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## Bereavement after the suicide of a significant other

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### ABSTRACT

**Context:** It is estimated that approximately one in four people know someone who has taken their own life and that one suicide death leaves six or more suicide survivors.

**Aims:** The aim of this paper was to review the literature regarding the association between suicide and bereavement, focusing also on the supportive and therapeutic resources available for survivors.

**Materials and Methods:** Careful MedLine and PsycINFO searches for the period 1980-2013.

**Results:** The review of the literature indicates that emotional turmoil in suicide survivors may last a long time and, in some cases, may end with their own suicide.

**Conclusion:** Future research should evaluate the efficacy of professional treatments and of support groups targeting suicide survivors.

**Practice Implications:** It is crucial to understand the bereavement process after the suicide of a significant other in order to provide proper care, reduce stigma, and improve the outcomes of related psychiatric conditions.

**Key words:** Grief, psychache, suicide, survivors

### INTRODUCTION

The “survivors of suicides” (or “suicide survivors”; in this paper we will consider these two terms interchangeably) include family members and friends who experience the loss of a loved one.<sup>[1,2]</sup> It is estimated that approximately one in four people know someone who has taken their own life and that one suicide death leaves six or more suicide survivors.<sup>[3,4]</sup> As Shneidman noted, suicide survivors represent the largest mental health casualty area related to suicide.<sup>[2,5]</sup>

The SOS Handbook for Survivors of Suicide published by the American Association of Suicidology reports that the trauma

of losing a loved one to suicide is “catastrophic”.<sup>[5-7]</sup> The grief process is always difficult, but a loss through suicide is like no other. It is shocking, painful, unexpected, and more challenging for several reasons.<sup>[3]</sup> For example, suicide can isolate the survivors from their community and even from other family members,<sup>[8,9]</sup> a situation exacerbated by stigma,<sup>[10]</sup> or the survivors may experience mixed emotions. On one hand, the suicidal act may seem like an assault on or a rejection of those left behind.<sup>[3]</sup> On the other hand, survivors may blame themselves for failing to predict the death or to have effectively intervened.

The risk of becoming depressed and/or abusing alcohol/

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substances is increased after the loss of a partner to suicide.<sup>[11,12]</sup> However, mental health symptoms usually subside after the first 3 years following the suicide, although sometimes the unbearable psychological pain of survivors may lead them to consider suicide and to ultimately take their life if they are not provided with help from adequate programs of assistance.<sup>[13,14]</sup> Suicide risk is elevated after stressful life events such as the death of a partner or even a twin from any cause.<sup>[12,15]</sup>

The aim of this paper is to review the literature regarding the associations among suicide bereavement, mourning, and risk of suicide in survivors; while also focusing on supportive and therapeutic resources available for suicide survivors.

## MATERIALS AND METHODS

We performed careful MedLine, PsycINFO, and TRIP searches for the period from 1980 to 2013. The following search terms were used: “survivors”, “bereavement” OR “mourning”, “suicid<sup>sm</sup>” (which comprises suicide, suicidal, suicidality, and other suicide-related terms). Each category was cross-referenced with the others using the MeSH method (Medical Subjects Headings). Those studies published in English peer-reviewed journals that added an original contribution to the literature were included.

## RESULTS

### The risk of suicide by survivors

Krysinska noted that suicidal behaviour may be precipitated by an individual’s experience of the loss of a loved one from suicide.<sup>[2,16]</sup> Suicide bereavement has certain typical characteristics that comprise the “suicide survivor syndrome” and may be linked to an increased risk of suicidal ideation and behaviour.<sup>[17,18]</sup>

Several factors at the individual level (e.g., the sex and age of the bereaved, the age of the deceased, and the method of suicide), the family level (e.g., transgenerational patterns, the current stage of the family life cycle, the role and the position of the deceased member inside the family structure and hierarchy, and whether the family was functional or dysfunctional before the suicide), and at the global level (e.g., rituals around bereavement, the social network of the bereaved, cultural and religious influences, possible stigma or taboo within the society, and political or economic factors) may influence the course of bereavement.<sup>[19]</sup> Survivors need more time to overcome the grief following the loss of somebody from suicide than from other causes of death.<sup>[20,21]</sup> Shneidman<sup>[22]</sup> argued that the real motive for suicide is mental pain (i.e., “psychache”). Suicide is often not an action to seek death, but rather to escape from unbearable mental pain. Bereavement is a stressful life event that increases the risk of many causes of

death,<sup>[23]</sup> including suicide.<sup>[24,25]</sup> Research has documented that the time period following the suicide is critical. For instance, suicide decreases in widows and widowers after the first year of widowhood until it is similar to the suicide rate of those who are not widowed.<sup>[24,26]</sup>

Using Swiss mortality statistics for the period 1987-2005, Ajdacic-Gross *et al.*,<sup>[27]</sup> examined the effect of time on suicide rates following the loss of a partner by any cause in widows and widowers – after one week, one month, and one year. The suicide rates were highest in widowed persons during the first week after bereavement: 941 per 100,000 per year in men and 207 per 100,000 in women. The corresponding standardized mortality ratios (SMR) were approximately 34 and 19, respectively. In the first months after bereavement, the rates and the ratios rapidly, then gradually decreased; however, they did not reach baseline levels during the first year after bereavement except in older widows.

The dramatic increase in the SMRs in Ajdacic-Gross’s study surpasses the odds ratio for the onset of major depression immediately after bereavement, which was reported to be 15.<sup>[28]</sup> The study also confirmed findings from earlier research that demonstrated that the suicide rates in young widowed persons were much higher than the suicide rates in older widowed persons.<sup>[12,29-31]</sup> The finding that suicide after bereavement is more frequent in men than in women applies only to older widows and widowers.<sup>[32]</sup> For younger adults, widowhood seems to be similarly as stressful for both young men and women.

### Grieving after a suicide

It is critical to determine whether or not bereavement following a suicide is different from the grieving after other types of deaths. Some researchers have argued that the differences may be minimal and that the loss of a loved one by suicide is no more burdensome as other losses;<sup>[33]</sup> whereas, others have suggested that suicide bereavement has three distinct characteristics<sup>[34]</sup> including; (i) the thematic content of the grief, (ii) the social processes surrounding the survivor, and (iii) the impact that the death has on family systems.

Farberow<sup>[21]</sup> noted that there are two emotions that are common in survivors of suicide, namely, feelings of guilt and shame and, in addition to the pain and suffering, there is also the unending question “Why?”. The fact the suicidal death is the result of a choice, causes a series of questions that a death from a disease does not. Family members, who experience the suicide of a loved one, face not only the typical reactions that follow the death, but also unique experiences.

### Recurrent images

One of the most common manifestations is the reexperiencing of images at the scene of the suicide. Actually seeing the body of the dead person may result in recurring nightmares involving the scene of death.

### Questions

Every death raises many questions, but a death from suicide inevitably leads to a continuous search, for an explanation of the tragedy, since the reasons which led their loved ones to this extreme action are often unknown. Each family member may formulate a different explanation, and this often can put a strain on family relationships.

### Guilt and shame

Grad and Zavasnik<sup>[33]</sup> wrote that suicide obviously provokes a turmoil of different emotions and some of them are ambiguous and difficult to differentiate. Two feelings commonly reported by survivors are shame and guilt. However, these feelings take many forms which are often expressed as self-blame, depression, humiliation, rejection, abandonment, loss, worthlessness, failure, embarrassment, unlovability, and others. Farberow noted that “shame may be one of the most basic affects in the area of suicide, so it is of interest that one searches almost in vain for the topic of shame in clinical or theoretical presentations in conferences on suicide and crisis intervention” (p. 157).<sup>[35]</sup>

### Sense of rejection and abandonment

Survivors often feel rejected and abandoned by those who take their own lives. The sense of rejection may lead survivors to think that they are worthless. Thus, they may isolate themselves from those who could bring relief and provide support.

### Shame and isolation

Most people do not want to talk about suicide. In general, people think it is better not to say anything, hoping that, by ignoring the suicide, survivors will get over the trauma more quickly. However, the silence that surrounds survivors places them in danger of further shame. If others are embarrassed, uncomfortable, and evasive; it is inevitable that survivors will feel isolated and want to protect themselves. Group therapy is often useful for survivors in this predicament because it provides them with social support.

### Farewell messages

The person who commits suicide often leaves a note. If this expresses affection, asks forgiveness or somehow exempts from liability those who remain, this can be a source of comfort. If the suicide was entirely unexpected, a note can at least eliminate any uncertainty about whether it is a suicide or not. However, these suicide notes can sometimes be unpleasant and painful and place the blame on somebody in particular. It is important to help survivors remember that the words reflect only a mood at a specific time. The note does not always help to explain the reasons for the act, but it can be even more heartbreaking not to find any message providing an explanation at all.

### Stigma

Several researchers have demonstrated that stigma plays an important role in bereavement after a suicide.<sup>[36,37]</sup> For example, Cvinar<sup>[8]</sup> noted that “the act of suicide has profound impact on the surviving family, friends, and associates of the victim [...].<sup>[8]</sup> One of the underlying elements that may contribute to the difference between those who grieve following a death by suicide and those who grieve following a natural death is the role of stigma in shaping behavioural and emotional responses in the period following the suicide” (p. 20).

In a study of 17 suicide survivors aged 26-54, 11 of whom had experienced the suicide of a parent and six experienced suicide of a sibling; Demi and Howell<sup>[38]</sup> found that “stigma was reported by the majority of the respondents” and was generally “expressed as feeling ashamed or tainted” (p. 353).

Harvey<sup>[39]</sup> documented that some bereavement experiences are “more intense or unique to suicide” (p. 213), and defined four specific bereavement experiences that are unique to suicide survivors: Stigma, blame, search for meaning, and being misunderstood. Stigma appears to be “an initial global reaction when someone learns of a suicide or suicide attempt” (p. 213).

### Therapists as survivors of suicide

The emotions experienced by suicide survivors in the family are similar to those experienced by mental health professionals. Additionally, mental health professionals may also react with emotions related to their profession, such as failure of personal responsibility, decrease in self-esteem, disrupted relationships with colleagues, social withdrawal and/or isolation, and questioning one’s skills and clinical competence. For trainees and newly-minted professionals, there may be added stress resulting from being under constant observation and evaluation, as well as concerns of potential criticisms from supervisors and academic faculty.<sup>[14]</sup> For example, Chemtob *et al.*,<sup>[40]</sup> examined 259 randomly selected psychiatrists who reported that a patient’s suicide had a significant impact on both their personal and professional lives, often leaving them with feelings of anger about the suicide, with some being affected for several years after the event. Moreover, many of the psychiatrists reported posttraumatic stress symptoms as well as distressed relationships with colleagues and friends, and social withdrawal that persisted for 6 months or longer after the death.

Bultema<sup>[41]</sup> estimates that for every publication reporting therapists’ reactions to such losses there are at least 25 articles describing the reactions of relatives’ bereavement after the suicide of a loved one. Such losses for therapists occur in practically all mental health disciplines and in all kinds of settings such as office practice, hospitals and

clinics; and for all sorts of therapists in training, including residents, interns, and trainees.

Research on therapists as survivors indicates that the frequency of the loss of a patient by suicide may range from 22 to 51%.<sup>[40,42-45]</sup> Chemtob *et al.*,<sup>[46]</sup> conducted a national mail survey of 365 psychologists, randomly selected from the National Register of Health Service Providers in Psychology, and found that 22% reported that they had had a patient who died by suicide. The researchers estimated that 39% of the psychologists would experience another patient suicide in their career. Almost half of the psychologists reported posttraumatic stress symptoms that did not subside until at least 6 months had elapsed.

Few events in medical practice engender such a sense of failure and guilt as the suicide of a patient.<sup>[47]</sup> On the personal level, the first reactions of the therapist are usually similar to those of family survivors. Anger may be directed at the patient, at self, family, or at police, press, or insurance companies if they are involved. The feelings related to one's professional role appear as feelings of failed responsibility, self-blame and guilt, loss of self-esteem, self-doubts about one's skills and clinical competence, fear of being blamed for the suicide, and fear of relatives' reactions. There may also be fantasies of unspoken criticism by colleagues (or supervisors), self-accusatory thoughts of omission and/or commission, and intrusive thoughts and dreams related to the suicide. Concerns about malpractice and legal issues often emerge. Changes in professional practice may result in the form of greater conservatism in the handling of patients and record-keeping, hospitalization of low-risk outpatients, and refusal to accept referrals of any patients known to have suicidal tendencies. Gender differences may also emerge, with female professionals; according to one survey, stating more often than their male counterparts that they had felt ashamed and guilty after a patient's suicide, needed more consolation, and had more doubts about their professional knowledge.<sup>[47]</sup>

Kahne<sup>[43]</sup> surveyed psychiatrists at McLean Hospital in Boston and estimated that one in every four of those working psychotherapeutically with hospitalized psychiatric patients would experience the death by suicide of a patient at some time in their career. Kayton and Freed<sup>[48]</sup> found that the psychiatric hospital staff reacts with the same patterns of feelings as has been reported for outpatient therapists. Clinically, there were tendencies for mental health professionals to be overcautious with their patients, to initiate suicidal precautions and one-on-one monitoring prematurely, and to become overly restrictive in terms of patient management. The reactions of other patients on the same ward were also of interest. Although feelings of shock and disbelief were common, there was also anger directed towards the staff for not having protected the patient from harm. Grad *et al.*,<sup>[49]</sup> reported

gender differences in hospital staff who had experienced a suicide with regards to handling emotions, with women reporting guilty and shameful feelings more often than men. Moreover, the most often reported coping strategy for women was to talk to other staff members; whereas men found that immersing themselves in their work, as well as talking with other staff members, was most helpful.

### Interventions for people bereaved through suicide

#### *The role of postvention*

Shneidman coined the word 'postvention' to describe the appropriate and helpful acts that come after the dire event.<sup>[50,51]</sup> Postvention consists of those activities that serve to reduce the after effects of a traumatic event in the lives of survivors. Its purpose is to help survivors live longer, more productively, and less stressfully than they are likely to do otherwise.

Conducting a psychological autopsy has been reported to be a beneficial way of assisting suicide survivors. The psychological autopsy method involves a retrospective investigation of the deceased person; the use of psychological information gathered from personal documents; and interviews with family members, friends, co-workers, school associates, and healthcare providers to classify equivocal deaths or establish diagnoses that were likely present at the time of suicide. In a personal communication, Shneidman conveyed to one of the authors (MP) that "The psychological autopsy introduced the psychological elements in the study of suicide. Before that, suicide had been studied anecdotally and demographically, but no emphasis had been placed on the psychological life of the deceased".

Research on the outcomes of postvention has not been encouraging, with several reviews demonstrating that interventions targeting bereavement have little or no efficacy.<sup>[52-54]</sup> For example, McDaid *et al.*, conducted a systematic review of clinical trials for individuals experiencing bereavement over a suicide.<sup>[55,56]</sup> The eight studies identified included one controlled study, four randomized controlled clinical trials, and three observational studies with a control or comparison group; one of which was retrospective in nature. McDaid *et al.*, reported that there was only a minimal benefit observed from interventions for people bereaved by suicide when compared with no intervention. Moreover, the results from studies comparing two or more active bereavement interventions were unclear.

Interventions targeting suicide survivors should provide a flexible, personalized approach which takes into account the extreme variability in distress experienced by each individual.<sup>[57]</sup>

In addition to structured interventions, clinicians and mental

health professionals who experience the death of a patient are in an important position to help survivors, especially given that few suicide survivors seek professional help after their loss.<sup>[58]</sup> Emergency physicians can also play a major role in supporting people who have lost a loved one to suicide. However, as Isaacs and D'Souza<sup>[59]</sup> have indicated, emergency department (ED) personnel need a rehearsed, systematic, and consistent approach for addressing grief. It is important to note that there are many components that should be considered when providing care to bereaved family and friends. First; personal issues of guilt, failure, and fear of death must be addressed and personally acknowledged internally before approaching the family. Caregivers must transit from coping with a medical crisis to responding to a family's emotional trauma in the hours following suicide. Moreover, it is often beneficial for an emergency physician to enlist the assistance of a nurse, chaplain, or social worker to share the emotional demands of the encounter with the family in the aftermath of a suicide. The family should be greeted immediately by an ED staff member, whenever possible, who can remain with them throughout their stay. The attending physician who cared for the dying patient is responsible for telling the family about the patient's death. However, sufficient time is necessary to communicate about the death to the family in a careful and caring way. It is important for the emergency physician to inquire about any relevant patient information, which often becomes difficult to obtain after the death has been acknowledged. Thus, the ED physician should then briefly convey to the family the problems that occurred, the actions taken, and the patient's response to each intervention, including the rescue squad's efforts. The gentle and gradual delivery of factual information is of utmost importance as it facilitates an intellectual acknowledgment of death, to which survivors can react with normal grief. Physicians must make an effort to provide adequate time for the family to absorb the information and, when the family is ready, to ask them if they have any questions. ED personnel must be prepared for different expressions of grief following the news of death, including calm or hysteria, shock, anger, disbelieving, numbness, crying, and even with violence. It is critical that physicians' responses be adapted to the needs of each specific situation.

Isaacs and D'Souza<sup>[59]</sup> noted that showing the body of the beloved to the family members can be painful but can reduce prolonged grieving by creating an increased sense of the reality of death. Physicians may need to provide the family members with explicit permission to touch the deceased. When the body is mutilated, viewing should be offered; however, families should be warned beforehand. It is often necessary to bandage the injured area in order to minimize the disfigurement. If possible, some whole body areas should be available for the family to touch. Finally, emergency physicians should provide the family with an opportunity to ask last minute questions. However, when

nothing more remains for the family to do, they should be told that they are welcome to stay as long as they wish, but that staying longer is not necessary.

If the suicide was a psychiatric patient, psychiatrists should consider the advantages and potential problems in providing care for the family of the deceased.<sup>[60]</sup> In many cases, survivors will appreciate the treating clinician's support as they seek to make sense of the death and process their own grief.<sup>[7]</sup> Clinicians may offer to provide referrals to community resources and support groups. Additionally, condolence cards from the psychiatrist, expressing caring and sympathy, are usually well received positively.<sup>[60]</sup>

#### *How to behave with a person who has lost a loved one from suicide*

Every person who commits suicide is responsible for having chosen death. The most important and useful thing that we can do for survivors is to listen to what the survivors tell us, without judgment or criticism. Because of the stigma, survivors are often reluctant to open up or to share their story and their feelings with others. Although it may be uncomfortable to discuss suicide and its consequences, the survivors need to be freed from their pain. It is important to be patient and to let them speak at their own pace. It is also better to use the name of the loved one who committed suicide rather than saying "he" or "she", so as to acknowledge that the deceased was a real person. This will comfort the survivors. The journey to overcome pain is unique to each survivor, and it is an error to force the process into preconceived stages, suggest what to do or how to feel, or even worse, suggest that by some specific time the survivor should already feel better. Statements like "I know how you feel" and "I understand" should be avoided unless the individual providing support is also survivor.

#### **The importance of self-help support groups for those bereaved by suicide**

Self-help support groups are a powerful and constructive way for people to share their stories in order to help themselves and each other. Research has shown that the groups significantly contribute to positive outcomes and there appears to be an increasing effort for individuals to join together and form such groups. The motivation behind the establishment of groups has come from two directions: From individuals in response to unmet needs; and from formal services in an effort to provide additional support and care.

The establishment of self-help support groups became popular following the Second World War. Survivor support groups have been gaining recognition as an effective means for providing support for survivors. Some are financially aided in through government funds, but also by religious groups, donations and the participants themselves. Over the past decade, the International Association for Suicide

Prevention (IASP) has noted a marked increase in interest in this area.

Unfortunately, the discussion of suicide continues to be a taboo subject, especially in relation to other forms of death. The suicide bereaved often find it difficult to admit that their loved one died by suicide, and people often are uncomfortable talking about the suicide with survivors. Consequently, those bereaved by suicide have less of an opportunity to discuss their grief compared to other bereaved people. Research has shown that support groups have a positive impact since lack of communication can delay the healing process. The joining together of those bereaved by suicide can provide a platform for people to really understand their personal experience related to the suicide death by sharing with others who have similar experiences and reactions. Participants also gain strength and understanding by providing the same help to others, an altruistic act which can facilitate the grieving process.

The group can provide:

- A sense of community and support
- An empathic environment and a sense of belonging at times when the bereaved person feels isolated from others
- The hope that “normality” can eventually be reached
- Experience in dealing with difficult anniversaries or special occasions
- Opportunities to learn new ways of approaching and coping with problems
- A sounding board to discuss fears and concerns
- A setting where free expression of grief is acceptable, confidentiality is observed, and compassion and nonjudgmental attitudes prevail.

The group may also emphasize education, providing information on the grief process, facts relating to suicide, and the roles that various health professionals may play in recovery. Another area is that of empowerment, which motivates individuals to regain some control over their lives. One of the most devastating aspects of a suicidal death is that there are often many unanswered questions, and yet the individual often cannot successfully resolve the situation. Finally, group support can assist in reducing feelings of helplessness and hopelessness, which, in turn, provides the means whereby to regain control.

## DISCUSSION AND CONCLUSION

Suicide survivors encounter the same emotions as anyone who mourns the death of a significant other. However, they also experience a unique set of painful feelings in addition to their grief, such as guilt and anger, as well as the stigma associated with suicide. The challenge of coping with a loved one's suicide is one of the most difficult experiences an individual will have to face.<sup>[61]</sup>

It is not uncommon for people to continue to suffer for many years following the suicide of a loved one because they refused, or were forbidden, to talk openly about the cause of death. There is a stigma attached to suicide, partly due to the myths surrounding it. Accordingly, friends and relatives of the survivors may not know how to handle the situation and/or provide assistance.<sup>[62]</sup>

They may rely on the survivors' initiative before talking about the loved one or offering support. Despite a growing number of resources for survivors, failing to successfully intervene may have detrimental effects. If family members are not initially helped, the resulting grief and psychache may eventually precipitate further suicides. The single most important and helpful response is to listen; that is, active listening, without judgment, criticism, or prejudice; to what the survivor is saying. In order to provide the most beneficial support, listeners must put aside any preconceived notions they may have about suicide. Reducing stigma by educating the general public about suicide is the most effective method to accomplish this goal. Although people may feel uncomfortable discussing suicide and its aftermath, survivors of loved ones endure great pain and are in need of compassion.

As de Groot *et al.*,<sup>[63]</sup> have indicated, relatives who are bereaved by suicide are likely to consult their general practitioner (GP) when they feel the need for professional help. Thus, GPs may play a key role in establishing who is at risk for adverse consequences after the suicide loss as they are familiar with the potential psychiatric vulnerabilities of the survivors and the available services that can be provided. However, GPs need additional training in order to be prepared to effectively cope with the complicated grief and the suicidal ideation that often emerges in bereaved individuals.

The present review should be considered in the light of some limitations. First, we presented an overview of the topic and no systematic review or meta-analysis was performed.

Although, the current review adequately summarizes the research in this field, focusing on relevant issues related to the phenomenon, and attempts to present key topics in order to offer an easy tool when facing survivors of suicide, the inclusion and exclusion of papers cited in this paper may reflect the authors' choice, both on the basis of their expertise and the consultations that they engaged with experts in the field.

Presently, the evidence for the efficacy of interventions for people bereaved by suicide is weak.<sup>[55,56]</sup> There are only a few studies investigating professional interventions for suicide survivors, and these have reported minimal effects. This means that more research must be conducted to evaluate treatments, including survivors' support groups.<sup>[64,65]</sup> This

is imperative for those countries, such as India, with huge increase in suicide rates in the last decades.<sup>[66-71]</sup>

Future researchers must also evaluate internet-based support groups for suicide survivors that are preferable because of their 24/7 availability, particularly by survivors who feel greater stigmatization as a result of the suicide.

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