Grief After Suicide

Understanding the Consequences and Caring for the Survivors

Edited by
John R. Jordan
John L. McIntosh
Grief After Suicide
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Grief After Suicide

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John R. Jordan
John L. McIntosh

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This book is dedicated to people everywhere who have lost a loved one to suicide. We hope that it helps in the growing effort to make the journey of survivors a healing one.
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SERIES EDITOR’S FOREWORD

Grief After Suicide is a volume written for two readerships: for every thoughtful clinician who welcomes an empirically informed orientation to the daunting terrain of suicide survivorship, and for every researcher who seeks to make a practical contribution to the growing knowledge base concerning the tragic aftermath of self-destruction. Both readers will be satisfied by what they find in this substantial compendium, the clinician by the book’s innumerable scientifically grounded and therapeutically astute insights into assessment issues and treatment strategies for working with the suicide bereaved, and the researcher by the sweeping and integrative review of decades of theoretical and empirical advances. As a piece of clinical scholarship that aims to bridge the sometimes distant domains of research and practice, this volume is a masterpiece.

And so it should be, in a sense, as it represents the culmination of the careers of two eminent clinical scholars, John R. (Jack) Jordan and John L. McIntosh. Each brings the wisdom of a long and deep engagement in suicidology to the authorship and editorship of this volume, a joint gravitas that informs their discussion of controversial questions such as whether suicide bereavement differs, and in what respect, from other forms of loss—particularly those under traumatic conditions. Likewise, countless hours of working alongside survivors to rebuild their shattered lives leavens the editors’ review of therapeutic issues and procedures, guiding them as they sift the most reliable of research findings for “news you can use” as a practicing clinician confronted by the distress and disorientation that is nearly always the emotional aftermath of a loved one’s fatal and tragic decision to choose dying over living. Moreover, beyond their own meaty contributions to the material between these covers, the editors have recruited a veritable Who’s Who of researchers and therapists active in the area, who collectively address in probing but readable terms nearly every facet of the topic the reader could imagine, while minimizing the risk of redundancy. Thus, whether the reader is
seeking information on the incidence, risk factors, coping challenges, family dynamics, or prospects for positive outcomes associated with suicide survivorship, or is hoping for research-substantiated guidance in working with grieving parents, spouses, children, adolescents, families, groups, or even organizations following the elective death of a member, he or she will not be disappointed.

As if this were not enough for one volume, the editors have included 18 brief chapters outlining the leading programs offering tailored services to suicide survivors, both in the United States and abroad. In an important sense, then, the book is more than an authoritative review of a broad-ranging field of scholarship, and more than a clinical handbook for dealing with the immediate and long-term challenges faced by clients touched by this life-altering loss. It is also a virtual blueprint for progressive programs to address a pressing social need that transcends national boundaries, calling for creative local solutions to a global problem.

Finally, the editors close the book—and in a sense close the circle—by considering thoroughly the sorts of methodological and substantive issues that should inform future research efforts if they are to be even more clinically useful in their yield. The consistent focus on bridging research and practice that weaves like a leitmotif through the pages of this volume is as clearly in evidence in the book’s closing chapters as it is in those devoted to the exploration of practice strategies stemming from different contemporary models (whether the dual process model of coping with bereavement or approaches to meaning reconstruction). It is this integrative thrust of the writing that marshals the disparate collection of the topical chapters into an integrative whole, and makes the volume in general a compelling read.

In short, Grief After Suicide easily nominates itself as the most comprehensively conceived, critically informed, and clinically useful book of its kind on the contemporary scene, and it is likely to retain this status for many years. Perhaps it is not too much to hope that the cogent scientific information and clinical wisdom distilled, integrated, and illustrated in frequent case studies in this volume will greatly benefit or perhaps even save the lives of many suicide survivors who might themselves otherwise succumb to despair. It is a certainty that it will greatly enrich and orient the professional lives of many of the therapists and interventionists who attempt to help them.

Robert A. Neimeyer, PhD
Series Editor
This rich offering presents a wondrous cornucopia of perspectives, specific theories, systematic research evidence, as well as hard won clinical experience regarding survivors of suicide. Inclusive it is, but not all-inclusive: selectivity both keen and wise has been employed by the editors—no surprise given their invaluable past contributions and leadership roles in suicidology. Their approach reminds one of the anecdote told of Arnold Toynbee who, following his public lecture at Oxford on religion, was approached by the mythical little old lady who sweetly asked him if one didn’t always have to have an open mind on such matters. Toynbee is said to have replied “Yes, but not so open that my brains fall out.”

This collection represents more than an update, a reference source, a milestone, though it obviously qualifies as all of these. It also deliberately constructs a launching platform with guidance for future research and for survivor service programs. Its vision is broad enough to deal sensitively with the legacy of postsuicide psychological, professional, and legal complexities bequeathed on therapists. Comprehensive, scholarly, often tough-minded, it buries—except for predictable Lazarus-like returns— many of our simplisms. It includes quite recent research, some not yet published, and has a strong integrative thrust where feasible. It represents a model of respectful forthright disagreement between major conceptual stances and disparate readings of evidence. Amidst a literature awash with methodological misdemeanors, felonies, and capital crimes, the authors here, in general, happily chose to extract and accent the best and predominant findings rather than scold and howl at the moon over shortcomings. Proper humility and caution about our current knowledge base is repeatedly evidenced in such phrases as “dearth of studies,” “few studies,” “not scientifically established,” “tentative findings,” and “relatively little controlled studies.”

At a substantive level the authors highlight many significant veins of ore. To mention but a few, one recognizes a more multilayered contextualism, an intensified recognition that no survivor is an island. Survivors are placed in surviving families, with heightened accent on the power of
Foreword

postsuicide family dynamics, family members’ asynchronies of coping styles and pacing that go well beyond matters of blaming or silencing. The role of peers is extended and dissected well beyond the customary focus on adolescents. A longstanding neglect of the reverberations on survivors within the workplace organizations that are so central a part of our existence is corrected. (Intriguingly, the one organizational context previously scoped and analyzed has been the mental health setting, pinpointing the swirling, oft destructive reactions of the “failed” therapist’s colleagues.) The survivor’s immediate social milieu has long been in our focus. But the picture now has become far more transactional, moving beyond one-dimensional images of social shunning or awkward avoidance to parallel, interactive concepts of survivor “self-stigmatization” and self-isolation. Beyond the immediate community context, the potency of broader cultural variables, doctrines (religious and otherwise), the meanings ascribed to suicide, the plethora of culturally assumed or assigned motivations of suicide (including benevolence), the availability or exclusion of redemptive ritual … all receive richer recognition or freshened analysis. And along with it, realization of the conflicting crosscurrents within societal domains rather than prior implicit assumptions of a single or even primary set of attitudes, values, and beliefs.

Amidst suicidology’s general well-differentiated approach to survivor groups, e.g., by age (children, adolescents, adults), kin relationship (widows, widowers, siblings, parents of adolescents), degree of involvement/intimacy (friends, acquaintances), or special functions (therapists), we begin to see in these pages emerging allusions to the reactions of old if not elderly parents to their adult children’s suicides, and—what may well await us in mounting numbers—adult offsprings’ responses to their aging parents’ suicides. Coming from a different sector entirely, we find suggestion that in considering survivor reactions (and services), perhaps we best first attend to a metric of survivor attachment to the deceased.

Joining trends in the psychological and psychiatric literature, more and more we find stress not just on the substantial percentage of survivors appearing at least as recovered as the nonsuicide bereaved, or even assessed as “within normal limits” on a set of measures, but emphasis upon and detailing of specific mechanisms of survivor coping and resilience, as well as multiple pathways to eventual adaptation. Heavy weight is assigned to the role of cognitive processes, the survivor’s construction of meaning, and a coherent narrative of the suicide that promotes an acceptable, nondestructive, self-esteem–supporting understanding of the suicide and its relation to the survivor’s life. Beyond that, as a relative latecomer to our formal literature, we find references to post-traumatic growth (with the savvy recognition this does not exclude the co-existence of suffering or damage).
Those systematic conceptual and empirical components of the book are, in welcome supplementation, followed by opportunities to learn of and from an array of descriptions of intervention programs for survivors. They represent well the current, ever evolving, expanding state-of-the-field of programs for survivors of suicide. They also represent our proud legacy from the seeds sown by an initial lonely band of survivor pioneers, who in a context of deep personal grief pitted their creativity, dedication, persistence, and resilience against powerful tides of ignorance, stigma, and avoidance. This section of the book represents must reading for any individual or organization seeking to initiate or expand services to survivors of suicide.

Suicide survivors here are variously defined, ranging from family members to a far wider set of those seriously affected by the suicide. The described programs for them range from national to local; from government to private foundations to a single individual’s efforts; from low cost to free; and from services set in schools, coroners’ offices, workplaces, places of worship, hospices, senior centers, or funeral homes. They involve face-to-face contact or telephone or Internet connection, and are freestanding or a component of broader organizations. Services are provided by professionals or lay survivors, or jointly; are targeted for any and all survivors or for specific age, gender, religious, ethnic, subcultural or indigenous groups; are provided one-on-one, or for families, extended families, or exclusively in groups; involve immediate proactive outreach orientations or require survivor initiative; are located in urban vs. rural settings; and may be open-ended or time-limited.

Such services often make available a burgeoning set of written materials for survivors—pamphlets, brochures, workbooks, books, newsletters, and so forth—as well as richly informative Web sites. Some include participation in the training of police, fire, and other first responders in immediate contact with survivors, or in the education of mental health professionals or clergy. At another level, we have graduated to the point of generating directories of suicide survivor services, quasi-accreditation of survivor programs, training manuals, segments of national and international conferences exclusively devoted to survivor issues, and the creation of formal, response plans vis-à-vis suicides in institutional settings. Truly a creative, productive ferment! How proud Shneidman would be!

Yet for all the progress of aid to survivors visible in and beyond the programs presented, there are gaps, blind spots, indeed possible sources of self-defeat also apparent, e.g., with a few admirable exceptions, too little outreach, early outreach, to those survivors who can accept it; too little attention to the obstacles survivors encounter in obtaining care. But above all we must be concerned about the lack of evaluation—oft
Foreword

unblinking indifference to objective evaluation—of the effectiveness of our services to survivors. We can only go so far in this realm carried by the virtues of our empathy and good intentions. Perhaps we can comfort ourselves for a while longer considering this period of invention as our “thousand flowers blooming” stage. But surely we must be working toward a point when we will have differentiated systematic intervention research-based best practice guidelines for our various forms of ameliorative work with suicide survivors.

It is said that generals are always planning for the preceding war, and intelligence agencies are always planning how to prevent their prior fiascos. Perhaps understandably: as a distinguished physicist once put it, “Prediction is very difficult, especially about the future.” But we do soon need to be thinking through the implications for survivors, for instance, of increasingly enhanced and easily available suicide “technologies,” physician-assisted suicides or what hospital associations much prefer to call “managed deaths,” ever-briefer psychiatric hospitalizations of the suicidal, aging populations, the downside of diminishing stigma surrounding suicide, and the unique problems of serving the immediate comrades and far-flung family members of suicides in the armed services. Past performance suggests we will. Meanwhile, this book’s editors and contributors have produced a document that will simultaneously energize, refine, and direct the future efforts of investigators, teachers, agency program leaders, mental health professionals, and lay volunteers alike in preventing the ugly arithmetic of adding the warping of suicide survivor lives to the life already tragically ended.

Albert C. Cain
For my part, this book has depended on the help of many people who have supported and inspired me in writing it. I think of myself as only a “distant” survivor of suicide loss (a great-uncle, Arthur Spencer). Arthur’s death was a sad experience for me, but it was not a life-transforming one. Instead, my clients who are suicide survivors have taught me almost everything that I know about the journey of despair and resilience that survivors walk. Therefore, I must first thank my clients for the gift of allowing me to share their journey with them—the knowledge that I have gained from walking that journey with so many people has led directly to this book, as well as the motivation to create it. Second, I thank the many, many students and trainees who have attended workshops that I have given over the years on grief counseling, traumatic loss, and suicide prevention and postvention. Although it may seem that students learn from their teacher, in truth the process is quite reciprocal and many of my ideas have been formulated and refined in the process of interacting with trainees around the world. Third, I express my gratitude toward my children, Kate and John, who deserve special thanks. Being a parent to them has taught me (sometimes unwillingly and certainly imperfectly) patience, persistence, and forgiveness—qualities that have helped me to complete this book. Their chosen paths of service to others continue to inspire and make both their mother and me very proud. Last, this book literally would not exist without the forbearance, patience, willingness to carry more than her share of the family load, and unending support of my wife, Mary Ruby. I am deeply grateful for all that she has given to me over the years of our marriage, including the time and space to allow this book to come to fruition.

—John R. Jordan
Acknowledgments

There have been no suicides in my family of which I am aware, but my contact with survivors began when among the first individuals associated with suicidology I met were two survivors, Stephanie Weber and Adina Wroblewski. Their sharing of their loss and the dearth of information and research about this topic raised my awareness and recognition of the importance of suicide survivorship. I extend special thanks to the many survivors who have taught me so much about suicide bereavement, sharing their experiences and providing information. In particular, I thank Adina Wroblewski, Stephanie Weber, Karen Dunne-Maxim, Edward Dunne, Iris and Jack Bolton, Betsy Ross, Michelle Linn-Gust, Frank Campbell and the LOSS Team from the Baton Rouge Crisis Intervention Center, Frank Jones, Judy Meade, and the many others who have played an important role. I also thank my family, specifically my wife Charleen, my children Shawn and Kim, Kim’s husband, Paul and son Ethan (who was born during the writing of this book), and my parents, Donald and Marietta, for their support and love. In addition I thank my institution, Indiana University South Bend, for its support of my efforts across the years, and my colleagues in the Department of Psychology and Academic Affairs. Finally, I acknowledge the role of my mentor, John Santos, Professor Emeritus of the University of Notre Dame, for the support and encouragement he has provided both early in my graduate years and throughout my career.

—John L. McIntosh
John R. (Jack) Jordan, PhD, FT, is a licensed psychologist in private practice in Wellesley, Massachusetts, and Pawtucket, Rhode Island, where he specializes in working with loss and bereavement. He is the founder and, until 2007, was the director of the Family Loss Project, a research and clinical practice providing services for bereaved families. Dr. Jordan has specialized in work with survivors of suicide and other losses for more than 30 years. As a Fellow in Thanatology from the Association for Death Education and Counseling (ADEC), he maintains an active practice in grief counseling for individuals and couples. He has run support groups for bereaved parents, young widows and widowers, and suicide survivors, with the latter running for more than 13 years.

Dr. Jordan is the Clinical Consultant for Grief Support Services of the Samaritans in Boston, where he is helping to develop innovative outreach and support programs for suicide survivors. He is also the Professional Advisor to the Survivor Council of the American Foundation for Suicide Prevention (AFSP), and a former board member of AFSP (New England Affiliate) and ADEC. In 2006, Dr. Jordan was invited to become a member of the International Workgroup on Death, Dying, and Bereavement, and was the recipient of the ADEC 2006 Research Recognition Award. He has been involved in several research projects on the needs of people grieving after a suicide, and in 2004 received research funding from AFSP to investigate the support needs of survivors after a suicide.

Dr. Jordan has provided training nationally and internationally for therapists, healthcare professionals, and clergy through PESI Healthcare/CMI Education, the American Foundation for Suicide Prevention, and
as an independent speaker. He has also helped to organize and lead many healing workshops for suicide survivors. His clinical and research articles in the areas of bereavement after suicide, support group models, the integration of research and practice in thanatology, and loss in family and larger social systems have been published in numerous professional journals, including Omega, Death Studies, Suicide and Life-Threatening Behavior, Psychiatric Annals, Crisis, Grief Matters, and Family Process. Dr. Jordan is the co-author, with Bob Baugher, of After Suicide Loss: Coping with Your Grief (Baugher and Jordan, 2004), a book on suicide bereavement for surviving friends and family.

John L. McIntosh, PhD, is Associate Vice Chancellor for Academic Affairs and Professor of Psychology at Indiana University (IU) South Bend. He has previously authored, co-authored, or co-edited six books on suicide, including Elder Suicide: Research, Theory and Treatment (American Psychological Association, 1994) and Suicide and Its Aftermath: Understanding and Counseling the Survivors (W. W. Norton, 1987). Dr. McIntosh has contributed many chapters and articles to books and professional journals and made numerous professional presentations and keynote addresses at professional conferences. He also serves on the editorial boards of Suicide and Life-Threatening Behavior, Gerontology and Geriatrics Education, and Crisis: The Journal of Crisis Intervention and Suicide Prevention, as well as on the Editorial Advisory Board of Advancing Suicide Prevention magazine. Dr. McIntosh is a past president of the American Association of Suicidology (AAS), the 1990 recipient of the association’s prestigious Edwin Shneidman Award (awarded to a person below the age of 40 for scholarly contributions in research to the field of suicidology), and the 1999 recipient of the Roger Tierney Award for Service. Dr. McIntosh’s work has been reported in newspapers and magazines across the country, including the Wall Street Journal, Washington Post, New York Times, USA Today, Boston Globe, Chicago Tribune, and Newsweek. He also appeared on The Phil Donahue Show (1986) and The Oprah Winfrey Show (1989) to discuss suicide in the elderly.

Dr. McIntosh has been recognized by his campus and university for his research and teaching. He is a recipient of IU South Bend’s Distinguished Teaching Award, the Eldon F. Lundquist Faculty Fellow, and the Distinguished Research Award, as well as an Indiana University all-university President’s Award for Distinguished Teaching.
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Suicide is a critical public health issue. Each year, nearly a million individuals worldwide take their own lives (WHO, 2009), with more than 33,000 Americans dying by suicide (McIntosh, 2009). These deaths leave in their wakes persons who are known as survivors of suicide or the bereaved by suicide. Although it has long been known that suicide can leave devastation in its wake (Cain, 1972), until recently suicide survivors have received relatively little attention in suicidology compared to the focus on understanding and treating suicidal individuals. We believe that the time has come for this to change. As Shneidman noted years ago, work with those bereaved by suicide is a direct form of prevention with a population at risk for suicide themselves, as well as many other mental health and social problems (Shneidman, 1972). This volume demonstrates the considerable empirical evidence substantiating the idea that intervention with suicide survivors is not just the correct thing to do ethically, it is clinically the necessary thing to do, given the potential psychiatric morbidity and even mortality that can follow for suicide survivors.

The suicide bereaved must not only attempt to cope with the death of someone close to them, but must do so in a likely context of shame, stigma, guilt, blame, and confusion about the responsibility for the death, all of which are frequently associated with bereavement after this type of death. Although no reliable determination of the number of suicide survivors exists, even by cautious estimates the numbers are substantial. For instance, in the United States alone, there are conservatively at least 4.6 million living individuals who have lost someone to death by suicide (McIntosh, 2009). These survivors represent mothers, fathers, siblings, grandparents, uncles, aunts, spouses, extended family members, fiancés, partners, friends, coworkers, classmates, teachers, therapists, neighbors, and the many others with whom those who die by suicide had significant relationships. The impact of suicide loss ranges from mild to
devastating, depending on many factors. For some, it can literally be life transforming.

Given the enormous impact that suicide can have on individuals, families, and communities, it is surprising and disheartening that in more than 20 years only two major books (Dunne, McIntosh, Dunne-Maxim, 1987; Mishara, 1995) have attempted to summarize the literature on the experience of losing someone to suicide. This lack of attention is the reason that we felt an urgent need to write this book. Although it reaches back to the very beginnings of the literature on grief after suicide, the present volume primarily focuses on the body of knowledge that has accumulated since the publication of Dunne, McIntosh, and Dunne-Maxim’s (1987) seminal compilation on the impact of suicide. Our overarching goal is to bring the field “up to date” on what we do (and do not) know about the experience of bereavement after suicide, and to address the various approaches that have been developed and are emerging to assist those who are bereaved by suicide.

The book provides new approaches to understanding the survivor experience as well as the definition of the term suicide survivor. A new perspective on suicide bereavement within the larger context of the general grief and bereavement research and theory is offered. Current evidence about bereavement following suicide is presented both generally as well as with respect to special populations of survivors. Although similarities between suicide and other bereavement circumstances are noted, the differences are detailed in particular, including those for which evidence already exists and those still to be empirically demonstrated. The full body of knowledge is brought to bear in characterizing suicide bereavement. Thus, the merit of research-based evidence is reviewed and applied to further our understanding and assistance efforts, but additionally, the highly valuable evidence that emerges from clinical practice and case studies, as well as personal accounts of survivors, are incorporated. This volume’s goals are to establish not only what is known about suicide survivors and postvention efforts to assist them, but also to draw attention to vital information that is not known but would help us to better understand and assist survivors of suicide. Recommendations for future research and postvention goals for the future are also thoroughly addressed.

The book is organized into five distinct sections. Section 1 is concerned with what we know about the general impact of suicide on survivors. Chapter 1 provides a conceptual framework and rationale for the study of suicide bereavement, and offers a new operational definition of survivorship that we hope will allow research and clinical intervention to advance significantly. Chapter 2 addresses a long-standing debate within the literature (including between the two of us) regarding whether
bereavement after suicide is the same as or different from bereavement after other types of losses. We provide a new and we hope more nuanced conceptual framework for answering this important theoretical and practical question.

Following these initial chapters, the first section of the book concludes with three chapters focused on the primary knowledge about suicide grief within particular subpopulations of survivors. Chapter 3 reviews the body of literature involving adults as survivors of suicide while Chapter 4 conveys the same information with respect to the impact of suicide on children and adolescents. Both chapters include a significant focus on the kinship relations of survivors and their deceased loved ones and how those relationships affect bereavement. Chapter 5 considers the often under recognized impact on caregivers of the suicide death of a patient or client.

Section 2 focuses on what we know about helping survivors after a suicide happens. Chapter 6 is based on the premise that intervention programs should be grounded in the empirically established needs of the people who are to be served. It provides an overview of the empirical literature on what survivors tell us has been helpful to them in their efforts to cope, as well as unpublished data from a new study on this subject. Chapter 7 suggests guidelines for mental health providers after the suicide of a client, with practical suggestions to assist both the clinician as well as other survivors of the client’s death.

The remaining six chapters of this section focus on various special approaches, settings, and populations with respect to helping after a suicide. These include postvention for organizations (e.g., schools, workplaces; Chapter 8), and grief counseling (primarily individual therapy) for adults (Chapter 9) and for child or adolescent survivors of suicide (Chapter 10). Different approaches to intervention with suicide survivors are also highlighted in Chapter 11 (a narrative or constructivist approach), Chapter 12 (an overview of group work with survivors), and Chapter 13 (a description of family techniques with suicide survivors). Chapter 13 also addresses special issues involved in providing culturally sensitive postvention services.

Sections 3 and 4 are organized around invited descriptions of what we consider promising suicide survivor support programs within the United States (Section 3) and internationally (Section 4). The “mini-chapters” in these sections describe innovative and model programs, including their histories and methods, as well as lessons learned during their development. In addition to a diversity of support and therapy approaches, several highly creative programs for special groups of survivors are detailed. Many of the programs are pioneers in the survivor movement. Resources and activities for and about survivors provided by
Introduction

national organizations in the United States devoted to suicide prevention are also included.

The book concludes in Section 5 with two chapters that look to the future of understanding and helping suicide survivors over the next decade. Chapter 33 considers the various methodological issues and problems associated with suicide bereavement research, as well as the value associated with combining the complementary bodies of knowledge derived from empirical research and qualitative, clinical, and anecdotal evidence. In addition, research priorities are described for future investigations that would enhance understanding of survivors and guide the therapeutic efforts that aim to assist their healing. Chapter 34 provides a call to action with respect to community and programmatic support that we believe need to be developed over the next 10 years for survivors. As Chapter 33 conveys an agenda for research, Chapter 34 proposes common elements of support infrastructure for survivors that we believe need to be developed for suicide survivors around the world.

References

The Impact of Suicide
Suicide Bereavement: Why Study Survivors of Suicide Loss?

John R. Jordan and John L. McIntosh

The personal narratives of many suicide survivors testify to the reality that the death of a loved one to suicide can be an enormously difficult experience, one that may have life-transforming effects on the mourner (Alexander, 1991; Jackson, 2004; Stimming & Stimming, 1999; Wrobleski, 2002). Empirical and clinical study of survivors also offers considerable support for this intuitive understanding that the loss of a loved one to suicide may be a particularly difficult form of bereavement (de Groot, De Keijser, & Neeleman, 2006; Jordan, 2001, 2008, 2009; Knieper, 1999). Nonetheless, the question of whether mourning after suicide is different—and, if so, whether the differences are quantitative or qualitative in nature (or both)—remains a challenge to be resolved (McIntosh, 2003). The answers to these questions have important implications for how we think about the impact of suicide on survivors and how we develop support services that might ameliorate some of the suffering of those left behind (Jordan, 2001; McIntosh, 2003). Beyond that, there are important definitional issues about survivorship that suicidology and
4 Grief After Suicide

thanatology have yet to address satisfactorily. These issues include determining (a) who is considered a survivor, (b) how many survivors there are, and (c) what the relationship is between exposure to suicide and the experience of becoming a survivor. Our goals for this opening chapter are twofold: to offer a framework for addressing questions (a) and (b) and to make the case for why specialized study of suicide bereavement is needed. In Chapter 2, we address the debate within the literature about whether bereavement after suicide may differ from bereavement after other modes of death—and, if so, in what ways. We also offer a conceptual framework for thinking about the differences and commonalities in bereavement after suicide and after other types of losses. In Chapters 3 through 5, we provide comprehensive reviews of the literature that address the actual impact of suicide on adults, children, and families, and on clinicians who work with suicidal patients.

The Definition of Suicide Survivorship

Who Is a Survivor?

The question of what constitutes survivorship is both conceptual and empirical. Perhaps surprisingly, the conceptual specification of who is a suicide survivor has never really been addressed, let alone agreed upon by writers in the field (Andriessen, 2009; Cerel, Padgett, Conwell, & Reed, 2009; McIntosh, 2003). Most survivor research studies simply define exposure to a suicide as the criteria for participation, and/or they study the immediate kin of the deceased—or, in the case of adolescents, the close friends of the deceased. Nonetheless, we believe that these definitions are, respectively, too broad or too narrow to denote who should be regarded as a potential suicide survivor. The reality is that we simply do not know how many people in a social network are negatively affected by a given suicide because the literature has made two simplistic assumptions: (a) that all suicides are more or less the same in their impact and (b) that the degree

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1 The phrase suicide survivor itself has presented problems within suicidology (Seager, 2004) and among the general public because the term could logically refer either to someone who has attempted suicide and survived the attempt or to someone who is surviving the death of a loved one to suicide (as in “Mr. Jones is survived by his wife and children.”). However, within suicidology and the survivor community in the United States, the meaning of a suicide survivor as someone who is grieving after the suicide of another person appears to have come into wide usage, and we will continue with that convention in this book (McIntosh, 2003).
of impact is largely a function of the degree of kinship closeness to the deceased. We believe that the time has come to develop a more inclusive and empirically based foundation for defining survivorship.

For example, consider the hypothetical suicide of a middle-aged man, a Mr. Smith. He is deeply involved in his small-town community as a son, husband, father, brother, professional person, volunteer soccer coach for his children’s teams, deacon in his church, and longtime resident of his town. Although it is obvious that Mr. Smith’s wife and children are likely considered survivors, there are many others in his social network who might also be significantly and quite negatively affected by his death. To name but a few, there are his parents, siblings, and extended family members; his colleagues and clients at work; his neighbors; the children and parents of the teams he has coached; his fellow church members; and his current friends not only from the town but from earlier in his life (e.g., a college roommate or a former girlfriend). Although not all of these people will necessarily be significantly affected by Mr. Smith’s death, it seems plausible that any one of them might, in fact, be a candidate for a problematic bereavement experience after his suicide.

Contrast Mr. Smith’s death with the suicide death of a Mr. Jones. He is an elderly homeless man who has suffered from mental illness most of his adult life. He has been reclusive for many years, having only sporadic contact with a small number of other homeless people and with social agency workers. He has only one living sister, with whom he has not had contact for many years. It seems plausible, in the case of Mr. Jones’s death, that there are far fewer people for whom his death will deal a severe and lasting psychological blow.

**Defining Survivorship**

As shown in the two examples offered previously, *survivorship* might be defined by at least three dimensions. The previously mentioned and most common one is kinship proximity—and, certainly, the family members of either Mr. Smith or Mr. Jones are at risk for having a difficult response to these deaths. Empirical evidence supports the idea that kinship proximity is directly related to the severity of impact of a suicide (Cleiren, Diekstra, Kerkhof, & van der Wal, 1994; Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004). However, if Mr. Jones’s sister has not had contact with him for many years and is dealing with her own medical or financial problems, she may actually have very little response to her brother’s death, despite the closeness of her formal kinship relationship with Mr. Jones. Thus, kinship proximity may not always be a marker of survivorship.
A second and more inclusive criterion for survivorship would be those people who have (or have had) a close psychological association with or attachment to the deceased, regardless of their kinship status. The circle of potential survivors grows larger when this definition is used. For Mr. Smith, a larger circle of individuals—for example, his close friends, the children whom he has coached, and a former college roommate with whom he had been very close—might all experience high levels of grief and distress at his passing. Even for Mr. Jones, the circle of potential survivors might be larger than first assumed. For example, an agency social worker who has known and worked with him periodically for many years might find herself feeling surprisingly sad and guilty after her client’s suicide. The impact of suicide on professionals who may have worked with the deceased, and the potential for these professionals to also become survivors, has been largely ignored in the mental health field (Campbell, 2006; see Chapter 5 for more information on this topic). A definition of survivorship that includes those who are more closely psychologically involved with the deceased has also received empirical support as an important predictor of grief intensity and distress (Brent, Perper, Moritz, Liouts, et al., 1993; Mitchell et al., 2004; Reed, 1993; Reed & Greenwald, 1991; J. Zhang, Tong, & Zhou, 2005).

A third definition of survivorship would include those who are greatly distressed after the suicide, regardless of their kinship relationship with or psychological closeness to the deceased. For example, the parent of one of the children coached by Mr. Smith who has known him only casually might feel quite angry with Mr. Smith’s “betrayal” of the children through the suicide and the bad role model that this parent believes has been set for them. Another example is a homeless person who has never met Mr. Jones but who has been depressed and struggling with his own suicidal feelings—he may hear the news of the suicide on the street and decide to take his own life. Yet another example is someone who feels psychologically responsible for causing, or failing to prevent, the suicide—for example, the engineer of a subway train that strikes and kills a young person who had jumped into the train’s path may experience haunting guilt and trauma symptoms after the death, regardless of his obvious innocence in the death.

A General Definition of Survivorship

We draw on all three of these criteria to propose a more precise answer to the question “Who is a survivor?”
A suicide survivor is someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person.

Note that embedded in this definition is an important distinction between exposure to a suicide and survivorship. Thus, only a subset of people who are exposed to a suicide will go on to become survivors. The obvious questions of what constitutes a “high” level of distress and a “considerable” length of time are important and, ultimately, empirical questions that can be answered by good research to establish the normative distribution of distress in social networks affected by suicides. The recent effort in thanatology to create a new diagnostic category called complicated grief (CG)—more recently referred to as prolonged grief disorder (PGD; Lichtenthal, Cruess, & Prigerson, 2004; Prigerson et al., 2009; Prigerson & Maciejewski, 2005)—is one possible (but certainly not the only) starting point for this endeavor. For example, people who meet symptom criteria for this new disorder after a suicide could be operationally considered survivors for research purposes. Note also that in our proposed definition, the distress can be self-perceived (e.g., the person reports feeling very guilty), observed by others (e.g., the person acts in very angry ways), or identified by more formal measurement (e.g., grief or depression symptom measures). However, we believe that a key element of the definition of survivorship must include self-definition, regardless of any attempts to “objectively” define this term. Survivorship frequently carries with it a number of negative (and perhaps some positive) consequences that transcend simple grief or psychiatric symptoms to include longer term changes in self-identity and life narrative as a result of the death (Feigelman, Jordan, & Gorman, 2009; Stimming & Stimming, 1999; see Chapter 11 for more discussion of the impact of suicide on meaning making and post-traumatic growth processes in survivors). Thus, we would be hard put to define as a survivor someone who did not personally feel that his or her life had been significantly affected by the death.

The time criterion for survivorship is more difficult to define because, in our experience, many people in the deceased person’s social network are initially upset and grieving after a suicide but will not necessarily show a lasting negative impact. Although the 6-month duration requirement for the PGD diagnosis is one possible criterion, our personal experience with survivors suggests that this may be too short a time period and is, therefore, likely to produce too many “false positives.” A 1-year duration criterion might better describe those who are significantly affected and who are likely to have lasting effects from the suicide. Again, this is ultimately an empirical question that is best answered by
solid research on (a) the types and duration of various bereavement trajectories after a suicide and (b) their relative frequencies in the general population of those exposed to suicide.

We are not suggesting that the PGD criteria are the only—or necessarily the best—specific standard to use in defining survivorship. The hallmark of PGD is yearning for the deceased, a characteristic that is most likely to occur in someone who was psychologically close or attached to the deceased but not necessarily in someone who is very affected without much previous relationship with the deceased (e.g., the subway engineer). We believe that responsibility rests with survivors, clinicians, and researchers to collaboratively develop—and, when necessary, adapt—an operational definition of survivorship that suits the goals of the particular project at hand.

Advantages of This Definition

We believe that the general definition of survivorship offered here has several advantages. First, it allows for the possibility that any person, regardless of their social relationship to the deceased, may be significantly distressed after the suicide and may, thus, become a survivor. This corrects what we believe to be a major error in most previous studies of survivorship: the assumption that kinship or psychological proximity is the defining criteria for survivorship. It seems very likely that the highest proportion of survivors will, in fact, be found in those who are either biologically related to and/or psychologically attached to the deceased. Nonetheless, to assume that these individuals are the only people who need to be considered as possible survivors misses an entire group who may be affected by a suicide but are not typically considered in research studies or for clinical services. In theory, this group could include individuals who did not even personally know the deceased but who can identify with him or her—for example, an adolescent who identifies with the music and lifestyle of a rock star who dies by suicide. We believe that our definition paves the way for research into suicide’s potentially widespread ripple effects in social networks (such as Mr. Smith’s community) that have, to the best of our knowledge, never been studied except for the peers of adolescents who died by suicide (Brent et al., 1992, 1994; Brent, Perper, Mortiz, Allman et al., 1993; Cerel, Jordan, & Duberstein, 2008).

Second, this definition can be operationalized in a way that allows research on the numbers of survivors to proceed in a more standardized fashion. For example, the use of the proposed criteria for PGD (mentioned earlier) would be one operational way of defining survivorship and
Suicide Bereavement

empirically studying how many people in the network of the deceased have become survivors after the suicide. Other ways of operationally defining a high level of distress for a considerable period of time can also be developed as suits the needs of the research study or clinical service of interest.

Last, although broad enough to include the more commonly used definitions of survivorship (exposure, kinship proximity, and perceived closeness), this definition draws an important distinction between simple exposure to suicide and actual survivorship. We believe this is important because only some people who are exposed to a suicide will be significantly negatively affected for a considerable period of time, and identifying those who are at greatest risk will be a key element of prevention efforts to reduce the harmful effects of suicide. It is likely that the risk profile for survivorship will share much in common with the risk factors for the development of post-traumatic stress disorder (PTSD) after other types of traumatic experiences (King, Vogt, & King, 2004) or for CG responses after other types of loss experiences (Hansson & Stroebe, 2007; Reed, 1998; Stroebe, Folkman, Hansson, & Schut, 2006). Nonetheless, certain factors may uniquely contribute to risk after suicide that help differentiate this pattern of bereavement from other types of traumatic events (Callahan, 2000; Jordan, 2001; Melhem et al., 2004a; Range, 1998; Sveen & Walby, 2008). This issue of distinctive factors that may be associated with suicide bereavement is discussed further in Chapter 2.

Here, we make the point that it is crucial for purposes of conceptual understanding and for clinical intervention that we learn more about who will likely have the most difficult bereavement trajectories among those exposed to suicide—something that our proposed definition of survivorship should help clarify and facilitate. This also fits with a growing recognition in thanatology that the most distressed mourners after any type of loss are also those who are most in need of—and the most likely to benefit from—organized, professionally based bereavement interventions (Currier, Neimeyer, & Berman, 2008; Jordan & McMenamy, 2004; Jordan & Neimeyer, 2003; B. Zhang, El-Jawahri, & Prigerson, 2006).

☐ The Impact of Survivorship

Exposure Versus Survivorship:
How Many Survivors Are There?

Previous reports of the number of survivors have generally failed to define criteria for survivorship, making an evidence-based answer to
this question very difficult to develop (McIntosh, 2003). Instead, most authors seem simply to have used “guesstimates” of the number of survivors. For example, Shneidman (1972) suggested that for every suicide, there are at least six survivors, or approximately 200,000 new survivors per year at current U.S. suicide rates. This figure has now been so widely quoted that it is sometimes repeated as an established fact when, in reality, it was only an educated guess by a pioneer in the field. In similar fashion, Wrobleski (2002) offered an estimate of 10 survivors for every suicide. To the best of our knowledge, no one has ever operationally defined survivorship and then conducted epidemiological research to obtain accurate estimates of the true number of people who are significantly affected within a social network after a suicide. This type of study is urgently needed and would greatly advance the field of survivor studies (Cerel et al., 2009; Jordan & McMenamy, 2004; McIntosh, 2003; see Chapter 33 for our proposed research agenda for survivor studies).

In the absence of this type of investigation, however, are there data about the number of people who are simply exposed to the suicide of someone they know? A study by Crosby and Sacks (2002) helps answer this question. Extrapolating from the sample in their well-designed telephone survey of U.S. households, these researchers calculated that approximately 7% of the U.S. population was acquainted with someone who died by suicide in the previous year. This equals about 1 in every 14 people or approximately 21 million people at current U.S. population levels. More surprisingly, slightly more than 1% of the respondents reported that they had a family member who had died by suicide in the last year. In this study, the authors allowed the term “family member” to include not only immediate kin (e.g., a sibling or child—slightly more than 3% of the sample) but also more distant kin (e.g., a cousin—slightly less than 14% of the sample). At current U.S. population levels, this means that approximately 3.3 million people in the United States reported that they had lost a family member to suicide within the last year. The remainder of the respondents reported that they were an acquaintance of the deceased (e.g., a friend or neighbor—about 80.4% of the sample). Extrapolating from the number of suicides in the U.S. in 1993 (31,102) and the percentage of people reporting exposure to a suicide in 1994, the year the data were collected, Crosby and Sacks estimated that for every suicide about 425 people knew about—and, therefore, were exposed to some degree to—the suicide. Taken together, these figures suggest that there is a startlingly high rate of exposure to suicide in the United States. Following our proposed definition of survivorship, even if only a small percentage of those exposed to a suicide are significantly and negatively affected for a considerable period of time—for example, 1 in 30—this would translate, on average, to about 14 people who become profoundly
affected survivors after every suicide, or almost 450,000 new survivors every year in the United States. We believe that these numbers on widespread exposure imply that previous estimates of the numbers of survivors in the United States are quite likely a significant underestimate of the true number of people affected by suicide. As we discuss in the section that follows, it also appears that exposure carries risk with it, including the risk of future suicidality in the person exposed.

**Risk Associated With Exposure to Suicide**

Chapters 3 through 5 of this book provide comprehensive reviews of the impact of suicide on those left behind. Therefore, we will only briefly note here that considerable and compelling evidence now shows that exposure to suicide carries with it the risk for a number of adverse sequelae. Perhaps the most disturbing of these risks is the elevated likelihood for suicide in a person exposed to the suicide of another individual. For example, on the basis of univariate data analysis, Crosby and Sacks (2002) reported that people in their sample who knew someone who had died by suicide within the last year were 1.6 times more likely to have suicidal ideation, 2.9 times more likely to have suicidal plans, and 3.7 times more likely to have made a suicide attempt. Hedstrom, Liu, and Nordvik (2008) found that men in Sweden who were exposed to a suicide within their family and in the workplace were, respectively, 8.3 and 3.5 times more likely to die by suicide than those not exposed (the workplace effect was limited to workplace settings of fewer than 100 persons, probably reflecting the importance of psychological propinquity in contributing to suicide). These authors note that although the risk of exposure to the suicide of a family member is higher, the likelihood of exposure to suicide through the workplace is much greater because of the larger number of people with whom one typically interacts in the workplace. Likewise, de Leo and Heller (2008) examined four large datasets, three of them multinational, and found compelling evidence showing that exposure to the suicide of non–family members also increases the risk of suicidal behavior and death by suicide in those exposed, particularly in young people. Similarly, in a series of large sample studies of the national health registries in Denmark, Agerbo, Qin, and colleagues documented the increased risk of death by suicide among people who have

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2 The odds ratios did not achieve statistical significance on multivariate analysis but remained greater than 1 for the presence of all three categories: ideation, plans, and attempts.
lost an immediate family member to suicide (Agerbo, 2003, 2005; Agerbo, Nordentoft, & Mortensen, 2002; Qin, Agerbo, & Mortensen, 2002). Note that the elevated risk also holds true for individuals who lose a spouse to suicide—as much as a 46-fold increase for men losing a spouse to suicide (Agerbo, 2005). This evidence strongly suggests that the hazard for survivors is not simply a function of shared genetics among blood relatives, but also involves psychological and/or role modeling effects on those exposed to a suicide. Moreover, although losing a child or spouse to any cause of death increases the risk of suicide, losing a spouse or child specifically to suicide carries an even greater risk than death from other causes (Agerbo, 2003; Qin & Mortensen, 2003). This elevated risk is also present for kin of family members who exhibit suicidal ideation, have made a suicide attempt, and/or have been hospitalized for psychiatric illness. A large number of additional studies have also documented that a family history of suicidal behavior or suicidal completion is associated with an elevated risk of suicide in the individual exposed to this behavior, particularly when coupled with a history of sexual abuse and/or impulsive aggression (Brent, Bridge, Johnson, & Connolly, 1998; Brent & Mann, 2006; Cheng, Chen, Chen, & Jenkins, 2000; Goodwin, Beautrais, & Fergusson, 2004; Mann et al., 2005; Melhem et al., 2007; Pleffer, Normandin, & Kakuma, 1998; Qin et al., 2002; Roy & Janal, 2005; Trémeau et al., 2005; Tsuchiya, Agerbo, & Mortensen, 2005).

Beyond the elevated risk for suicide, there is also evidence of other negative psychological, physical, and social consequences of exposure to suicide (see Jordan, 2001; McIntosh, 1996, 1999, 2003; see also Chapters 2 through 5 for reviews). For example, researchers have found that people who lose a close relative to suicide demonstrate greater rates of psychiatric disorder themselves (Kessing, Agerbo, & Mortensen, 2003; Tsuchiya et al., 2005). The literature suggests that survivors may be particularly vulnerable to an increased incidence of complicated or traumatic grief (Bailey, Krahl, & Dunham, 1999; Barrett & Scott, 1990; Clarke & Wrigley, 2004; de Groot et al., 2006; Dyregrov, Nordanger, & Dyregrov, 2003; Melhem et al., 2004b; Mitchell et al., 2004); depression (including suicidal ideation; Brent et al., 1994, 1998; Brent, Moritz, Bridge, Perper, & Canobbio, 1996; Crosby & Sacks, 2002; Mitchell, Kim, Prigerson, & Mortimer, 2005; Murphy, Tapper, Johnson, & Lohan, 2003; J. Zhang et al., 2005); and PTSD (Brent et al., 1995; Murphy, Johnson, Chung, & Beaton, 2003). These effects appear to be strongest in the familial relatives of those who died by suicide but are also seen in nonfamilial peer survivors, particularly in adolescents (Brent et al., 1996; Cerel, Roberts, & Nilsen, 2005; Poijula, Dyregrov, Wahlberg, & Jokelainen, 2001). Data also support the contention that survivors experience more stigma and less social support after the loss of someone to suicide than
after other types of losses (Cleiren, Grad, Zavasnik, & Diekstra, 1996; Farberow, Gallagher-Thompson, Gilewski, & Thompson, 1992; Harwood, Hawton, Hope, & Jacoby, 2002).

Taken together, these studies offer evidence that exposure to suicide is frequently associated with many negative sequelae, the most important of which is an elevated risk for subsequent suicide in the person exposed. But is this true only of bereavement after suicide, or is this simply a consequence of bereavement of any type? In the next chapter, we explore the question of whether bereavement after suicide is “different” and “worse” than bereavement after other types of losses.

References

14 Grief After Suicide


Suicide Bereavement

Grief After Suicide


