

Bereavement after Suicide

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The loss of a loved one to death is widely recognized as a challenging stressor event, one that increases risk for the development of many psychiatric conditions. One key risk factor is the mode of death. This article briefly reviews the literature about the impact of suicide as a mode of death on those who are grieving this type of loss, known as suicide survivors. Within suicidology, the term “suicide survivor” has come to refer to a person who is grieving after the suicide of a loved one, not someone who has survived a suicide attempt. This article also describes some of the interventions that may be appropriate for survivors and offers general guidelines for the provision of compassionate bereavement care after a suicide.

RESEARCH ON THE IMPACT OF SUICIDE

The common observation that the suicide of a loved one can be a devastating loss is backed by a considerable body of research literature, as well as the many first-person accounts of survivors. Unfortunately, a clear definition of who

is a survivor has not really been formulated within suicidology. For the purposes of this article, a suicide survivor is anyone who is significantly negatively impacted by the suicide of someone in their social network. It is likely that the commonly used figure of six survivors for every suicide considerably underestimates the true number of survivors in the United States.¹ Crosby and Sacks² found that 7% of the U.S. population reported that they knew someone in their social network who had died by suicide within the last year. About 1.1% reported that they had lost an immediate or extended family member to suicide within the past year. Of course, exposure to suicide does not necessarily mean that the individual will be significantly negatively impacted by the death. Nonetheless, the data suggest that each year millions of people in the United States are exposed to a suicide and become potential suicide survivors. Unfortunately, the lack of a clear operational definition of a suicide survivor, along with a relative lack of interest in suicide survivors within suicidology, has meant that a community-based longitudinal study to determine the extent of impact of suicide has yet to be done.

A number of literature reviews have found that, in addition to the sorrow and yearning that are common after all losses, suicide survivors often show high levels of distress in several domains of their functioning. First, and perhaps foremost, is the elevated risk of suicidality. Several studies have confirmed that exposure to the suicide of a loved one is associated

with an elevated risk of suicide completion in survivors. For example, Crosby and Sacks² reported that people who had known someone who died by suicide within the past year were 1.6 times more likely to have suicidal ideation, 2.9 times more likely to have suicidal plans, and 3.7 times more likely to have made a suicide attempt than those who did not. Similarly, in a series of large sample studies of the national health registries in Denmark, Agerbo, Qin, and their colleagues have documented the increased risk of completed suicide among people who have lost an immediate family member to suicide.^{3,4} Several studies have found similar phenomena in adolescents, whether exposed to the suicide of a family member³ or a peer.^{4,5}

Beyond this, many studies have found high rates of problematic grief experiences in survivors, such as intense guilt or feelings of responsibility for the death, a ruminative need to explain or make sense of the death, strong feelings of rejection, abandonment, and anger at the deceased, trauma symptoms, complicated grief, and shame about the manner of death.⁶⁻⁹ There has been some debate within the literature about whether and in what ways bereavement after suicide is qualitatively and/or quantitatively different from mourning after other types of deaths.^{4,5} Although more research into this question is needed, the available literature and clinical experience suggest that suicide bereavement contains what Jordan⁴ has called thematic issues that are likely to be more prominent and in-

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tense after a suicide than after most other types of loss. It is also true that bereavement after suicide shares many aspects of the grief response seen after other types of bereavement, particularly after other sudden, violent deaths such as homicides, accidents, and natural disasters.^{8,9} A recent literature review by Sveen and Walby examined 41 controlled studies comparing suicide survivors to survivors of other types of losses.⁶ The authors concluded that there were few differences to be found on mental health outcome variables such as depression or anxiety symptoms, but more reliable differences on several grief specific variables such as shame and stigma, rejection, blaming, and guilt/responsibility early on in the mourning process. This reinforces Jordan's point⁴ that the subjective experience of suicide survivors is often different than that of survivors of more natural and expected deaths, even if this is not detected by standardized measures of psychopathology.

The next section will briefly describe some of the thematic issues that are likely to be more intense and prolonged in survivors of suicide loss.

PROMINENT THEMATIC ISSUES FOR SUICIDE SURVIVORS

"Why?" and Guilt/responsibility

The suicide of a loved one frequently unleashes an emotional tsunami of guilt and self-reproach in survivors. Suicide can be understood as shattering the assumptive world of the survivor, meaning the foundational beliefs about one's world. For example, a mother whose 15-year-old son hanged himself in his bedroom after an argument with his parents was struggling with whether her son had intended to die. As she commented, "If the answer to that question is yes, then it means that I didn't know my son." In essence, her son's death had profoundly called into doubt who her son was, the nature of their relationship, and her own

identity as a "good" mother. As an often inexplicable death for many survivors, the need to make sense of the frame of mind and motivations of the deceased are major preoccupations for many survivors. In the author's experience, most survivors overestimate their own role in contributing to the suicide or in failing to prevent it. Survivors are frequently unaware of or minimize the many other factors that may have contributed to the suicide, including the fact that up to 90% of people who die by suicide meet criteria for a psychiatric disorder.⁷ This intense need to conduct a personal psychological autopsy is a hallmark of bereavement after suicide. It helps the survivor to make sense of the death and place in perspective the role the survivor played in the suicide, both deeply troubling issues in the wake of a suicide. It may also help survivors come to terms with the incomplete knowledge and unanswerable questions that accompany many suicides.

Shame, Stigma, Social Isolation, and Family Relational Disturbance

Mourning after a suicide can become a profoundly isolating experience, one that may have a significant and quite deleterious impact on the survivor's relationships with family and friends. Cerel, Jordan, and Duberstein⁸ have noted three types of communicational distortion that may occur in families and social networks after a suicide. These include the development of blame for the suicide, the perceived need to keep the suicide a secret (particularly from children and people outside the family), and social ostracism and self-isolation among survivors. The emergence of angry blaming can severely impact the cohesiveness of a family and should be considered a significant warning sign of family distress after a suicide. Likewise, the choice to keep the nature of the death a secret may distort other areas of family intimacy and warp longer-term developmental

processes in the family.⁹ There is also considerable evidence that suicide survivors experience more stigmatization from their social networks than survivors of most other types of death.¹⁰ Although some of this may be outright condemnation, much of it is also the social ambiguity created by suicide bereavement. Many members of the community do not know how to help, and therefore avoid contact with the bereaved, a response that Dyregrov¹¹ has labeled "social ineptitude" in the network. Survivors may also "self-stigmatize" and avoid contact with friends and family out of a sense of shame and guilt around the death.¹² All of these factors may make the usual sources of social support, both within families and from the larger community, more problematic after a suicide.

Perceived Rejection/abandonment by the Deceased

The causality of suicide is multi-determined and often difficult to ascertain. Reflective of this uncertainty is the confusion felt by many survivors about whether to view suicide as a choice or an act to which the deceased was driven by mental illness and/or life circumstances. This ambiguity may then contribute to distress about whether the survivor's feelings, such as fury at the deceased, are "appropriate." When seen as voluntary, the suicide may be construed as either a willful rejection or an abandonment of the survivor, and therefore likely to generate intense anger at the deceased or profound feelings of unworthiness about the self.

Horror/trauma Symptoms

As with other violent deaths, suicide survivors often experience trauma symptoms of horror about the manner of death, along with the signs of the intrusive reliving and avoidance behaviors that are typical of posttraumatic stress disorder (PTSD).¹³ Rumination about the emotional and physical suffering of

the deceased at the time of the death is very common. This is likely to be intensified if the survivor either witnessed the suicide or found the body, although many survivors will show these symptoms even if they were not eyewitnesses to the death scene. The comorbidity of PTSD symptoms with other grief responses is likely to complicate the clinical picture and require the use of specialized treatment techniques to deal with the traumatic symptomatology.

Complicated Grief and Suicidality in the Survivor

As mentioned previously, the evidence suggests that exposure to the suicide of a loved one increases the risk of suicidality in survivors. In addition, there is growing evidence that mourning resulting from any cause of death is associated with higher levels of suicidal ideation, particularly when the mourner develops complicated grief (CG), (also known as prolonged grief disorder). Complicated grief is a syndrome characterized by intense and unremitting yearning for the deceased, coupled with trauma-like symptoms such as numbing, feeling life is meaningless without the deceased, and difficulty accepting the death.¹⁴ There is also recent evidence that suicide survivors are more likely than natural death survivors to show symptoms of CG.¹⁵ Clinical practice, along with this emerging data, indicates that many suicide survivors will experience at least some suicidal ideation after the death of their loved one, particularly when associated with comorbid CG.¹⁶⁻¹⁸

INTERVENTIONS TO HELP SUICIDE SURVIVORS

Jordan and McMenamy have recently reviewed the research on interventions to provide assistance to suicide survivors.¹⁹ Research that inquires about the self-perceived needs of survivors suggests that among the greatest concerns are buffering the impact of the suicide on children

in the family, dealing with trauma symptoms, difficulties finding suicide specific support services, and problems in family communication after the suicide.²⁰⁻²² Unfortunately, Jordan and McMenamy concluded that there appear to be very few studies of interventions specifically designed to help suicide survivors. In the nine studies that they were able to locate, the interventions generally showed some positive impact, although typically on only a few of the outcome measures employed. It is also worth noting that, although not suicide specific, there have been promising developments in the past 5 years in the treatment of syndromal CG, PTSD, and substance abuse disorders that are likely to have applicability to suicide survivors.^{23,24} In general, there is an unfortunate dearth of controlled studies of interventions that are specifically designed to help survivors of suicide loss.

Types of Interventions for Survivors

Despite the lack of controlled empirical support, clinical experience has highlighted a number of interventions or programs that may be of help to suicide survivors. A small amount of survey data suggest that either individual therapy with a mental health professional, or a bereavement support group (both peer or professionally led), are the most common interventions offered to suicide survivors.²¹⁻²³ Individual counseling may be most necessary when the survivor is deeply traumatized and/or at risk for suicide themselves; when they develop CG or another psychiatric disorder; or when there are other complicating circumstances (eg, a hostile family environment in which the survivor is blamed for the suicide). Additionally, individual therapy may be indicated when no support group is available, or when the survivor is reluctant to participate in a support group intervention. A variant of individual therapy that may be very useful is conjoint family therapy with

survivor families.²⁴ When facilitated by a competent clinician, such meetings can provide invaluable psychoeducation about the causes of suicide and its impact on the family system, and help to promote open communication and good bereavement self-care for all members of the family.

Contact with other survivors, most often through participation in peer or professionally led support groups, appears to offer a highly valued resource for many survivors.²¹ Support groups can provide a safe harbor to compare and normalize experiences, reduce the sense of social isolation and stigma, learn more about suicide and suicide bereavement, and receive non-judgmental support for one's grief. Finding a suicide specific support group may sometimes be difficult. The American Foundation for Suicide Prevention (AFSP) now offers a training program and self-study manual for lay persons and professionals wishing to start such a group (see www.afsp.org). In addition, internet support resources for survivors are also developing.²⁵ Likewise, bibliotherapy can be a valuable resource, as can local crisis hotlines, particularly ones that are organized around suicide prevention, which may be able to provide linkage to other programs for survivors. Finally, a new service that shows promise is the development of survivor to survivor outreach programs, in which trained survivor volunteers, sometimes accompanied by a mental health professional, provide in-home support for new survivor families.²⁶ There is also new evidence that recipients of such services are much more likely to subsequently access additional support services and to do so in a much shorter time period.²⁷

GUIDELINES FOR CLINICAL WORK WITH SUICIDE SURVIVORS

The Clinician as Survivor

The complex legal, ethical, and psy-

chological issues involved in losing a patient to suicide is beyond the scope of this article, and the reader is referred to more comprehensive discussions of these matters.^{28,29} Mental health professionals are no more immune to becoming survivors than anyone else, and clinicians may experience all of the reactions that are typical of other survivors. Therapists who lose a patient to suicide should seek consultation from a trusted and experienced colleague who can serve as a sounding board and source of emotional support to help work through the clinician's own reactions to the death, while also consulting on the most helpful response to the survivors impacted by the death. They should consider the advantages and potential problems in providing care for the family of the deceased. Many survivors will welcome contact with the treating clinician as they seek to make sense of the death and process their own grief.²⁸ Generally, clinicians should proactively offer to meet with family members after a suicide unless there are clear reasons to not do so. The clinician can provide support, help to normalize the reactions of family members, provide referrals to community resources, and within the bounds of confidentiality, offer a perspective on the suicide that may assist family members in reducing their confusion, guilt, or anger about the death. The meeting(s) may also be helpful to the clinician in processing their own grief.³⁰ Impacted professionals might also consider enlisting the assistance of an experienced colleague who was not directly involved with the case to facilitate the meeting(s) with the family, thus lessening the burden on the grieving clinician to be a caregiver while also dealing with their own reactions.

Therapeutic Work with Survivors

This next section provides guidelines for providing ongoing therapeutic services to survivors, whether the treating clinician was directly involved with the

deceased or not. First, an examination of one's own attitudes about suicide is in order, including the clinician's beliefs about the causation of, responsibility for, and morality of suicide. All of these are likely to be activated in work with survivors. In addition, the clinician should be prepared to revise their assumptions about mourning and the role of professional help in facilitating recovery after a suicide. For example, it is likely that the intensity and duration of the psychological pain experienced by many survivors will exceed that of more normative types of losses, as well as the expectations of the clinician who is not familiar with grief after a suicide. The ability to be "present" with the pain of survivors, without a rush to fix the problem, is a crucial skill in working with traumatic bereavement. Likewise, the goals of therapy with survivors are not so much resolution of grief, but integration of the loss into the survivor's life narrative, so that they are able to bear the loss while still reinvesting in life. Most survivors will be better served by an intervention model that is conceptualized as long-term "expert companionship" with survivors as they learn to psychologically carry the loss,³¹ rather than a medical model of short-term, crisis-oriented "treatment" of acute psychiatric disorder. This is particularly true for the issues of guilt and abandonment, resolution of which can be a complex and lengthy process for many survivors. The central role of a compassionate, empathic, and patient therapeutic relationship in facilitating the long term healing process for survivors cannot be overstated.

Second, there is an important function for psychoeducation about the nature of psychiatric disorder and its role in contributing to suicide that can be invaluable to survivors. This perspective can help survivors make sense of the death and put into realistic perspective their guilt and feelings about the preventability of the suicide. Likewise,

many bereaved persons have unrealistic expectations about the grieving process (eg, grief should be over in a year, everyone should grieve the same, etc.) that can be corrected with accurate information about the unique bereavement trajectory taken by each mourner.

Third, clinicians should be ready to address issues that are common among suicide survivors. The horrific manner of death in some suicides may lead to clinical levels of PTSD and impede the healing process. Trauma reduction techniques such as eye movement desensitization and reprocessing³² and prolonged exposure therapy³³ may be helpful in the course of treatment. Likewise, since suicide is often experienced as a rejection, betrayal, or rupturing of the relationship with the deceased, relational repair techniques in which the mourner symbolically deals with unfinished psychological business while also reworking the relationship into an adaptive "continuing bond" with the deceased can be enormously helpful to survivors. Treatment models that incorporate techniques such as "empty-chair" conversations³⁴ or letter writing to the deceased³⁵ are examples of this approach. As previously mentioned, contact with other survivors through support groups, online chat sites, and other venues appears to be very helpful in reducing the stigma, isolation, and bewilderment experienced by many survivors. Clinicians should be familiar with resources for survivors in their community and encourage participation with those resources when the client is ready to do so (see www.afsp.org and www.suicidology.org for resources).

Lastly, clinicians should be mindful of the potentially devastating systemic impact of a suicide on family systems.^{4,8,24} Psychoeducation efforts should be directed not just toward individuals, but toward the family as a unit. Gathering information about the functioning of all family members (including children and adolescents) and providing appropriate

treatment or referrals are a necessity. Clinicians should be particularly vigilant about the development of symptoms of PTSD, complicated grief, and suicidality in any of the impacted family members. Education about differences in grieving styles and the expectable tensions this may create in family relationships can be helpful in minimizing the impact of the suicide on family functioning. Joint marital or family meetings can be invaluable in fostering mutual support and open communication of bereavement needs among family members.

SUMMARY AND CONCLUSION

Not all persons exposed to suicide will develop problems and require professional intervention. Nonetheless, the evidence clearly suggests that suicide can be one of the most catastrophic of losses, one that requires extra vigilance and outreach on the part of caring mental health professionals. A portion of the considerable empirical evidence to support this assertion has been reviewed here. More research is needed to determine the extent of the impact of a suicide on social networks, which survivors are at greatest risk for developing complications after the death, and in identifying effective interventions to help those who are suffering the most. Jordan and McMenamy¹⁹ have called for a research program focused on what survivors already do to cope, as well as the study of the existing support resources that have evolved (such as peer-led support groups). From that foundation, specific and targeted interventions for survivors can be developed. This empirically grounded base, along with a growing awareness of the sequelae that survivors may experience, can promote the growth of compassionate and effective support resources for those who lose a loved one to suicide.

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