Stigmatization and Suicide Bereavement

William Feigelman [a]; Bernard S. Gorman [b]; John R. Jordan [c]
[a] Sociology Department, Nassau Community College, Garden City, New York, USA [b] Psychology
Department, Nassau Community College, Garden City, New York, USA [c] Private Practice, Providence, Rhode
Island, USA

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STIGMATIZATION AND SUICIDE BEREAVEMENT

WILLIAM FEIGELMAN

Sociology Department, Nassau Community College,
Garden City, New York, USA

BERNARD S. GORMAN

Psychology Department, Nassau Community College, Garden City,
New York, USA

JOHN R. JORDAN

Private Practice, Providence, Rhode Island, USA

With survey data collected primarily from peer support group participants, the authors compared stigmatization responses of 462 parents losing children to suicide with 54 other traumatic death survivors and 24 child natural death survivors. Parents who encountered harmful responses and strained relations with family members and non-kin reported heightened grief difficulties. After controlling for time since the death and whether a child's death was traumatic or not, stigmatization continued to be associated with grief difficulties, depression, and suicidal thinking. Suicide survivors reported little differences in stigmatization from other-traumatic-death survivors, a result consistent with other recent studies, suggesting more convergence between these two populations than divergence.

The literature on suicide bereavement identifies survivors as highly stigmatized (Cvinar, 2005; Dunne, McIntosh, & Dunne-Maxim, 1987; Harwood, Hawton, Hope, & Jacoby, 2002; Jordan, 2001; McIntosh, 2003). Historical records show that during the Middle Ages suicide stigmatization was fully institutionalized: suicide corpses were regularly mutilated to prevent the unleashing of evil spirits; suicides were denied burials in church cemeteries; and the property of their families was confiscated and put into the control of local agents, with the excommunication of these families from the community (Cvinar, 2005). After a suicide loss families often

lost their land holdings because they were unable to pay the heavy tithes exacted by the church, which caused their pauperization and emigration (Dunne-Maxim, 2007).

Such repressive practices no longer apply today in the United States. Perhaps the only vestige of their existence can still be found in the insurance industry where policies generally will not be paid (except for premiums and interest) if an insured commits suicide within the first two years after issuance. Insurance companies have occasionally denied the claims of suicide survivor families on the grounds that the policy was invalidated because the insured consumed illegal and/or controlled substances (Bleed, 2007). Of course, drug consumption occurs in many instances of suicide. Today, however, it seems likely that the biggest obstacles suicide families confront are acts of informal social disapproval. The suicide survivor family may be suspected of being partly blameworthy in a suicide death and consequently may be subjected to informal isolation and shunning.

Today's stigmatization is often subtle. It can be manifested in overt actions taken against the suicide survivor, as well as by omitted actions, which are probably far more common. When people experience the untimely loss of a family member they generally expect their intimate associates to offer comforting and supportive responses. As their expectations to gain nurturing responses remain unfulfilled, they often feel offended, wounded, or abandoned—an empathic failure that is the core of disenfranchised grief (Neimeyer & Jordan, 2002).

Today some analysts suggest that the stigmatization experienced by survivors may greatly complicate their bereavement experiences (Cvinar, 2005; Dunne et al., 1987; Jordan, 2001; McIntosh, 2003). One early empirical study based on medical examiner records and a mail-back survey of survivors found evidence consistent with these assertions. Reed (1993) found more grief-struck survivors detached from their families than those who were less grief-struck.

Until now, few researchers have explicitly quantified stigmatization and systematically examined its association with grief difficulties. Barrett and Scott (1989) developed a 55-item scale measuring grief difficulties including 10 items pertaining to stigmatization ("feel like a social outcast; feel like no one cared to listen to you; feel that neighbors and in-laws did not offer enough concern; feel avoided by friends; think that people were gossiping about you

and the person; think that others didn't want to talk about the death; feel somehow stigmatized by the death; feel that people were probably wondering what kind of personal problems you and the person had experienced; think that people were uncomfortable offering their condolences to you; and feel like the death somehow reflected negatively on you and your family"). These items have face validity but are also repetitive, which unfortunately does little to clarify the most important elements in stigmatization.

Because of these shortcomings, in the present investigation we developed our own measure of stigmatization by asking survivors open-ended questions where they could enumerate the acts of stigmatization they had encountered since the death of their loved one. Following a sociological definition, wherein "stigma refers to a deeply discrediting attribute, reducing a person from a whole and usual person to a tainted and discounted one" (Goffman, 1963, p. 3), we developed a stigma scale operationalizing it as exposure to harmful responses from socially significant others following the loss of a loved one and perceived strains in relationships emerging between those so discredited from their significant others. Accordingly, we asked respondents about the perceived harmfulness they experienced from various significant others, and if and how relationships changed and had become strained following the loss of a loved one.

We tested whether more stigmatization from significant others was associated with greater grief difficulties, heightened depression, and more suicidal thinking among survivors. An additional question was whether suicide survivors had a higher risk of stigmatization than other survivors of untimely deaths. Most discussions of suicide stigmatization imply that the suicide survivor is likely to be subjected to greater social isolation and stigma than other survivors, such as accidental death survivors and survivors of untimely natural deaths. Yet, two early studies yielded results somewhat inconsistent with this expectation (Cleiren, Diekstra, Kerkhof, & van der Wal, 1994; McNiel, Hatcher, & Reubin, 1988).

Method

Respondents

This research was part of a larger study of suicide survivors who use support groups. For analytic simplicity, we confined the study

to parent survivors of child loss. We obtained lists of support groups from the American Association of Suicidology, the American Foundation of Suicide Prevention, and the Compassionate Friends and distributed our 27-page survey among support group members in various parts of the country. We also distributed the survey among the memberships of two Internet support groups (The Parents of Suicide Support Group and Parents Grieving Children of Suicide Group) and current and former patients of several bereavement counselors and practicing psychologists. Also, many survivors spontaneously offered the names of additional respondents who they thought would want to complete the survey. Typically, support group facilitators posted announcements in their newsletters calling for volunteers to participate in a confidential and anonymous survey of survivors. Volunteers were directed to contact William Feigelman, who was identified as both a sociologist and a survivor of his son's suicide.

A total of 754 surveys were mailed, and 540 surveys returned, yielding a response rate of 72%. Of the 540 respondents (458 women, 82 men), most (395, 73%) were between the ages of 46 to 65, but some (103, 19%) were 66 or over, and some (42, 8%) were 45 or under. The sample also over-represented upper-socioeconomic status respondents: 33% reported household incomes of $90,000 or higher; 43% between $40,000 and $90,000; and 24% below $40,000. Also, 51% reported having managerial or professional occupations. In education 41% reported completing four or more years of college; 42% reported some college; and 17% had high school degrees or less schooling. In religious affiliation, 36% were Protestant, 26% were Catholic, 10% were Jewish, 19% were other faiths, and the remaining 9% reported none. The sample was predominately White and native-born (506, 95%). Respondents came from every state in the United States, 7 were from Canada.

The sample over-represented suicide survivors (462, 86%) but 24 were natural death survivors and 54 were survivors of other traumatic deaths (45 accidents, 4 homicides, and 5 ambiguous circumstances). Respondents who lost children to homicide and ambiguous death circumstances were combined into the same category with accidental death survivors, comprising a subgroup of other traumatic death survivors ($n = 54$). This group was contrasted against survivors of a child's natural death ($n = 24$) and suicide ($n = 462$). In how long ago the deaths occurred, 9%

were within the last 12 months, 40% were between 1 and 4 years ago, 30% were between 4 and 10 years ago, and 21% were more than 10 years ago, yielding a mean of 5.6 years ($SD = 5.03$), range = .08 to 27 years. At least 12 respondents reported multiple untimely deaths. Decedents ranged in age from 8% being 15 or younger, 20% between 16 and 21, 36% between 22 and 28, 17% between 29 and 35, and 10% over 36. Clearly, adolescent and young adult deaths predominated in our sample, with over 80% of respondents reporting the loss of a son or daughter between ages 16 and 35.

Materials

Societal stigmatization was defined by a composite Stigmatization scale consisting of two subscales: (a) a family and social strain and (b) a family and social harm/help subscale, both 11 items. The strain questions asked respondents, after the loss of their child, whether relationships changed with any one of 7 different family members (spouse, ex-spouse, parents, in-laws, children, siblings, and other relatives) or 4 social groups (coworkers, closest friends, less close friends, and neighbors). Respondents could choose between the following answers: not applicable, remained the same, became closer/stronger, or became weaker/strained relations. Strain subscale scores were the sum of the number of relationships that became strained, so could range from 0 to 11.

The family and social harm/help subscale was logically similar to the strain subscale. It queried respondents' experiences with these same 11 different family and social relationship groups in terms of how harmfully or helpfully the groups had acted during the first year after the loss of their child. Respondents answered on a 5-point scale, from 1 (*very harmful*) to 5 (*very helpful*). We scored any 1 and 2 responses as harmful ones. Again, harm subscale scores were the sum of the number of relationship groups that demonstrated harm, so they could range from 0 to 11.

These two subscales were moderately correlated ($r = .55$). The strain subscale ($\alpha = .72$), harm subscale ($\alpha = .73$) and overall stigma scale ($\alpha = .76$) were internally consistent. About half of present respondents (55%) reported one or more strained family relationships after their loss; 47% reported one or more strained social relationships; 53% reported harmful responses from one or more

family member groups; and 32% reported harmful responses from at least one non-kin group.

An abbreviated Grief Experience Questionnaire (GEQ; Barrett & Scott, 1989) included the 16 items that had the highest loadings on each of the scale's eight factors (Bailley, Dunham, & Kral, 2000). The scale included Likert items from 1 (*low grief*) to 5 (*high grief*). Alpha in this sample was .87. In the present sample the abbreviated GEQ correlated highly (above .70) with the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979) and the Complicated Grief Scale (Prigerson, 2002). Responses to the brief GEQ measure averaged 39.13 ($SD = 11.5$, actual range = 16 to 80).

The Inventory of Complicated Grief (Prigerson, 2002) included 12 items in Likert format, most of which were scored from 0 to 5 so that higher numbers indicated more complicated grief. In theory a respondent could have scored as high as 51. Responses averaged 27.75 ($SD = 8.9$, range = 11 to 51). Alpha in this sample was .89.

The 1998 Mid-Life Development Survey (Wethington, Kessler, & Brim, 1998) asked respondents a single screener question: "During the past year was there ever a time when you felt sad, blue or depressed for two weeks or more in a row?" Possible answers were the following: yes, no, or not depressed because of taking anti-depressant medication. Those indicating depression answered seven additional yes–no questions: During this period did you lose interest in most things? Did you feel more tired out or low on energy than is usual for you? Did you lose your appetite? Did you have a lot more trouble concentrating than usual? Did you feel down on yourself or worthless? Did you think a lot about death—either your own or someone else's or death in general—during this time? and Did you have any sleep disturbances? An 8-point scale created from these questions was internally consistent ($\alpha = .92$). Among all respondents, 355 (66%) reported some level of depression by answering affirmatively to the initial screener question. The depression scale yielded the following statistics: $n = 522$ (among all respondents offering useable answers to the scale), $M = 4.0$, $SD = 3.15$, range = 0 to 8.

Suicidal ideation was measured by one item: "How often during the past 12 months did you think about taking your own life?" Respondents could answer from 1 (*almost never or never*) to 5 (*very frequently*). Respondents reported rare to occasional suicide thoughts ($M = 1.75$, $SD = 1.11$).

The survey also included open-ended questions where respondents offered more information on their particular bereavement experiences. Respondents were asked to fill in the troublesome things said and done to them that had made their adjustments difficult.

Results

Table 1 presents the analysis of variance (ANOVA) of mean differences in stigmatization scale scores as a function of modes of death. The mean stigmatization score of suicide survivors (3.51) was similar to those of traumatic death survivors (3.15), and both groups tended to have higher mean scores than those for survivors for a child's death from natural causes (1.78). However, the omnibus ANOVA was non-significant at the .05 level, $F (2, 495) = 2.76$, $p = .06$, Cohen's $r = .11$. Table 1 also displays the ANOVA test results for the strain and harm subscales, which paralleled the overall scale comparison. Here, too, in both instances the differences were non-significant at the .05 level.

Grouping the suicide survivors with traumatic death survivors into a single category ($n = 498$), and comparing them to the natural death survivors, however, yielded significant differences. All traumatic death survivors were significantly higher in experiencing stigma ($M = 3.47$) than natural death survivors ($M = 1.78$), $F (1, 496) = 4.96$, $p = .03$, Cohen's $r = .10$. All traumatic death survivors were significantly higher than natural death survivors in experiencing strain ($Ms = 1.92$ vs. 1.09), $F (1, 529) = 4.16$, $p = .04$, Cohen's $r = .09$ and harm ($Ms = 1.52$ vs. .68), $F (1, 498) = 4.37$, $p = .04$, Cohen's $r = .09$. (These analyses were not included in Table 1.) Thus, after losing a child, all trauma survivors reported moderately higher levels of rejection and shunning by significant others than was reported by the survivors of a child's natural death. The data also suggested little difference in this respect between suicide survivors and other traumatic death survivors.

See Tables 2A and 2B for a display for suicide survivors only of each of the 11 family and social relationships and the levels of strain and support reported from those groups. Tables 2A and 2B also displays the groups offering the least (to the most) hurtful responses following the suicide death of a child. Over two-fifths

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TABLE 1 Overall and Subscale Stigmatization Means by Type of Death ($N = 540$)

Stigmatization	Suicide ($n = 462$)	Accidental/homicide/ ambiguous deaths ($n = 54$)	Natural causes ($n = 24$)	Total $n = 540$	f value/(df) Mean/n	p value (*Std. Dev.*)
Harmed & strained family & social relations (Actual range 0–17)	3.51/433 (3.2)	3.15/47 (3.0)	1.78/18 (1.7)	3.41/498	2.76 (2,495) (3.2)	.06
Strained family & social relations (Actual range 0–9)	1.94/456 (1.9)	1.87/53 (1.7)	1.09/22 (1.3)	1.89/531	2.11 (2,528) (1.9)	.12
Harmed family & social relations (Actual range 0–8)	1.54/434 (1.7)	1.23/47 (1.5)	.68/19 (1.2)	1.48/500	2.90 (2,497) (1.7)	.06

Note. Data taken from the Survivors Child Loss Survey, 2006–2007.

TABLE 2A Percent Experiencing Strained and Improved Relationships with These Significant Others Following the Loss of a Child to Suicide $(N = 462)^a$

Relationship	% reporting strained relations	Number[b,c]	% reporting improved relations
Children	16.5	407	63.9
Neighbors	18.6	388	22.9
Other relatives	19.3	383	24.8
Coworkers	22.1	339	28.6
Closest friends	22.1	440	48.4
Siblings	22.7	392	41.1
Spouse	23.6	339	58.1
In-laws	23.8	235	21.3
Parents	26.6	267	27.7
Less close friends	33.1	411	15.6
Ex-spouse	38.4	177	23.7

Notes. Data taken from the Survivors Child Loss Survey, 2006–2007.

[a]Each relationship group is listed in order of its occurrence of strained relations and unhelpful responses by percentage from lowest to highest.

[b]Each percentage was calculated from the number reporting a weaker or strained and/or harmed relationship divided by the total number reporting having that type of a relationship.

[c]Each percentage was calculated from the number reporting an improved relationship and/or helped response divided by the total number reporting having that type of a relationship.

TABLE 2B Percent Experiencing Unhelpful and Helpful Responses from These Significant Others Following the Loss of a Child to Suicide $(N = 462)^a$

Relationship	% reporting hurtful responses	Number[b,c]	% reporting helpful responses
Children	10.0	398	69.6
Closest friends	13.2	426	63.4
Spouse	16.6	331	67.4
Less close friends	17.0	407	24.3
Coworkers	17.4	310	40.0
Other relatives	17.6	353	27.8
Neighbors	17.7	362	24.3
Siblings	21.6	380	43.4
Parents	28.4	232	36.6
In-laws	31.8	211	30.8
Ex-spouse	44.0	141	21.3

Notes. Data taken from the Survivors Child Loss Survey, 2006–2007.

[a]Each relationship group is listed in order of its occurrence of strained relations and unhelpful responses by percentage from lowest to highest.

[b]Each percentage was calculated from the number reporting a weaker or strained and/or harmed relationship divided by the total number reporting having that type of a relationship.

[c]Each percentage was calculated from the number reporting an improved relationship and/or helped response divided by the total number reporting having that type of a relationship.

of ex-spouses and nearly one-third of in-laws expressed harmful responses to the parent survivor. Surprisingly perhaps, more than one-quarter of parents acted hurtfully.

About half of all suicide survivor respondents reported closer relationships with children, spouses, and close friends. Children appeared to be the most accepting and helpful category, even more than spouses, with only 10% acting unhelpfully. Close friends appeared as the second most helpful category with only 13% acting unhelpfully. Generally, between 10–20% of relationships included harm and around 20% were strained. Close to half of suicide survivors reported closer relationships to children, spouses, and close friends, with about two-thirds of these groups offering helpful responses.

Table 3 presents a multiple regression analysis of grief difficulties (GEQ). Independent variables included stigma, time since the death, and type of death (traumatic vs. natural). The beta weights suggest the relative importance of stigma. Together, all variables accounted for 26% of the variance of grief difficulties scores. In a separate equation, not presented here, we re-computed the same analysis without the stigma scale and the total R^2 dropped sharply to .13, suggesting the importance of stigma in explaining grief difficulties differences. We also completed an analogous multivariate test of these same three predictors against another dependent variable, the Inventory of Complicated Grief scale (not shown here). The presence or absence of the stigma scale again was associated with a similar differential in variance accounted for in Complicated Grief, declining from 27% to 12%, when the stigmatization variable was excluded, $t(497) = 10.83$, $p < .0001$.

TABLE 3 Multiple Regression Analysis of Grief Difficulties (GEQ Scores) by Stigma Scale Score, Time Since Death, and Type of Death

Independent variables	Corr. coefficient	Beta	p
Stigma scale score	.44	.42	.0001
Years since death	−.32	−.22	.0001
Type of death	.17	.12	.0030

Notes. Number of obstacles = 449; $F(3, 445) = 52.7$; $R^2 = .26$. Data taken from the Child Loss Survey, March 2006–May 2007.

TABLE 4 Multiple Regression Analysis of Depression by Grief Difficulties, Stigma Scale Score, Time Since Death and Type of Death

Independent variables	Corr. coeff.	Beta	*p*
Grief difficulties	.60	.47	.0001
Stigma scale score	.39	.18	.0001
Years since death	−.33	−.16	.0001
Type of death	.07	−.07	.0850

Notes. Number of obstacles = 439; $F(4,434) = 70.8$; $R^2 = .39$. Data taken from the Child Loss Survey, March 2006–May 2007.

Overall, depression was widely reported, with 66% of respondents reporting current depression on the initial screener question. When the loss was between 4 and 6 years ago, the depression rate was 66%; when the loss was 10 or more ago, the depression rate was 42%. In comparison, with the same screener question, 32% of a nationally representative sample of middle-aged adult women and 17% of men reported depression. In our sample the comparable depression rates by gender were 68% for women and 52% for men.

Table 4 presents a multiple regression analysis of the correlates of depression in our sample. The model included stigma, time since the death, type of death, and grief difficulties. All variables accounted for 41% of the variance. Type of death had a zero-order correlation with depression and did not contribute additional statistically significant variance to the multiple regression equation.

Table 5 presents a multiple regression analysis of the reported presence of suicide thoughts. The model included stigma, time since the death, type of death, grief difficulties, and depression. Type of death did not contribute uniquely to explaining variability in suicidal thoughts but the other variables explained 33% of the variance. All other correlates—grief difficulties, depression, time since the death, and the stigma scale—offered unique contributions to explain the overall variance of suicide thoughts.

One concern about the stigma scale relates to how long survivors would be able to accurately recall hurtful responses from significant others many years after losing a child. Over a longer course, as a relationship with a significant other might change, so might a survivor's recall of that person's helpfulness (or

TABLE 5 Multiple Regression Analysis of Suicidal Thoughts by Depression, Grief Difficulties, Stigma Scale Score, Time Since Death and Type of Death

Independent variables	Corr. coeff.	Beta	p
Depression	.50	.260	.0001
Grief difficulties	.51	.290	.0001
Stigma scale score	.33	.090	.0500
Years since death	−.27	−.090	.0300
Type of death	.07	−.002	.9600

Notes. Number of obstacles $= 437$; $F (5,431) = 70.8$; $R^2 = .33$. Data taken from the Child Loss Survey, March 2006–May 2007.

harmfulness). To investigate such changing perceptions, we replicated the same multiple regressions (presented in Tables 3, 4, and 5) including survivors who lost a child only within the last four years ($n = 235$). Results yielded the same pattern. Stigma was the strongest single correlate with grief difficulties and was significantly associated with suicidal thinking but not depression.

The open-ended questions yielded comments from between 80 to 85% of respondents. We grouped all comments into one of three valences: positive, approximately 15%; ambiguous, approximately 5%; and the remaining 75 to 85% were either negative or mixed negative, statements including negative with positive and/or ambiguous comments. We grouped the negative comments into one of seven types: (a) avoidance (expressed most frequently; e.g., "People avoided me"); (b) unhelpful advice (expressed by a majority; e.g., "It's time to move on"); (c) absence of caring (expressed by a majority; e.g., "no one asked me how I was feeling afterwards"); (d) spiritual (expressed by a minority, e.g., "God called him"). Although at first it might seem these remarks were ambiguous, respondents did not appear to take them that way. One male physician said, "If there was anything I found exasperating it was people saying 'He's with God now.' How do they know I'm a Christian?" An office manager said, "I was annoyed with people saying he's with God. I wanted him here with me now, alive." The other three types were (e) blaming the victim (expressed by a minority; e.g., "He was so reckless in how he lived"); (f) blaming the parent (expressed by a minority, e.g., "Didn't you see it coming?"); and (g) other negative (expressed by a minority; e.g., "Well at least he didn't kill anyone else when he died").

Discussion

Our assessment of stigmatization offers solid empirical confirmation of the important, previously unexplored assumption that stigmatization contributes to problems in the mourning process after suicide, as well as with other traumatic losses. Suicide survivors may not be surprised by this conclusion, knowing full well the damaging influence of societal stigmatization upon their healing.

Actually, more than four-fifths of present respondents had stigma scale scores of 6 or less. It would be hard to imagine anyone having all their significant others act harmfully (and having strained relations with them) following their loss. This simply did not happen. The main point seems to be that survivors EXPECTED their significant others to act supportively and helpfully following what they felt was the most devastating tragedy of their lives—the loss of their child. Even one significant others' negative response was felt as very troublesome to a survivor. As survivors found themselves in great psychological pain after the loss of a child or other loved one, and then finding strain or unhelpfulness where they expected solace and support, it was not surprising that empathic failures with friends and family may have exacerbated the grief of survivors (Neimeyer & Jordan, 2002). Finally, this analysis also suggests that the heightening of survivor grief difficulties may also place survivors at risk for depression and suicidal thinking.

Our qualitative data sheds more light on how survivors are stigmatized following the loss of a child. From a preliminary review of more than 200 of these comments, three recurrent themes in particular stood out: (a) "a wall of silence," where significant others studiously avoided all further discussions about the deceased child; (b) "the absence of a caring interest," where significant others rarely asked about survivors' well-being; and if they did, it was superficial, despite the fact that survivors had experienced what they thought was the most devastating tragedy of their lives; and (c) "unhelpful advice," where suggestions completely disregarded the long-term and transformative nature of the grieving process after suicide, such as by saying "It is time to move on" or "Why are you still going to that support group?" The qualitative comments these survivors expressed suggests some encountered extreme scorn from significant others. We

expect to complete a future paper systematically analyzing these qualitative comments (Feigelman, Gorman, & Jordan, 2009).

These findings point to important clinical implications. First, as a matter of course therapists need to query their bereavement patients about the kinds of social support they are receiving from their significant others following any traumatic death losses. It is precisely in those cases where supportive responses are missing that a compounding of a survivor's grief difficulties may ensue. Second, mental health practitioners may also need to encourage their patients to take stock of their intimate associates and help them evaluate which relationships may be worth preserving, and which may need to be temporarily avoided or even discontinued, given the toxicity of maintaining further association. Third, mental health practitioners also need to offer guidance on how survivors can "teach" their important intimates, who may be unable to get past their own fears and lack of familiarity with loss, on how to better support them. Clinicians and support group facilitators may also need to encourage survivors to show socially significant others how to act more supportively and allow these close associates sufficient opportunities to act more helpfully. In short, survivors may have to educate people in their social networks and show them how they can help while also accepting the possibility that some close associates will have a limited capacity to offer comforting responses. Fourth, interventions that directly involve members of the social network, such as couple, family and network interventions, may also have the potential to ameliorate some of the distress documented in this study (Jordan, 2001). Though it may seem paradoxical for grief-struck survivors to have to take a lead role in guiding their personal support network, it seems likely that, if they can marshal caring responses from their significant others, instead of avoidance and scorn, their healing can occur.

Our findings also suggest that after a loss, adult survivors can generally expect to find their most important grief assistance from children, spouses, and close friends. When these groups fail to offer the kinds of support needed, as our study suggests may happen in a considerable number of cases, then survivors will feel obliged to look for help elsewhere, probably from bereavement professionals and support group memberships. In another analysis of suicide survivors comparing those who were members of Internet support

groups to those that belonged to face-to-face groups exclusively, the Internet support group affiliates were likely to spend much more time in their support group, where they especially appreciated its 24/7 availability (Feigelman, Gorman, Chastain-Beal, & Jordan, 2008). They also reported greater grief difficulties and stigma from their close associates. These findings suggest that as survivors encounter more stigma and grief difficulties their needs for support group participation will rise, as well.

Our findings showing that one-fourth of the parents of survivors said something harmful and induced strained relationships may appear surprising and perhaps mistaken. Yet, this finding emerged twice in our results, once when respondents reported on their strained relationships, and again when they reflected upon the groups presenting the most harmful responses, suggesting it was not a statistical anomaly. These results may have occurred because older parents may hold traditional stigmatized views of suicide, and may be more inclined to hold their adult children responsible in the deaths of their grandchildren than would younger persons. Alternatively, there may be generational differences in coping styles, with older people employing more stoic and avoidant coping styles in dealing with traumatic events, as has often been noted about the parents of the depression era and World War II generation. These are speculative explanations, suggesting another important topic for future research: namely, to systematically investigate the general population to see how views of suicide and suicide stigmatization may be shifting across generational cohorts.

An additional important finding from the present investigation was the convergence with other studies that have shown more similarities than differences in the grief trajectory of survivors of different types of traumatic deaths (Jordan, 2001; Sveen & Walby, 2008). Our findings about the general similarities in the reported social stigmatization of suicide survivors and other types of traumatic death survivors supports the observation that there may be many similarities between the experiences of various types of traumatic loss survivors and confirms some of the recent work of Murphy, Johnson, Wu, Fan, and Lohan (2003), who noted more convergences than differences in the grief experiences of these two populations. Accordingly, we would suggest that the acts of suicide and those of homicide, drug overdose, vehicular accident

deaths, and other traumatic accidental deaths generally evoke similar responses among the significant others of survivors. Such traumatic losses may elicit fear, dread, and a sense of impending danger that "it could have happened to us, too" and for that reason, result in similar avoidance responses on the part of people in the social networks surrounding the survivors. It is also possible, in addition, that the absence of clear-cut social norms on how to relate to survivors of traumatic deaths, compared with the survivors of more commonplace somatic-illness deaths, may also contribute to avoidance responses. It is also possible that traumatic loss survivors engage in "self-stigmatization" (Dunn & Morish-Vidners, 1988), in which they assume that others are condemning them and thus either perceive the actions of others as reflecting negative judgments, or even act in ways that elicit avoidance and rejection from other people. Present correlational data do not permit the investigation of this complex and quite possibly circular causality in the social stigmatization processes that may occur after traumatic losses such as a suicide. These findings, as well as the others presented here, deserve further investigation.

Finally, the limitations of this study need to be taken into account. Although this sample is perhaps the largest sample of parental survivors of suicide loss ever studied, it is nonetheless a convenience sample that may not be representative of all survivors. In addition, the sample of non-suicide deaths was small. Although the response rate was acceptable for this type of study, we simply do not know whether these conclusions apply to all parent survivors, or just to those who agree to participate in survivor research, a group that, for example, may be more distressed than non-participating survivors. Secondly, we used simple, and in some cases, single-item measures in this study. Moreover, the stigma measure needs further psychometric development. Lastly, a cross-sectional and correlational study such as the present one can only demonstrate the association between stigmatization and a more difficult bereavement trajectory, not the direction of causality. Thus, it is quite plausible that higher levels of depression and grief difficulties may be the cause of more interpersonal strain and unhelpful responses from significant others in the survivor's social network, rather than being the result of social processes. Perhaps the most likely explanation is that events such as the traumatic death of a loved one may set up interactional feedback loops

in social networks in which depression and grief difficulties both result from and contribute to problems in relationships. Longitudinal designs in survivor research would help greatly in furthering our understanding of the likely complex and circular causality between psychological difficulties in the mourner and the interpersonal strains within their social networks.

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