, or perhaps many different ones. For the time being, what had happened could only be spoken of in whispers: "Tuesday." "The day before yesterday." These were ordinary words used to describe an utterly extraordinary event—the moment when the family's previous world ceased to exist. Perhaps that was why they could only be spoken in whispers. After the parents had uttered these words, the therapist turned once more to the younger daughter. "Do you remember what happened?" The girl replied, "I didn't see it, because nobody saw it. Mum came and told me." The therapist acknowledged her words

with a quiet "Mm-hmm." The girl continued, "A. was already gone." Once again, step by step, the therapist moved closer to the moment that, in the family's experience, marked the end of the world they had known.

The clinical encounter described above illustrates the family's first attempt to speak about the traumatic rupture created by the suicide of a child. From that moment onward, everyday life may become an ongoing struggle either to re-engage with life or to remain psychologically suspended, as though life itself has been interrupted. It is this existential "blow"—the abrupt collapse of the assumptive world—that becomes the starting point for the therapeutic work described in this article.

The experience of this existential "blow" may be illuminated by Tadeusz Różewicz's 1946 poem *The Survivor* (*Ocalony*):

Translated from the Polish by Anna Maria Nowak
I am 24 years old
I was saved
From the path to the slaughter
These are names that are empty and unequivocal
A human and an animal
Love and hate
An enemy and a friend
Darkness and light

The traumatic impact of suicide raises an important therapeutic question: How can this "blow" be received within therapy? Are there words capable of carrying meaning for a family whose world has been shattered? Therapists may wonder whether anything they say risks becoming little more than an "empty name," devoid of the capacity to reach those who are overwhelmed by loss. More fundamentally, they may ask whether their therapeutic presence—their voice, their gaze, their willingness simply to remain with the family—can reach an inner world that has itself been profoundly struck by trauma. Reflecting on the devastation of war, Różewicz writes elsewhere in *The Survivor:* "Concepts are only words."

The remainder of this article therefore focuses on the nature of the therapeutic relationship, the interventions available to the therapist, and clinical work that supports both the family's continuing relationship with the deceased and an exploration of the inner experience of each bereaved family member.

At the outset, it is important to consider the position in which the therapist is placed and the needs that families may bring into the therapeutic encounter after experiencing such a devastating loss. During the initial sessions, therapists meet people who remain in a state of acute traumatic stress, for whom, to borrow Różewicz's words, "words, sight, and hearing have lost their meaning." This requires creating a space for conversation in which experience can gradually be given language again—to establish a conversation in which things may be "named anew." Such a therapeutic space privileges understanding over interpretation, curiosity over certainty, and creates room for understanding, exploration, and the transformation of the family's relationship with the deceased.

Shame is one of the central emotional experiences encountered in this process. It often becomes intertwined with guilt arising from the belief that one failed to prevent the death

of a loved one. Family members may also begin to experience themselves as fundamentally inadequate or morally deficient. Yet even the suicide of someone known only peripherally—a colleague encountered in the corridor or an acquaintance from the workplace—can provoke unsettling questions about the nature of human relationships and our responsibilities toward one another. Wisława Szymborska captures this experience with remarkable precision in the opening stanza of her poem *The Suicide's Room (Pokój samobójcy):*

Translated by Clare Cavanagh and Stanislaw Baranczak.

I'll bet you think the room was empty.
Wrong. There were three chairs with sturdy backs.
A lamp, good for fighting the dark.
A desk, and on the desk a wallet, some newspapers.
A carefree Buddha and a worried Christ.
Seven lucky elephants, a notebook in a drawer.
You think our addresses weren't in it?
(...)
You think at least the note could tell us something.
But what if I say there was no note—-
and he had so many friends, but all of us fit neatly
inside the empty envelope propped up against a cup.

Szymborska confronts the reader directly, without softening the impact of the question: were the addresses of those closest to the deceased really absent from that room? One might add that the addresses written in the notebook were of no help, just as the desk, the lamp, Christ, Buddha, and the carved elephants offered no protection. In much the same way, people bereaved by suicide ask themselves: What failed? What was missing? Were we truly close to them? Or were we, in some essential way, absent? In Szymborska's poem, the lamp is unable to dispel the darkness that fills the room. This darkness reflects a familiar inner experience of many people bereaved by suicide. They experience a world in which certainty has collapsed and familiar meanings have been shaken. In an effort to escape this darkness, the mind searches relentlessly for answers: Perhaps the mystery can still be solved. Perhaps there is information we have not yet discovered. Yet, to return to Szymborska's imagery, the letter ultimately explains nothing—the envelope remains empty. For many bereaved families, this "empty envelope" becomes a powerful metaphor for the unanswered questions that remain after suicide. It evokes profound shame arising from the belief that they failed to recognize what their loved one was experiencing before the death. When this shame remains unspoken, it isolates survivors and deepens their sense of marginalization.

Unexpressed shame also impairs the capacity to maintain close relationships and to repair disrupted attachment bonds. Because shame develops within relationships, it is likewise within relationships that it can be understood and healed [11]. This helps explain why family and group therapy may be particularly valuable for people bereaved by suicide. Therapy offers a relational space in which shame, guilt, and the persistent belief that one could—or should—have prevented the death can be expressed without fear of judgment. At such moments, one of the most healing experiences may be hearing another person

say, “Me too.” Statements such as “I also feel that I failed” or “I also feel ashamed” help transform an isolating experience into a shared human one. Regardless of whether these feelings correspond to any realistic possibility of preventing the suicide, their open expression fosters connection and restores a sense of belonging. Acceptance of shame becomes an essential part of the healing process. For this reason, therapists need to remain attentive to the often subtle moments in which shame emerges during conversations. Giving shame a voice allows family members to explore not only the emotion itself but also the beliefs about themselves that sustain it. As others have observed, secrecy, silence, and judgment intensify both shame and guilt [12]. By contrast, acknowledging shame with curiosity, compassion, and careful exploration of its origins creates conditions in which healing becomes possible [13].

The following excerpt is taken from the first therapy session with another family following the suicide of a son. Both the mother and daughter are crying. Breaking the silence, the therapist says, “It’s probably difficult to find words for what you’re experiencing right now. Are you worried? If so, about whom? Perhaps about each other?” Silence follows. The daughter begins to cry more intensely. In a muffled voice, the mother replies, “We’re worried... (pause)... we’re worried that... (pause)... it will be difficult for us to be...” The therapist gently encourages her to continue with a quiet “Mm-hmm.” The mother resumes, “We’re worried that it will be difficult for us to support our younger daughter.” The therapist nods. Another silence follows. Still crying, the daughter reaches for her mother’s hand. The mother continues, “Because it’s very hard for us—I mean, for me.” After allowing another moment of silence, the therapist asks whether this concern relates primarily to the family’s current situation or also to the future. The mother replies that it concerns both. “I’m afraid that our behaviour—our way of thinking—will become a burden to her.”

This excerpt illustrates a form of suffering that resists language. Faced with such pain, the therapist’s question about the family’s worries—although grounded in genuine concern—can touch only the surface of their experience. Beneath it lies a deeper current of anguish that unfolds through silence, tears, and the simple act of holding one another. The mother’s words express concern for her younger daughter while simultaneously revealing how profoundly her identity as a mother has been shaken. Following the suicide of her older son, her sense of herself as a mother has been fundamentally called into question. She fears that her own grief, thoughts, and emotional suffering may burden—or even harm—her younger daughter. Such fears are common among parents bereaved by the suicide of a child. They often assume responsibility for the death, repeatedly asking themselves what they overlooked, what they failed to do, or how they might have contributed to what happened. Exploring these beliefs, together with the fantasies and emotions that sustain them—including profound shame—is a central task of therapy. As discussed earlier, hearing another person simply say, “Me too,” can foster the development of secure attachment within the family or therapeutic group. It helps restore the relationship not only with others but also with oneself, while gradually allowing the image of the loved one’s life to become more accessible than the traumatic image of their death. This gradual shift—from memories dominated by the suicide to memories in which the person’s life once again comes to the foreground—typically occurs during the later stages of therapy.

Toward remembering a life

This process is illustrated by a statement made by the mother of another family, whom we have not previously introduced. Unlike the earlier examples, drawn from first therapy sessions, this excerpt comes from a meeting approximately six months after the suicide of her son. She reflected: "Interwoven with all these tears and this pain are funny memories of my son. I often find myself thinking about them... Recently I've realised that when I feel we're all carrying this together, everything becomes a little lighter."

The experience of togetherness—and of preserving continuity within family relationships—appears to be fundamental in coping with despair, grief, and shame [14]. It reminds family members that their suffering is not borne in isolation but exists within relationships that continue despite the loss [15]. We understand "remembering" the life of a person who has died by suicide as a gradual movement away from an exclusive focus on the death and toward renewed engagement with the person's life. This shift helps repair the attachment injury created by the suicide. One of the most painful aspects of suicide bereavement is the feeling of ultimate rejection, or the belief that the death somehow communicated the message: "I would rather die than remain with you."

Family therapy provides a space in which such painful beliefs and their emotional consequences can be spoken aloud, however irrational they may appear or however little evidence supports them. Rather than attempting to dismiss these beliefs, therapy seeks to understand the meanings they hold for bereaved family members. Equally important is attending carefully to the moment in which these beliefs emerge and exploring the emotions that accompany them.

During one family session, approximately a year after the death, the father described how intensely he missed his son, particularly during moments of beauty or joy, such as while travelling, when his absence became especially painful. "You know, a person keeps asking whether he could have done something differently. What weighs on me most is wondering what part I played in his decision." The therapist responded: "I hear two kinds of pain. One is the pain of his absence—that he isn't here to experience the world with you. The other is your question about your own part in what happened, and that seems to be the burden that weighs most heavily on you now." The father nodded. "Yes, exactly." The therapist then asked: "When you think about it now, do you believe there was anything you realistically could have done to change what happened?" This question introduced a gentle therapeutic confrontation. The father responded just as directly: "Everything in the world has a reason. If you're asking whether I know what could have changed his decision—I don't. That's exactly where I experience my failure. I don't know." The therapist nodded, inviting him to continue. "I was so close to my son. We lived together, under the same roof, and he made this decision without giving me any chance. So I keep wondering whether he was trying to tell me something that I failed to see. He never said anything directly, but perhaps something was happening that I simply didn't notice." The therapist remained silent, encouraging him to continue. "Whether that's irrational, I don't know. It doesn't feel irrational to me." The therapist responded: "It seems we're beginning to disagree, and perhaps that's important. Having come to know your family—and, in a sense, your son as well—I wonder whether it's

possible that, in this particular matter, he simply gave you no opportunity to intervene." The father continued to resist this interpretation. "I can't believe that. It's very difficult for me to accept that he made such an irrational decision. There had to be a reason. Since I can't find it anywhere else, I keep looking for it in myself. My wife has another way of understanding it. She thinks he may have been struggling internally, or that something happened suddenly. I can't accept that. It feels too easy."

This exchange illustrates a search that is characteristic of suicide bereavement —the relentless attempt to answer the questions: What happened? Why? Why didn't I see it? Yet no definitive answers exist. To return to the image introduced through Wisława Szymborska's poem, the envelope remains empty.

The father's reflections prompted his wife to respond: "It's not entirely as you're describing it. During those first weeks I kept replaying the days before his death over and over again—thinking about him, remembering what he did, what he was like. I couldn't find anything that distinguished those days from all the others. He was always making plans... always full of life. I still see him exactly as he was until the very last day, and I cannot find any sign that would have allowed us to recognise his sadness or help him. I know there are illnesses of the mind in which people suddenly find themselves surrounded by darkness... something can change very suddenly." Her response shifts the conversation away from searching for a hidden explanation toward acknowledging the limits of what could have been known. Rather than continuing to reconstruct the circumstances of her son's death, she redirects attention toward the life he lived and toward accepting that it may not have been possible to recognize what he was experiencing.

From our perspective as therapists, conversations about whether something could have been noticed are clinically important. Equally important is allowing family members to disagree with one another. Such dialogue interrupts the repetitive, often ruminative questions that dominate bereavement after suicide: What did I fail to do? What did I miss? The father's words reveal several intertwined layers of meaning. Beneath the question "What didn't I notice?" lies a deeper struggle to preserve the meaningfulness of his son's life. Paradoxically, he is also searching for meaning in his son's death. Within therapy, we therefore encourage family members to articulate every hypothesis, belief, and self-accusation about what they believe they failed to do. Thoughts that remain unspoken often become fixed and increasingly powerful. Bringing them into conversation allows them to be examined rather than silently endured. At the same time, therapy also requires making room for uncertainty. There are aspects of another person's inner life that none of us—including therapists—can fully know. In this sense, we too must sometimes remain "in the dark." The therapeutic task is therefore not to eliminate uncertainty but to help families tolerate it: to continue searching for meaning while gradually accepting that some questions will remain unanswered. Sharing these thoughts inevitably involves emotional risk. It may evoke shame, guilt, anger, or despair, together with other painful emotional states. Yet, as clinicians have observed, emotions such as anger can only be worked through by being experienced, expressed, and understood in relation to the beliefs that sustain them [17]. Anger often serves as a protective response, concealing more vulnerable experiences of rejection, abandonment, or shame arising from the conviction that one should somehow have prevented the death.

Accepting the unknown—and the helplessness that accompanies it—is a central task in adapting to the suicide of a loved one. This acceptance is not achieved by suppressing anger or guilt but by allowing these contradictory emotions to be expressed and reflected upon. As illustrated in the dialogue above, acknowledgement of the unknown emerges only after family members have had an opportunity to voice their guilt, anger, and search for meaning. One mother expressed this process with remarkable clarity: "I know this will always remain a mystery. I also know that these questions will keep returning, but my task is to make sure they don't take over my whole life. I want to learn to accept that mystery."

Patrick Casement's book *On Learning from the Patient* (2017) offers an apt reminder that therapists are often taught most profoundly by the people they accompany. The mother's words suggest that therapeutic work following suicide may ultimately involve learning to live with mystery rather than resolving it. She continued by responding to her husband's earlier reflections: "What worries me now is what my husband is saying. There is something about another person's actions that is incredibly difficult to bear, and yet that is precisely what freedom means." Within these words one can hear a profound understanding of love as inseparable from freedom. Loving another person ultimately means accepting that they remain beyond our complete control, even when that freedom confronts us with unbearable suffering.

The therapist reflected: "Earlier you described your son as someone who experienced life as meaningful and full of possibilities. I wonder whether you're trying to tell your husband that this remains the most important part of his story—more important than endlessly asking what either of you might have done differently." The mother nodded and replied: "I don't know why this happened. That part will always remain a mystery. But knowing that doesn't stop me waking up at night and going over every moment before his death: What did I do? What did I say? Those thoughts come whether I want them to or not, just like sadness or tears. We don't have complete control over them."

After a pause, the mother turns to another concern—one that, at that moment, feels even more difficult to bear: "What worries me now is that our youngest daughter no longer has the kind of home she used to have." The therapist responds: "One might say that none of you has that same home anymore. Y.'s death has changed your family so profoundly that each of you has been changed by it. At the same time, none of you yet knows what your home will become, because all of you are still finding your way through this experience. Your daughter will grow up not only with the knowledge that her brother died by suicide, but also with the memory of how your family lived through that loss. However much pain remains—and however much life gradually returns—nothing can erase what happened. What matters now is the kind of life that continues within your family."

We regard this therapeutic intervention as particularly significant because it identifies an area in which the family can regain a sense of agency and thereby establishes an important direction for therapeutic work. As this example illustrates, therapy gradually helps parents reconnect with memories of their child's life, their shared love, and the ordinary moments that constituted their relationship. Creating a sufficiently safe therapeutic space enables family members to return repeatedly to these memories, allowing them to rebuild both their continuing relationship with the deceased child and their sense of themselves as parents. Following the traumatic "blow" of suicide, this parental identity is often obscured

by intrusive images of the death itself, together with overwhelming helplessness, guilt, and shame. Reconstructing the child's life story within the family allows parents to reclaim an enduring sense of parenthood that continues despite the child's death—even when this continuing bond is not always recognised or understood by those around them.

Conclusion

This article does not provide a comprehensive description of the entire therapeutic process conducted with families following the suicide of a loved one. Instead, its primary aim was to outline the key issues that emerge in psychotherapy with families experiencing such a loss.

1. The first area discussed concerns the immediate period following a child's suicide, when family members are often unable to express the full range of emotions they experience. During this stage, the therapist's role is to carefully explore and describe both the experiences of individual family members and what is happening between them.
2. The second important issue concerns the impact of a child's suicide on parental identity. Such a traumatic experience frequently undermines parents' sense of competence and alters how they perceive themselves both as parents and as individuals. The therapist's role is to normalize these reactions as natural consequences of traumatic loss while preventing them from becoming generalized to the person's overall self-perception and other relationships. Long-term therapeutic work therefore involves the gradual deconstruction of this image of oneself as a parent.
3. Another crucial aspect of psychotherapy involves addressing the overwhelming feelings of shame and guilt that commonly arise after the suicide of a family member. These emotions often lead individuals to withdraw from others and conceal their thoughts and feelings even from close relatives. The therapist's role is to create a space for open conversations about shame and guilt and to allow family members to share these experiences for as long as needed. This helps prevent painful emotional withdrawal, the development of taboo subjects, and the formation of family secrets.
4. A recurring theme throughout the therapeutic process is the persistent question of why the suicide occurred. As emphasized in this article, the question "Why?" should not be prematurely answered, as it provides an opportunity to understand how parents perceive their child and their relationship with them. Discussing this question together during therapy may reduce its recurrence as rumination. At the same time, an essential component of therapy is acknowledging and accepting that the decision to die by suicide may remain, at least to some extent, an enduring mystery.
5. As therapy progresses, its focus gradually shifts from the causes and circumstances of the suicide to remembering the life of the deceased. This therapeutic direction promotes the gradual internalization of the relationship with the deceased.
6. The ultimate objective of therapy is to restore parents' sense of agency and identity. As illustrated in the final excerpt, the therapist emphasizes that parents still have influence over what will happen to their home and family in the future, including their relationships and whether a sense of safety and moments of joy can gradually be restored.

In conclusion, our clinical experience with families who have lost a loved one, most often a child, to suicide suggests that many gradually regain hope for change and the ability to enjoy life again, while preserving cherished memories of the deceased despite the enduring pain of the loss. The suicide of a loved one profoundly changes the family's inner world, their beliefs about the world, and their everyday interactions both within and beyond the family. The therapist's role is to recognise where each family member, and the family as a whole, is on this journey. It is essential to understand the thoughts and experiences that shape the inner lives of those who are grieving and to explore the effects of these recurring thoughts. Therapeutic interventions should create space for understanding and accepting the experiences of bereaved family members and the meaning of the life that was lost, alongside the enduring pain and longing that remain.

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