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**A QUALITATIVE STUDY OF  
THE COPING STRATEGIES AND NEEDS  
OF ADULTS BEREAVED BY SUICIDE**

*A thesis presented in partial  
fulfilment of the requirement  
for the degree of Master of Arts  
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## **ABSTRACT**

The aftermath of suicide can have devastating effects on family and friends. Research has shown that the complexities of suicide bereavement can lead to physical and mental health problems, increased risk of suicide, pathological grief, and non-specific stress disorders. How the bereaved cope with the loss of a loved one by suicide was the focus of this study. It explored factors that were helpful or unhelpful, as well as the specific needs of this group. Fifteen volunteers over the age of 18, bereaved for more than two, and less than five years, told their stories in 45-60 minute semi-structured interviews. Using interpretative phenomenological analysis, results revealed a variety of coping strategies, and highlighted a number of factors that helped or hindered the individual's ability to cope. Results also highlighted a need for training for personnel dealing with the bereaved, suggested improvements in procedures following a suicidal death, and indicated a need for professional help and support immediately following the death. The findings of this study could be beneficial to policymakers at many levels, and to medical and associated professionals. Understanding the factors that can help or hinder the bereaved's ability to cope will help in the assessment of risk, and consequently be useful in the development of early intervention strategies to minimize the risk of physical and psychological problems that can result from such a traumatic event.

## **Abandonment**

Abandoned to the vagaries of  
misconception  
misunderstanding  
swept along by life's strong currents  
eddy  
always around

your legacy for years of  
trust  
was abandonment

we are not angry  
just tired  
tired of having to rebuild  
re-explain  
re-fashion our lives  
to accommodate  
your abandonment

we are tired of the tears  
and the fears you left us with  
we are tired of facing each new day not knowing how—  
to accommodate  
your abandonment

children  
banish the fears  
and start anew  
bathe in the waters of life and  
enjoy the sparkling droplets of  
trust and love

(Jenny, 2003)

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# TABLE OF CONTENTS

	<b>Page</b>
Abstract	ii
Survivor's poem	iii
Acknowledgements	iv
<b>INTRODUCTION</b>	<b>3</b>
<b>LITERATURE REVIEW</b>	<b>7</b>
1. The impact of suicide on survivors	7
Grief reactions	7
Psychological responses	10
2. Risk factors for complicated grief	14
3. Is suicide bereavement different to other traumatic deaths?	17
4. Coping and adapting to loss	19
5. Meaning reconstruction for recovery	22
6. The needs of the survivors	25
<b>METHODOLOGY</b>	<b>30</b>
1. Rationale	30
2. The Participants	33
3. Data Collection	34
4. Analysis	36
<b>RESULTS</b>	<b>38</b>
Coping strategies	38
Contributing factors	49
Needs	76
<b>DISCUSSION</b>	<b>85</b>
Coping strategies	85
Contributing factors	87
Needs	92
Implications of findings	95
Limitations of the present study	97
Future Direction	97
<b>REFERENCES</b>	<b>99</b>

<b>APPENDIX A</b>	<b>108</b>
<b>APPENDIX B</b>	<b>109</b>
<b>APPENDIX C</b>	<b>110</b>
<b>APPENDIX D</b>	<b>112</b>
<b>APPENDIX E</b>	<b>114</b>

## INTRODUCTION

More than 30 years ago, Albert Cain (1972) highlighted the plight of people bereaved by suicide in his edited book *“Survivors of Suicide”*. Cain and his contemporaries in the field of suicidology recognised the “unique anguish” suffered by these people, and were concerned about the vast numbers of people affected by a suicidal death. They recommended that help for survivors of a completed suicide should be routinely offered so that they could come to terms with their complex reactions to the death. Shneidman (1972) refers to this kind of support as postvention. On reviewing his research on suicide survivors and based on the knowledge about suicide at the time, Resnik (1969b cited in Cain, 1972) considered postvention seemed to be “the most promising avenue toward reducing the large number of suicides that occur annually” (p.10).

In recent years, the growing number of suicides in New Zealand, especially among young people, has been a cause for concern. Research attention has been, and continues to be focused on ways to reduce those numbers. However, little attention has been given to those left behind to cope with the burdens that suicide inevitably creates for them – family members, friends, neighbours, work colleagues, and others who may have been closely involved with the deceased.

Provisional figures from the Ministry of Health show that 460 people died by suicide in New Zealand in 2002 (New Zealand Health Information Services, 2005). One can only guess at the number of people affected by each suicide. Shneidman (2001) conservatively estimated that at least four survivors would be created for every suicide each year. Lukas and Seiden (1987, cited in Wertheimer, 1997) calculated that between seven and ten people would be ‘intimately affected’ by each suicide. Based on these figures, between 2,000 and 4,600 people in New Zealand are significantly affected by a completed suicide each year.

Bereavement by suicide is a traumatic event that can have devastating effects on those left behind. Not only do they often feel in some way to blame for the action, but there is also a stigma attached to a self-inflicted death, which makes coping with the event more difficult

than other kinds of bereavement. Whether the stigma is real or perceived, for those bereaved by suicide it becomes very real. For these reasons, it has been argued that suicide bereavement is different from other kinds of bereavement – “the ultimate abnormal life crisis”(Salvatore, 2002b) and therefore deserves special attention.

There is some consensus among clinicians and researchers that the grief process following a suicide is different to that of other types of bereavement. Suicide survivors experience grief that is more intensified and often problematic (e.g. Henley, 1984; Jordan, 2001; Ness & Pfeffer, 1990; Shneidman, 2001). The suicide bereaved report more negative changes in social interaction than other bereaved groups. The bereaved often lie to others about the cause of death (e.g. Jordan, 2001).

Suicide affects many aspects of the bereaved person’s life, including their ability to perform normal functions, such as going to work, and making everyday decisions, as well as isolation from family and friends. The isolation from natural support networks appears to occur because those people are unable to “truly empathise” with the bereaved, and feel awkward with them, not knowing what to say (James & Gilliland, 2004; Parkes, 1996; Wertheimer, 1997). Family members may blame each other for the death and may be unable to discuss the suicide with each other for fear of unleashing the anger that they feel towards those that they blame (Provini, Everett, & Pfeffer, 2000), or they may be unable to talk to one another because they know that the others are hurting too.

Research has shown that the complexities of suicide bereavement can lead to physical and mental health problems including an increased risk of suicide, pathological grief and non-specific stress disorders (e.g. Parkes, 1996). Some have gone so far as to suggest that people bereaved by traumatic death such as suicide often have symptoms of post-traumatic stress disorder (Callahan, 2000; Simpson, 1997). It is clear that the physical and mental health of this group is at risk.

Considering the difficulties associated with suicide bereavement, and the recognition by suicidologists more than 30 years ago that postvention was a vital part of understanding and

preventing suicide in the community, it is surprising that no immediate professional crisis/trauma intervention - postvention - is available in New Zealand to the survivors of suicide.

Help at an early stage of bereavement could prevent the development of psychological disorders in the future (Parkes, 1996). It could also provide much needed help to deal with the immediate trauma, and the intense feelings of guilt, blame, and shame about the way in which their loved ones died. It has been reported that the bereaved often voice the need for professional help, but have no idea how to get it, or are afraid to ask (Brownstein, 1992 cited in Parkes, 1996; Provini et al., 2000). It follows, then, that if the bereaved have voiced a need for professional help in the early stages of their grief, then a prompt system of referral by agencies initially involved should be available. Such a system would ensure that the bereaved were visited immediately following the suicide by a member of a professional crisis intervention team, such as psychologists or counsellors trained to deal with traumatic bereavement, and provided with support to deal with practical issues such as the funeral and coroner's inquest, as well as the emotional difficulties.

The suicide bereaved have become an area of increasing interest for researchers since Cain and his colleagues brought them to attention. However, most of the research concentrates on three main areas: (1) grief responses of suicide survivors; (2) whether suicide bereavement is different to bereavement from other types of traumatic loss; and (3) the risk factors that influence bereavement outcomes. There is little research relating to the coping strategies used by the bereaved, or the effectiveness of early intervention in the recovery process, and consequently, the prevention of long-term physical and mental health problems.

Understanding the different grieving styles and coping strategies - the factors that promote resilience and strength - of people bereaved by suicide, establishing the perceived obstacles to effective coping, and the sort of help they believe to be of value, is the first step in providing effective postvention (Clark, 2001; National Strategy for Suicide Prevention, 2004; Salvatore, 2002a).

The following section reviews the contemporary literature on suicide bereavement, beginning with an overview of the impact of suicide on the bereaved, including grief reactions, psychological responses, and the risk factors influencing bereavement outcomes. Later sections review the research relating to the notion that suicide bereavement is different to bereavement from other types of traumatic death; coping through adaptation and meaning reconstruction, and concludes with a consideration of the needs of those bereaved by suicide. Finally, the present study is introduced, raising issues that explain and justify the research project and its particular focus.

# LITERATURE REVIEW

## 1. The impact of suicide on survivors

### Grief reactions

The impact of a suicide on the survivor is complex, and reactions to the event are different for each individual. However, researchers and clinicians alike have identified some common themes (Clark & Goldney, 2000), a syndrome (Dunne & Dunne-Maxim, 1987), or a cluster (Cain, 1972) of reactions which include shock, disbelief, guilt, blame, anger, rejection, stigma, searching for answers, depression and suicidal thoughts. Whilst many of these reactions are common amongst people bereaved in other ways, there is some consensus among researchers and clinicians that for the survivors of suicide they are more intense, more prolonged, and can lead to tragic consequences (Davison & Neale, 2001; Hauser, 1987; Henley, 1984; James & Gilliland, 2004; Jordan, 2001; Ness & Pfeffer, 1990; Parkes, 1996; Rubel, 1999; Rudestam, 1992; Sheldon, 1998; Shneidman, 2001; Stillion, 1996; Van Dongen, 1989; Wertheimer, 1997).

Suicide is often an unexpected, untimely, and violent death. The survivor's initial response is **shock** and **disbelief**. Even where there has been mental illness, or other difficulties during which time the deceased had made suicidal threats, the survivors are rarely prepared for the final act (Hauser, 1987). The enormity of such a tragic event is difficult for the survivors to comprehend; their loved one has chosen to end his or her own life, police will investigate the death, a funeral needs to be arranged, and family and friends have to be informed of the death. For some survivors the nature of the death is so incomprehensible and unacceptable that they refuse to accept suicide as the cause of death. Hauser (1987) suggests that **denial** is a coping mechanism that enables the survivor to deal with the intense feelings of guilt, blame, and anger that follows the initial sense of shock and disbelief.

Survivors may **blame** themselves for the death, especially where their relationship with the deceased had been difficult or ambivalent. They may also experience blame from others, such as in-laws, other family members, friends, and colleagues who can be quick to judge the reasons for the suicide. Clark & Goldney (2001) report that the contents of a suicide note 'may influence the bereaved into assuming responsibility and guilt', citing a study by Rudestam and Agnelli (1987) which found that the bereaved were more remorseful when the deceased's suicide note blamed him/herself rather than blaming the survivor (p.473).

The bereaved often feel an intense sense of **guilt** that they may have contributed to the death, and were unable to prevent it. They constantly ruminate about the possibility of having missed signs of the impending action, as well as how they might have dealt with the situation differently. Guilt can also be a result of the **anger** that they feel towards the deceased for choosing to end his/her life, leaving them to deal with the practical, social, and emotional difficulties resulting from that decision.

Bereavement by suicide is often perceived as **rejection** and/or abandonment of the survivor, which not only leads to anger, but also to a lack of trust in others, and a fear of committing to other relationships. Anger can also be directed at others for failing to prevent, or be otherwise responsible for the untimely death, such as healthcare workers, and other family members (Clark & Goldney, 2000; Hauser, 1987; Lindemann & Greer, 1972; Rubel, 1999; Van Dongen, 1989).

A reaction that has been particularly associated with suicide bereavement is **stigma**. Whether real or perceived, many survivors of suicide feel that their friends, neighbours, and acquaintances react negatively towards them, and that they are the subject of gossip because of the nature of the death (Hauser, 1987; Range, 1998; Wertheimer, 1997).

Colt (1987) describes stigma as "a mark of shame or disgrace, whether visible or not" which has developed from centuries of superstition and taboo about suicide (p.4). He suggests that many survivors feel "branded". There are examples in the literature of survivors who felt as if they were wearing a badge, had a sign on their car, or were being

pointed out to everyone in the marketplace as the one whose family member had killed themselves (e.g. Colt, 1987; Van Dongen, 1989; Wertheimer, 1997).

Although suicide is still a criminal offence in some countries, the survivors are no longer punished for their family member's 'crime'. However, social attitudes to suicide are slow to change (Lindemann & Greer, 1972) and survivors often face difficulties dealing with people in the community, such as insurance companies, funeral directors, and the church, whose attitudes to suicide can elicit feelings of shame and guilt, as if the survivors themselves were responsible or accountable for the death (Colt, 1987; Van Dongen, 1989).

Some researchers have suggested that stigma is a reflection of the survivor's own experiences and attitudes towards suicide, rather than actual negative attitudes communicated by others, and that the reasons why others appear to avoid others may be the survivor's own reluctance to talk about the event (e.g. Rudestam, 1987). These explanations may go some way to explaining the survivors' sense of stigma and isolation, but it is clear that suicide remains a death that invokes a sense of outrage, has connotations of unnaturalness and abnormality, and causes embarrassment and discomfort for all concerned.

Survivors of suicide are constantly searching for answers in an effort to understand suicide in general, as well as to make sense of their loved one's suicide (Wertheimer, 1997). The **why** questions are relentless - why did s/he do it? Why did s/he do it to me? What could I have done to stop it? This list goes on.

Hauser (1987) describes the constant pursuit of the "why" as a "hope of finding that which will assuage the guilt" (p.64) but suggests that the search actually unleashes more questions, doubt and guilt. Cain (1972) concurs that the search for meaning "provides too few answers not colored by guilt, with perceived responsibility, with despair beyond redefinition or reparation" (p.14).

Lukas and Seiden (1987 cited in Van Dongen, 1989) suggested that the continued search for answers was a “fruitless quest” by survivors, and that it was a means of avoiding dealing with their feelings about the suicide (p.37). Hauser (1987) agreed, stating that the lack of information feeds into the denial process. However, Wertheimer (1997) reports that seeking information not only helps the survivors to make sense of the death, but it lessens their sense of isolation. She documents one survivor’s comments: “I so wanted to read about other people who had lost someone by suicide, what their feelings were, to reassure myself that I was not losing my mind” (p. 70). Berrett (1998) referred to the suicide of a family member as a ‘puzzle’ and reported that “searching for missing pieces which might help solve those puzzles” (p.66) was a common reaction among the participants in her study.

Grief reactions to a death by suicide are many and varied. Some of these reactions are the same as those experienced by people bereaved by other types of traumatic death, but it appears that they may be more intense and prolonged for suicide survivors. The nature of the death is perplexing for the survivors; they search for answers to the myriad questions that it raises. Often those questions are never answered, and the survivors face the future without any clear resolution to their quest.

## **Psychological responses**

**Depression** and **suicidal thoughts** appear to be the result of the complex nature of suicide bereavement, and the intensity of the survivors’ responses to it. Whilst depressive symptoms are often a part of normal grief, traumatic bereavement such as death by suicide can place the survivors at risk of more intense and prolonged symptoms of clinical depression (Gintner, 2001; Parkes, 1996).

In Rudestam’s (1977) study of families bereaved by suicide, he found that 26 of the 39 participants reported having been depressed or deeply unhappy within the first six months after the suicide. Nine of the 26 respondents indicated that there had been no change in the

following six months, 12 were more depressed, and only five less depressed. These findings were supported by Van Dongen's (1989) research which reported that 20 out of the 35 participants described themselves as "feeling significantly depressed" at some time following the suicide; nine of them said that the first three to four months were most pronounced, whereas eleven reported their symptoms as more severe some three to five months after the suicide.

Similarly, Murphy (1999) and her colleagues assessed parents following the violent deaths of their children aged between 12 and 28 years old. Violent deaths in this study were death by accident, homicide, and suicide, and were included because of the intensity of grief reactions for those bereaved by these types of death, as well as the unique elements of each, such as a need for revenge in the case of murder, and the stigma and vulnerability of suicide survivors. The study found that 89% of mothers, and 64% of fathers reported clinically significant levels of depression at four months following the death. These levels dropped only slightly to 70% and 57% respectively, after two years.

Wordon (2001) suggests that although grief and depression share similar features, they are quite different conditions. He considers that the distinction between grief and depression is that in grief reactions the bereaved do not experience a loss of self-esteem, which is a common factor in depression. However, anecdotal evidence suggests that loss of self-esteem is a common response among those bereaved by suicide, borne out of a sense of rejection and abandonment, as well as having their previously held values and beliefs about self, others, and the future shattered as a result of the suicide.

Negative beliefs about self, others and the future were referred to by Aaron Beck and colleagues (1979) as the negative cognitive triad; the cornerstone of depression. Beck and colleagues described these three major patterns of thinking as creating faulty and negative thought processes, which are a central feature of depression and suicidal thoughts. Whilst Wordon acknowledges that, "such negative evaluations can exist in the bereaved", he dismisses them as being "more transient" than in the depressed (P.22). The abovementioned studies clearly do not support this assumption. Depression, whether

clinically significant or not, is not an uncommon reaction to a death by suicide, and can have long-term effects on the everyday functioning of the bereaved.

As mentioned, depression can lead to suicidal thoughts, and sometimes, suicidal behaviour. Clark and Goldney (2000) consider suicidal thoughts to be, in part, a longing to be with the deceased and a need to complete unfinished business. Colt (1987) suggests that depression and self-destructiveness are “bred of guilt, shame, rage, unmet yearning and unresolved grief...”(p.14).

Perhaps some bereaved are so overwhelmed by the pain that their loss has inflicted upon them that they suffer the phenomenon referred to by Edwin Shneidman (2001) as “psychache”. Psychache is described as “a drama in the mind, where the drama is almost always driven by psychological pain, the pain of the negative emotions” (p.200). Whatever the reasons for suicidal thoughts and actions may be, the literature is clear that those bereaved by suicide are themselves, at risk of self-destructive and impulsive behaviour (Cain & Fast, 1972; Rando, 1995; Silverman, Range, & Overholser, 1994/5), and as such deserve closer attention from the medical and psychological professions.

It has been argued that sudden, violent, or traumatic death can place the bereaved at risk of developing symptoms of **Posttraumatic Stress Disorder (PTSD)** especially if they are associated with painful, haunting memories or images (Callahan, 2000; Gintner, 2001; Parkes, 1996; Simpson, 1997). According to the *Diagnostic and Statistical Manual of Mental Disorders*, symptoms of PTSD can develop after exposure to an “extreme traumatic stressor” which includes witnessing or hearing about the violent death of a loved one. The three main characteristics of PTSD are re-experiencing the traumatic event, avoidance of reminders or numbing, and anxiety or hyperarousal (American Psychiatric Association, 2000).

Most suicides are violent and unexpected. It is often a family member who discovers the body, but even for those who do not witness the immediate aftermath, anecdotal evidence suggests that they imagine how it must have been, and replay it time and again in their

mind's eye. The responses to such a stressful event include nightmares and intense, emotionally charged re-experiencing of the event, avoiding places and people that are reminders, dissociation or amnesia, sleep disturbances, anger outbursts, and hyper-vigilance (Gintner, 2001).

Callahan's (2000) study found that seeing the body of a loved one at the scene of the death was the most significant predictor of the overall level of grief in those bereaved by suicide. He noted the "powerful impact" that such an experience had on the bereaved, commenting that reports of "flashbacks" and "intrusive images" suggest that these experiences are posttraumatic responses, rather than symptoms of grief (p.121).

Zisook and his colleagues assessed 350 newly bereaved widows and widowers for the prevalence, chronicity, comorbidity, and consequences of PTSD. Two months after the death of the spouse 9% of those bereaved through chronic illness, and 9% of those bereaved through "unexpected death" met criteria for PTSD, and 36% of those bereaved through "unnatural" causes such as suicide or accident experienced PTSD. Although the rates of PTSD decreased over time, 40% of those with PTSD still met criteria at 13 months, and 60% of those meeting criteria at 13 months continued to do so at 25 months (Zisook, Chentsova-Dutton, & Shuchter, 1998).

Murphy, Johnson, Chung and Beatson (2003) followed 173 parents for five years after losing their children through accident, suicide, homicide, or undetermined causes. Five years after the death of their children, 27.7% of the 115 mothers in the study, and 12.5% of the fathers continued to report symptoms of PTSD. Within the three diagnostic clusters 55% of fathers and 61% of mothers reported re-experiencing, 38% of fathers and 48% of mothers reported avoidance, and 33% of fathers and 47% of mothers reported hyperarousal symptoms.

These findings concur with other similar studies that people bereaved by violent and unexpected death such as suicide, are at serious risk of developing a chronic pattern of

PTSD, which needs to be recognised as distinct from, but comorbid with grief (Breslau et al., 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Murphy et al., 2003)

## **2. Risk factors for complicated grief**

There is much discussion in the literature relating to normal and abnormal grief. However, contemporary theories of grief suggest that there is no clear evidence for the existence of a normative pattern of grieving, and therefore no justification for the diagnosis of any symptomatic deviations from that pattern as “pathological” or “abnormal” (Neimeyer, 2001). Further, the language of traditional models of grief and psychotherapy are suggestive of disease, and deviation from the norm, whereas the emergent theories consider the experiences caused by grief and trauma to be temporary “difficulties” (Elliott, Davis, & Slatick, 1998). For the purposes of the present study, therefore, it is more helpful to focus on the factors that influence the grief process, and can help professionals to identify those who are most at risk of intensified or complicated grief.

Parkes (1996), for example, suggests that risk factors can be divided into two categories; “unusually traumatic circumstances”, and “unusually vulnerable people” (P.79). Gintner (2001) refers to four sets of factors; type of death, developmental factors, survivor factors, and the post-loss environment. Regardless of how these risk factors are categorised, there is consensus among researchers (Gintner, 2001; Murphy et al., 2003; Parkes, 1996) that there are a number of common factors that place the bereaved at risk of complications to the grieving process.

### *Type of death*

The death of a spouse or child is a traumatic event that carries greater risks than the loss of a sibling or grandparent. Mothers who lose children are at greater risk than fathers, and young and adolescent children who lose a parent carry a particularly high risk (Parkes, 1996).

### *Mode of death*

Sudden, unexpected, and untimely deaths are particularly difficult for the bereaved to deal with; not only must they cope with their loss but also deal with the nature of the death. Death by suicide, murder or manslaughter challenges the bereaved's basic assumptions about the world, making them vulnerable and anxious (Gintner, 2001).

### *Gender*

Research shows that females are more likely to have more severe reactions to traumatic losses, and a more chronic course of bereavement, although it is suggested that males may be reluctant to report strong emotional reactions (Cleiren, 1993; Gintner, 2001; Kessler et al., 1995).

### *Kinship*

A close relationship with the deceased has been associated with a chronic course of bereavement with strong emotional reactions to the loss (Gintner, 2001).

### *Race and ethnicity*

Cultural norms regarding bereavement may be different for individuals from other ethnic backgrounds. The outward expression of grief, and particular rituals, may be considered normal in one culture, but abnormal in another, posing a risk of misinterpretation of the bereaved person's actions (Gintner, 2001).

### *Post loss environment*

Social support has been shown to have a positive effect on the bereaved's ability to cope with their loss. The main source of support usually comes from family and friends, but for those without such support, their loss can be too overwhelming to cope with alone (Gintner, 2001; Parkes, 1996).

Subsequent stressors such as, difficulties with the police, dealings with the justice system, financial difficulties, negative attitudes towards the bereaved in deaths such as suicides, and media attention can all contribute to complicated grief (Gintner, 2001).

### *Personal vulnerability*

Vulnerable people are those who have low self-esteem, an ambivalent relationship with the deceased, a dependent attachment to the deceased, and poor coping skills. Concurrent mental distress such as guilt, and feelings of hopelessness can also contribute to personal vulnerability (Gintner, 2001; Parkes, 1996).

In 1998, the Scott & White Grief Study investigated seven high risk factors that were hypothesised to predict intensified grief symptomology. These factors were sudden, unexpected, or traumatic death; death following a long illness; death of a child or young person; a death that is perceived to have been preventable; a relationship with the deceased that was ambivalent, conflictual, or dependent; the bereaved's mental health difficulties or prior losses, and the bereaved's perceived lack of social support. The results of the study showed that the young age of the deceased was the strongest predictor of complicated mourning, with the bereaved's relationship with the deceased, and their own mental health problems also being strongly associated with "greater grief misery" (Gamino, Sewell, & Easterling, 1998; 2000, p. 635).

Phase 2 of the Scott and White Grief Study sought to clarify the risk factors as well as to investigate the pathogenesis of grief. The researchers aimed to determine whether some factors were "more robust predictors, whether certain combinations were particularly problematic, or whether the factors interrelated in a hierarchical rather than additive fashion." (Gamino et al., 2000, p.635).

The study found that traumatic death, the age of the deceased, and the perception that the death was preventable were the most influential predictors of difficulty in dealing with the death of a loved one. In addition, the bereaved's mental health, and number of other losses rated high scores on the Hogan Grief Reaction Checklist (Gamino et al., 2000), supporting its earlier findings, as well as Parkes' (1996) two categories of "unusually traumatic circumstances", and "unusually vulnerable people".

### **3. Is suicide bereavement different to other traumatic deaths?**

It could be argued that the variety of grief reactions, and the psychological responses to a death by suicide are the same as those experienced by people bereaved by other types of traumatic death. However, for some time there has been a body of opinion that considers suicide bereavement to be different to other types of bereavement; in particular, that grief reactions appear to be more intense and protracted (e.g. Hauser, 1987).

Investigations in recent years have reached conflicting conclusions. Clieren (1993) found that there were more similarities than differences, and that any differences tended to be based on “themes” rather than “intensity”. According to Clieren, suicide survivors tended to ruminate about the way in which the death occurred more than survivors of other modes of death, and showed “markedly more feelings of guilt”(p.252).

Barrett and Scott’s (1990) research supported the notion that suicide survivors experience more grief reactions than survivors of other modes of death. They suggested that suicide survivors experience four distinct types of grief reactions; those that are common to all forms of bereavement, those experienced after “other than natural death”, those following an unexpected death, and those related to suicidal death. In their study of 57 participants they compared four groups by mode of death; suicide, accident, unanticipated natural, and expected natural. On all 11 subscales of their measurements, suicide survivors scored consistently higher, especially on those relating to responsibility, shame, rejection, self-destructive behaviour, and unique grief reactions.

Silverman and colleagues (1994/5) compared five groups of participants according to mode of death; suicide, homicide, accident, unanticipated natural, and expected natural. The results of their study showed that suicide survivors suffered higher levels of grief, which included both general grief reactions as well as reactions that were more intense and ‘unique to suicide’. Suicide survivors had significantly higher scores in the areas of searching for meaning and explanation, loss of support, stigmatisation, responsibility for the death, shame, rejection, and self destructive-behaviour.

Many researchers agree that suicide bereavement is 'qualitatively different', but suggest there is insufficient evidence to support the view that the mode of death is responsible for more pathological or complicated grief reactions or the course of recovery for suicide survivors. Other factors such as personal vulnerability, concurrent stressors, relationship with the deceased, and family history can have a significant influence on the course of bereavement (Barrett & Scott, 1990; Ness & Pfeffer, 1990; Van der Wal, 1989-90).

Reviewers of the literature on traumatic bereavement have been critical of some of the methodology that has been used in the past to reach the conclusions that suicide bereavement is different (Clark & Goldney, 2000; Ness & Pfeffer, 1990; Van der Wal, 1989-90). The previously cited studies have used more systematic methods of investigation, and provided statistical information to support their findings. However, Jordon (2001) notes that some of the thematic differences such as pre-occupation with the reasons for the death, and heightened sense of guilt and responsibility "are more likely to be observed in qualitatively based research methodology that allows research participants to explain their experiences to the researcher in their own words" (p.5).

Anecdotal evidence suggests that suicide bereavement is different to other forms of bereavement because of the stigma attached to death by suicide, either from a religious or ethical perspective, or from a social perception that wanting to take one's own life is unacceptable. At the very least, there is a lack of understanding about suicide, which creates some difficulty for people who are exposed to the bereaved. The fact that death is self-inflicted creates a need to blame someone else for the death. In accidental deaths or homicides there is usually a focus for this emotional outlet - the perpetrator of the crime, or a drunk driver - but for the survivors of suicide the finger of blame can be pointed at anyone from the medical profession to the surviving spouse. In addition, there is a perception that there is more sympathy for those who have suffered their loss at the hands of someone else, than for those bereaved by a self-inflicted death. This perception can be intensified by the sensationalism of media reports and the conjecture, and ghoulish interest about how the person committed suicide. As Jordan (20021) suggested, such intense qualitative information is difficult to capture on a scale of measurement.

Clinical evidence may not be sufficient to support claims of distress levels in suicide survivors for a number of reasons. Some individuals consider their distress to be a normal part of their grief, and not something that can be treated by a GP or therapist; they may be afraid of being ridiculed for seeking help, or concerned that they are wasting a professional's time; or their perception of counsellors or therapists, and what they do is not positive.

Regardless of whether or not suicide bereavement is different, suicide and self-inflicted deaths accounted for around 30% of all fatal injury deaths in 2001, following motor vehicle accidents at around 25%. It is possible that some of the motor vehicle accidents could also have been suicides, but have not been investigated, or recorded as such. Nevertheless, in the light of these figures it would seem clear that suicide survivors deserve increased attention (New Zealand Health Information Services, 2005).

#### **4. Coping and adapting to loss**

As well as investigating the pathogenesis of grief, Phase 2 of the Scott and White Grief Study looked at the reasons why some bereaved individuals adapt to their loss despite their painful, traumatic, and often complicated experiences. In other words, as well as asking how complicated grief develops (a pathogenesis model of grief), the researchers wanted to know how to help the bereaved recover from it (an adaptive model of grief). The former would help clinicians to understand the bereaved who seek help, and the latter to provide effective intervention strategies (Gamino et al., 2000).

Gamino and his colleagues (2000) suggested that the bereaved individuals most likely to have positive outcomes were those who take an active role in their readjustment by “engaging others” such as talking to supportive friends, family, or professional counsellors, and “engaging the environment” such as keeping busy, going to work, and maintaining routines. They suggested that being involved and active gave individuals a sense of control by being able to manage some aspect of the death. Findings from Gamino and colleagues' earlier study had shown that those bereaved who were involved in planning their loved

one's funeral, for instance, had lower negative grief affect than those who did not, or who had experienced a problem at the funeral (p.636).

In addition, Gamino and his colleagues (2000) were interested in the growing literature relating to personal growth following loss and trauma. Researchers report that despite the painful experience of losing a loved one, many bereaved individuals consider themselves to be stronger and more self-reliant than before, not only as a result of having to deal with the difficulties arising from the death, but also because they have been forced to accomplish tasks that they had never undertaken before their loss. The sense of achievement helps the bereaved to reassess their levels of strength and resilience and to view themselves and their abilities in a more positive light (Calhoun & Tedeschi, 2001; Frantz, Farrell, & Trolley, 2001). Accordingly, the study included personal growth as well as functional adaptation to investigate and identify factors that might influence better coping and personal growth in the bereaved. The four factors identified by Gamino and his colleagues (2000) were: having the opportunity to say goodbye to the deceased; recognising that good can result from the death; spirituality; and positive memories of the deceased. Other researchers agree with these findings.

Jann Fielden (2003) conducted in depth interviews with family members who had lost a loved one to suicide. Using hermeneutic phenomenology to analyse the interviews she found that the bereaved moved through several levels of coping with their grief. In the early stages coping centred around preparing for the funeral, selecting clothes for their loved one, and spending time with the body, all of which they considered to be important opportunities to say goodbye to their loved ones. Other levels of coping, or managing their grief were for the bereaved to take time out - avoiding contact with others and spending time alone to reflect on events, and their feelings; to treasure photographs, mementos, and gifts that the deceased had given them before the suicide; and to be comforted by the feeling that the deceased was still present in a spiritual sense.

A longitudinal study carried out by Frantz, Farrell and Trolley between 1989 and 1996 aimed to identifying any positive experiences resulting from the death of the bereaved's

loved ones, as well as any strategies they used that led to a positive outcome to their bereavement. In response to the question of something good coming from the death, 33% of the participants identified stronger communication and bonds with family and friends; 20% had a more focussed and appreciative outlook on life; and 14% said they were stronger and more independent. The ways in which participants helped themselves were many and varied, but the most positive strategies included keeping busy and maintaining routines; helping others; talking, crying and expressing emotions; thinking of the deceased, looking at photos and sharing happy memories of the deceased with friends and family; and a strengthening of their faith or spirituality. When asked, "In what way are you different?" respondents identified being stronger, more confident and independent; more appreciative of life; more compassionate and understanding, and emotionally demonstrative; and closer to friends and family (Frantz et al., 2001, pp. 201-202).

Frantz and colleagues' (2001) results concur with those of the Scott and White Grief Study – Phase 2: The ways in which the participants helped themselves included engaging others by talking, crying, sharing memories, and expressing their emotions, as well as engaging the environment by maintaining routines, keeping busy, and helping others. Further, the participants identified three of the four factors suggested to be indicative of better coping and personal growth: they recognised that good could come from the death of a loved one; positive memories of the deceased were important, and that spirituality gave them strength and security. The authors noted that those individuals who cope with death best "may be those who both embrace and avoid grief, at times feeling the pain and at other times finding ways not to" (p.205). Whilst this may sound paradoxical, the dual process model proposes that the balance between experiencing the grief and re-engaging in work or activity can be a measure of how well a bereaved individual will emerge from the process (Stroebe & Schut, 2001).

It makes sense to anyone who has experienced bereavement that there are times when the pain of losing a loved one is so overwhelming that they feel the need to express that pain and sadness. There are other times when it is essential to carry out everyday activities; they serve as temporary distractions as well as providing a sense of control over the situation,

purpose and achievement. The crucial point here is that providing the bereaved person does not engage in one of these aspects of grief to the exclusion of the other, there is every chance that there will be a positive outcome for them.

## **5. Meaning reconstruction for recovery**

For many clinicians, counsellors and other helping professionals, grief is understood, and diagnosed, in psychiatric terms and as such, some of the coping skills identified in the previously mentioned research may be viewed as avoidance strategies. For example, having the deceased at home for more than a day or two before the funeral is often considered to be a way of delaying the inevitable physical separation. Admitting to sensing the deceased's presence either spiritually or in the form of some other animate object, and the displaying of treasured items made or given by the deceased may be deemed to be a lack of acceptance; and talking to, or 'seeing' the deceased may be construed as psychosis or hallucination.

Such attitudes stem from a history of understanding bereavement as a process of breaking one's attachment to the bereaved, gradually recovering from the depression caused by the loss, and returning to 'normal'. As the literature on bereavement has grown this view has expanded to identifying symptoms of 'complicated' and 'uncomplicated' grief, and the universal stages through which the bereaved were presumed to progress in order to 'resolve' their grief (Neimeyer, 2001).

Researchers and clinicians such as Robert Neimeyer (2001) take issue with this conceptualisation of bereavement, pointing out that empirical studies have failed to support any clear sequence of emotional phases, or that a "normative pattern of grieving exists that would justify the confident diagnosis of symptomatic deviation from this template as 'disordered' or 'pathological' (p.3). Recent attention has focused on the way in which conventional models of bereavement "disempower" the bereaved and their caregivers by suggesting that the bereaved should "quietly and privately" work their way through a series of "psychological transitions" imposed on them by external forces (p.3). In addition, critics

are concerned that by placing emotional states at the centre of these theories, they are ignoring the importance of meaning and action in the bereavement process.

As a result of these criticisms a “new wave” of grief theory is emerging that reflects a constructivist and interpretive move in psychology. Some common themes of the newer models include a move away from the concept that successful grieving means breaking emotional ties with the deceased, and moving towards recognition that “continued symbolic bonds” to the deceased can play a potentially healthy role (Neimeyer, 2001; Silverman & Klass, 1996; Walter, 1996). These models also suggest that there should be greater awareness that major loss can have a significant impact on an individual’s sense of identity, as well as a focus on the way in which specific groups accommodate their loss, rather than emphasising universal syndromes of grief. These models are based on the assumption that “meaning reconstruction in response to a loss is the central process in grieving” (Neimeyer, 1998 cited in Neimeyer, 2001, p.4).

This is a particularly appropriate model for suicide bereavement, where researchers have consistently found that survivors have a compelling need to make meaning of the suicide of their loved ones, and that finding a plausible explanation for the death is important for them to be able to move on.

Thomas Attig (2001) succinctly states that “grieving is nothing less than relearning the world of our experience....It involves simultaneously finding and making meaning on many levels” (p.33). He describes *finding meaning* as an active process in which we consciously bring new meanings into our existence, and read new meanings from our surroundings. This entails the restructuring of our life narratives, and the re-evaluation of our perception of where we fit into the larger scheme of things. *Making meaning* on the other hand suggests a more passive role where we turn to experiences and actions that hold familiar and well-established meanings, which help us to recognise those parts of our everyday life narratives that remain meaningful and provide hope for the future. In research conducted by Marwit and Klass (1995, cited in Walter, 1996) a sample aged between 18 and 54 were asked to write about a significant person in their life who had died.

They were asked to identify the roles that the deceased currently played in their lives. The study found that there were four types of roles played by the deceased: firstly, as a role model; secondly, to provide guidance in certain situations; thirdly, in defining and validating the survivor's values; and finally, as an integral part of the survivor's life narrative. This being the case, the loss of a loved one strikes a severe blow to the survivor's world as he or she has known it; they have been deprived of a relationship in which they developed and maintained their sense of self, shared experiences, and made meaning of the world. New grief theories propose that it is important to help the bereaved to make meaning of the changes in their lives, helping them to redefine themselves and their changed roles through language and the use of narratives (Attig, 2001; Neimeyer, 1995; Silverman & Kass, 1996; Walter, 1996).

In an interesting autobiographical account of two significant personal bereavements Tony Walter (1996) recounts the healing power of talking to others about the deceased through the "process in which we negotiated and re-negotiated who [the deceased] was and what she had meant to us." (p. 13). He discusses the realisation that everybody who had known the deceased had known her in a different context and that as much as they were able to talk about the person they all knew, they also discovered something that they had not previously known about her. The experience of talking to others added to, challenged, and corrected his own understanding of who the deceased was, and provided him with more complete and accurate memories of her, enabling him "to find a stable place for her" in his life (p.13).

Walter (1996) emphasises that where a death is sudden or difficult survivors may also want to talk about the death because it is important to be able to tell a credible story about the deceased's life and death eventually. However, there are a number of reasons why talking to others is not always possible: people grieve differently and at different rates making communication difficult; cultural and religious norms create uncertainty about how one should behave; geographical distance of family and friend can mean that there is nobody with whom stories of the deceased can be exchanged.

In situations such as these, the bereaved may seek counselling, or join a self-help group in order to find someone who is prepared to listen to their repeated recollections of the deceased without feeling that they are an embarrassment to their family, friends and colleagues (Attig, 2001; Walter, 1996).

The implications for bereavement professionals are that rather than encouraging the bereaved to let go of the dead and get on with their lives, they need to give them permission to continue the bonds. Clinicians and counsellors need to encourage the bereaved to talk about the deceased, and to help them restructure their life narratives, their roles, and their values in order for them to reach a point where they can adapt to, and accommodate their new reality without the deceased (Silverman & Klass, 1996). For many this will mean a reassessment of their own values and attitudes. Walter (1996) reflects on the traditions of other cultures and how they can be helpful for the bereaved to adjust to their loss. For instance, the Jewish tradition of *shiva* sets aside seven days in which friends and neighbours call at the house to offer condolences and talk about their memories of the deceased. The Shona tradition of “living in the presence of the ancestors” suggests that the deceased should be acknowledged as a continuing part of the family by keeping the spirit alive (p.9).

In New Zealand, where the indigenous people also ‘live in the presence of their ancestors’ and tangi (cultural practices on death), are opportunities for people to see the deceased and to exchange memories and thoughts about the deceased, it is incumbent upon practitioners to be open-minded and flexible in their approach to assisting the bereaved through their journey of meaning-making, and reconstruction of their life narratives.

## **6. The needs of the survivors**

Throughout the review of the literature, the most distinctive theme in suicide bereavement appears to be the need to make meaning of the death, which is an essential part of the survivors’ ability to adapt to life without the deceased. However, little research focuses on

what survivors perceive they need to help them through this process following the suicidal death of a loved one.

Shneidman (2001) considered that communities should “routinely provide postvention” for the survivors of suicidal deaths, not only because of the impact that suicide has on them, but also because of the vast number of people involved (p. 154). Gary Gintner (2001) suggests critical incident debriefing for survivors of sudden violent loss, similar to those developed for emergency workers following a disaster. In Gintner’s model of crisis intervention, first responders or their agencies would contact a mental health professional who would meet with the people in need of assistance within 72 hours of the incident. The meeting may be a single event, but it provides an opportunity to assess whether or not there should be some follow up. Some researchers suggests that survivors would like professional help but do not know where to go, or are too afraid to ask for it (Provini et al., 2000).

Kari Dyregrov (2002) conducted a study in Norway in which he asked suicide survivors about their needs. One of the questions survivors was asked was, “What would be ideal help from local authorities?” Results from the open questions indicated that 88% of the respondents were in need of professional help, and there was a significant correlation between the survivor’s evaluation of need for help and psychosocial complaints. Dyregrov noted that “the psychologist was the most frequent missing helper.” (p. 656). Forty five percent of the survivors wanted psychosocial care to be available routinely, with one of the respondents noting that there were clear routines and procedures for deaths by accident, but nothing for survivors of suicide. Twenty-two per cent of the sample considered that peer support would be ideal because they could talk to others who had been through a similar experience, and 13% said that they needed information such as advice on how to deal with surviving children, and how to respond to different grief reactions within the family. It was interesting to note that many respondents commented on their sense of numbness, and their poor memory functioning in the wake of the suicide, and the need for written information.

The results of Dyrerov's study concur with those of other researchers (e.g. Parkes, 1996; Provini et al., 2000) that the bereaved often voice a need for professional help but are unable to ask for it. This point was made clearly by one of Dyrerov's participants who commented that "when you experience such a disaster, you are not capable of asking anyone for anything" (2002, p.656). The need for immediate professional assistance identified by these studies is almost identical to the postvention programmes suggested by specialists and researchers in the area of suicide bereavement.

In reviewing the literature for a report on suicide postvention for the Ministry of Youth Development, the researcher (2004) contends that there is a lack of evidence relating to the effectiveness or efficiency of interventions and programmes specifically aimed at individuals bereaved by suicide. In addition, she states that there is evidence to suggest that critical debriefing does not decrease the risk of mental health problems but may in fact increase the risk of PTSD. In view of these shortcomings, and "the relatively small number of deaths by suicide" she appears to recommend a cautious approach to the development of postvention support, and strengthening existing networks around existing service providers (p.44).

At present in New Zealand, volunteer workers from Victim Support provide the only immediate assistance available to survivors of suicide. Victim Support workers usually accompany the police to talk to the families of a sudden death in order to provide emotional support, information and advice, and practical help. These volunteers have very little formal training, and often no personal experience of suicide bereavement or trauma, which may not make them the most appropriate people to provide critical incident support. Again, the service provided by Victim Support volunteers has not been evaluated, and there is no evidence that their service has any benefit for those bereaved by suicide (Beautrais, 2004).

Clearly, there is much research needed to be undertaken in New Zealand with respect to the needs of people bereaved by suicide. However, it is ironic that a cautious approach to developing postvention support for the bereaved is recommended based on "the relatively small number of deaths by suicide", when generous levels of funding have been placed at

the disposal of suicide prevention researchers to give priority to reducing the rates of suicide. Researchers have estimated that between four and ten people are affected by every suicide (Shneidman, 2001; Lukas and Seiden, 1987 cited in Wertheimer, 1997). Taking a conservative estimate of four survivors coping with the effects of every suicide, there are four times as many individuals at risk of serious mental health problems as there are suicide completers, and yet a “cautious approach” is recommended for the care and support of this group of bereaved individuals.

Assuming that the Ministry of Health’s figures of 460 deaths by suicide in 2002 are reasonably constant over the years, (which they have been over the previous three years) then each year the number of survivors compounds to make a significant number of people at risk of serious mental health problems in the community. The development of a crisis intervention model such as that suggested by Gintner (2001) would be appropriate and could, in the long term, reduce the cost of long-term mental health treatment for some. Critical incident debriefing would provide the opportunity for a mental health professional to make contact with the bereaved within 2-3 days of the incident, to offer assistance and advice, and to assess their needs. For many these would probably be one-off visits, but for others it would be a vital source of support.

From the review of the literature relating to suicide survivorship, it is evident that suicide bereavement is a complex experience, which has a dramatic impact. The nature of the death is so perplexing for the bereaved that they are often left with unanswered questions that prevent them from successfully resolving their grief, although there are many other factors that influence the grief process, and the risk of difficult bereavement for some. There is some consensus that bereavement by suicide is different to other forms of death, with those bereaved by suicide suffering higher levels of grief, and more intense reactions, that can lead to long-term mental health problems. However, some studies suggest that the effects are not as severe as previously reported, and others propose that methodologies used in previous studies may not have been appropriate for the nature of the research.

The bereaved cope with their loss in numerous ways. In particular, the literature discussed positive strategies including keeping busy, helping others, expressing emotions, sharing positive memories of the deceased and faith or spirituality. A new wave of grief theory recognises the potentially healthy role of maintaining 'symbolic bonds' to the deceased, as well as helping the bereaved to reconstruct the meaning of their lives without the presence of the deceased in the physical sense, moving away from the earlier concept that successful grieving meant breaking emotional ties with the deceased.

The literature identified the need for professional help for those bereaved by suicide and identified a clear need for research in this area. In addition, initial findings from the Ministry of Youth Development's report into suicide bereavement, suggest that more research is needed to find "the extent to which a range of individual, social and family factors contribute to bereavement outcomes" (Beautrais, 2004).

The purpose of the present study was to address some of the deficits in the research, and to explore ways in which people cope with their bereavement, using an interpretative, meaning-focussed approach. The aim was to explore what and who makes coping easier or more difficult; what kind of help, support, and information the bereaved have received, or feel they should have received, and at what stage it should have been available. Further, the study explored the notion that early intervention for those bereaved by suicide could promote positive outcomes, preventing or minimising the risk of physical and mental health problems by providing emotional and practical support, and teaching skills that improve their ability to cope or adapt to their new situation.

One of the difficulties of conducting research with survivors of suicide is the sensitive nature of the investigations. Consequently, research participants tend to be those who have been bereaved for a number of years. Ideally, investigations need to be undertaken early in the post-suicide period to prevent the passage of time altering the reality of the processes and events that are important to understand if meaningful assistance is to be provided to this population. The present study went some way to addressing this by limiting the time of the participants' bereavement to not less than two years and no more than five years.

# METHODOLOGY

## 1. Rationale

Conventional methods of psychological research have been quantitative - based on the empirical epistemological assumptions that all objects of study can be categorised, quantified, controlled, and manipulated in order to uncover relationships between cause and effect (Parker, 1996). However, there has been an emerging trend in recent years to include methodologies that are less concerned with eliciting facts, and more interested in understanding “the unique and common perspectives of the persons being studied” (Stroebe, Stroebe, & Schut, 2003, p. 238).

Qualitative research provides an alternative paradigm for particular kinds of investigation: Where there is a need for sensitivity; and a rich, in-depth understanding of the unique perceptions that are associated with an individual's, or groups' reactions and responses to certain conditions or situations. However, qualitative research not only provides a more appropriate approach to some studies, it also reflects a different philosophical understanding of knowledge, and the way in which people make sense of their experiences (Cohen, 2000). Although there are a number of qualitative methods that have slightly different philosophical bases, many subscribe to a phenomenological approach, whereby knowledge is acquired through everyday practical activity, interaction with others, language, events and experiences that are interpreted by each individual in terms of their political, social and environmental framework (Packer, 1985). As such, the object of the investigation becomes the individual, and its focus is the importance of understanding “the meaning of experiences, actions and events as these are interpreted through the eyes of particular participants, researchers and (sub)cultures” (Henwood, 1996, p.27).

The changing philosophical approach to research suggests an interesting shift in the role of the researcher. No longer is the researcher considered the expert; instead, the experts are the participants in their studies - experts of their own knowledge. The qualitative

researcher immerses him or herself in the 'lifeworlds' and minds of the participants, eager to learn about the meanings they ascribe to their experiences, in an attempt to understand and interpret them. Having said that, there are times when it can be an advantage for researchers to demonstrate their expertise, or personal experience, in some areas to gain access to the groups they wish to study, and to obtain the rich and meaningful data essential for this type of investigation (Sciarra, 1999). For instance, in the present study the researcher has experienced the loss of a loved one by suicidal death, which provided the first hand knowledge and empathy to encourage the participants to share their most personal and painful experiences in the knowledge that the information was being disclosed to someone who was sensitive, caring and understanding from an 'insider's' point of view.

A relatively recent addition to the qualitative research methodologies making their way into psychological research is Interpretative Phenomenological Analysis (IPA).

As the name suggests, IPA is founded on the principles of phenomenology and symbolic interactionism (Smith, 1996). Briefly, the phenomenological approach developed from Edmund Husserl's philosophy, is concerned with an individual's 'lifeworld' - their unique perception of an object or event (Smith, 1996; Smith, Jarman, & Osborn, 1999; Smith & Osborn, 2003). Symbolic interactionism, which emerged from the USA in the 1930's, posits that the meanings ascribed by individuals to events should be a central concern for researchers, and that those meanings are discovered through a process of interpretation. The central aim of IPA is to discover what an object or event is like from the participant's perspective by "allowing them to tell their stories, in their own words, about the topic under investigation" (Smith, Flowers, & Osborn, 1997, p.68)

Whilst IPA is a relative newcomer to psychology, it has a well-established history in medical sociology where studies have been concerned with individual 'themes' extracted from transcripts of semi-structured interviews with patients. Drawing on that history, in the 1990s Jonathan Smith, a health psychologist in England, proposed IPA as a useful method of investigation for health psychology. He believed that there was a need to examine in detail the way in which individuals perceived their illnesses, and the processes by which they attempted to deal with them. Since then, the use of IPA has been extended to other

areas of psychology, including clinical psychology where studies have been undertaken to discover what strategies cancer patients use to cope with their illness (Taylor, 1983 cited in Smith et al., 1997), and how stigmatisation impacts on the lives of schizophrenics and their families (Knight, Wykes, & Hayward, 2003).

IPA was selected as the most appropriate methodology for the present study for several reasons: Firstly, IPA does not attempt to test any predetermined hypotheses, instead, research questions are broadly framed to provide the researcher with the flexibility to explore areas of interest in detail. It is an idiographic method of investigation, which painstakingly analyses each case one at a time, providing specific information about those particular individuals rather than generalisations to the wider population.

Secondly, the aim of the study was to investigate the ways in which the suicide bereaved cope, and their perceived needs immediately following the suicide of a loved one. From personal experience, it was understood that this would be both a painful, yet cathartic experience for the participants, and as such, the methodology of choice would need to provide the levels of sensitivity, and personal involvement to ethically elicit such personal and painful information. Smith and Osborn (2003) describe IPA as “a dynamic process” whereby the researcher takes an active role, entering the participant’s world so that s/he can understand the other person’s world through interpretation that draws upon his or her own thoughts, ideas, and experiences (p.51). The researcher’s first-hand knowledge of losing a loved one to suicide would provide the ‘expert’ knowledge, and empathy to gain access to participants’ world, and gain their confidence so as to elicit rich, and meaningful data.

Thirdly, much of the extant quantitative research relating to the coping strategies of bereaved individuals has used questionnaires and various assessment measures to provide statistical information on the frequency and intensity of grief responses (e.g. Calhoun & Tedeschi, 2001; Frantz et al., 2001; Gamino et al., 2000). The intention of the present investigation was to provide more subjective and meaning-focussed data on the topic by allowing the participants to relate, in their own words, how they cope with their loss, and what they thought might help them to cope better. IPA posits that, central to its philosophy

is “allowing people to tell their own stories, in their own words, about the topic under investigation” (Smith et al., 1997, p.68).

Finally, anecdotal and empirical evidence suggests that individuals bereaved by suicide suffer a severe blow to their values, beliefs, and sense of identity, constantly asking ‘why?’ – Why did it happen? Why didn’t I see it coming? Why didn’t I stop it? As well as, why did it happen to them? The effects of a suicide can cause serious mental health risks for survivors. Smith suggests that IPA would be useful for studies that try to reflect the ways in which individuals respond to, and deal with a particular situation, especially where people feel that their sense of identity is under threat, and they waste mental energy revisiting the event, asking why it has happened to them (Smith, 1996; Smith et al., 1997). This suggestion positions itself well with the aims of the present study.

## **2. The Participants**

Having chosen the methodology it was necessary to decide upon the size of the sample. IPA studies use small sample sizes because the intensive analysis required can be extremely time consuming. IPA studies have ranged from a single case to 15 participants, depending upon factors such as the level of analysis required, time constraints, or indeed, the number of people wanting to take part in the study (Smith & Osborn, 2003). Considering the time constraints of this particular study, together with some concerns that it may be difficult to attract volunteers for this topic, a sample size of between 12-15 people was considered appropriate.

Participants had to be adults aged 18 years or over, and been bereaved by a suicide of a family member, friend or other significant person in their lives. The bereavement should have occurred not less than two, and no more than five years prior to the study. These criteria was intended to ensure that participants were less vulnerable than they would be at an earlier stage of their bereavement, and were less likely to have ‘reconstructed’ or embellished their experiences over a more extended period of time. It was considered that memories for the previous two to five years would still be reasonably fresh and in tact. In

addition, the suicides must have occurred in New Zealand because the study was concerned with the individual's perception of the treatment they received from authorities and communities within New Zealand.

Participants were recruited through an advertisement (Appendix A) or a press release (Appendix B) placed in various local and community newspapers throughout the lower and central North Island of New Zealand. The first 15 respondents who met the criteria were recruited and an Information Sheet (Appendix C) was posted to them.

There were four male and eleven female participants, with ages ranging from the mid-twenties, to the mid-sixties, 14 were of European descent, and one was Māori. All participants had lost a family member through suicide. Five participants had lost a son or daughter, four had lost their husbands, one had lost her ex-husband, four had lost a brother or sister, and one participant had lost his friend, who was also his partner's son. Four of the participants were from one family, which provided an interesting range of data from the deceased's wife, mother, mother's partner, and brother. Two participants were husband and wife who provided similar, yet different perspectives on the death of their daughter.

The individuals who had suicided were nine males and two females and ranged in age from mid teens to late fifties. Methods of suicide included six hangings, one carbon monoxide poisoning, one shooting, one poisoning, and two unspecified. Of the six hangings, three were teenagers, and two were female. At least one of the completers had made previous suicide attempts, eight had histories of serious health, or mental health difficulties, two had been victims of child abuse in their early years, and eight had experienced serious negative life events or losses in the year leading up to their deaths.

### **3. Data Collection**

In accordance with IPA guidelines, semi-structured interviews were conducted. The format of the semi-structured interview provides the researcher with the opportunity to establish a rapport with the participant, to probe other interesting issues that arise, and to follow topics

that the participant considers to be of interest or concern. An interview schedule was designed (Appendix D) to provide some direction for the interviews. The schedule contained a number of questions that covered areas of interest to the researcher, and invited the participants to discuss these areas, or to use them as a framework for their own narrations. The questions were arranged in a logical order beginning with some background information about the deceased, the suicide, procedures that followed, funnelling into questions relating to coping strategies and perceived needs. However, the participants were encouraged to tell their own stories, in their own way with minimal interruption from the researcher.

The interviews were arranged at times and locations convenient to the participants. Eleven interviews were held in the participants' own homes, two in the family home, one in a workplace, and one in a hotel room. The interviews lasted between 45-60 minutes and, with the consent of the participants, were audio taped. The researcher allowed at least 15 minutes before the interview to establish a rapport with the participant, to provide a brief overview of the procedure, and to obtain informed consent in writing from the participant. The participants were asked to indicate on the Consent Form (Appendix E) if they wished to have their audio tapes returned at the end of the project. They were advised that unwanted tapes would be destroyed when the study was completed. At the end of the interview another 15-30 minutes was spent debriefing the participant, and talking informally to ensure that they were not unduly disturbed by the experience, before leaving them. They were also reassured that there would be no identifying information relating to themselves or any third parties in the research report. The researcher later transcribed the audiotapes. Individual transcripts produced between 20-30 pages, totalling approximately 400 pages of material for analysis.

For security purposes, all data, including audio tapes and consent forms, were kept in a lockable document case, and later transferred to secure storage at Massey University, where they are to be kept until the five-year storage period expires. All electronic versions of material were password protected.

The Massey University Human Ethics Committee approved the procedures for recruitment and data collection under Palmerston North Application 05/06.

#### **4. Analysis**

As mentioned, IPA is an idiographic mode of investigation, which involves intense analysis of each transcript in an attempt to understand the complex meanings of the respondents' narratives. In order to capture the meanings that are not immediately available, the researcher engaged in a process of interpretation as follows:

*Initial notes* – transcripts were analysed individually in sequence, using the left-hand margin to note anything that was significant or interesting, including poignant background information, descriptive labels, similarities and differences, and preliminary interpretations.

*Identifying themes* – the next step was to use the right-hand margin to note emerging themes. In essence, the initial notes in the right-hand margin became succinct phrases capturing the essential character of the text, and using the participants' own words as far as possible. The emerging themes were then recorded in chronological order onto sheets of paper, which identified the participant by a code number, and provided the relevant pages and line numbers of the transcript where instances of each theme could be found.

In a variation of Smith's suggested system of analysis, necessitated by the number of participants, the emergent themes from each transcript were merged into what was affectionately referred to as the "freefall" list of themes – a complete list of themes identified from all 15 transcripts.

*Connecting themes* – the "freefall" themes were then structured by finding relationships and making connections to form clusters of themes. These clusters were checked against the transcripts for validity, and a list of participants' phrases included in the list in order to provide support for the themes at a later stage. Finally, a master table of themes for the

group was compiled giving each cluster of themes a name, representing the *superordinate theme*, and listing the relevant *subordinate themes* beneath them. The thematic structure of the results is shown in Table 1 below.

**Table 1: Master table of themes**

<b>Superordinate:</b>	<b>Coping strategies</b>
<b>Subordinate:</b>	Acceptance Reassessment, transition, and restructuring life without the deceased Avoidance/Routines, rituals, and being active Personal strengths/Gender differences
<b>Superordinate:</b>	<b>Contributing factors</b>
<b>Subordinate:</b>	Beliefs, spirituality, and connections Taking care of the living/Friends, family, and community First responders, agencies, and institutions Personal factors/ Reminders and triggers Negative impact on personal physical and mental wellbeing and on the family/Positive outcomes
<b>Superordinate:</b>	<b>Needs</b>
<b>Subordinate:</b>	Information/Professional help Training for people dealing with the bereaved Appropriate services and programmes, and funding to help the bereaved

In the following chapter, results of the analysis are presented according to the superordinate and subordinate themes identified. Quotations from participants' transcripts are used to support the interpretation of the thematics.

## RESULTS

Three superordinate themes emerged from the analysis, which were also the areas of interest in this investigation: (i) coping strategies, (ii) contributing factors, and (iii) needs. These themes were validated through reference to the participants' transcripts.

In the following sections each of these superordinate themes are explicated and the related subordinate themes are illustrated with examples from the participants' narrations. For instance, the superordinate theme of *Coping Strategies* has six subordinate themes: *acceptance; reassessment, transition and restructuring life without the deceased; avoidance; routines, rituals, and being active; personal strengths; and gender differences*. For each of these subordinate themes, passages from the transcripts demonstrate the way in which the participants used that coping strategy. The examples were not chosen for their prevalence, but for the richness of the passage that helped to highlight the themes. Although the choice of examples was contingent on the interpretation of the researcher, there was constant reflection and re-examination of the transcripts to ensure that the themes related to the primary source material. The overall effect of this process was that some themes were deleted, and others were expanded until the final themes represented here emerged.

### **Coping Strategies**

Coping strategies are the ways in which individuals adapt to changes in their physical and social environment, and in particular, the resources mobilised by the individual to handle change. In the present study, one of the key questions of interest was how people cope when someone close to them takes their own life, and what resources do they call upon to help them to adapt to such an adverse event, and move forward.

The subordinate themes that constitute the superordinate theme of coping strategies are *acceptance of the deceased's decision; reassessment, transition, and restructuring life without the deceased; avoidance; routines, rituals, and being active; personal strengths;*

*and gender differences related to coping strategies.* The subordinate themes are the resources identified by the participants of the present study as those used to cope with their situation.

One of the key ingredients to successfully coping with the death of a loved one by suicide appears to be the acceptance of that person's decision to take their own life. However, before they can do this, the bereaved need to understand the reasons behind that decision. It is important, therefore, that they are able to access all the information that is available from medical records, police investigations, Coroners' reports, friends, neighbours, or any other sources, so that they can piece together the "puzzle" and put it into some form of comprehensible framework that they are able to live with.

#### *Acceptance*

The need to find a coherent reason for the suicide of a loved one is apparent in the detailed accounts that participants provided in their interviews. Each one of them traced the history of the deceased, pinpointing events that appeared to establish a pattern leading up to the final act. Thirteen of the fifteen participants referred to long-term physical and/or psychological problems endured by the deceased, and the other two noted significant life events that had severely affected them.

Participant 3 recalled how her healthy teenage son had been affected by the sudden death of his father, and then supported his mother through chemotherapy for breast cancer, caring for his younger siblings, and helping around the house as well as attending school: all during the year leading up to his suicide. She commented:

*...I just believe that a lot of it was too much for a 14 year old to take on.*

Participant 13 talked of a gradual "*pulling back*" from school activities by her teenage son after a series of family upheavals, and recalled his dissatisfaction with life:

*... on two different occasions – probably about a year apart – he said to me, ‘Mum, I don’t like my life. I wish I wasn’t here. I wish I didn’t have this life.’ ... those sort of comments.”*

The parents of a teenage girl talked about their daughter having “*a history*” which caught up with her. They later heard from her friends and her brother that she had tried to talk to her boyfriend about it, but he walked away rather than discuss it with her:

Participant 12: *“And then we learned all the different scenarios of what happened. A had had an argument with her boyfriend..... I think that was the straw that broke the camel’s back. He just walked away.”*

A’s mother ((Participant 11) added:

*... all I’m assuming is that she hit the brick wall, didn’t realise there was no light on from that and felt – obviously her heart was broken...*

Rationalising the suicide leads to acceptance of the deceased’s decision - this is not necessarily the same as agreeing with it. Participant 11 rationalises her teenage daughter’s decision to end her own life and accepts it in these terms:

*...without sounding really weird, my hat goes off to her for doing what she felt she had to do for herself. She did what she felt was right for her. It’s just, I suppose, they just don’t think at the end of what they’re leaving behind; that’s not part of the equation. At the time, they’re looking at – this is for me, and I can’t deal with the rest of the world at the moment, and I’ve got to do this for me.*

A young widow (Participant 7) with three small children recalls the problems that preceded her husband’s suicide: alcoholism, depression, an isolated indiscretion, and finally, financial difficulties with his business. She referred to her husband as “*morally sound*”

and believed that he could not live with the shame that he perceived he had brought on his family:

*...sometimes the darkness is bigger. Well, actually, I think he thought that he was helping and doing the right thing, and it wasn't so much that 'this darkness is overcoming me and this is the problem; this is the predicament I've got my family into, and I'm the one to fix it and I need to look at everything' – because he was always thinking – “and this is the best option. She gets her whole life back – a new life – she'll get over it. She's a strong woman. She'll do a great job with the kids.’*

Participant 15 explained that after questioning himself as to whether he should have seen that his brother was not coping and offered help, he decided to take a more positive stance:

*... it was his decision, that's what he wanted to do, so you know, accept it and that's it – his choice; if he wanted to go that way, well so be it.*

Participant 13 talked of forgiveness as “*the biggest key*” in accepting the deceased decision and coping with their loss. She said that she had realised that her strength came from having been able to forgive her son for taking his own life, as well as forgiving herself “*...for anything I might have done to...cause it.*” She realised that: “*There was nothing else that we could have done. This was a choice that he made. And in understanding that, it's been easy to let go*”

Being able to forgive oneself and others releases the bereaved from the negative emotions, such as guilt, blame, and anger that can hinder their ability to accept the situation, which in turn enables them to cope with their changed circumstances and move on with their lives.

#### *Reassessment and restructuring life without the deceased*

This follows on from understanding and accepting the deceased's decision to end his or her own life. It is the process of adapting to life without the physical presence of their loved

ones, and finding other ways to keep them in their lives. Participant 1 describes this process:

*I looked for answers; I looked for answers in the present and the past. And I looked for answers to sort of face the future that incorporated the past. And having to look for a way to face that pain without having A around.*

Participant 12 described the importance of keeping his daughter's memory alive:

*...we talk about her virtually, you know, 24/7 and every day that goes by we mention her name. She'll always be a part of our family...*

He adds:

*...even though she's not here in the physical shape, she's here in the mental stance...she's here.*

On the other hand, Participant 7 said that learning "...it's OK to let go and it's OK to move on..." was hard for her until she realised that

*"...S would never have wanted that – I mean, he's got other things to do out there, wherever he is, you know, I don't expect him to be hanging around me forever – he's got other stuff to do, so have I. And you take it with you wherever you go, so just keep moving forward..."*

The transition between a loved one's physical existence and finding a way to accommodate them in a different form after their death can be difficult for those left behind. The journey takes many routes, including searching for answers to provide reasons for the death, sharing happy memories about the deceased with others and keeping those memories alive, and letting go of the past and learning to live without them.

### *Avoidance*

In the process of understanding and accepting the deceased's decision to end his or her life, avoidance is a useful coping strategy, which helps the bereaved to manage the overwhelming emotional responses from self and others. Avoidance for most individuals entails compartmentalising painful issues and putting them aside until they feel able to deal with them.

Participant 1 told how she used strategies that she had previously used as an abused child to cope with her sister's suicide:

*"...just being able to use those dysfunctional ways in functional ways: like being able to compartmentalise some of that grief, and just bring it back, bring it out when it suited me, and sort of open the lid and let a few worms come out and deal with them...otherwise it became too overwhelming. And too, like as an abused person it gives you a sense of control..."*

Participant 10 shared her very sad story about her husband who had suffered from Asperger's disease. Over the years, he had changed from the man that she had met and fallen in love with, to someone whose behaviour had become so bizarre that she avoided talking about him because of the numerous sad and unhappy memories that were hard to deal with:

*We just don't talk about him – except when we do, it's sort of: wasn't that funny, in a strange way [recounting some of the strange events from the past]...So there's all these really sad memories, really...It's very hard.*

Participant 9 packed away some of her husband's things until she was able to deal with them:

*...I couldn't cope with any of his bowls about; I couldn't cope with anything my husband had done, I couldn't cope with any of the beauty that he had created*

*around... And I packed them up and I thought – because when you're in a time warp of sort of denial, you're liable to do things which are really stupid.”*

Clearly, there is a diversity of strategies used by individuals in an attempt to avoid the pain of their loss. Some people compartmentalise their grief and deal with it as and when they feel able, others avoid talking about the deceased because it invokes unhappy memories that they are unable to revisit, or they remove from view anything that might trigger emotions that are too overwhelming for them to manage for the time being. In this respect, avoidance helps the bereaved to work through their loss in manageable stages.

#### *Routines, rituals, and being active*

One participant succinctly described this process as being “...*more about getting on with life, really*” (Participant 8). Getting back to normal routines and keeping active is an important coping strategy; it provides distraction and temporary relief from the enormity of the event that the bereaved are dealing with – and is often an additional source of comfort and support from work colleagues, or a wider network of contacts. All participants agreed that getting back to normal routines and keeping busy were vital ingredients to being able to cope:

Participant 2: *...I always concentrated on doing the things that I needed to do to keep myself perked up, so I'd do things like, I would do gardening, even if it was just doing weeding, because it was something repetitive, and it's almost like – I suppose a bit like meditation.*

Participant 5: *I wrote to the Sunday Star Times a letter when the Fight for Life thing was going on at the same time, saying how ghastly and inappropriate I thought it was.*

Participant 13: *...don't just sort of sit in a pool of mire – it's all too easy to get bogged down. Just get out and be active, and take action and get out of your old ways. And that's what I've done all the way through; that's how I've coped.*

In the initial stages of bereavement, the single most important activity is to organise the final farewell for the deceased. Although this is a challenging task, it can often be a source of great comfort, and an opportunity to share happy memories of the deceased with others, and celebrate the life, rather than mourn the death of the individual. Eleven of the fifteen participants found the funeral to be a positive, comforting experience as well as a useful coping strategy.

One family had their daughter's body returned to their home and placed her on her bed for a week before the funeral. During that time, her family were able to sit with her and talk to her; her friends came to the house and sat with her, and played her favourite music; and her parents were able to share with her friends special memories of their daughter, and learn about other aspects of her life. Her father describes how important that was for them:

*Participant 12: I think the biggest thing that got us through it was having A at home; having her that week it was kind of like, yeah, she's here... We could sit in the room, we could talk to her – even though she wouldn't answer back – and I think it helped us to, kind of like to deal with the fact – yeah, OK, our daughter's gone, we're doing what we're doing, but we've got to keep on going; we can't suddenly stop, hold everything because we're fine."*

Another family decided upon a very different kind of farewell for their loved one. The informal occasion was held at a park close to the beach – a place that was dear to the deceased and his family. Family and friends had decorated the coffin with painted handprints, flowers, etc. – “*something personal and special*” (Participant 4). Children ran around with balloons, which they later released into the air and was “*a joyous thing, it was*” (Participant 4). The deceased's wife described it as “*remarkably healing*” (Participant 7):

*Participant 4: The kids were running around yelling and screaming, people read poetry, and [his wife] played a few songs, and we used his old car – a big old Falcon station wagon – we used that as a hearse to take him from the house down*

*to the beach, for a final walk along the beach. The coffin was in the back, and the kids were hanging out of the back of the hearse, grinning and carrying on. Oh, it was just, it really took all the feel of a funeral and that sort of thing away”.*

Participant 1 told how she and her sister’s best friend worked together to prepare her sister for her final farewell:

*A’s best friend and I were allowed to dress her, we were allowed to put her makeup on, do her hair – just little things like, yeah, I can remember going with [the friend] to A’s home picking underwear and kind of, as women, A and I and her friend we all like really nice lingerie, so we were rifling through the drawers to make sure we had the nicest lingerie, shoes, and little things like that. Yeah, some of those things they were fun.*

Other rituals were also helpful. Participant 14 told how his father, a farmer, had ploughed up a piece of greenstone in the horse and plough days, and it had been in the family ever since. When his mother died it passed to his brother, and on his passing the greenstone, along with all other family possessions was bequeathed to one of the brother’s lady friends who was not known to the family. After some discussions with the solicitors, the greenstone was returned to the participant, who proceeded to trace the original Maori owners of the greenstone and return it. He described how the greenstone was returned:

*...these people they put on a special ceremony at a little church ...and they went through the full protocol...They called us on with a karakia, and we carried it in, in a little flax basket, and it was something that I doubt whether we’ll ever forget – and actually it was quite therapeutic, too.*

Routines and rituals are healing processes for most bereaved individuals; whether it is simply getting back to work and facing the world, having a funeral that celebrates the life of the deceased, or returning a piece of greenstone to its owners with full protocol, it provides the solace necessary to move on.

### *Personal strengths*

Personal strengths play a large part in being able to achieve the understanding necessary to accept the deceased's decision, and to reassess and restructure life without them. When asked how they got through their experiences many participants responded in a similar manner, referring to inner strength, natural resources and resilience:

Participant 1 *How do I cope? I'm strong and resilient, pig headed, a bit outspoken at times, I've got a good sense of humour...*

Participant 3 *I think it's just myself: just being strong in myself and I think it was just me, and knowing in my mind that you know, "come on, just pick yourself up. You'll get through this.*

Participant 7: *...I can always get some perspective on things...*

Participant 13 *I was really focussed.*

Those who did not specifically mention it certainly conveyed their strength of character through their interviews and transcripts: the fact that they volunteered to participate in this research, and share so much personal and painful information, and in such detail, was testament to their personal strength.

### *Gender differences*

Whilst many of these coping strategies are common to both men and women, there are some differences in the ways that men cope with loss. Generations of socialisation have indoctrinated men with the belief that they need to be strong at times of trouble, to look after the women and children, and to put their own feeling on hold.

When asked if he had been offered, or sought, any counselling after finding his partner's son's body, Participant 4 replied:

*I was too busy working and then keeping an eye on [deceased's mother and participant's partner] and making sure that she was alright, trying to be there and available, but not being too intrusive, you know, 'are you alright?' ...You know, that's just what you're here for, that's what you do, and I wouldn't have had it any other way, yeah, so I didn't have any time to go and get sort of professional help or anything like that.*

Participant 8 described the ways in which he had coped with his brother's suicide:

*The acceptance was pretty much, well it's – even before the funeral – it's happened, now we've just got to watch out for the ones that are still here and make sure that they're OK and everybody's looked after, because that was the major concern that I had was: S's gone and he's in a – I wouldn't say a better place – but he's in another place, and we've got to worry about those that are here now, and how they're going to cope. And that was my major concern right from the start. So, I never went to any support groups or anything like that.*

Participant 11 told how one of her daughter's male friends was not coping well with her suicide, and she was concerned "...that he may end up joining her" if he did not talk to someone:

*Whether or not this young man would actually talk to anybody like that, I'm not sure...It's a peculiar male thing; I'm strong. I'm tough. I can cope."*

The subordinate theme of gender differences highlights particular difficulties for males in dealing with loss. The traditional perception that men need to be strong for others, that they can cope, and that men do not talk about their feelings, means that they do not allow themselves time to address their own physical and psychological needs, which places them at a distinct disadvantage.

To illustrate this point, seven months after completion of the interviews, one of the participants told how she and her partner (who was also a participant) have separated because of the impact of the suicide on him. He had been unable to communicate to his partner how he felt about putting his own feelings on hold to protect and take care of her, but had done so in the interview for this research. When he received the transcript of his interview, he used it as a channel to spell out these issues to her. The participants believe that the man's inability to express those feelings at an early stage of their bereavement has disadvantaged both him, and their relationship.

### **Summary**

The first superordinate theme of *coping strategies* identified a number of resources that participants used to cope with the suicidal death of a loved one. These resources were reflected in six subordinate themes. *Acceptance* of the deceased's choice to end his or her own life helped the participants to adapt to the changes in their environment through *reassessment, transition, and restructuring* their lives without the deceased. *Avoidance* was a way of managing the overwhelming responses to their grief; *routines, rituals, and being active* provided distraction and temporary relief from the event; and *personal strengths* helped the participants to accept the deceased's decision and move forward. In addition, results showed some *gender differences*, which suggested that men may be disadvantaged by the traditional perception that they should be strong in order to support others. Consequently, men may not allow themselves time to address their own needs.

### **Contributing factors**

The second superordinate theme, contributing factors, reflects the participants' perceptions of the positive and negative influences on their coping strategies. These include the positive benefits of beliefs, spirituality, and a connection or continuing bond with the deceased; taking care of the living; support from friends, family and the community; helpful first responders, agencies and institutions; personal factors; and positive outcomes.

However, some of these factors can also hinder the bereaved person's ability to cope: some participants found first responders such as police, Victim Support volunteers, and funeral directors to be disrespectful and insensitive; other people's reactions to a suicide can be extremely unpleasant; and prior family difficulties, especially with in-laws, can present unexpected challenges. Personal vulnerabilities have also been recognised as being unhelpful in the coping process. Each of these possibilities for hindering the ability to cope are discussed in the appropriate sections below.

### *Beliefs, spirituality and connection with the deceased*

Seven out of fifteen participants indicated that spirituality, faith, or some other form of connection to the deceased played a significant role in coping. Three others commented on positive spiritual/supernatural experiences, strengthening their beliefs in an afterlife, or the existence of something more powerful than ourselves.

Spirituality was often expressed in terms of symbolism, or a sense of presence.

*Participant 4: He appears to us in things like, orange things; monarch butterflies and bottle caps. Now there's a weird story...he used to drink Stella Artois – that was his drink, sort of thing – and we went and sat down in this really nice, spotlessly clean bar with big comfy leather chairs, and we sat down, and as I sat down in my seat I saw something stuck down the side of my seat, and I picked it up and it was a Stella Artois bottle cap, and that was like a little message; S saying 'Hi guys.' You know, he's still with you. Mmmm. Things like monarch butterflies, when I see them I say 'Hi S. How's it going' It's weird, I know, but...*

*Participant 6: I have actually only 'seen' him once, even though I feel him around me often, and I can smell his cigarette smoke, especially when his children are with me. One time the children were staying at my house overnight and I got up in the middle of the night to check that they were O.K. They were all fast asleep and he was sitting in my green chair watching them. I said, 'I didn't know you were here, S.' and he replied, 'I am always here, Ma.' I went back to bed, reassured, realising*

*that he didn't mean he was always in my house, but that he was always watching over the children."*

Participant 11: *And every now and then at certain times we have the odd fantail who comes around. She said 'I'm going to come back as a bird, Mum.' And we have this fantail that always comes to visit... and if they were having a bit of a do over in our garage, this fantail would fly into the garage and watch, and it would primp and preen, move it's tail feathers around, and I'd say, 'Mmmm, she's here. She's strutting her stuff.' It was just weird that she had come back as a bird, and she was making sure that we were fine."*

A strong faith in God helped one of the participants to cope with the loss of her son just one year after the sudden death of her husband:

Participant 3: *Because I believe in God, and I think it's more or less my faith that has actually brought me out of it ...spiritually, yes, my Maoritanga does help me because I believe that we will see each other again, and that M and his father have gone to a better place. And I suppose that's one of my strategic plans that has helped me."*

A sense of connection, or continuing bond with the deceased generally came in the form of 'messages' from the deceased through dreams, third parties such as clairvoyants or other people with 'psychic abilities'. One participant tells how the family have each had dreams about her teenage son, and the most poignant part of all the dreams is "*the golden light and the arms pulling and lifting him.*" However, the comforting factor for her is that on various occasions complete strangers have validated those messages or connections:

Participant 13: *...a friend of mine told me about a guy that he knew...who'd got a little message for me. So he gave me the number and I called...And he told me: 'I was busy working late one night... and I had this overwhelming vision of a young man who was lost, so I closed my eyes and went into the vision and I had a*

*conversation with him and he was very unwilling to open up, but then I saw the golden light with arms reaching for him.*

Another recounts numerous stories of messages received by family members through dreams and signs. In particular, she recalls a message that she received from an acquaintance when she was agonising over whether she should take a trip that had been planned before her son's death, or whether she should cancel it:

Participant 6: *She said that S, whom she had never met, was telling her to tell me that I was to go on the trip as planned, and H (his wife) and the children would be well looked after. V was using words and phrases that that I recognised as coming from S, she could not have guessed them."*

Other spiritual experiences are explained in the form of *sensations*:

Participant 15: *...the day he died...or that's the day I believed it happened...I woke up on the Friday morning and I felt this incredible pressure around my head – it was very, very strange. I've never felt like it before or since. Anyway, I just laid in bed all day and my son stayed home from school and both of us, I think, could not explain what happened that day, it just, the day went... and I believed that those sensations that I went through were what he was experiencing as he died."*

Participant 13 described herself as having a strong spiritual background, and recounted one of her experiences whereby a ball of light "*manifest itself in the figure of my son*" and she had a conversation with him. She emphasised that this was not a physical light, but something in her mind's eye and went on to say:

*I feel that I've been gifted, because I'm open to listening to that kind of thing, so I've been gifted with these opportunities – whether they're real, whether they're imagination or whatever – I don't care. To me, they work for me, and I think if people can open up to that, then there's a huge amount available to them.*

No doubt, there are many who would consider these experiences to be ‘grasping at straws’ - not being able to face the reality and finality of death. Some would even question whether these people really believe that their experiences are real, or whether it is just ‘wishful thinking’ – real or imaginary, they provide comfort to the bereaved, and the strength to accept their loss, and move on with their lives.

### *Taking care of the living*

Many of the participants indicated that looking after children or other family members provided them with the motivation and strength to carry on at a time when self-indulgence and self-pity could easily have taken over:

*Participant 7: If I didn't have the children to come home to I think it would be very easy to get lost, and they always bring, well, they keep you busy, you know, if you're busy you can't dwell too much on one thing that snaps, you know, you can't get lost in yourself."*

*Participant 15: I think when you're grieving it's not a steady state; you have ups and downs, and you have to go with the flow and do what the fancy takes you. People can't put a set prescribed pattern on to you – and of course, because I had the children I had to keep going for their sake."*

One participant recalls her own fleeting suicidal thoughts after the suicide of her teenage daughter:

*Participant 11: I have thought about it myself after A had gone. I had been really low myself and I often wondered: what's the point? And like, I've got my son, I've got my husband. I would love to be with my daughter but no, living is still too important to me."*

Another recalls that one of her brothers stayed with her for a couple of weeks during the Christmas period following their younger brother's suicide, which served two purposes:

firstly, she was able to help and care for her brother, and secondly, it provided her with company at a vulnerable time for both of them:

Participant 2: *...so that was good for me to have him here for a couple of weeks, it was so that I could look after him, but I knew that in order for him to start to recover he needed that – he had no-one else to do it...*

It would appear that taking care of others, especially children, provides a sense of purpose and a welcome distraction from self-pity, loneliness, and desperation that the bereaved can resort to without it.

#### *Family, friends and the community*

Family, friends, and others in the community can be a tremendous source of support at times of tragedy and loss. Support comes in many guises, from best friends who provide a shoulder to cry on, a sympathetic ear, and practical assistance, to complete strangers who have had a similar experience and empathise with the bereaved. All of the participants have similar stories of support and kindness from a variety of sources:

Participant 12 recalled how the extended family arrived promptly to support him and his family on being told of his daughter's death:

*We had to do all the things, and D's [wife] parents came out and everybody else. I rang my parents and told them that A had passed away, and Mum and Dad were here the next day - from [South Island] it was brilliant.*

He also indicated that his daughter's friends and family were a great comfort to the family:

*...I suppose all of A's friends and their families helped us more than what they'll ever know. You know, we thought we were helping them, but they were helping us to get through it too.*

At the time of her husband's death, Participant 5 and her family had been in the throes of moving to a new location. She and the younger children had already moved and her husband was waiting for confirmation of a new position, and for the older children to finish schooling in that area before moving them. She recalls how wonderful his employer of 14 years and the staff were to her and the children:

*When we got back...our friends and everybody had taken care of what needed to be taken care of...everyone was wonderful in that respect...On the funeral side of things, they were incredibly wonderful – it was one of the best funerals I have ever experienced... and that helped me a tremendous amount.*

Participants 9 and 10 were widowed with children and neither had any extended family in New Zealand to provide the support that bereaved individuals normally rely on. They both depended heavily on their friends:

Participant 9: *“It’s a time when the people you want around you are people who can understand... I was very, very lucky having friends coming round...and I’d sort of phone up and say to people, “If you’ve got any spare time, if you come round I can spend a couple of hours sorting things out...” I felt like I had really run everybody down, and you know, wrung everybody out.*

Participant 10: *...I relied really heavily on friends to do things for me because couldn’t go anywhere near the place where he died because I felt left out in his life for quite a long time. My neighbour...and a friend of mine...they cleaned up the whole flat – took everything away, put it on the market and they were quite incredible.”*

However, the unexpected kindnesses were especially touching for the bereaved:

Participant 15: *There was one very touching experience; an old chap down in F, he rang me up to convey his sympathy, and he was most upset. He sort of apologised*

*and all that, that he couldn't come to the funeral. He said: "I dearly want to come, but I can't" and very tragically, he had lost a son in a road accident some years previously, and the day of my brother's funeral was going to be the anniversary, and they always have a meet, you know, they go to visit the son's grave on the anniversary of his death, so he was unable to attend my brother's funeral. But he did the next best thing he could do which was to ring up, and you could tell how sincere he was...*

*Participant 12: I had a person come to the door ... and gave me a bouquet of flowers. "You don't know me and never will, but I've been through this before." And she walked away. I wouldn't know this person from a bar of soap.*

Unfortunately, family, friends and others in the community are not always supportive, especially after a suicide. Perhaps a lack of understanding, an inability to deal with the subject, or prejudice relating to suicide leads some people to respond negatively. Negative responses tend to be insensitive comments to the bereaved, not wanting to listen to them talk about their loss, or avoiding the bereaved altogether and contributing to the sense of stigma and isolation experienced by many individuals bereaved by suicide.

Several participants commented on the lack of support and understanding from their immediate family:

*Participant 5: I didn't have a huge amount of support or understanding from my immediate family, who are very caring, stable, practical people but don't want to know things – and still don't... they still don't really want to know the why's and wherefore's of things, and they don't really want to get into the personal side of anything, and that's been pretty hard over the years...*

*Participant 3: ...their attitude is "well, get over it...you've got the other kids...yeah, it's really hard sometimes talking to people that don't understand...they're caring and that, but they're lacking in empathy.*

Participant 9 recalled that her mother blamed her for her husband's death:

*...mum and dad knew that there were problems within the marriage and I got a letter from mum saying that it was all my fault...you know in your own heart where you're at and so you know that certain things that people throw at you are just nonsense.*

Other difficulties that arose with families were those that result from divorce – former in-laws, and former spouses and their children. Participant 14 shared her story of some of the difficulties encountered with her ex-husband's family.

The participant and her children were unaware that anything untoward had happened to her ex-husband because his family, with whom he lived at the time, decide not to provide them with information. Despite their divorce, the couple continued to have a good relationship and maintained regular family get-togethers. It was approaching one of these family times – their son's 13<sup>th</sup> birthday – when they received a message from the family to say that the participant's ex-husband had gone missing, and that they should not to go to his property. It was six weeks before they had another message telling them that his body had been found:

*I had a 12 year old and a 14-year-old child desperately wanting to know what had happened to their father. It went on for six weeks – you can imagine what that was like...*

She went on to tell how the children were invited to a memorial service, but were never given any mementos of their father, and how, some twelve months later, their daughter asked where her daddy's body was, they eventually discovered that his mother was holding on to his ashes. After a lot of unpleasant exchanges between the participant and her former husband's family, they were finally given access to the deceased's property. She recalled that it was around Christmas time:

*We walked in and on the dining table was a parcel wrapped up. The children ran in ahead of me and said, "Oh, someone's left us a Christmas present." I unwrapped the parcel and it was his ashes in a box. That is the level of understanding from his family that we encountered as to the needs of two young children grieving for their father.*

Participant 9 talked about the arrival of her husband's former wife following his death:

*I knew she was going to come because she had children by him, and so they would come because she was looking after their interests. We had always got on fairly well, but this one really was the straw that broke the camel's back. But I was expecting them to come in and just take mementos of their father – just something to remember him – but they turned up with a dirty great big van, ready to just, sort of... I took one look and thought...*

Dealing with the aftermath of a suicide creates a sense of vulnerability for the bereaved and they often develop high levels of sensitivity; they become overly alert to other people's comments, actions, and reactions and feel the need to defend themselves and the loved one who took their own life. In some cases, this may be an over-reaction, but in others, it is clear that people can be judgmental and insensitive.

Participant 1: *After she died, when we got back home I felt like I had to justify and explain to people how she died. So often people would say things like "Oh, I can't believe she suicided" instead of "I can't believe she's dead". Church people, they were the worst; they brought their food, they brought their soup, and they brought their baking, and then they asked: "Did she know God?" It was like I felt they were making a moral judgment. After the soup and biscuits stopped it was: "Have you got over it yet?" or "Something good will come from this" and I thought to myself ... There's nothing good about losing a loved one to suicide.*

Participant 8: *...some people never came to the funeral, and they didn't come to the funeral because of their beliefs, and their beliefs were that it was a wrong thing for him to do...they didn't turn up because they thought they were condoning the act, where in fact...they're not objecting to it – they're actually thumbing their nose up at the people that are still here and actually need the support right now.*

Participant 9: *...it cut away the people who really, really couldn't cope. It left me with a core of friends. I'm very grateful for that because it was time for deadwood, I think, to desist.*

Participant 11: *We went to McDonalds and I said, "Do you feel like everyone's looking at you? Like everyone knows what's gone wrong" It just felt like everyone's staring at you – they weren't but you felt like everyone was watching you – and it was just a very odd sensation*

She adds:

*But it's not very easy to talk about. It almost reminds me of when cancer first came out – like "the big C" – don't talk about it, you might catch it. I think people are scared to talk about suicide because they think if we talk about it, we might...*

Participant 13: *I was back at work straight off – although ironically, people stayed away – it was very weird... They were almost afraid.*

Whilst family, friends, and others in the community can provide comfort and support to the bereaved, clearly, they can also be very unhelpful in some situations. Suicide is a subject that evokes negative attitudes from some people, manifesting as prejudice, insensitivity, and a lack of sympathy and understanding towards the already sensitive and vulnerable bereaved. Negative attitudes are often exacerbated where relationships were difficult before the death, and where divorce or separation from the deceased has created tension between the bereaved and the deceased's family, and/or former spouse.

### *First responders, agencies and institutions*

Those involved immediately following a suicide tread a fine line between carrying out their routine duties, and dealing sensitively with the bereaved. As with family and friends, their actions, comments, and attitudes can be influential in the success or hindrance of coping with loss.

Victim Support volunteers have minimal training for dealing with people bereaved by suicide. According to the participants' narratives, the level of assistance received by the bereaved is a 'lucky dip'; it appears to depend upon the individual volunteer's personal experiences, social networks, and interpersonal skills:

*Participant 3: The main question that they [Victim Support people] (they didn't even say hello) they just came over and they just said, "Oh, was he on P?" ...That's the first thing that they, because of his age, they said, "Well, was he on P?" ...I was just very angry because I just didn't want to hear people say that about him, and they didn't even know him and all of a sudden, he was a drug addict...*

*Participant 6: The woman from Victim Support arrived not long after the police...she was very comforting and really helpful and arranged for someone else from Victim Support to go immediately to be with [son's wife]...brought another funeral director to meet us all at [son's wife's] place the next day...arranged for [son's wife] and me to meet with the Mental Health Staff at [name of hospital] where [son] had been assessed several hours before he died.*

Police officers have extensive training in dealing with crime, traumatic incidents, and victims of those situations, but it would seem that many police officers do not have a great deal of compassion when it comes to dealing with a suicide:

*Participant 14: ...we were all fingerprinted and when we got back, there was a message on the phone from one of his brothers to say that his body had been found the previous day. That was how bad the lack of information to us was; that the police had fingerprinted us when their colleagues in [another city] had already*

*found his body, and when I mean, they didn't know, obviously they knew were I was; they'd been here and interviewed us...*

*I think that what added a lot of unnecessary grief and stress in our situation was that as ostensibly the ex-wife I was cut completely out of the process by the police.*

*Participant 5: The difficulty for us was the police, who were heinous. They were dreadful...[husband] had written a note that afternoon ... that didn't make the remotest amount of sense to me...something to do with him, us seeing a lawyer to get separated...and the police saw that, didn't tell me about it, took it away...and they thought: "Ah, these people are separated or divorced" and went, "they're not going to care" ...so they had the completely wrong end of the stick, treated us with – not contempt, but like we were a family that didn't exist in his life at the moment, so we didn't get much compassion...[at] the police station ...the sergeant there...was really very patronising, condescending, almost rude to us.*

*Participant 10: ...they said they would pick up my other son from his friend's place, which they did. Now, unfortunately, the friend's parents were in town - there was just the friend and my son, and the police explained why they were there...He was meant to come to where I was [police took him home instead] so...he was by himself in the house – the police didn't check whether anybody was there – so he was there for quite a long time before we realised that he was by himself...which I find quite – bloody awful.*

Other participants reported positive experiences:

*Participant 6: I found the police to be very considerate and sensitive...The young policeman who returned [son's] clothes later, was very polite and respectful and seemed a bit nervous about telling me that [son's] underpants were soiled. I reassured him that I understood that.*

Participant 15: *...there were two constables involved here and the first one that came out and broke the bad news to us – but I've certainly got no problems with their handling of things...They were very good indeed. Very compassionate and understanding, and devoted a bit of their time to us – because they're pretty busy – and when he came out and told me, and I said "This is a pretty stink job for you to have to do" he just said, "Oh, that's what we're trained for; that's what we're here for."*

Participant 12: *So then, we dialled 111 and had the police up there, and [son] coming out screaming, you know, "what's going on?" And then he saw his sister, and this poor cop – I remember this guy – [son] just turned round and punched him, and this poor cop just dropped his arms and [son] just laid into him. He just hammered him like hell. I felt so sorry for this guy.*

Funeral directors are perhaps more familiar with the needs of the bereaved and usually work with them in a sensitive, helpful, and respectful way:

Participant 1: *We had a woman funeral director ...she was just amazing, and it's an experience that left our whole family with something really positive...They were respectful...We were informed all the way through of the processes like embalming and all of that, and why. They talked about [sister] as a person.*

Participant 3: *...he just said, "What's going to happen now is that we are going to take him to [name of city]...we're going to go to the morgue, and then they're going to go to [city], and then they'll bring him back the next day." And they told me that they had to have different tests and stuff because of the situation of his death.*

Participant 7: *I said, "Look, I want to have a beach service, because that's his favourite place." And she [Victim Support volunteer] said, "Oh, well, I'll tell you what – I'll ring up this guy because he's very open-minded as opposed to the other*

*one.” And that was a simple thing, and it made all the different...I ended up running the funeral – he didn’t say no.*

But funeral directors, too, can sometimes forget that whilst they deal with dead bodies every day, to the bereaved the newly deceased is still their husband, son, brother, sister, or daughter:

*Participant 11: ...the people who came to collect her were so inconsiderate – like, they just – they’re used to dealing with, obviously, dead bodies, but they had no consideration for the people who are left behind. All they want to do is, like, whack her up, get her out of her. It’s like, that’s our daughter, you know, we’ve just lost her, come on, she was 15 years old! They took her away and we said, “Well, where’s she off to? When can we come and see her?” And they just said, “She’ll be at the morgue at [city] hospital.” With that, we didn’t really know where we were going, what we were allowed to do....*

The inquest and the Coroner’s court is an institution that few people ever have to be involved with, and as such, it can be a daunting experience. The coroner receives the details of a death as investigated and presented by the police. Some bereaved individuals find this a helpful process that answers some questions and helps to complete the puzzle; others consider it unhelpful and lacking in many respects:

*Participant 5: ...it was a whole day of suicides...What I noticed when sitting through them was that both of those two were the same as [husband] – the suicides occurred during a relatively calm, and seemingly, a very good progress time of their lives of all their history – that’s why it was unexpected. We found that even though they were three totally unconnected types of scenarios, totally – you know, one was quite a psych patient, another was a random runaway, and [husband] was sort of just a long-term life thing – it was all in phases of their lives when it was least expected, because they seemed to be going through a good progressive patch...So that was interesting...*

Participant 6: *The coroner withheld his final verdict because he felt that Mental Health might not have done their job properly, but after interviewing the staff he said he felt that they had done all that they should.*

Alternative comments related to the length of time it took to hold the inquest, and the validity of the information placed before the Coroner from police investigations:

Participant 1: *...that took along time and I couldn't understand why it took so long. It wasn't, well, put it this way, it was a straightforward suicide, there was no sort of mitigating circumstance that needed to be investigated...even going into the room, it just seemed, it was so, it sort of smacked of a very British white male sort of patriarchal system – yeah, it was like a court – it is a court.*

Participant 14: *The investigation into this one was a total farce, and all sorts of untruths were said by his family...the police interviewed them, took what they said at face value, wove that into a report, the Coroner just regurgitates it and it's taken – it's not investigated – I think it's utterly appalling that comments were allowed to go forward about his marriage, and his relationship with me and the children, sourced from other people, and not from myself, and not from – as I say, very circumspect, independent witnesses...So the Coroner's report was utterly untrue, utterly unhelpful, and there's no real point in having a Coroner's court and Coroner's findings unless they are reasonably accurate...*

Responses from schools and colleges were also helpful or unhelpful factors that participants reflected upon:

Participant 9: *When the school knew what had happened they came round – even though it was school holidays – the headmistress came round and she was very, very supportive to the boys: “...anything we can do, please ask” and I just said, “Look, can you please, please make sure that if there is any – just any peculiar*

*behaviour, let me know and we'll get on to it immediately... So they were very, very good.*

Participant 14: *The schools were both very good.*

Participant 5: *...when they returned to school, my eldest son's best friend's mother had died that year, and the principal of the college (whom we knew) his wife had just died – there were three – and [husband's] death – there were three deaths in a small town in a short space of time, within a few months. Ours got no attention or support whatsoever from the college, even though they knew us...the school held services for the others, but [husband's] death was completely ignored...*

Participant 7: *...going to school was the worst thing – being with other kids. I think that was one part where I think schools and, I think, teachers training college, they really need to learn how to cope in those sort of situations – how to act, how to talk about it – because what happened was all the other children knew that [son's] dad had killed himself...you know, he was just bombarded with it [questions] and then people were just whispering, you know, the older kids. They're just kids, they weren't being malicious; it was just kids being kids, you know, they're curious. And the school really needed to address that...*

Participant 11: *...the college was useless. A lot of them [teachers] said, "Come on, it happened. Get over it. Move on." They'd just lost one of their best friends! And there was one teacher that we had actually heard from a lot of the school, from pupils, even my daughter, he'd said, "Society would be better off without you."*

Helping agencies for bereaved children drew similar responses:

Participant 7: *[Son] went to Skylight, children's grief counselling and they were great – after finally getting him up there kicking and screaming, kicking and screaming, punched everything, and everything he could possibly do.*

*It was interesting for me to meet other people...I was 27 when [husband] died...I was a widow and I had three children, and I was widowed by suicide. I don't know anybody like that...I was very isolated – and it still is isolating...it was interesting to hear everyone's stories and I realised I've got just the most amazing family...*

Participant 9: *Skylight were suggested as somebody who would help, but...they weren't willing to do anything for six weeks, when there would be a group of people.*

Participant 14: *I thought I would do the right thing and get professional grief counselling – so I took them to an agency called the Skylight Foundation, but I had already, a couple of years previously when it was first established, made enquiries there because they also dealt with grief of children over marriage break-up, and I had formed the view that they weren't a very responsive organisation because for starters, they wanted to see children during school hours...Anyway, we went to see the person there and the children didn't react terribly favourably...she did say that they were going to set up some group sessions and I thought that a group work session could be much better...But those things never eventuated...*

Several participants commented on attitudes and responses of ambulance staff, a specialist, and a general practitioner. In the first situation, the ambulance staff members made incorrect assumptions about the participant's relationship with her husband and consequently were reluctant to speak to her about her husband:

Participant 10: *...I got a phone call that night, on a Saturday, from the hospital ambulance staff, for [son] not for me, they couldn't talk to me, [son] was out so they did talk to me in the end...*

The second situation was a mother, whose daughter was diagnosed as epileptic, but despite the medication, her mother was still concerned about her erratic behaviour – she described

it as living with “*Dr Jekyll and Mr Hyde*”. She had told the specialist that she thought that something else was wrong, but was told that she was being a neurotic mother. She recalls:

*She used to cut herself...not badly – but there were scars on her arms, and she used to set up the lighters and burn herself, and I’m not qualified – but I often wonder if she was in that much pain and this she could deal with – she could feel that, she could see it, she just didn’t know how to work with that. I used to mention it to her specialist...He didn’t care...That’s why I got labelled a neurotic mother. I’m worrying too much. I should have worried more!* (Participant 11)

The third instance was a positive one:

Participant 6: *Our family GP was very helpful and made [son’s] medical notes available to us. She explained to us that [son] probably felt that he was fixing everything by his suicide.*

Dealing with financial institutions such as banks, insurance companies and the Inland Revenue Department can be difficult. One male participant who attended to his brother’s financial affairs after his death commented on his experiences:

Participant 8: *... [there was] a very large bill with the IRD which had to be sorted – who, by the way were fantastic... Which was amazing because that was the crux of the [brother’s] problem – the large bill that he had.*

*...the banks wanted all sorts of things. It was unbelievable what they needed just to close the thing! Just to close the account. I mean, there was no money in it...I rang them up and I said, “It’s in reference to this.” And they said, “Oh, we can’t talk to you about this, you’ll have to put [deceased] on.” And I said, “Well, he’s dead.” And they didn’t know how to handle it.*

There is a diverse range of services and personnel that the bereaved need to deal with following the suicide of a loved one, from police and funeral directors to teachers and bank staff. The participants' experiences with these contacts have been just as varied, and the positive or negative attitudes have influenced their coping abilities. It is clear that those who work in these services should be appropriately equipped to communicate with the bereaved, whilst putting aside their own prejudices and discomforts.

### *Personal factors*

Personal factors play a vital role in an individual's ability to cope with adversity. In addition to personality and strength of character, environmental influences contribute to the success or otherwise of coping with loss.

On the positive side, participants talked about taking time for self, being creative, and expressing emotions as being positive influences:

*Participant 14: We just take each day as it comes...We had a little break away... having that space, and just having that time away...*

*Participant 7: Oh, being creative, definitely. Yeah, I'm a painter, and I'm a musician, so yeah...I finished an album...I've just finished my exhibition...and that was all based on widowhood...about the isolation that comes from being a widow...doing those sort of things is a huge help.*

*Participant 5: We did a lot of talking...*

*Participant 13: I still cry, and I know that the crying is like a release of energy...so let it out – and I was not bashful about crying in public. If I needed to cry, I cried..*

Other participants referred to issues surrounding their loved one's passing as being comforting:

Participant 12: *In a way, I'm pleased she did it at home, otherwise we would never have found her.*

Participant 9: *...he [police officer] showed me them [photographs that police had taken when they found her husband] and it actually settled something.*

Personal factors that contribute to difficulties in the bereaved individual's ability to cope include relationship problems with the deceased, prior unresolved losses and events, finding the deceased, parents burying their children, and negative emotions.

Participant 10 recalls how her husband's behaviour affected her own mental health, which now contributes to her slow recovery from his death:

*...I had had a nervous breakdown because he always told me that everything was my problem...a lot of emotional abuse... So I was hospitalised for a while, and came out again but to him I was always the mentally ill person, he used to say, whereas really it was him and his totally bizarre behaviour that drove me to the psych ward in the end.*

Another participant told how he had never dealt with the death of his mother:

Participant 4: *My mum died when I was about 11 and she'd had a brain tumour for about three years, and was around the house for a couple of years, and then she was really ill for a year and spent most of the time in hospital, so I don't have a lot of memories of her, but that's still a thorn in the side. I still haven't dealt with that problem.*

A prior relationship break-up was a contributing factor for Participant 14:

*...a relationship which I'd been in for seven years fell apart ... my life fell apart – and [former husband] came into the house and stayed with us for a while and he*

*helped me, and I know that physically, I literally aged over night, and so this whole other scenario coming within a couple of months...*

Discovering the body of someone who has taken their own life is unimaginable and not easily be forgotten.

Participant 4: *The worst bit for me – the bit that I found really hard was coming home from work every day because...I'd have to come home and the...first thing I had to do was open the French doors and I couldn't help myself but look down and look for that bit of paper on the floor [suicide note which led to the discovery]...*

Participant 3 gave a detailed account of how she found her 14-year old son hanging in the bathroom, and how she removed him from the noose, laid him on the ground, and hugged him. When asked if those images played on her mind she replied:

*Oh yeah, I'll always see that image, but I just think, well he's with his dad, and I know God will look after them...The only negative thing I see is the expression on his face, and it's the loss... It's like he was lost and lonely.*

Participant 11 responded to a similar question as follows:

*I know it's there. It's like I was meant to find her...I'm gutted I found her, believe me I am. It's – there's my pride and joy dangling, hanging from a bloody rope.*

The death of a child is always difficult for parents to cope with. This is expressed simply by the parents of a 14-year-old girl who took her own life:

Participant 12: *Kids are supposed to bury their parents, and we're not supposed to bury the kids...This one has taken a lot of things away from me, I must admit...no grandchildren...she's robbed me of a lot of things...But I still love her no matter what. It's unconditional...*

Participant 11: *...I feel like I've had something taken away...I suppose at times you feel a little angry with her because she took that away. You know, her Dad's never going to get to walk her down the aisle...*

These parent participants illustrate the mixture of emotions that the bereaved experience; on the one hand the positive emotions such as love, and on the other hand, anger, disappointment, and sometimes resentment. Observations suggest that negative emotions can be detrimental to the healing process after loss.

The unpleasantness surrounding the death of Participant 14's former husband has caused her much consternation. Her interview is littered with instances of anger and resentment towards the police, her former husband's family, his girlfriend, and other people. She admits that:

*The anger and the resentment that the whole process has brought about is very detrimental to me and the children recovering...*

Participant 10 expresses how her own sense of guilt, and anger towards her deceased husband have affected her progress:

*What I also found very hard was that I was really angry with him for being what he was, and how he was, for years...I felt mean to reject him because he needed me, obviously, but there was nothing I could give, and what about me? I'd already been with him 25 years...I felt cheated out of my life...I'm losing my focus a bit at the moment because I don't feel very good in myself.*

Apart from personal strength, other factors play a role in the individual's ability to cope with adversity. On the positive side, creativity, making time for self, and expressing emotions freely were helpful personal strategies. On the negative side, prior unresolved losses and events, finding the body, and a difficult relationship with the deceased before the death were unhelpful factors for the participants.

### *Reminders and triggers*

Reminders and triggers can be very powerful emotional stimuli that can be unnerving for the bereaved. All participants agree that the sense of loss after the death of a loved one never goes away because of the constant reminders that seem to appear from nowhere.

Participant 9: *I went into the supermarket and there was a piece of music playing and I'd started doing the shopping and I was with my youngest son, and I said, "I just can't cope. Come on, we're going." Tears were streaming down my face, and we just waked out, and he just looked at me and he said, "Have we got enough in the pantry?" Don't need it. I felt really bizarre... and I was really surprised...It came from nowhere and it just knocked us sideways...*

Participant 4: *It's funny the things that push your buttons – the last things you think of – like someone I saw the other day; there was a tall young man in a Tibetan hat and a stripy orange and white top waking up and I thought, "[friend's name] no, no, no, it can't be" you know, and you get flashes like that.*

All the participants agreed that those reminders and triggers ensure that the sense of loss never goes away, but does ease with time.

### *Negative impact on personal physical and mental wellbeing, and on the family*

The participants' narratives revealed that the suicide of a loved one can have far-reaching ramifications. Many of them talked of the isolation, stigmatisation, and loss of privacy as illustrated earlier under the headings of *Friends, family, and community*. Others referred to a lack of trust, a loss of confidence, undermining of beliefs, trauma, and experiencing poor health:

Participant 9: *the really bad thing that I noticed was it just totally, totally laid waste to all confidence: confidence in relationships...The big one is trust, and the other one is belief in yourself, and my big one – because I've always believed in the power of love – my big, big questions is, why wasn't love enough? And that...is the*

*biggest one and it's also the most frightening one because it undermines a whole belief system, and a societal system, and a mindset, and so many other things...*

*Participant 10: My husband committed suicide about – that's the point, I don't even know when – it was two or three years ago – it's still such a trauma that I've been thinking about it really hard over the last few days and I can't remember...*

*Participant 12: I was on Prozac for a while, because I had that depression sort of thing, and I was on Prozac for a while.*

*Participant 15: I got stricken with bowel cancer...I think stress can cause things like that, and we were definitely under a lot of stress at that time...I was a smoker, and I just started smoking something terrible – I was damn near chain smoking there at one stage...We were just going through a bad patch there.*

Several participants referred to dealing with a suicide as a “learning curve” (Participant 6) for themselves and their families. Some described how it caused cracks in family relationships, negative consequences for the children and siblings, and in general had some detrimental effects on everyone concerned:

*Participant 11: My mother's sister...said, “I know how you feel; it's just like when M left home.” And, excuse me, I thought M can come home again, [daughter] can't – never. [Husband's] never forgiven her for saying that.*

*Participant 12: ...they're [grandparents] trying to hold on to something that's not there, we know the feelings, we know what happened. Even [daughter] wasn't even close to [grandparents]; she said they weren't a grandparent – they could have been like the other grandparents but they never made the effort – you know...  
...[son] went through a bad patch too [after his sister's death]. It's in the back of his head that he'd do the same thing...I must admit, I wanted to...do the same thing. I think [wife] wanted to do the same thing too.*

Participant 14: *And here I am today with my son truanting from school, and I'm sorry, but these are all consequences of the appalling way in which this was handled...*

Clearly, the death of a loved one by suicide can have detrimental effects on the bereaved, which include psychological difficulties such as depression, trauma, and suicidal ideation, physical illness, relationship problems, and behavioural problems in children.

#### *Positive outcomes*

Despite the pain and anguish that the bereaved have suffered, many of them are able to reflect on some positive outcomes following the loss of their loved ones such as strengthening bonds with the living, improved communications, strengthening their faith or spirituality, reinforcing the value of life, and providing unexpected opportunities.

Participant 4 on strengthening bonds – personally:

*[B, friend of deceased] he's a really nice guy...and still, every time we see each other we give each other great big hugs and it's nice...we're always pleased to see each other. It [their friend's death] gave us a bond that we wouldn't have had otherwise.*

For others:

*...it seemed to bring [deceased's brother] closer to [deceased's mother], he spent more time with her, because he's a busy, busy bloke...He seems to be much more relaxed, and makes a point of coming and spending time with [his mother] and you know, [brother's wife] and the kids...and looks after the family sort of thing and that was really neat to see...*

Participant 6 on improving communication:

*So that's the best thing that happened, I think, is that everybody's more open – I'm allowed to say these things and other people will arrive and say something that, you know, just puts things into perspective – helps the puzzle.*

On strengthening beliefs:

*So, we've all come to that understanding; that there really is an afterlife. It's a big change.*

On reinforcing the value of life, and providing unexpected opportunities:

Participant 8: *It reinforced, for me, that you should get your papers in order; get a will, but not only the will, get all the accounts, all your investments all in one place so that for anyone going through it, it's so easy to do.*

Participant 13: *My business has continued to grow since then.*

Participant 15: *...he [neighbour] came round...and said, "Oh, you wouldn't consider leasing the farm?"...The thought of leasing the farm had never entered into my head...I felt comfortable straight away with it and I thought, yes, this is me; to hell with the work, let some other clown get on with it. It put an end to everything there, and he [deceased brother] had all the money in the world, so that's not very important – there's better things than that.*

Not everyone who has experienced the tragedy of suicide or sudden death is able to accept that anything good can come from such a loss. However, in this study, for those who were able to put their experience into perspective and restructure their lives in a way that accommodates the loss of their loved one in a positive way, were able to reflect on small, but valuable lessons that they and others have gleaned from their journey.

## **Summary**

The positive and negative influences that contributed to the participants' ability to cope with their loss were identified in the superordinate theme of *contributory factors*. Eight subordinate themes represented these influences. *Beliefs, spirituality, and connections* played an important role in coping, as did *taking care of the living*. However, results showed that whilst some contributing factors such as *friends, family, and community; and*

*first responders, agencies and institutions* were helpful for some bereaved individuals, others found them to be unhelpful because of negative attitudes and assumptions about suicide, or an inability to understand the impact that it has on those left behind. *Personal factors* were similarly reported to be both helpful and unhelpful. Creativity, making time for self, and expressing emotions were helpful, whereas prior losses, difficult relationships with the deceased and finding the body were unhelpful. Participants acknowledged that although *reminders and triggers* were unnerving when they occurred, the sense of loss that they evoked eased with time. Some participants reported a *negative impact* on themselves and their families as a result of the suicide, including physical illness, trauma, and relationship problems. Others related *positive outcomes* such as strengthening bonds with the living, improved communications, reinforcing the value of life, and providing unexpected opportunities.

## **Needs**

The third superordinate theme represents services that participants suggest should be available to assist individuals and families bereaved by suicide. The subordinate themes include the provision of information, professional help and counselling, training for people dealing with the bereaved, appropriate services and programmes, and funding specifically aimed at helping those bereaved by suicide.

### *Information*

As previously mentioned, the need for the bereaved to be in possession of all information is vital in order for them to piece together the puzzle and make sense of the death of their loved ones:

Participant 5: *We wanted answers. We weren't given any. We weren't given a detailed breakdown of what the police came to when they arrived at his death – where he was in the house – all these things. We weren't given that...at the time it was important.*

Participant 13: *...I did go and see a local counsellor...I just wanted to sort of check out what might have been the cause...and he said it's a very common thing – it sounds like he had an overdeveloped sense of shame...and I went all through his [son's] life and I could see all the little places where that came up...That's [some answers] all I wanted.*

In addition, the bereaved also need to be informed of the processes and procedures followed by first responders, and other agencies and institutions that they need to deal with:

Participant 14: *I was never notified of the inquest, I subsequently found out that he had left a suicide note in the car, so we could have been spared six weeks of anxiety of not knowing.*

Participant 8: *I wanted a handbook on all the things you need to do when someone dies, and there isn't one...it was like, where do I start? Who do I see?*

The participants refer to the sense of shock that they experienced when told of the suicide of their loved ones, and how they were dazed, confused, working on autopilot, going through the motions, and feeling so overwhelmed by the entire situation that it was difficult to comprehend what was happening in the first few days. Specific information about the circumstances of the death, what happens to the loved one's body immediately following the discovery, the process of investigation, and the inquest, need to be conveyed to the bereaved in a clear but sensitive and compassionate manner. In addition, there should be informative leaflets provided that relate to the more practical matters of dealing with the deceased's affairs, which can be referred to when the bereaved have had the opportunity to deal with the more immediate matters of concern.

### *Professional help*

Participants repeatedly commented on the need to talk about the suicide, and to express their feelings to someone other than friends and family. None of them used the Victim Support volunteers in this way, nor did they feel able to contact them or anyone else at a

later stage with respect to counselling or similar assistance. Only one participant had been offered counselling but was disappointed with the service that was offered. He telephoned the number given to him by the police, expecting to make an appointment to see someone. Instead, the counsellor “chatted” to him over the phone:

*Participant 15: I thought it would have been a bit more on a one-to-one basis. You know...trying to discuss the thing over the phone...*

Another participant sought grief counselling for herself and her children but felt that the counsellor lacked the understanding to deal with people who had been bereaved by suicide, and was judgmental:

*Participant 3: ...it was just the questions that she was asking. I mean, her approach – I just didn't like it...the counsellor didn't really help, that was because she didn't know where I was coming from and couldn't relate, and I'm sure I felt like she was saying “what a naughty boy he was to do that.”...and I think that people shouldn't judge...*

Most of the participants felt that the bereaved needed professional and experienced help to cope with their loss. They discussed the importance of having helpers who have experienced a suicide themselves - how good it is to talk to others who have experienced suicide and understand the myriad emotions and problems that the suicide bereaved experience. In addition, the helpers need to have appropriate professional status, rather than volunteers with minimal training to deal with those who have lost their loved ones to suicide.

*Participant 2: I think it would have been helpful to have someone who was experienced in dealing and supporting you when relatives take their own lives...Someone to talk to...someone trained to listen, that they're not going to say the wrong thing...So really, that's the one thing that would have been a big help and would have probably hastened my adjustment.*

Participant 9: *...you need people who do understand.*

Participant 14: *...recognise that when children have lost a parent or lost a sibling they're more likely to be at risk, and they should be defined as 'at risk', and there should be follow-through.*

As some of the participants pointed out, voluntary helping agencies are well meaning and provide a very good service in many areas, but they are not paid for their work, have minimal training and are not appropriate agents to be dealing with people who have experienced a traumatic loss such as suicide.

#### *Training for people dealing with the bereaved*

One of the largest causes for complaint by participants related to schools, colleges, banks and associated industries. It would appear that teachers, school counsellors, and educational institutions in general are reluctant to deal with suicide. Anecdotal evidence suggests that because of the surge of youth suicides in the last decade teachers and school counsellors tread a fine line between talking about suicide too much and perhaps drawing attention to it, and not doing enough for those bereaved by suicide. This would suggest that teacher and school counsellors have not received adequate training – if any – to deal with suicide bereavement.

Participant 7: *...I think schools...teachers training college, they really need to learn how to cope in those sorts of situations – how to act, how to talk about it...*

Participant 12: *...he [headmaster] gave the kids no room – he'd promised that he would give them a place that they could go in, to chill out, but that never happened. The counselling at the school for her [daughter's] friends never happened. It was kind of like, as I said, under the carpet.*

For the staff working in banks, insurance companies, and other, similar institutions dealing with the bereaved probably constitutes a reasonably small proportion of their business.

Nevertheless, it makes sense that these industries should prepare their staff for the inevitability of dealing with sensitive matters. Participant 8 summed up this situation:

*Now this is crazy: this is something that happens everyday – people die everyday – and yet no one is geared up to deal with people who die, and what you need to do around...I just find it ludicrous...*

Again, the people working in these industries should be aware that whilst they know the procedures to be followed, their clients or customers may not, and that some clear information, sensitively given is appropriate.

In addition to schools, colleges, and financial institutions, several participants criticised the people-skills of some police officers, suggesting some reviews in their training:

Participant 5: *...a completely new strategy that they identify from the people who work with suicide, not from their own intelligence, but from listening and learning from the people who are in it, that suicide is a different death to all other deaths.*

Participant 14: *If the police had a liaison officer...[who] identified who were the key people to be kept in the loop – namely, the mother of his children... that would have made a huge difference. I think that every time someone suicides the police should very carefully define who the key point of contact should be, and if it has to be two, perhaps, different people then so be it, because there's always situations where that's necessary.*

Clearly, there is a need for those working in these various areas to be conversant with the need for sensitivity in the way they communicate with the bereaved regardless of what proportion of their workload that may entail.

#### *Appropriate services, programmes and funding to help the bereaved*

There was a perception amongst the participants that there is not enough help or support in the community for people bereaved by suicide. They believe that this is because

policymakers do not recognise the impact that a suicide has on bereaved individuals, families, and the community in general, nor do they appear to realise the huge number of people involved:

Participant 1: *There's nothing out there for adolescents who are survivors who have lost a mother or father. But there is for alcohol, drugs...*

Participant 12: *...if only the government got off their arses to do something about it and help to acknowledge the fact that kids are doing this – not only kids, but adults are doing it too – maybe something could be done, but...Nothing, nothing... A lot of people [are affected by a suicide]. I'd say that in the hall [funeral service] there would have been well and truly over 300 people...There were a lot of people out there that were hurting and nobody was doing anything about it...*

Some participants suggested that policymakers, mental health professionals, and researchers should recognise that caring for those bereaved by suicide is part of a general suicide prevention strategy, and use suicide prevention funding more appropriately to include the bereaved:

Participant 1: *They talk about depression as being the common cold of psychiatry. There's so much money going into the prevention of suicide – and rightfully so ...but at the same time...if more time and money was placed with the survivors they may then, because of timely support, be less prone to ongoing depression, and less likely to contemplate suicide themselves.*

Participant 5: *...don't fix something after it's already shown symptoms, fix what causes it – which is the inability for people to speak out. That whole cycle of abuse issue, which I know doesn't cause all suicides, but it all comes down to the basic ability to communicate...being able to deal with the suicide bereaved is also a part of that cycle of preventing suicide.*

One participant considered that the Mental Health Service could improve its record keeping and information sharing to ensure that mental health patients who move around the country receive consistent care:

*Participant 14: ...the difficulty of getting help for people, and the whole...confidentiality issues, and the whole secrecy around it, and the way in which somebody can be mentally unwell and go from one area to another and maybe tell different stories to different people and take some medication here and not there...and for a proper case history to follow someone so that there is a real focus on the person's case history and their needs.*

Other suggestions made by the same participant related to improving suicide investigations, and protecting children's rights when a parent commits suicide:

*Participant 14: We talk about being concerned about our suicide rate...particularly in relation to young people and middle aged men, people whose lives, apart from the emotional cost...have a value to our society economically, and for that reason alone policy should dictate that more funding goes into Coroners courts, and that there are independent investigators attached to Coroner's offices, not simply reliant on police report. [In my case] the whole Coroner's report was utterly untrue...and there's no point in having a Coroner's court and Coroner's findings unless they are reasonably accurate...*

*...I believe that when someone dies and leaves children under 20 or 21, the Commissioner for Children should be appointed as an automatic trustee of the will, of the estate to cater to the needs of the children...I believe that there should be, just as there are court-appointed people to ensure access rights, then there should be court-appointed people to ensure that children inherit, and the whole process...*

There are some far-reaching suggestions relating to the improvement or establishment of appropriate services and programmes for the suicide bereaved. However, the underlying issue for all of these proposals is funding.

Two main points arise in relation to funding. Firstly, the need to fund research and intervention programmes relating to those bereaved by suicide, and secondly, to use any funds allocated for this purpose in a more appropriate manner:

Participant 1: *...I just wonder...whether there needs to be more, definitely more research...and stuff put in place...a bit of money and time spent on intervention [for the suicide bereaved].*

Participant 5: *...for the government to take on board...and give real, real, real resources...that aren't just things in the name of 'Fight for Life' and this silly nonsense.*

The needs of the bereaved, as identified by the participants of the present study, are not unreasonable. The participants identified areas that they believed could be of benefit to those trying to recover from the effects of a suicide, from personal experience, and after careful consideration. All of their suggestions are practical and realistic such as the provision of information, training, and improved services and programmes to assist the bereaved. These services need not be costly – rather, a redistribution of allocated funds - but could have substantial benefits for the bereaved, as well as for the community at large.

### **Summary**

The third superordinate theme of *needs* identified services that participants felt should be made available to assist those bereaved by suicide. Four subordinate themes represented their suggestions. *Information* is vital to enable the bereaved to make sense of the suicide, accept it, and reconstruct their lives without the deceased. *Professional help* was considered to be an important factor in expressing feelings and working through the confusion that follows a suicide, with someone who is independent, non-judgmental, and

has first-hand knowledge of bereavement by suicide. Participants reported a lack of sensitivity from a number of agencies that they dealt with following the suicide and they considered that *training for people dealing with the bereaved* should be an integral part of personnel training in these areas of employment. A lack of understanding and recognition by policymakers of the impact of suicide on the bereaved was considered to be the reason for the deficiency of *appropriate services, programmes, and funding to help the bereaved*. Some suggestions were made for improving existing institutional procedures such as Mental Health Services record keeping and information sharing, police investigations of suicidal deaths, and the redistribution of funds set aside for suicide prevention research and programmes to include assistance to the bereaved, thereby including them as part of an overall suicide prevention strategy.

## DISCUSSION

The purpose of the present study was to investigate the ways in which people cope when losing a loved one to suicide, what factors influenced their ability to cope, and what they perceived to be the needs of the bereaved, using an Interpretative Phenomenological approach. The study also sought to examine the idea that early intervention could promote positive outcomes for the bereaved, and reduce the risk of long-term psychological problems by providing the necessary help to adapt to their changed situation. Results of the research revealed that the participants used a variety of resources to grapple with their sudden loss, and supported the need for early intervention for the traumatically bereaved.

### Coping strategies

The first superordinate theme of *coping strategies* included the subordinate themes of *acceptance; reassessment, transition, and restructuring life without the deceased; avoidance; routines, rituals, and being active, personal strengths; and gender differences*. Acceptance of the deceased's decision to take their own life appears to play a large role in successful coping. In order to be able to do that, the bereaved need to make sense of the death by piecing together the deceased's history, recent events, and any other information that might provide some answers that will help them to restructure their lives without the physical presence of the deceased.

These findings concur with those of other research in the area of suicide bereavement, but do not support the contention that the search for answers was a way for the bereaved to 'assuage' their guilt, as suggested by Hauser (1987) and Cain (1972). The participants of the present research did not feel responsible for their loved one's death, and were able to relate a full and coherent account of the deceased's background that provided the rationale, and *subsequently*, the acceptance that it was the deceased's choice, and it had no bearing on their own actions or inactions.

It was also suggested by one of the participants that forgiveness was the key to acceptance. Forgiving the deceased, self, and others released the bereaved from negative emotions, such as guilt, and enabled them to accept the death and move on. The concept of forgiveness is not discussed in previous research, but guilt is frequently referred to as a common negative emotion experienced by the suicide bereaved.

It is interesting to note that the search for answers and other acceptance-related activities are referred to in the literature as 'grief reactions' but in the present research, they have clearly emerged as coping strategies. There are several reasons why these inconsistencies might appear. The first, and most simple, explanation is that the participants in the present research were more positively focussed than those from other studies were. Other explanations could relate to the method of enquiry.

Much of the previous research has used questionnaires to elicit information relating to grief reactions and coping strategies, consequently the responses are limited to the options provided. Questions may have focussed on the negative reactions to the exclusion of positive ones. Consequently, prior research does not address the links between the bereaved individual's need to know and understand, restructuring life without the deceased, and acceptance as a way of coping with their loss. The use of interviews, on the other hand, provides the participants with the opportunity to relate, in their own words, how they reacted to their loss – their emotions, thoughts, and actions – in context, which provides the researcher with a larger body of information from which to establish concepts and to interpret how they were utilised by the bereaved individuals. Jordan (2001) noted this point in his discussion relating to thematic differences, such as preoccupation with the reasons for the death, in research comparing suicide to other traumatic deaths.

Avoidance was included in the subordinate theme of *coping strategies* because it was utilised by several participants as a way to cope with the overwhelming sense of loss and intensity of emotions experienced by them after the suicide of a loved one. It provided them the opportunity to put aside painful thoughts, deeds, and reminders until they felt strong enough to deal with them, or to revisit them a little at a time until they were ready to

confront them fully. As noted earlier, many professionals regard avoidance strategies negatively, believing them to be an unhealthy reaction to grief. However, Frantz and colleagues (2001) referred to avoidance as a factor that was 'indicative of better coping', and agreed with Stroebe & Schut's (2001) dual process model, that it could be a valuable attribute to the coping process provided there was a balance between 'embracing' the grief and avoiding it.

Other subthemes of routines, rituals, and being active and personal strength are well supported in the literature, with planning the funeral, selecting clothes for their loved one, and spending time with the body playing important roles in coping (e.g. Fielden, 2003). Of course, in all of these themes, there are gender differences. Some men have been socialised to be strong for others, and to keep their feelings to themselves. They perceive that they should be able to fix everything, and when they are unable to do so, feel that they have failed. In times of adversity, these men may be disadvantaged by their socialisation because they do not allow themselves the opportunity to address their own needs. Research suggests that women suffer more severe reactions to traumatic loss, although it is acknowledged that men may not readily report emotional reactions (Cleiren, 1993; Gintner, 2001; Kessler et al., 1995). This supports the view that men may be disadvantaged, not only because they are unable to express their feelings, but also because they are not recognised as in need of assistance.

### **Contributing factors**

The second superordinate theme of *contributing factors* produced the subordinate themes of *beliefs, spirituality, and connections; taking care of the living; friends, family and the community; first responders, agencies, and institutions; personal factors; reminders and triggers; negative impact on personal physical, and mental wellbeing, and on the family; and positive outcomes*. These factors reflected both the positive and negative influences on the participants' coping strategies. For instance, all participants reported that beliefs, spirituality, and/or the sense of some continuing connection with the deceased had an extremely positive influence on their ability to cope, as did sharing positive memories of

the deceased with others, and the need to take care of others rather than indulging in their own sense of loss and sadness.

All of these positive influences are well supported in the literature (e.g. Gamino et al., 2000) However, some of these factors, such as *friends, family, and the community*, and *first responders, agencies, and institutions*, can be a double-edged sword; for some bereaved individuals they can be a huge source of support, and consequently, positive influences, but for others they are unhelpful and can have a detrimental impact on the coping process. The negative impact of these factors is barely touched upon in the literature.

The results of the present research provide numerous instances of unhelpful experiences with family, friends and others in the community, including funeral directors, police, and Victim Support volunteers. Some of these experiences occurred where the participant's family lived overseas and were unaware of the reality of the bereaved's relationship with the deceased before the suicide; where there was a divorce, or some form of separation between the deceased and the participant; or where the deceased was a teenager.

Suicide is a subject that is difficult for many people to deal with or to understand, and as such, people tend to make assumptions about why an individual takes his or her own life, and the circumstances surrounding the death, which includes the deceased's family arrangements. There are four excellent examples of this in the results:

In the case of the participant who was living in another location in preparation for the relocation of the entire family, she believed that the treatment that she and her family received at the hands of the police when her husband suicided was because of incorrect assumptions by the police. They had assumed that she and her husband were separated, and that she would not care about his death, and was not entitled to be informed. It is possible that the police also assumed that since the participant was living in another location that she had left her husband, and that was the reason why he took his life.

Another participant was divorced from her husband but still maintained close contact, which included their two children. Her ex-husband was missing for six weeks before he was found during which time, the participant and her children were not informed by his family or the police, were fingerprinted by the police in one city after his body had been found in another, and were not included in any other way with the investigation, or any follow-up procedures. Again, the participant perceived that because she was divorced from the deceased his family and the police did not consider it necessary to inform her or include her despite the fact that she was the mother of his two children. The participant commented that people assume that when a couple divorce they “stop caring” for each other, “or maybe hate” each other, but that is not always the case (Participant 14).

The third example was that of a 14-year-old Maori boy who had taken his own life. The first thing the Victim Support volunteer asked was, “Was he on P?” Clearly, the volunteer had made generalisations and assumptions about the young boy because he was a Maori teenager who lived in a particular area of town.

Finally, the parents of a 15 year old girl who suicided were distressed at the way the funeral directors manhandled their daughter into the hearse to take her to the hospital, showing little sensitivity to the parents who had no idea where they were taking her, or what they were going to do with their beautiful daughter. Had these people assumed that it was another troublesome teenager whose had caused heartache for her parents? Or perhaps an unhappy teenager from bad parents? Or was it simply that they were used to dealing with dead bodies and did not consider the feelings of the bereaved as they went about their normal duties? In any case, people who deal with death on a daily basis should be cognisant of the newly bereaved individual’s vulnerability and treat them with compassion and respect.

*Respect*, or lack of it, was referred to by several participants, generally in response to the shoddy treatment they received at the hands of some first responders. They felt that the lack of respect emerged from the assumptions and attitudes held by some first responders about suicide, and contributed to their sense of isolation and stigmatisation. The

participants talked about feeling “empowered” on occasions where they were treated respectfully (Participants 1 and 5).

These examples give rise to the argument that suicide *is* different to other traumatic deaths. Previous research is relatively silent on first responders, dealing mostly with the differences in grief reactions, and levels of grief. It would be interesting to hear the experience of individuals bereaved by homicide, accident, or other traumatic deaths in relation to first responders. One might imagine that first responders in these cases would not make the same assumptions that they might make in relation to suicide.

The participants in the present research interpreted some other people as having more negative attitudes to death by suicide, either from personal or religious attitudes relating to the morality of taking one’s own life, or from a lack of understanding and fear of the subject. They considered that other traumatic deaths have a focus for blame, such as the perpetrator of the crime, whereas in a suicide, there seems to be a need to blame someone. Consequently, there is less sympathy for those bereaved by suicide. This was illustrated by one participant’s report of the reactions of the school that her children attended. Her husband’s death was the third parent death within a few months. The school held services for the other two deaths, but completely ignored the death by suicide. These findings support those of Silverman and colleagues (1994/5) who found that suicide survivors had significantly higher scores in the areas of lack of support, isolation, a sense of rejection, and stigmatisation.

In addition to mode of death, other factors influence the course of bereavement, as recognised by other researchers. The subtheme of *personal factors* identifies some of these influences. On the positive side, taking time for self, being creative, and expressing emotions were valuable elements in coping with grief. On the negative side, a difficult relationship with the deceased during his or her lifetime, previous unresolved losses and events, finding the deceased’s body, parents burying their children, and negative emotions such as anger and resentment were factors that hindered the participants’ healing process.

All of these factors have been discussed in the literature, and the negative factors are those that have previously been identified as placing the bereaved at risk of complicated bereavement.

All participants agreed that the sense of loss after the death of a loved one 'never goes away'. *Reminders and triggers* can 'appear from nowhere' years after the death. Anniversaries, Christmas, special tunes, seeing someone who looks like the deceased – all of these things can invoke powerful emotions. However, beyond the reminders and triggers, the impact of suicide on the bereaved can be far-reaching. Participants reported a sense of rejection, a lack of trust, a loss of confidence, undermining of beliefs, trauma, and poor health, as well as placing an enormous strain on relationships.

Several couples who participated in the present research reported separation or difficulties in their relationships as a direct result of the suicide of their loved ones. They believed that this could have been prevented, or at least handled differently, had there been some form of counselling or therapy available to them as part of an early intervention programme for the suicide bereaved.

One participant, who found his daughter hanging in their garage, consulted his doctor for depression and was treated with Prozac for some months, which he reported, "got me going" (Participant 12). The anti-depressant may have helped to relieve his symptoms, but it did not reach the heart of his problem, or help him to work through his thoughts, feelings, or responses independently of other members of his family who were coping with their grief in different ways. Similarly, for participants who reported a sense of rejection, lack of trust, undermining of beliefs, and trauma there was nobody to help them to work through those issues.

Despite the detrimental effects that suicide can have on the bereaved, most of the participants were able to report some positive outcomes following the death of their loved ones. The ability to recognise that something good can emerge as a result of death has been identified by researchers as a factor that influences better coping. The participants of the

present research confirmed earlier findings, reporting positive outcomes in terms of strengthening of bonds with the living, improved communications, strengthening their faith or spirituality, reinforcing the value of life, and providing unexpected opportunities (Frantz et al., 2001).

## **Needs**

From the third superordinate theme of *needs* emerged the subordinate themes of *information; professional help; training for people dealing with the bereaved; and appropriate services and programmes, and funding to help the bereaved*. There is little research available on the needs of people bereaved by suicide. However, the need for information and professional help concurs with those expressed by Kari Dyregrove's (2002) research participants.

Information is of prime importance to those bereaved by suicide, from a detailed account of the death itself, to the procedures to be followed by first responders, through to dealing with the deceased's affairs. Initially, information is vital for the bereaved to gather the information that will help them make sense of the death, but beyond that, they also need to know the procedures relating to the removal of the deceased's body, post-mortem, investigations, return of the body, and funeral arrangements. Participants have reported that in those first few days they are too dazed to understand what is happening and rely on professionals to provide that information in a clear, but sensitive way.

Participants in Dyregrove's (2002) study commented on their sense of numbness and poor memory functioning in the wake of suicide, and suggested that written information would be helpful. One participant in the present study expressed the need for a 'handbook' informing people how to deal with the deceased's affairs (Participant 8). Perhaps some informative leaflet provided to the bereaved in the initial stages of their loss could offer them practical advice on dealing with the immediate matters relating to the death, as well as more practical issues concerning the deceased's affairs, which can be considered by the bereaved in their own time

Many of the participants in both studies agreed that they would have liked help, but did not know how to ask for it, where to go for it, or even have the mental capacity to think about it at the time. Participants considered the need for professional help to be important for the bereaved to address their concerns, emotions, negative responses, and relationship difficulties. They believed that they needed to talk to someone independent of their friends and family, who would not be judgemental, or give them advice, but help them to normalise their experiences, adapt to their loss, and move on. At the same time, they asserted that anyone who provided this type of assistance should have specific experience of dealing with suicide bereavement, as well as the professional credentials to do so. They did not consider it appropriate for volunteers with minimal training, and often no personal experience in suicide bereavement to be involved in this area.

The participants thought that any counselling or therapy should be on a face-to-face basis because whilst telephone counselling can provide anonymity, it lacks the human contact that is essential to enable the bereaved to feel comfortable enough with the counsellor to speak openly and honestly about their experiences.

Most participants reported their sense of relief when they talked to others who had also been bereaved by suicide, realising that they were not alone, that suicide affected more people than they had realised, and in similar ways. Some commented that it was probably a relief for some of those people, too, to be able to share their loss with others who had experienced a suicide – perhaps they had never been able to talk about it until then.

These findings indicate a clear need for early intervention to assist people bereaved by suicide. This could take the form of a crisis intervention or critical incident professional visiting the bereaved within two or three days of the incident, offering assistance, advice, and assessing their needs, as suggested by Gintner (2001). One or two initial visits may be all that is necessary, but these visits would provide the opportunity for the professional to develop a rapport with the bereaved, which may in turn help the bereaved to confide matters of concern for them, or past difficulties that may place them at risk of difficult

bereavement. This would help the professional to identify the bereaved's needs more accurately.

The second subordinate theme of *training for people dealing with the bereaved* relates to a variety of institutions including educational institutions, police, banks, and associated industries. Results show that schools and colleges are reluctant to deal with suicide, and that teachers and school counsellors are not adequately trained to deal with those bereaved by this type of death. Similarly, people who work in banks and related industries lack the skills to deal with the sensitive nature of bereavement, and its consequences. Participants perceived a need for training for people working in these areas, to develop the skills to provide a sensitive and informed service to this population. In particular, they considered educational institutions and the police to be in need of a review of training policies to ensure sensitivity in the way they communicate with individuals bereaved by suicide. Finally, the third subordinate theme of *appropriate services, programmes, and funding to help the bereaved* reflects the participants' views that there is not sufficient support in the community for those bereaved by suicide. They consider the reason for this to be the lack of understanding by policymakers relating to the impact of suicide bereavement on individuals, families, and the community. Several participants reasoned that, caring for the bereaved should be an integral part of a suicide prevention programme since research demonstrates that the bereaved can also be at risk of suicide.

One participant suggested that Mental Health services should improve their record keeping and information sharing in order to provide consistent care to outpatients who move around the country. Other suggestions were that suicide investigations should be improved to ensure more thorough enquires; that legal provisions should be put in place to ensure children's rights are protected following the suicidal death of a parent; and that Coroner's Courts should be less formal and more appropriate to the sensitive nature of the inquiry.

The participants recognised that funding for new or improved programmes is always a problem, but suggested that money presently allocated to suicide prevention should be redistributed, and used more appropriately. There was a great deal of criticism regarding

the amount of money directed towards suicide prevention research and intervention programmes that appeared to be fruitless, whilst the bereaved continue to be overlooked.

An ongoing study on suicide postvention, commissioned by the Ministry of Youth Development (2004) and referred to earlier in this report, has identified many of these shortcomings in services provided to the suicide bereaved, and makes suggestions for improvement. However, it refers to the lack of research-based evidence relating to the 'efficacy or effectiveness' of psychotherapeutic interventions or other support programmes, and the absence of a universal model of grief, as a reason to be cautious about implementing specific policies for the suicide bereaved. It goes on to point out that "gaps in knowledge about bereavement by suicide imply the need for research to be conducted to provide information about the needs that those who are bereaved by suicide have, and how these needs can best be met" (p.43). Certainly, research on the needs of those bereaved by suicide is sparse, but those studies already conducted, including the present research, indicate a need for professional help to be high on their lists. Accordingly it would seem appropriate to trial a pilot scheme modelled on Gintner's (2001) suggestion as mentioned earlier, which would involve a critical incident professional visiting the bereaved within two or three days of the incident, offering assistance, advice, and assessing their needs, developing a rapport with the bereaved, and being available for longer term assistance and support where necessary.

### **Implications of findings**

The present findings have policy and clinical implications to the extent that suicide bereavement is deserving of increased attention. There is an obvious need for early intervention in the form of a crisis or critical incident unit, which provides immediate professional assistance to the bereaved, and an assessment of their on-going needs. The inclusion of care for the bereaved, as an integral part of suicide prevention programmes as suggested by Cain (1972) thirty years ago, and by the participants of the present study, should be a serious consideration.

Participants of this and previous research have commented that they are not comfortable seeking professional help for depressed moods following the suicide of a loved one because they are considered to be a natural part of bereavement which will pass with time. In this respect, the cost of short-term interventions early in the bereavement process could easily outweigh the costs of long-term mental health care in later years. In addition, those individuals who receive help to cope with their loss are more likely to return to work and be more productive than those whose depressed moods keep them from carrying out their daily routines, and cost employers in sick leave payments and loss of productivity.

Recent research relating to adolescents and depression found that those showing symptoms of depression but not meeting the recognised criteria for major depression were at increased risk of suffering future mental health problem, including suicidal behaviour, similar to those faced by individuals who were diagnosed with major depression. It suggests that these problems may be evident up to seven years after the initial episode (Fergusson, Horwood, Ridder & Beautrais, 2005). In the light of these findings, it would seem prudent to ensure that people who are struggling to cope with the complexities of suicide bereavement are provided with professional help and support to prevent the risk of developing major depression, and possibly suicidal behaviour in the future.

Clinical implications are that health professionals will need to reassess their working models of grief and bereavement, especially traumatic bereavement, and understand the factors that help or hinder the bereavement process in order to provide appropriate assistance. They may also need to re-evaluate the use of criteria measurements in the categorisation of symptoms relating to bereavement, recognising the value of treating present difficulties to prevent the risk of later treatment of full-blown disorders.

Traditional models of grief are being challenged by new theories that focus on helping the bereaved to reconstruct the meaning of their lives without the physical presence of the deceased, rather than forcing them to break all emotional ties. It is a more appropriate concept of grief and bereavement, which recognises the individual nature and rate of recovery from loss, and challenges professional helpers to be receptive to other ways of

thinking about grief, death and dying. Various therapeutic paradigms lend themselves to work within these theoretical perspectives.

### **Limitations of the present study**

A number of limitations apply to the present study. Firstly, the participants were recruited from newspaper advertisements and may not be typical of all people bereaved by suicide. Secondly, as is the nature of qualitative methodology, the sample size was not large enough to generalise the results, but it does provide rich and valuable information from personal narratives relating to coping strategies, and the needs of people bereaved by suicide that other methodologies would not have obtained. However, many of the results concurred with those of other studies that used larger samples with quantitative methodology, which reinforces their validity.

### **Future directions**

The present study has provided a valuable insight into the way that individuals cope with the loss of a loved one by suicide, and some realistic and practical suggestions to assist the bereaved through the complexities of their bereavement opening up a number of interesting avenues for future research. Other directions in this area might be the use of longitudinal studies to track the progress of the bereaved over a period of, say, three to five years from the death. Access to the participants within the first few weeks of bereavement would be beneficial in this respect. Comparative studies into the experiences of people bereaved by suicide and other traumatic deaths with respect to first responders would add to research that suggests that suicided is different, and that people are less sympathetic to those bereaved by suicide. Studies into the effects of suicide on children, and the role of spirituality and symbolism in adapting to loss would both provide different, but valuable insights into suicide bereavement. Finally, comparative studies of treatment versus support without treatment would help to advance the efficacy and effectiveness question, which presently prevents psychotherapeutic interventions routinely being offered to those bereaved by suicide.

In conclusion, this study has found a variety of coping strategies that individuals use to cope with the loss of a loved one by suicide, and highlighted a number of factors that can help or hinder that process. This information can be useful for professional helpers to identify those individuals who may be at risk of difficult bereavement and/or psychological difficulties, and in need of additional support. The study has also suggested a need to review the training of personnel who deal with the bereaved, as well as a review of the investigation and legal procedures following a death by suicide. Additionally, it has indicated a need for a postvention intervention - professional helpers, with personal experience of suicide bereavement, who can offer support and advice to the bereaved, whilst assessing their ongoing needs. As part of an overall suicide prevention strategy, the cost of such an intervention need not be great, as funds directed towards suicide prevention could be redistributed to include care of the bereaved.

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## **APPENDIX A**

### **ADVERTISEMENT**

# **Coping strategies and the needs of adults bereaved by suicide**

I am looking for volunteers to take part in a study that I am conducting for my Masters Thesis. I am interested in hearing about how adults cope with the loss of a loved one, friend or other significant person in their lives by suicide. I would like to know what kind of support they have received, and what additional resources or assistance they think should have been available to help them cope more effectively.

I am looking for people over 18 years of age who have been bereaved by a suicide in New Zealand for no less than two years, and not more than five years. If you feel that you would like to share your experiences by participating in this study, or would like more information, please telephone me at home on (07) 349 0881, or write to me: Linda Kelly, C/- School of Psychology, Massey University, Private Bag 11 222, Palmerston North.

## **APPENDIX B**

### **PRESS RELEASE**

#### **RESEARCH INTO THE COPING STRATEGIES AND NEEDS OF ADULTS BEREAVED BY SUICIDE**

Linda Kelly is a researcher at Massey University who is studying the coping strategies and needs of adults bereaved by suicide. She wants to find out how people cope with the trauma of losing a loved one, friend, or other significant person in their lives to suicide, as well as what kind of support they have received, and what additional resources or assistance they think should have been available to help them cope more effectively. The information gained from the study could be of value in the development of early intervention strategies to minimize the risk of physical and psychological problems that can result from such a traumatic event.

The reason for choosing this topic came from Linda's own experience of losing a loved one by suicide. She hopes that this fact will encourage participants to talk to her about their own personal experiences.

Volunteers are required for the study. Linda would like to talk to anyone over the age of 18 who has been bereaved by suicide for not less than 2 years, and not more than 5 years who would be interested in participating in the study. For more information you can contact Linda by phone at home on 07 349 0881, or C/- School of Psychology, Massey University, Private Bag 11-222, Palmerston North.

# APPENDIX C

## INFORMATION SHEET

### COPING STRATEGIES AND THE NEEDS OF ADULTS BEREAVED BY SUICIDE

#### **The Researcher**

My name is Linda Kelly. I am an MA (Psychology) student at Massey University, and this research is for my Master's thesis. I have a BA in Political Science and a Graduate Diploma in Arts (Psychology). My supervisor is Dr Mandy Morgan, a staff member of the School of Psychology at Massey University. Dr Patrick Dulin is my co-supervisor and is a member of staff in the School's Clinical Psychology programme.

#### **The purpose of this study**

I am interested to learn how people cope with the trauma of losing a family member, significant other, or a friend by suicide. By exploring the ways in which people cope with their bereavement, including issues that can aid or hamper their ability to cope, I hope to gain a better insight into the needs of this special group of people. This information will be of value in the development of early intervention strategies that could improve the rate of recovery, and minimize the risk of physical and psychological problems that can result from such a traumatic event.

#### **Participation in this study**

Participants must be over the age of 18 and have been bereaved by the suicide of a family member, friend or another significant person in your life. The bereavement should have occurred in New Zealand for **not less than two years** and **not more than five years** prior to the study.

You are invited to participate in an audiotaped interview with the researcher. The interview will take approximately 45 minutes, and will be at a time and place of your choice. You will be asked to describe the way in which you have coped with your bereavement, who and what makes coping easier or more difficult, what kind of help/support/information you have received, or consider you should have received, and at what stage it should have been available. Your audio tape will be transcribed by the researcher at a later date. No research assistants will be used in this study.

It is expected that a maximum of 15 participants will be required to take part in the study. If more than that number of people express an interest, then the first 15 applicants who meet the above criteria will be accepted.

Recalling unhappy events may cause some discomfort or distress either during the interview, or afterwards. Such a response is natural, and it can often be therapeutic to talk about sad and painful experiences. I, too, have experienced the loss of a loved one by suicide over 10 years ago, so with the benefit of my personal experiences, as well as the skills learned during several years working with the bereaved at a hospice, I will be able to provide any support necessary to help you through any discomfort or distress during the interview. In addition, you can be put in contact with a trained counsellor if you would find this useful.

### **Participant's Rights**

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question or withdraw from the study at any time;
- ask for the audio tape to be turned off at any time during the interview.
- ask any questions about the study at any time during participation;
- provide information on the understanding it is confidential to the researcher and the researcher's supervisor, and will not be shown to anyone else without your permission.
- be given a copy of your transcription so that you can read over your interview and edit it to your own satisfaction before the information is analysed.
- have all identifying information changed during transcription so that you cannot be identified in any way.
- be given access to a summary of the project findings on completion of the study.
- have your information stored securely at all times
- decide on the disposal of your audio tape on completion of the study. Your transcription will be kept in secure storage.

Please feel free to contact me, or my supervisor, either before you agree to take part, or at any time during the study, for further information or to discuss and clarify any questions you may have about the study:

Linda Kelly, C/- School of Psychology, Massey University, Palmerston North  
Home phone: (07) 349 0881  
e-mail: LGKelly@xtra.co.nz

Dr Mandy Morgan, School of Psychology, Massey University, Palmerston North  
Phone: (06) 350 5799  
e-mail: C.A.Morgan@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Application 05/06. If you have any concerns about the conduct of this research, please contact Dr John G. O'Neill, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5799 x 8635, email humanethicspn@massey.ac.nz.

## APPENDIX D

### COPING STRATEGIES AND THE NEEDS OF ADULTS BEREAVED BY SUICIDE

#### SEMI-STRUCTURED INTERVIEW SCHEDULE

The following topics will be covered in the interview, but participants will be invited to tell their own stories, in their own way, of the events, and how they have coped with them.

- Background – who died? How old were they? What did they do (student/occupation)? What were they like? What kind of relationship did they have with the deceased?
- Discovery – how did you find out? Who told you – where, when and how? Was the informant sensitive?
- Identification – who identified the deceased? What support was offered to you for this purpose?
- Funeral arrangements – who made the arrangements? Who helped? Were the funeral directors helpful, supportive and sensitive? Was there any professional offer of support or assistance at this time?
- Coroner’s hearing – how long after the event did this occur? What information or advice were you offered from the police or coroner’s office? Was any support offered? Did you attend the hearing? Who supported you, and how? Were officials sensitive and helpful?
- Coping with your loss – who made your days better, and who made them more difficult? What ongoing support do you have? Who do you find most helpful and supportive? Have you been offered, or sought any professional assistance, eg your GP, a priest or other religious/spiritual person, counsellor, psychologist, etc.

- Family and friends – how have family relationships been affected by the suicide? Has it brought you closer and helped you to cope? Has it caused rifts and difficulties that have made coping more difficult? How have your relationships with friends helped or hampered coping?
- Work – How helpful or difficult has it been going back to work? Did you feel uncomfortable about facing people at work? Did you find your work colleagues and other associates to be supportive and understanding?
- Health and wellbeing – Has your health suffered since the bereavement? Has your temperament changed – easily upset or angered? Describe your mood, in general.
- Comment on what or who could make coping easier. What additional resources, information, and/or support would have helped you? From whom, and when should these resources, information, and/or support been available?
- Others comments, including comments relating to the current study.

# APPENDIX E

## *COPING STRATEGIES AND THE NEEDS OF ADULTS BEREAVED BY SUICIDE*

### PARTICIPANT CONSENT FORM

**This consent form will be held for a period of five (5) years**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I wish/do not wish to have my tapes returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

**Signature:** ..... **Date:** .....

**Full Name – printed** .....