Beyond normal grief: A critical reflection on immediate post-death experiences of survivors of suicide
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Abstract
An exploration of the literature was undertaken on the question of whether or not bereavement after suicide, as opposed to other modes of death, renders individuals more susceptible to enduring and complicated grief reactions. The literature from qualitative research indicated that there appeared to be a greater prevalence of individual and contextual risk factors leading to complicated bereavement for survivors of suicide, as opposed to those bereaved through most other modes of death. Trauma-related research and survivors’ anecdotal reports emphasised the potential for proximal factors and specific experiences in the immediate aftermath of a suicide that could facilitate, or complicate bereavement. Factors found to indicate that suicide bereavement is distinct include survivors more often experiencing feelings of rejection, responsibility, guilt and blame, with feelings of shame and embarrassment interacting with a sense of stigmatisation. In addition, reports indicated ambivalent, challenging and negative relationships with service providers after the suicide. The impact of such factors remains largely overlooked in the context of suicide, and we therefore argue that the immediate post-death experience, specific to suicide survivors, presents a critical primary site for risk prevention and building resilience with survivors. We reflect on training for front line workers in this context.

Keywords
grief and loss, suicide, suicide bereavement, resilience, risk and protective factors

‘…vividly remembered for the rest of the recipient’s life…. ’ (Parkes, 1985, p. 15)

Introduction
Suicide continues to constitute ‘a major public health issue’ with substantial human and economic costs (Australian Bureau of Statistics, 2007a). In 2005, official Australian statistics indicate that 2,101 deaths (1.6% of total deaths) were attributable to suicide; however, suicide accounts for 26.2% of deaths from external causes (Australian Bureau of Statistics, 2007a). Often labelled ‘survivors of suicide’, family members, friends, co-workers, teachers, classmates and therapists feel the direct impact of a suicidal event.

This paper focuses on the impact of bereavement on survivors of suicide. The aims are: firstly, to review the literature so as to provide understandings of the nature and impact of suicide on the bereavement for survivors; then,
secondly, our discussion centres on the need to assess the impact of suicide by linking it to the unique components of bereavement faced by suicide survivors, including the specific, deleterious but thus far ignored effects of immediate event-related characteristics of suicide. This article contributes to thinking in the area of grief and suicide as it differentiates a preventive intervention site for survivors of suicide.

We make no pretence of being exhaustive in addressing the literature, as the aim of the paper is not to provide a definitive account of the current status of suicide bereavement. Rather, our aim is to paint a broad landscape so as to establish understandings of any distinctive issues that can accompany bereavement for the survivors of suicide. Furthermore, it should be noted that the literature review is mainly reflective of dominant western cultural ideas and ways of being, so that the nature of suicide, bereavement and grieving, in this paper is seen through this cultural lens.

This article is informed and shaped mainly by portions of postgraduate research undertaken in Australia to explore the experiences of survivors of suicide in the time following suicide, to determine the existence of any experiences that they believed to have impacted on their respective bereavement and grieving processes, and to highlight any areas of service provision or support that the survivors deemed as weaknesses and through which improvement efforts could be directed (Botha, 2005).

### Epidemiology

Whilst definitions of who constitute survivors of suicide vary from study to study, conservatively estimated numbers range from between five to ten bereaved individuals per suicide (McIntosh, 1993). Less conservative research postulates that the number of affected people extends to well over twenty (Dunne, McIntosh & Dunne-Maxim, 1987). We should note that even this factor is conservative, as suicides affect extended families, as is the case in Australian Aboriginal contexts (see Elliot-Farrelly, 2004; Guilfoyle, Coffin & Maginn, 2008; Hunter, 2007). Any estimate is complicated: Stack (2007) argues suicidal persons are shown to have less dense social networks, and this is a sign of fewer potential grievers than in the case of natural deaths. Much depends on the culture of a society too (Paletti, 2008; Rosenblatt, 2008); suicide can also affect whole societies especially when the victim is popular or well known; and more work needs to be done around what constitutes an affected network.

For illustration, Table 1 estimates the impact of suicide on the number of survivors in Australia based over the six-year period, 2000-2005. Whilst a proportion of individuals who suicide do not have any immediate family, and notwithstanding the potential compound effects for extended families, one factor suggesting a conservative estimate for ‘survivors of suicide’ is the average Australian family size, embracing only the immediate family members (Holmes & Rahe, 1967). A second is Lukas and Seiden’s (1987) estimate of a factor of 10 survivors of

<table>
<thead>
<tr>
<th>Year</th>
<th>Population of Australia (000's)</th>
<th>Total number of suicides in Australia</th>
<th>Average Australian family size</th>
<th>Estimated number of survivors of suicide</th>
<th>Estimated number of survivors of suicide (10 per suicide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>19,153</td>
<td>2,363</td>
<td>3.8</td>
<td>8,979</td>
<td>23,630</td>
</tr>
<tr>
<td>2001</td>
<td>19,413</td>
<td>2,454</td>
<td>3.7</td>
<td>9,080</td>
<td>24,540</td>
</tr>
<tr>
<td>2002</td>
<td>19,641</td>
<td>2,320</td>
<td>3.7</td>
<td>8,584</td>
<td>23,200</td>
</tr>
<tr>
<td>2003</td>
<td>19,873</td>
<td>2,213</td>
<td>3.7</td>
<td>8,188</td>
<td>22,130</td>
</tr>
<tr>
<td>2004</td>
<td>20,092</td>
<td>2,098</td>
<td>3.7</td>
<td>7,763</td>
<td>20,980</td>
</tr>
<tr>
<td>2005</td>
<td>20,340</td>
<td>2,101</td>
<td>3.7</td>
<td>7,774</td>
<td>21,010</td>
</tr>
</tbody>
</table>

suicide for each suicide. Table 1 (columns 4 and 5) finds nominal estimates for survivors of suicide in Australia in 2005 ranged between 7,774 and 21,010 people.

**Impact of bereavement on individuals**

Whilst the loss of a loved one is a universal human phenomenon, the impact of the bereavement and grief associated with such a loss is considered highly individualised and complex, and includes numerous interwoven behavioural, psychological, cultural, social, spiritual and physiological components (Cowles & Rodgers, 1991; Payne, Horn & Relf, 1999; Reed, 1998).

The literature has consistently referred to the critical nature of the impact for bereavement related stress, with bereavement a risk factor for adverse physical and mental health outcomes (Brent, Perper, Moritz et al., 1993; Clayton, 1990; Helsing & Szklo, 1981; McEwen & Stellar, 1993; McKissock & McKissock, 1991; Mor, McHorney & Sherwood, 1986; Ness & Pfeffer, 1990; Parkes, 1985; Payne et al., 1999). Physical and mental impairments and disturbances related to bereavement include heart problems, cancer, and symptoms of depressive and anxiety disorders (Beautrais, 1999; Clayton, 1990; Hall & Irwin, 2001; Sanders, 1999; Zisook & Shuchter, 1993), and post-traumatic stress (Beautrais, 1999; Dyregrov, Nordanger & Dyregrov, 2003). The nature and intensity of these impairments and disturbances will, naturally, be dependent upon the given circumstances in each particular case. Beautrais (1999) has outlined in detail the effects of youth post-suicide grief as a risk factor for suicide and we reiterate in this paper how this can be extended to survivors generally.

The link between bereavement and a myriad of adverse health outcomes, themselves correlated to increase risk of suicide, cannot be ignored (Szanto, Prigerson, Houck et al., 1997). For example Birtchnell (1970), Lichtenstein, Gatz and Berg (1998), and MacMahon and Pugh (1965) have identified that bereavement increases the risk of both suicidality and general mortality. With specific reference to bereavement subsequent to suicide, a number of researchers have concluded that while there is a small but real chance of suicide among the generally bereaved, there is a somewhat higher risk for those who themselves are bereaved by suicide (Cleiren, Diekstra, Kerkhof & Van der Wal, 1994; Hazell & Lewin, 1993; Ness & Pfeffer, 1990; Stroebe, Stroebe & Abakoumkin, 2005).

**Beyond normal grief**

When individuals become overwhelmed by their intense grief, they may resort to maladaptive behaviour, or remain unable to move forward in the mourning process when their grief involves processes which lead to extensive interruptions in healing (Horowitz, Wilner, Marmar & Krupnick, 1980). In contrast to early research which proposed a simple dichotomy of normal and pathological grief, as defined by the presence or absence of specific symptoms (e.g., Freud, 1917/1957), contemporary approaches describe grief reactions on a continuum where one end indicates healthy grieving and the other indicates more intense and pervasive reactions (Horowitz et al., 1980). Such grief reactions have been classified in numerous ways and afforded various labels (Horowitz et al., 1980; Mitchell, Kim, Prigerson & Mortimer, 2005; Prigerson & Jacobs, 2001; Raphael, 1985). It is important to note that, despite an increased labelling of this severe grief form, Feifel (1998, p. 3) has stated, ‘…the line between healthy and unhealthy grief, at times, can get blurred and difficult to distinguish’ and there are more recent debates of what constitutes ‘recovery’ (e.g., Kauffman, 2008; Rosenblatt, 2008; Sandler, Wolchik & Ayers, 2008)

Nevertheless, if the risks of grief can be associated with severity of grief, it is important to ask whether certain aetiologies of grief can be associated with more severe grief reaction. Rando (1993, p. 4) posited the need to study differential bereavement experiences when she stated, ‘…although it is always dangerous to compare different losses… it is equally dangerous not to look at the unique dilemmas posed by specific types of losses and to ignore the distinct needs of mourners experiencing different types of bereavement’. However, what is not clear-cut, despite significant clinical and theoretical implications, is whether grief reactions do vary across various types of losses. The first focus for us, therefore, is whether or not ‘survivors of suicide’ are the exception.
Problems of differentiating grief: quantitative studies

Results of a range of quantitative studies have either failed to support the unique attributes of suicide-based grief (McIntosh & Kelly, 1992), or have produced mixed results (McIntosh, 1993). For example, Van der Wal (1989-1990) not only suggested that the grieving process after a suicide is comparable to that of other sudden and unnatural deaths (deaths from external causes), but also suggested an apparent dearth of empirical evidence supporting the idea that suicide survivors exhibit a greater incidence of complicated, prolonged or pathological bereavement.

Unnatural deaths, including suicide, are more likely to be characterised by common elements than are deaths following illness or ageing (Parkes & Weiss, 1983). Deaths which are sudden and unexpected will tend to impose a greater burden on the bereaved (Cleiren et al., 1994; Parkes & Weiss, 1983; Rynearson, 1987). However, other research has formed different conclusions and argued that positing similarities between suicide bereavement and unnatural death bereavements collectively, creates a ‘diluting’ of any distinct differences (Ellenbogen & Gratton, 2001; Jordan, 2001).

Several authors such as Ellenbogen and Gratton (2001) and Clark (2001) have identified that the majority of studies that have failed to find any fundamental differences in the grief experienced after suicide, have primarily utilised quantitative methodological approach. They argue a number of the conventional research methods used are insensitive to qualitative differences unique to suicide grief and it is consequently, and mistakenly, assumed that differences in the mourning process between suicide and other types of losses fail to exist (Ellenbogen & Gratton, 2001; Jordan, 2001). In contrast, evidence supports the idea of such differences as largely qualitative in nature, and includes data contained within clinical and anecdotal reports from: 1) survivors themselves (e.g., Begley & Quayle, 2007; Wertheimer, 1991); 2) those who work with survivors (e.g., Dunne et al., 1987; Payne et al., 1999); and 3) results of public perception studies (e.g., Allen, Calhoun, Cann & Tedeschi, 1993).

Some understandings of complex grief: qualitative studies

Albert Cain (1972), a forefather in suicide-related research, suggested that bereavement after suicide is in several ways a qualitatively unique experience and early clinical and anecdotal reports have supported his suggestion of a fundamental difference to other types of death, often being more difficult or complicated (Dunne et al., 1987; Rando, 1984, 1993). Subsequent qualitative studies have tended to converge on the idea that feelings of rejection and responsibility specifically are two reactions that clearly distinguish grief associated with suicide from grief resulting from other causes (Bailey, Kral & Dunham, 1999; Ellenbogen & Gratton, 2001; Jordan, 2001).

For example, Calhoun, Selby and Selby (1982) in an early review of the literature on suicide survivors, drew three tentative conclusions. First, suicide survivors tend to experience less social support than do survivors of other modes of death. Second, they search for an understanding of the death and the motivation for the suicide (Lord, 1987; Lukas & Seiden, 1987; Wertheimer, 1991), and third, they experience feelings of guilt and blame more often than those bereaved by other modes of death (see Clark & Goldney, 1995 for a review). Ness and Pfeffer’s (1990) subsequent review of death-related literature concluded that while certain common themes prevail throughout the general bereavement experience, the type of death may indeed affect the psychology of grieving, and that a consistency regarding the prevalence of common themes exclusive to each mode of death was clearly apparent.

Citing a wide range of evidence from clinical reports which suggested that bereavement after suicide may be more complex for the family than bereavement subsequent to a natural death, Jordan (2001) identified specifically the dearth of research addressing the impact of the social network on suicide survivors. This included how the general stigma attached to suicide often permeated bereaved family members who often felt more stigmatised and isolated than other survivors, and the impact that suicide had on family systems. We focus therefore on this interaction of grief and stigmatisation.
Suicide bereavement and stigmatisation

This stigma surrounding suicide has its roots in the way it was viewed prior to the 19th century when, in legal terms, it was regarded as a crime, and within the eyes of the church, a sin. Since the deceased was no longer able to be punished for their transgression, the punishment was enacted upon the family (Knieper, 1999). It has been suggested that this stigma stems from society’s need to blame or place the responsibility for the suicide on someone, and invariably it is those closest to the deceased who are held accountable (Appleby, 1992). Furthermore, there are two common and damaging socially constructed and taken-for-granted myths associated with suicide: firstly, ‘nice’ people do not take their own lives, and secondly, suicide does not happen in ‘nice’ families (Wrobleski, 1985). Shneidman (1993, p. 165) commented, ‘…it is obvious that some deaths are more stigmatising or traumatic than others: [such as] death by the negligence of oneself or some other person, or by suicide’.

Solomon (1982) viewed the stigma surrounding suicide as being capable of turning the grief process into an extended and contorted one for the survivor of the suicide. Dunn and Morrish-Vidners (1987-1988, p. 175) also sought to highlight the impact of such feelings when they stated, ‘… unlike other types of death, suicide causes feelings of stigma, guilt, anger, and confusion strong enough to overwhelm the bereaved, prolonging the grieving process and putting the bereaved at increased psychological and physical risk’ (see also, Sveen & Walby, 2008). Thus, the ‘spilling over’ of historical attitudes may result in isolation and stigmatisation of survivors, which in turn may provoke or cause complicated grief reactions (Cvina, 2005; Seguin, Lesage & Kiely, 1995; Wertheimer, 1991).

Feelings of shame and perceptions of being stigmatised may also interfere with how survivors interact with others, and the manner in which social services and support are offered to them (Seguin et al., 1995). It may lead survivors to feel awkward, and cause them to isolate themselves. Consequently, even if the support is present, survivors may report perceived low levels of social support (Seguin et al., 1995). The aforementioned negative attitudes toward survivors may not directly result in differential treatment of survivors in the community however. Individuals may genuinely want to assist the survivors but are unsure how best to offer their services (Jordan, 2001). This awkwardness and hesitation may then be communicated to survivors and be mis-interpreted as further rejection (Seguin et al., 1995).

In Calhoun et al.’s (1982) previously mentioned review, non-bereaved individuals reported finding communications with suicide survivors to be more stressful and more constraining than communications with other survivors. Thus, even if individuals feel great compassion for the suicide survivors, they may avoid interactions for fear of doing or saying something they should not, or because they are unsure of the informal ‘rules’ which guide such interactions (Calhoun, Selby & Abernathy, 1984).

Furthermore, beyond the problem of perception by others, Jordan (2001) stated that it is equally as important to ascertain survivors’ views of themselves, as any adverse attitude towards suicide in current society may be mirrored within the survivor. In this context then, ‘self-stigmatisation’ may result in survivors assuming that others are judging them, not discussing the event/grief with others (Clark, 2001), and withdrawing further, making support provision even more complicated (Jordan, 2001). Irrespective of the basis of such integrating complexities, it does appear that personal interaction and social support are frequently more challenging after a suicide than after most other types of loss (Breen & O’Connor, 2007; Calhoun, Selby & Abernathy, 1986; Jordan, 2001). Where does this leave us for interventions into the complex issues relating to grief for survivors of suicide?

The critical time immediately following the suicide

Drawing on our review, and the above argument about the centrality of stigmatisation, we argue that the case for suicide being different to other types of grief is furthered by literature that suggests immediate post-death experiences specific to suicide do impact suicide survivors in ways that are different to other grief situations. This is a critical turning point, as what happens with, and to, survivors in the time immediately
following the death might determine in part how well they cope with their bereavement (Wertheimer, 1991). Parkes (1985, p. 15) suggested that the initial moments following a suicide will be ‘...vividly remembered for the rest of the recipient’s life’. It has also been suggested that the period immediately after the suicide is crucial in determining functional adaptation to the loss, with early adaptation being highly predictive of longer term adaptation (Cleiren et al., 1994).

Dubin and Sarnoff (1986) referred to the important role which authorities involved in the immediate aftermath of a suicide play in the facilitation of a healthy grieving process, as a survivor’s grief reactions can be compounded or exacerbated by inappropriate responses from the community services to the suicide (Knieper, 1999). Knieper (1999) has also supported the idea that survivors of suicide tend to experience a very complicated form of bereavement; and attributed this to the combination of the unanswered question ‘why’, the sudden shock of the death, the trauma of possibly discovering or witnessing the suicide, and the additional negative impact that inappropriate responses and interactions from service providers and the community may have on the bereavement process.

Trolley (1993) has drawn attention to the fact that any negative support or involvement from emergency-responders, police, medical examiners, funeral directors and clergy tends to create more isolation between the survivors and the professional world. Invariably these authorities are strangers, intricately involved in what is a very personal and private traumatic event. In the case of suicide, families can find themselves unwittingly exposed to the scrutiny and unsolicited involvement of these strangers, and the need for tactfulness and sensitivity by those involved becomes necessary. Thus, the importance of front line responders (e.g., police and emergency response services), and their manner of interactions with survivors, cannot be overemphasised in terms of the profound impact which they have on the way survivors cope with the bereavement (Dunne et al., 1987). For instance, in terms of the death notification (i.e., being formally or informally notified of the death by a third person), this experience alone (Jurkovich, Pierce, Pananen & Rivara, 2000) represents a significant, life-altering event for the bereaved (Stewart, 1999). This means that, ultimately, breaking the news to the family represents a vital opportunity to influence the course positively or negatively, and perhaps the outcome, of bereavement. In this sense, notification processes comprise a secondary site for preventive intervention if the notifiers are sensitive to the immediate needs of the survivor (Jurkovich et al., 2000; Lord, 1987).

**Positioning of resilience**

Our review indicates inconclusive findings regarding two primary questions: a) is bereavement after suicide different to bereavement resulting from other modes of death? and b) is suicide bereavement more difficult or complex than bereavement stemming from other modes of death? Some quantitative studies have failed to find differences between bereavement according to mode of death, while qualitative studies have uncovered specific variations that are unique to suicide. We agree with Jordan (2001) that despite the inconsistencies in the literature regarding variations in grief reactions according to mode of death, there appears to be sufficient evidence of such variations to warrant continued investigations. The fact that immediate post-event interactions seem critical is a sufficient basis for action.

In Australia, increasing attention is directed to North American models for suicide ‘postvention’ supports for survivors (Campbell, 1997; Campbell, Cataldie, McIntosh & Millet, 2004; Dyregrov, 2002; Maples, Packman, Abey et al., 2005; Shneidman, 1972; Wilson & Clark, 2004), and initiatives under the National Suicide Prevention Strategy (e.g., English, 2007). These initiatives link to recent work promoting resilience to suicide by involving a whole of community strengths-based approach to suicide prevention (e.g., see Costello, Johns, Scott & Guilfoyle, 2006). Individual resilience refers to a person’s ‘…ability to bounce back or recover after adversity or hard times and to be capable of building positively on these adversities’ (Mission Australia Research and Social Policy, 2005). We agree with Sandler et al. (2008) for example, who argue that ‘resilience’ provides a better concept of response to bereavement than ‘recovery’ because it centres on person-
environment rather than intrapersonal processes. Individual resilience is bound to a community environment providing a supportive base for resilience through effective person-environment interactions. A resilient community can ‘...respond to crises in ways that strengthen community bonds, resources, and the community’s capacity to cope’ (Chenoweth & Stehlik, cited in Healy, Hampshire & Ayres, 2003). Community resilience responses need to be interagency and led by the needs of the community and there are appropriate models for this (Forde & Devaney, 2006; Guilfoyle, forthcoming; O’Connor, 2008; Scocco, Frasson, Costacurta & Pavan, 2006). However, these interventions rely on commitment by front line responders in particular.

While resilience has a broad definition, it is not always easy to cite examples of how resilience can be specifically developed within a community (Guilfoyle, forthcoming). Our review highlights the importance of front line responders (emergency responders, police, medical examiners, funeral directors and clergy) (Dunne et al., 1987; Wertheimer, 1991) and allied service professionals in interacting with survivors of suicide, as one site to build resilience. We link the influence of immediate responders on the bereaved to recent developments in community resilience. These responders are critically situated to create the primary interactions between the bereaved and others in the immediate aftermath of suicide that affect the bereaved individual’s subsequent grief processes. Their behaviours aid the grieving process, or potentially cause additional pain and suffering through immediate unintentional insensitivity (Wertheimer, 1991). Dunne et al. (1987) suggested that by being cognisant of their role in facilitation, these front line individuals can initiate processes in the required courses of action that help to cushion the trauma of loss for survivors. The case in point is responders understanding the needs of specific cultures such as Australian Aboriginal people, Australian defence force personnel, and political and social refugees in Australia. Front line responders who are likely to be in contact with survivors from specific cultural sets, however these are defined, would according to our argument need to have heightened awareness of the intricate, acute, and specific sensitivities and vulnerabilities that are critical in affecting culturally bound grief reactions. This calls for thoughtful and careful training. There is also a need to consider specific survivors’ context such as work done with youth (Beautrais, 1999) and resiliency of parentally bereaved children following suicide (Brown, Sandler, Tein et al., 2007).

Notwithstanding the need for broader postvention, and individualised and group-based clinical interventions for unique aspects of survivorship in the context of suicide, and further study of survivor networks; we argue the community services and individuals instrumental in shaping specific immediate events and responses faced by the bereaved provide a critical site for intervention. Such a direct intervention is built by first understanding how these immediate post-event responses can critically influence suicide survivors’ grief reactions, and then providing education to the front line responders to suit. We hope this article makes a contribution in opening up critical dialogue and thinking in the area of grief and suicide by differentiating a preventive intervention site for survivors of suicide. Beyond our scope for this paper, there is a future research niche which asks systematically: how could training for front line workers be improved and in what ways can we develop and evaluate training for front line workers? A precursor is a review of any culturally specific or general guidelines, any training that currently exists, and whether relevant evaluations have been performed.

Concluding comments

Our reflection suggests that raising service providers’ awareness of their influence on bereavement-specific experiences in the immediate period surrounding a suicide is one potential site for building community resilience. Our review also found relatively little scrutiny of survivors’ experiences of the social, community and authority network in the immediate period after a suicide. More work should be done to estimate the networks of people affected by any given suicide. We therefore suggest that research exploring survivors’ experiences interacting with front line responders is a crucial next step in providing some further understandings of specific issues which survivors of suicide need to deal with in coping with their bereavement.
References


