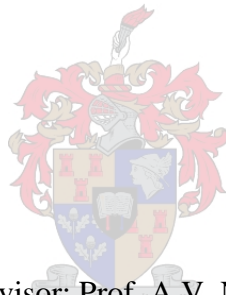


SUICIDE AND BEREAVEMENT:

An Interpretive Study

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degree of Masters in Clinical Psychology and Community Counselling at the
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Declaration

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

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Signature

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Date

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Abstract

Suicide is the third leading cause of death worldwide, and its social ramifications are far-reaching. Due to the stigma associated with suicide, as well as the unique emotional processes that occur during bereavement following this mode of death, suicide bereavement is regarded as different - and more intense than - other grief experiences. While the effects of suicide on the suicide-bereaved have been well-documented using objective measures of outcome, the subjective, and often unquantifiable emotional, familial and social consequences of suicide have been largely under-researched. By using an interpretive approach, this study focuses on the subjective experiences of those who have lost a loved one to suicide. Five suicide-bereaved individuals were sampled from a particular community, and their experiences were elicited using semi-structured interviews.

The results indicate a number of emotional as well as social processes that occur after suicide, including intense longing for the deceased; rationalisation, disbelief, and denial; feelings of anger, guilt, regret, and sadness; a search for answers, meaning and closure; and blaming and social isolation. While these processes cannot be said to occur exclusively in suicide bereavement, they appear to be experienced more intensely during this form of grief.

OPSOMMING

Selfmoord is die derde hoogste oorsaak van dood wêreldwyd en dié sosiale implikasie kom voor oor die hele spektrum van die wêreldbevolking. Oor die stigma geassosieer met selfmoord, sowel as die unieke emosionele prosesse wat plaasvind gedurende die rouproses, na aanleiding van die wyse van afsterwe, word dié rouproses as verskillend – en meer intens – as enige ander rou ervarings beskou. Terwyl die effekte van selfmoord op die naasbestaandes van die selfmoordenaar baie goed gedokumenteer is met die gebruik van objektiewe metings van uitkoms, is die subjektiewe emosionele, familiaal en sosiale konsekwensies van selfmoord, in 'n groot mate, die minste navorsing oor gedoen. Deur gebruik te maak van 'n vertolkende benadering, het hierdie studie gefokus op die subjektiewe ervarings van diegene wat 'n geliefde aan selfmoord afgestaan het. Vyf persone wat al iemand aan die dood afgestaan het as gevolg van selfmoord, is uit 'n spesifieke gemeenskap geneem en hul ervarings is gedokumenteer deur gebruik te maak van semi-gestruktureerde onderhoude.

Die resultate verwys na verskeie van emosionele, sowel as sosiale prosesse wat plaasvind na selfmoord: kragtige verlanke na die oorledenes; logiese redes, ongelowigheid, weiering, gevoelens van kwaadheid, skuldgevoel, spyt en hartseer; 'n soektog na antwoorde, die doel en die afsluiting van die selfmoord; blamering en sosiale isolasie. Terwyl hierdie prosesse nie te sê alleenlik net met die naasbestaandes van selfmoordgevalle gebeur nie, is dit dat hul dit meer intensief ervaar in hul rouproses as enige ander normale rouproses.

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Introduction

In the year 2000, an estimated 1 million people worldwide died by suicide. It is further estimated that suicide is attempted every 3 seconds, and that every 40 seconds, somebody in the world succeeds in ending his or her own life. Suicide is now one of the three leading causes of death among people aged 15-35 years worldwide (World Health Organisation, 2000). These alarming statistics point to the rapid increase in suicide over the last 50 years, and provide fitting justification for the magnitude of the body of literature devoted to the topic. Suicide has been studied, scrutinised and explained from various perspectives; its causes and effects have been documented; and it has even endured and enjoyed both disapproval as well as meritorious acclaim¹ (Cvinar, 2005). On the surface, it seems as though suicide has received all the attention that could be given to one topic, and that its ramifications have been thoroughly researched – and understood. There is, however, one aspect of suicide where the facts remain murky, where research has been forthcoming, but largely unhelpful to those who are most affected by the phenomenon – the suicide-bereaved.

Most studies rely on quantitative measurement of observable signs and symptoms following suicide, and, in so doing, attempt to reach conclusions about the effects of suicide on survivors. Insofar as delineating the dimensions of suicide bereavement as a condition which predisposes survivors to certain patterns of extended and complicated grief, as well as identifying particular aspects of grief after suicide, the literature to date is comprehensive indeed. But what does this mean for the mourning individuals who have to contend not only with the loss of a loved one, but also the harrowing questions that the tragic and often silent act of suicide inevitably raises? How do suicide-bereaved individuals cope with the loss of a loved one who has *chosen* to create that loss? What are the implications for the bereaved beyond the normal grieving process of natural death? These questions are what have motivated the researcher to undertake to attempt to clear the shadowy nature of suicide; to understand the subjective experiences of the suicide-bereaved; to understand the effects of suicide not by quantitative measurement, but by empathic listening to the voices of those who have been left behind.

¹ In the Greco-Roman, Far Eastern, and other cultures, suicide was often seen as a politically and morally acceptable solution to problems.

Aims of the study

While countless studies have explored the reasons for, and consequences of suicide, little has been achieved in terms of understanding the subjective experiences of bereaved suicide survivors. Furthermore, a gap seems to exist between empirically validated studies on suicide bereavement, and the personal narratives and subjective experiences of those who have experienced the loss of a loved one to suicide. By using an interpretive approach, the researcher aims to achieve the following broad goals:

- Gain an understanding of the subjective experiences of those bereaved by suicide
- Review existing literature on the topic of suicide, and
- Compare the subjective experiences of the suicide-bereaved participants with the available literature.

By focusing on the survivors of suicide, this study further aims to achieve the following, more specific goals:

- Understand the adjustment process after suicide
- Understand the emotional reactions of suicide survivors
- Create an awareness of the devastation that suicide brings upon surviving loved ones
- Understand the impact of suicide on the interactions between the bereaved and society
- Aid in the prevention of suicide-bereaved pathology (including suicide of the survivors of the initial trauma)
- Aid in the provision of appropriate postvention

Literature Review

The phenomenon of suicide has generated a wealth of literature. In reviewing the literature relevant to this study, numerous conflicts and inconsistencies have been uncovered. What follows is a summary of the themes that the researcher has found to be useful in understanding suicide and its ramifications.

A Broad History of the Perceptions of Suicide

The way in which suicide has been perceived has fluctuated over time. Suicide can be traced back to the earliest documented history of mankind. In the early Greco-Roman world, as well as Far Eastern cultures, suicide was often viewed as a politically and morally correct solution to difficult life problems. Indeed, there were often instances where suicide was seen as a brave act (particularly in times of war) (Cvinar, 2005). The attitudes towards suicide during this time are obviously markedly different to current perceptions. The change in attitudes towards suicide began during the early Middle Ages, when spiritual beliefs regarding the act took precedence over the situational factors that may have been involved. The movement away from the positively viewed act was underscored by a growing belief that taking one's own life wrecked havoc with the spirit world. It was common, during this period, for suicide corpses to be mutilated in order to prevent the unleashing of wandering spirits. This mutilation was often so extreme, that family and friends could not recognise the deceased. Thus suicide survivors were often not given the opportunity to get closure (by performing burial rituals, for example) on the loss of their loved ones. Furthermore, families of suicide completers were ostracized, and not given support (both emotionally and financially) by communities because of fears of spiritual consequences. Also, survivors of suicide often had to pay a fine because suicide was seen as a "victimless crime" and was thus regarded as a waste of officials' time (Parrish & Tunkle, 2005). It is believed that the lack of support for the suicide-bereaved, as well as the penalties imposed on them, was a primitive means of suicide prevention. In other words, punishment of the suicide-bereaved was seen as a deterrent to the act of suicide (Cvinar, 2005).

During the 18th century legal, religious and social systems began to reduce negative consequences of suicide on the suicide-bereaved. The survivors of suicide were not directly punished. However, the negative attitudes towards suicide remained, and consequently, the suicide-bereaved attempted to hide the suicide, or it was given different nomenclature by authority figures. Though there was an attempt to reduce the suffering of survivors, the stigma associated with suicide was not reduced. Thus the suffering was not lessened, but rather changed into a less public, more secretive form (Cvinar, 2005).

The 19th century began to see the relief of the stigma that followed suicide. However, the medical domain embraced the notion of heredity as a determining factor of suicide, further stigmatising suicide survivors. This tendency still contributes to the difficulties that suicide survivors face at the present time. While research has explained the complex nature of suicide, thereby reducing the negative consequences for survivors, little attention has been given to social difficulties following suicide. Thus perceptions of suicide have changed over time, but the social stigma associated with the phenomenon continues to haunt the lives of the suicide-bereaved (Cvinar, 2005).

Why Is Suicide Bereavement Different?

Social Stigma

The social stigma discussed above points to at least one difference between the suicide-bereaved and those who have lost a loved one due to other causes (Cvinar, 2005). Indeed there is a rich body of literature that supports the generally held contention that suicide bereavement is different - and more difficult. A study by De Groot, De Keijser and Neelman (2006) found that individuals bereaved by suicide are perceived as more psychologically unstable, less likeable, more blame-worthy, more ashamed, more in need of professional help, and more likely to remain sad and depressed for a longer time. This stigmatisation leads to disruptions in support networks that would have been available to survivors of other forms of death (by illness, for example), which, in turn, causes the suicide-bereaved to become isolated from their communities (Jordon, 2001). It must be noted, however, that the feelings of isolation experienced by suicide survivors are not the result of rejection by the

community, but are caused by the awkwardness which community members experience because of the sensitive nature of the loss. This awkwardness may be experienced by the suicide-bereaved as rejection.

Numerous studies (Currier, Holland & Neimeyer, 2006; Provini, Everett & Pfeffer, 2000; Wertheimer, 2001) support the view that social stigma is a distinctive element in suicide bereavement. Going against the very basic human tendency toward the preservation of the self, suicide, unlike any other form of death, is a social taboo. For this reason, the suicide-bereaved often lie about the cause of death of the deceased, fearing that they will be negatively judged (Jordan, 2001). In addition to the taboo surrounding suicide, Cvinar (2005) states that suicide is often perceived as a failure on the part of the victim and family to overcome some emotional or interpersonal issue. Ultimately, survivors are blamed for the death of their loved ones, which creates a unique stress for suicide survivors. Finally, it has been suggested that the actual cause of death may have less of an impact on survivors than the social reactions to the suicide (Calhoun, Shelby & Abernathy, 1984). In their analysis of the perceptions of those who knew others who have been bereaved by suicide, Calhoun et al (1984) note that suicide is seen by others to have the most devastating effects on the bereaved. Moreover, they found that negative social interpretations of suicide lead to a lower level of support for suicide survivors. It seems that social perception of suicide plays a crucial role differentiating suicide bereavement from that of other modes of death.

Emotional Reactions of Survivors

As a result of the stigma attached to suicide, numerous emotional reactions appear to be distinctly involved in the grief following suicide. Edward Schneidman (1972, cited in Wright, 1998, p1) wrote:

“I believe that the person who commits suicide puts his psychological skeleton in the survivor’s emotional closet – he sentences the survivor to many negative feelings and, more, to become obsessed with thoughts regarding his own actual or possible role in having precipitated the suicidal act or having failed to abort it”.

Cvinar (2005) suggests four unique grieving experiences within suicide bereavement, namely, stigma, blame and guilt, search for meaning in the loss of the loved one, and

being misunderstood by the community. These feelings most probably result from a combination of social isolation, and not having had the opportunity to understand the reasons for the suicide. Also, the negative societal attitudes towards suicide are often internalised by survivors (self-stigmatisation), intensifying their feelings of guilt and shame (Jordan, 2001). Parrish *et al.* (2005) noted that when suicide is reported to authorities the scene of the act is regarded as a “crime scene”, and people involved are regarded as “suspects”. Also, suicide notes are often confiscated for forensic purposes, despite its tremendous value to survivors. These factors add to the negative attitudes towards suicide that are internalised by survivors. In addition, suicide survivors often try and find meaning in their loss (Currier, Holland & Neimeyer, 2006). They endeavour to make sense of the motives and state of mind of the deceased. Failure to do so results in feelings of abandonment as well as anger towards the deceased.

In a comprehensive meta-analysis of the results of studies conducted previously, Neary (2000) has identified additional emotional reactions that seem to be especially strong with regard to suicide, including: feelings of loss, sorrow, separation, desertion, shame, embarrassment; impulses towards suicide; and anger toward the deceased and extended social network. Seguin and Kiely (1995) note that the suicide-bereaved also feel that they are being punished for something (more so than survivors of other types of death). They also distinguish between feelings of guilt, where the survivor feels some level of responsibility for the death, and feelings of shame, which implies the transgression of a social standard of rule. It has also been noted by several researchers (Jordan, 2001; Latham & Prigerson, 2004; Neary, 2000) that suicide survivors often experience feelings of relief, particularly when the suicide completer has had a history of substance abuse, or has caused ongoing emotional distress.

There seems to be considerable evidence that suggests that the thematic and qualitative aspects of suicide grief differentiate it from other forms of bereavement (Currier, Holland & Neimeyer, 2006; Jordan, 2001; Neary, 2000). It must be noted, however, that suicide survivors do not only experience the feelings mentioned above, but may be flooded with a variety of feelings, depending on the relationship between the survivor and the deceased. Similarly, survivors of other modes of death may experience feelings similar to that of suicide survivors. Qualitative studies seem to

suggest, however, that those bereaved by suicide are more prone to such feelings, and that the nature of the act of suicide intensifies survivors' emotional reactions.

Impact on Family Life

Jordon (2001) notes that suicide often results in dysfunctional patterns of interaction between family members. Because a dysfunctional family environment can act as both a predisposing element as well as a precipitating factor of suicide, survivors often blame one another for the suicide. Families that have a history of dysfunction (alcoholism, marital conflict, abuse, etc) tend to disintegrate after the suicide of one of the family members. It seems as though this reaction to suicide is related to the tendency of survivors to search for meaning in (and reasons for) the loss of their loved-ones. Also, the stigma attached to suicide often causes the creation of powerful family secrets, which has long-term implications for survivors.

It has also been noted that adults caring for children who are grieving the loss of a family member due to suicide, have the additional responsibility of recognising child grief, as well as providing information about the suicidal nature of the death. Tasks such as these are not easy to perform, and add an additional layer of stress to an already difficult situation (Provinci et al., 2000).

In a nation-wide study on bereaved children and adolescents in Norway, it was found that suicide-bereaved parents tend to panic that something would happen to the surviving children (Dyregrov, Nordanger & Dyregrov, 2003). Surviving children were also found to worry excessively about their grief-stricken parents. The study also revealed that siblings of suicide completers often restrain themselves from mentioning the lost person. In examining the psychological functioning of child and sibling survivors of suicide, Wright (1998) found that loss of a parent due to suicide causes long-term behavioural problems, which has obvious negative implications for the family's psychosocial health and cohesion. These findings lend support to the generally held contention that suicide-bereaved families suffer dysfunctional patterns of interaction and disintegration.

Post-Suicide Pathology in Survivors

A vast amount of empirical data exists on post-suicide pathology (i.e. survivors' psychological problems resulting from the suicide). De Groot et al. (2006) conducted a study comparing the self-reported psychiatric problems and general health of 153 relatives of 74 suicides and 70 relatives of 39 natural deaths. Their results indicate that suicide bereaved persons are lonelier, function less well on physical measures (general health), and have a much higher incidence of depression than the naturally-bereaved. Furthermore, of the suicide-bereaved, 6.5% reported attempting suicide, which is much higher than the reported suicide attempts of the naturally-bereaved (2.9%).

An increase in the quantification of symptoms and maladaptive responses to suicide has led to the formulation of diagnostic criteria for complicated grief (De Groot et al., 2006). Complicated grief (CG) has been shown to form a "unidimensional cluster" of symptoms, including: separation distress and traumatic distress (Latham & Prigerson, 2004). Unlike the depressive-like symptoms of normal bereavement, CG persists for a long period of time (minimum of 6 months), and is associated with a higher risk of suicidal ideation. It has been observed (Latham & Prigerson, 2004) that CG was associated with a 6.58 times greater likelihood of suicidality. Latham and Prigerson (2004) also found that suicide bereavement increases the risks of Major Depressive Disorder and anxiety-related disorders, and is associated with impaired immune functioning, increased physician visits, poorer physical health, and increased use of alcohol and cigarettes. These conclusions are supported by other studies indicating that suicide-bereaved individuals constitute a high-risk group of mourners needing specialised intervention (De Groot et al., 2006; Mitchell et al., 2005; Wright, 1998). Long-term effects of suicide on the bereaved also include unrelenting depression, chronic posttraumatic stress symptoms, interference with normal development (in children), and the use of unhealthy problem-solving strategies (e.g. use of alcohol) (Wright, 1998). Another study (Dyregrov et al., 2003) found that the sudden, unexpected death of a loved-one accounts for approximately one-third of all posttraumatic stress disorder cases. The effects of suicide on bereaved pathology can thus be summarised as: decreasing general health, increasing the risk of suicidal behaviour, increasing the likelihood of developing complicated grief symptomology (including persistent depressive and PTSD symptoms). These factors, though not

exclusively found in suicide bereavement, seem to be characteristic to this type of loss, and therefore strengthen the argument that the suicide-bereaved suffer more than naturally-bereaved individuals.

Similarities between Suicide Bereavement and Grief Following Natural Death

Though suicide is generally perceived to be associated with more negative bereavement outcomes, recent quantitative studies found differences between suicide bereavement and grief following natural death to be minimal. Dyregrov et al. (2003), in their comparison of outcome and predictors of psychological distress of parents after suicide, sudden infant death syndrome (SIDS), and child accidents, showed that the similarities are more striking than was previously thought. Feelings of guilt and isolation were found to be common amongst all three modes of death (suicide, SIDS, and accident). They argue that the traumatic aspect of these modes of death predispose survivors to more complicated grief processes. They also note that there is no evidence to prove that suicide survivors have greater difficulties in adapting to the loss compared with survivors of SIDS and accidents. A study (Murphy, Johnson, Wu, Fan & Lohan, 2003) focusing on posttraumatic stress disorder and mental distress of survivors of suicide, homicide, and accidental death of children yielded similar results. They concluded that “contrary to established belief, [bereavement following] a child’s death by suicide was not the most profound or long-lasting” (Murphy et al., 2003, p.58).

These findings are in stark contrast to the results of the studies mentioned previously. With such variation in outcomes, it is extremely difficult to draw conclusions about the differences or similarities between suicide bereavement and that of other modes of death. The disparity, however, points to conflicting views of different approaches to research on the topic. This is discussed in the following section.

Qualitative versus Quantitative Methods of Studying Suicide

While both qualitative and quantitative research methods have contributed considerably to the body of knowledge on suicide, results seem to indicate conflicting findings between these two approaches. Numerous researchers (Dyregrov et al., 2003;

Ellenbogen & Gratton, 2001; Murphy et al., 2003) have found suicide bereavement to be no more devastating than that of other sudden modes of death (accidents, for example). These studies tend to be quantitative in nature, focusing on observable grief reactions such as posttraumatic stress and depressive symptoms. Ellenbogen and Gratton (2001) list several critiques of studies that conclude that suicide bereavement is fundamentally different to other forms of bereavement: 1) concepts are not always operationalised; 2) grief is rarely studied longitudinally; 3) few studies have an adequate comparison group; 4) group sizes are usually quite small; 5) measures used are often not intended for the study of grief; 6) the theories on which studies are based are not always explicitly stated; 7) refusal rates are high; 8) sampling is sometimes suspect; and 9) there is almost never a control of confounding variables (e.g. quality of the relationship and kinship to the deceased).

Other writers have stressed the importance of understanding the subjective experiences of suicide survivors, and have thus given qualitative methods greater priority. In his assessment of the literature on suicide, Jordon (2001) attributes the apparent similarities between suicide bereavement and other types of grief to the narrow focus of most of the quantitative research that has been conducted. He contends that suicide bereavement, when observed from a qualitative point of view, is different in at least three significant ways: the thematic content of the grief, the social processes surrounding the survivor, and the impact suicide has on family systems (Jordon, 2001). Simple quantitative methods do not detect these important aspects of suicide bereavement, and it is precisely the qualitative element of suicide bereavement that sets it apart from other modes of death. Nuttgens (1997) states that the typical quantitative methods do not preserve the integrity, and contextualised meanings contained in survivors' stories.

Given the valid arguments from both sides of the debate, it seems fitting to conclude that one's preference for either of these methodologies should be based solely on the outcomes one wishes to achieve. Thus a psychologist wanting to be able to empathise with a client more intensely may find qualitative research on the topic more useful, while a more outcomes-based oriented psychologist may want to compare probable outcomes from different modes of death. The "correct" methodology is therefore a matter of choice.

Suicide and Spirituality

Due to the sensitive nature of suicide, as well as the somewhat otherworldly characteristics of spirituality, *empirical research* on the spiritual aspect of suicide bereavement is scarce. However, the topic of suicide and spirituality has been extensively written about.

In a comprehensive review of literature regarding the adjustment process of suicide survivors, Janet Nel (2001) observes that particular religious ties may have the effect of intensifying the anguish that survivors experience. She further notes that literature about life after death does not always satisfy the suicide-bereaved. In addition, a number of metaphysical aspects of suicide are discussed. Research has shown that near death experiences often lead to renewed purpose in life in people who attempt suicide. It has also been concluded that suicide deprives people of the opportunity to acquire knowledge that they are still lacking. Based on the literature reviewed by Nel (2001), it seems as though, ultimately, there are no hard and fast rules regarding suicide and spirituality, yet there is consensus that the experience of suicide should be understood from the spiritual premise that "...there is a larger meaning to all" (p. 39).

Falkenstein (2003) investigated the relationships between spirituality, and coping skills and depression, in an attempt to test the hypotheses that higher levels of spirituality result in higher levels of coping and lower levels of depression. Her results indicate insignificant relationships between spirituality and coping, as well as spirituality and depression. However, without controlling for social support, a significant relationship seems to exist between spirituality and depression. In other words, higher levels of spirituality do not seem to lower levels of depression in acutely bereaved individuals, nor does it increase coping skills. When spirituality is combined with social support, however, it seems to lower depressive symptoms.

An interesting study by Walker and Bishop (2005) showed that the extremely low rates of suicide amongst African Americans (compared to their Caucasian counterparts) can be attributed, at least in part, to religious factors. Because African Americans are less likely to make use of professional mental health resources, they

are inclined to participate in non-traditional, collective religious practices. These practices are said to have a protective effect against suicidal behaviour.

The relationship between spirituality and suicide, though thoroughly pondered and debated, has not yet been adequately studied, and therefore scientific knowledge of this relationship is lacking.

Suicide in South Africa

Poor quality national-level data make it difficult to posit an accurate estimation of suicidality in South Africa. A document entitled “*Adult Mortality (age 16-64) Based on Death Notification Data in South Africa*” (Statistics South Africa, 2006) provides statistics on unnatural causes of death for men and woman aged 15 to 64 years (2 899 and 748 per 100 000, respectively). However, this document does not provide data on specific causes of death (suicide, homicide, illness, etc). It is estimated that South Africa’s suicide rate is 17.2 per 100 000 people – which is higher than the global suicide rate (16 per 100 000) (Meehan & Broom, 2007). The ethnic distribution of suicide is as follows: 47.4% Black, 33.9 % White, 14.9% Coloured, and 3.8% Asian.² It is argued that insecurity brought about by social change (such as the transition from apartheid to democracy) links the social, economic and political context of South Africa to the rate of suicide (Meehan & Broom, 2007). Factors such as unemployment, poverty, low levels of education, lack of access to basic needs, and increases in substance abuse are also seen to have contributed to the increase in suicidality in South Africa (Meehan & Broom, 2007). In addition to these factors, for every 100 000 people in South Africa, there are only 2 psychiatrists, 2 psychologists, and 3 social workers working in mental health (Meehan & Broom, 2007). Thus it seems as though the socio-political history of South Africa and its ramifications, coupled with a severe lack of psychological and psychosocial services partly accounts for the high suicide rates in the country.

² Given the political history of South Africa, the researcher has inserted these racial categories merely to illustrate how suicide affects these categories of people in an ever-evolving nation. Its inclusion is not intended to be used to draw general conclusions from.

Burrows and La Flamme (2006) view suicide rates as an important indicator of community health. As such, they undertook to study and compare suicide rates across six South African cities, with the aim of understanding the trends underlying these figures. The results indicate that the suicide rate is generally higher for white South Africans than Black South Africans³, and that more males than females commit suicide in South Africa.

Help for the Suicidal and Suicide-Bereaved: Prevention and Postvention

Prevention

In South Africa, no specialised suicide prevention centres exist. However in 2003, a national toll free crisis line was established in response to the raising rates of suicide in the country (Meehan & Broom, 2007). The crisis line could be accessed by individuals experiencing acute distress, thereby connecting such individuals to mental health services. In their analysis of the crisis line as a preventative intervention, Meehan and Broom (2007) concluded that it was still in its infancy, and that further investigations were needed. However, the crisis line was seen to be a step towards a more comprehensive prevention programme.

The World Health Organisation (2000) has identified several psychological and psychosocial disorders that are regarded as risk factors for suicide, namely:

- Depression
- Personality disorders (antisocial and borderline personality traits with impulsivity, aggression and frequent mood changes)
- Alcoholism and substance abuse
- Schizophrenia
- Organic mental disorders
- Other mental disorders

These clusters of disorders are listed in decreasing order of suicide risk. Health care professionals should be aware of the risks of suicide associated with these types of disorders in order to help prevent suicide.

³ The apparent disparity between suicide rates of these studies is accounted for by the vast difference in population size between black and white South Africans.

In helping potential suicide-completers, the World Health Organisation suggests that the primary goal is to “...bridge the gap created by mistrust, despair and loss of hope and give the person the hope that things could change for the better” (p.11). Suggestions on how to communicate with potential suicide-completers are also provided:

- Listen attentively, be calm
- Empathise
- Provide non-verbal messages of acceptance and respect
- Express respect for the person’s opinions and values
- Talk honestly and genuinely
- Show concern, care and warmth
- Focus on the persons feelings

[Retrieved from: WHO, GENEVA, 2000]

Postvention

Postvention, a term that has come to be specifically associated to suicide, is defined as: “a set of strategies aimed at helping individual survivors of suicide, comprising efforts to ‘reduce the after effects of a traumatic event in the lives of survivors... to help survivors live longer, more productively, and less stressfully than they are likely to do otherwise’” (Schneidman, 1984, p. 143, cited in Parrish & Tunkle, 2005). Such intervention is usually started soon after the traumatic event. Parrish and Tunkle (2005) believe that suicide bereavement is distinct from other forms of bereavement, and that special interventions should be directed towards the suicide-bereaved.

Schneidman (1984, cited in Nel, 2001) provides suggestions for postvention

- Attempt to start working with survivors within the first three days
- Caregiver should maintain a neutral stance, without blame or punishment
- Negative feelings (such as anger) towards the deceased should be explored later in the process
- Caregivers should test reality for survivors, and not feed into their conscience
- Survivors should be medically and psychology evaluated.

Nel (2001) lists some important principles that underlie postvention, including: allowing family members to accept the death at their own time; bearing in mind that children are especially prone to self-blame; teaching the family that grief is typically self-limiting; allowing children to grieve.

Support groups have been shown to have a positive outcome with regard to suicide bereavement. Pietilla (2002) attributes the positive outcome of support groups to the fact that survivors are able to share their experiences with others who have had similar experiences.

Mitchell et al (2007) further suggest that specialised support group interventions be implemented for suicide-bereaved children. They propose an 8 week group intervention for children which allows them to articulate their feelings and experiences without feeling that they are being judged. Given that the group members have all experienced a loss by suicide, it is believed that this type of intervention is the most effective and least threatening for children.

Summary of Literature Review

Stigma, blame and guilt, search for meaning in the loss of the loved one, and being misunderstood by the community are elements of suicide bereavement that differentiate it from other modes of death. In addition, suicide bereaved individuals suffer greater and more intense feelings of guilt, anger and abandonment. Suicide also affects family structures in a negative manner, causing social isolation and increased family discord. People who have been bereaved by suicide are considered to be a high-risk group of individuals, being more susceptible to Major Depressive Disorder, anxiety-related disorders, impaired immune functioning, poorer physical health and increased use of substances. As such, the suicide-bereaved constitute a group of mourners requiring specialised intervention.

Conflicting views about the differences and similarities between suicide bereavement and that of other modes of death exists. While some authors argue that the emotional responses of suicide-bereaved individuals are what differentiates it from other forms

of death, others maintain that these are similar. The incongruence is best accounted for by the differences in the methodological approaches used by various researchers.

South Africa's suicide rate is greater than the global rate, and this is attributed to the turbulent socio-political history and climate of the country. Also, it is believed that poor delivery of psychological and psychosocial services is a contributory factor in the high rate of suicide in South Africa.

Finally, it has been well established that suicide bereavement requires specialised intervention. *Postvention* entails working with families who have lost someone to suicide, with an emphasis on preventing post-suicide pathology. It is generally accepted that suicide-bereaved families experience a number of different reactions to the suicide, and that it is important that families be allowed to accept the loss at their own time.

The literature presented above, though conflicting at times, highlights the devastation that suicide leaves in its wake. Hence this study seeks to understand the subjective experiences of the suicide bereaved in order to aid in the provision of postvention, as well as to compare these with the available literature.

Methodology

The researcher has chosen to use an **interpretive** approach in collecting and analysing data for the present study. Interpretive methods are characterised by the following assumptions:

- People's subjective experiences are real and important
- Understanding others' experiences requires interaction with them and listening intently to what they have to say
- Qualitative methods are best suited to achieve this task

(Terre Blanche & Durrheim, 1999)

It is believed that this approach will be most useful in understanding the experiences of the suicide-bereaved.

Participants

Due to the sensitive nature of the topic of discussion, as well as the social stigma associated with suicide, finding bereaved survivors of suicide who were willing to participate in the study proved to be quite challenging. However, the researcher was able to secure interviews with 5 people who have been bereaved by suicide within his community. Four of the participants have experienced the loss within the past 7 years, while the fifth participant experienced the loss approximately 50 years ago. The participants were sampled from a working class, "coloured" community in the Western Cape, and were identified by word-of-mouth in that community.

Description of participants

It was agreed that the identity of participants would remain anonymous, and that only relevant demographic information will be included in the study. A brief description of the participants, as well as the mode of suicide that their loved ones chose to use, is included here for the purpose of acquainting the reader with the suicide-bereaved, and to provide a context for each participant's experience.

Participant 1 (P1)

P1 is a 24-year-old, single female. Her cousin committed suicide 5 years ago, by shooting himself in the head. He was 35 years old. Her cousin's (the deceased) wife, as well as another cousin, had left the house seconds before they heard two gunshots (the first one was to "test" the gun). P1 was informed about the event by telephone, after which she drove to the scene. She did not view the body.

Participant 2 (P2)

P2 is a 47-year-old male. He is married and has two children. His youngest brother, who had been estranged from the family after moving to a different town, took his own life by cutting his wrists approximately three years ago. The body was found in the deceased's bedroom, kneeling over the bed. The deceased was married and had two young children (6 and 9 years old). P2 described his younger brother as "fun-loving" and does not believe that he would have taken his own life. An investigation into the possibility of murder is still pending, though the family have generally accepted that he has committed suicide.

Participant 3 (P3)

P3 is a 79-year-old, divorced male, who has 5 children. His elder brother committed suicide approximately 50 years ago (P3 was not sure what year, but remembered all other details). The deceased committed suicide by throwing himself in front of a moving train. P3 stated that his brother took his own life because he had impregnated a woman, and was overwhelmed by the pressure that the situation caused, as well as the disgrace that it would bring upon the family. P3 adds that he blames his father for the suicide, since he (the father) was not willing to discuss the matter with the deceased, prior to the suicide.

Participant 4 (P4)

P4 is a 77-year-old, single female. Her brother committed suicide by hanging himself 7 years ago. He was 69-years-old at the time. The deceased was a bachelor, and was described as the "grandfather" of the family, although he did not have any children of his own. A suicide note reading "Those who know me will understand" was found, but this did not provide any information as to the reasons for the suicide. P4 also

obtained the “design plans” of the structure that the deceased built in order to hang himself.

Participant 5 (P5)

P5 is a 30-year-old male, who is married and has two children. Four years ago he found his brother hanging by the neck from a beam in their garage. The deceased was recently divorced, and had two young children. He was diagnosed with Major Depressive Disorder.

The Interviews

The interviews took place at the participants’ homes, at a time that was convenient for them. Prospective participants were contacted by telephone, informed about the aims and nature of the study, and it was left to them to decide whether or not they would be willing to partake in the study. Upon a follow-up telephone call, the 5 prospective participants were willing to participate in the study, and it was arranged that the researcher would contact them to negotiate a suitable date and time.

Data Collection

Data⁴ were collected using semi-structured interviews. An interview schedule was developed, based on the aims of the study (see appendix A). The researcher obtained the consent of the participants to make use of an audio recorder. The recorded interviews were then to be transcribed.

Data analysis

Data analysis took place in five steps, as recommended by Terre Blanche and Durrheim (1999). The steps are:

- 1) Familiarisation and immersion – becoming immersed in the collected data
- 2) Inducing themes – identifying the organising principles that underlie the collected material
- 3) Coding – marking different sections of the data as being instances of, or relevant to one or more of the identified themes

⁴ The term “data” generally represents pieces of discrete information. In this interpretive study, however, the “data” encompasses the entirety of the participant’s input, at a number of different levels.

- 4) Elaboration – exploring themes more closely; looking at the relationships between coded sections of data, and
- 5) Interpretation – generating a written account of phenomenon that has been studied, using thematic categories as sub-headings

Ethical Considerations

The ethnic background of participants was not considered for this study. However, given that the participants were sampled from a particular community, all the participants are of the so-called “coloured” group. Readers are reminded that although suicide is a universal phenomenon, the reactions of the suicide bereaved may vary across different ethnic groups, and may be individually unique.

The participants were given guarantees that they would remain anonymous, and that only the necessary demographic information would be included. They completed a consent form prior to commencement of the interviews (see appendix B).

Great care was exercised to ensure that interview questions were handled sensitively. However, it was expected that certain questions would evoke strong emotional reactions. Thus the participants were told in advance to be prepared for the emotional responses which could arise.

Most of the participants responded to the questions in an emotional manner. The researcher allowed the participants to express their stories in their own way, and only asked particular questions when these had not been covered by the participants’ accounts. The interviews were approximately one hour long, but time was allocated afterwards for debriefing purposes. This time was used to ask participants how they felt after talking about their loss, as well as to provide them with referral numbers in case of further reactions. All of the participants felt a sense of relief after the interviews, and some indicated that they enjoyed talking about their lost loved ones.

Researcher’s comments on the process

The researcher’s interest in post-suicide bereavement stems from an alarming increase in suicide within his community over the past five years, as well as his family’s experience of having a lost a loved one to suicide. The process of interviewing was

therefore particularly difficult. However, the commonality between the researcher and the participants seemed to enhance rapport during the interviews, and self-disclosure on the part of the researcher had the effect of creating feelings of trust in the process. In the same manner, the researcher's personal experiences aided in the debriefing process.

Results

This section will present the themes that were generated from the interviews under the broad headings of *emotional reactions to suicide*, *the adjustment process following suicide* and the *social ramifications of suicide*.

Emotional Reactions to suicide:

Longing for the deceased

“...I would love him to sit there today... in my company, [to] sit and to chat”
(P2)

“...something that mingles in my mind about it... that we could have had a better relationship because he was only 23 when this happened. I just feel that we could have developed a better relationship as we grew older. That is, I regret [that] I have lost a brother” (P3)

As with all types of grief, the participants expressed an intense longing to be reunited with the deceased - to be able to share their current experiences with their lost loved ones. This finding supports the results indicated by numerous other researchers (Currier, Holland & Neimeyer, 2006; Jordan, 2001; Neary 2000), who claim that suicide bereavement entails a distinctive pattern of emotional responses, as well as more intense experiencing of normal grief reactions. In addition, those who experienced the loss at a much earlier time (More than 5 years), tended to ponder what the suicide-completer's life would have looked like, had that person not taken his or her own life. Although all of the participants expressed their longing for the deceased, none volunteered that they would have changed the course of events if they had the ability to do so.

Rationalisation, Disbelief and Denial

“One would want them to investigate the matter and then find that he didn't commit suicide, but then, on the other hand, if he didn't commit suicide there was foul play...”(P2)

“You know you have the wisest and the richest and the cleverest of people committing suicide over stupid things, so you don’t know...” (P2)

The participants involved in this study tended to speak about the deceased in idealistic terms. They spoke about their positive qualities and their zest for life in a manner that seems to contradict the actual trajectory of events. It comes as no surprise, therefore, that the reactions of the suicide-bereaved upon receiving the news of the suicide included rationalisation, disbelief and denial. In all cases, the news was met with disbelief, followed by a strong urge to explain the suicide as something over which the suicide-completer had no control (rationalisation). One of the participants did not accept that the loss was due to suicide and suspected foul play (murder), which may be an indication of disbelief or denial, since accepting that a loved one has taken his or her life may be more difficult than ascribing the loss to an external force.

The Premeditated Nature of Suicide

“He put in a very safe hook in this garage and with the drawing it showed that he was going to make sure that this thing was not going to come undone” (P4)

“...the plotting and planning, what goes through the person’s mind? That is what was so hard for me. It must be so sad to premeditate something like that.” (P4)

“...it was difficult for me to understand that he lost it and that this is just something he did in the heat of the moment. He didn’t, it was calculated...” (P1)

During the interviews it became clear that an aspect of the suicide that was particularly difficult to accept was that, in all cases, a level of forward planning was required. Some of the suicides seemed to be quite impulsive, occurring directly after an identifiable stressor, which implied that the suicidal act was an immediate response to an insurmountable problem. However, the suicide-bereaved in such cases were still tormented by the thought that their loved ones must have had suicidal ideas prior to the actual act, and that the suicide itself was merely an ending to the overwhelming pain and suffering. One suicide was planned months in advance and it was

discovered that the suicide-completer had secretly designed and built the platform from which he would hang himself. The survivor (P4) reported that the amount of time spent planning the suicide – which was established after the event when the design sketches were found – was “unthinkable”. Literature on the premeditated nature of suicide is scarce, though it could be argued that the element of forward planning adds a new dimension to suicide bereavement, which lends support to the idea that suicide bereavement is distinguishable from other modes of death (Currier, Holland & Neimeyer, 2006; Groot, De Keijser & Neelman, 2006; Jordan, 2001; Neary 2000).

Mode of Death

“...the manner of it yes, it was a gruesome death... Hanging is one thing, but diving into an oncoming train? There’s a question of pain involved as well! I suppose you don't feel pain at that stage because you determined to do it, but his head was bashed in. So the gruesomeness of the injury - it also worried me.” (P3)

“The first shot they heard was him firing a test shot, sitting in bed, like, into the corner, and the second shot was a straight blow to the head. So he knew exactly what he was doing at the time” (P1).

The manner in which the suicide was carried out seems to have had a profound effect on the participants of this study. Various methods were reported, including using a firearm, hanging, cutting of the wrists, as well as throwing oneself under a moving train. All of these methods are violent in nature and indicate feelings of extreme desperation on the part of suicide-completer, which in turn, adds to the disbelief described above. The participants all had difficulty in accepting the extreme means by which their loved ones chose to end their lives.

Feelings towards the deceased

“...sometimes you feel like you are close to somebody, that you are close enough to someone that that person could confide in you and you feel...let down.

You feel that how come, wasn't that bond strong enough to have warranted just some appeal at the last minute or something like that you know? I just felt that was so unacceptable - that you could do something like that without just asking or confiding. You've been there for all of us, now we weren't there for you. I said to myself, and I said it hundred times over, how could you do something like this to me, to us, how could you do something like this to us?" (P4).

The above extract encapsulates the range of feelings that arise towards the deceased after suicide. Other researchers (Currier, Holland & Neimeyer, 2006; Groot, De Keijser and Neelman, 2006; Jordan, 2001; Neary 2000) have noted the range of feelings experienced by survivors, which include: disbelief, anger, sadness, regret for some or other negative interaction with the deceased prior to the suicide, and guilt for not preventing the suicide. An aspect of suicide bereavement that has not been adequately explicated in the literature is the sense of being deprived of the opportunity to nurture and maintain a relationship that might otherwise have been deeply meaningful and rewarding. All of the participants experienced these feelings at various times after the suicide. While these feelings were often pronounced, some participants reported that they were "confused" around the time of the suicide and were only able to identify their feelings in retrospect. Those who experienced the suicide more recently seemed to be more conflicted about their feelings than those who have had more time to process the traumatic event. This was noted qualitatively by their behaviour during the interviews. The more recent survivors became more tearful whilst talking about their experiences. However, all of the participants, regardless of the length of time that has elapsed since the suicide, reported that they still experienced the same feelings at various times, though at lower intensity. Although the participants experienced negative feelings towards the deceased, they all spoke very highly of their lost loved ones, making sure to emphasise their positive qualities.

Guilt about Prevention

"I feel guilty about it, yes. I just feel I could have prevented the suicide. That's how I feel. He came to me, and I could not help him...it will always be with me. I will not be able to shed it" (P3)

“I don’t know if I’d been closer whether I’d have heeded warning signs...” (P5)

It has been argued that the guilt that suicide-bereaved persons experience is what sets this type of grief apart from others (Jordan, 2001). The sample investigated in this study certainly seems to support this idea. All reported feelings of guilt related specifically to prevention. In general, it was felt that more should have been done to prevent the suicide-completer from going to such extreme measures.

The Search for Answers, Meaning, and Closure

“I am a believer and I also feel that certain things in life happen and there’s no way that you can question. I suppose that this is something beyond questioning... If you believe, if you pray everyday ‘thy will be done’ and you find peace in that.” (P4)

“I believe that he must have felt that he has resolved it with his higher being before he did it, and that gave him peace of mind.” (P5)

“You wish you had just a little bit of an inkling on what was really on the back of their mind, what triggered it, what was the lost straw that caused it to happen.” (P4)

The act of suicide often leaves those left behind with the unenviable task of consolidating and integrating many small and often conflicting pieces of information in order to make sense of the event as well as to understand the deceased’s state of mind (Currier, Holland & Neimeyer, 2006). All of the participants in this study reported the harrowing experience of having to continuously ask the question *why?* Why has their loved one chosen this fate, in the face of what they considered a multitude of mitigating factors? In most cases the reason for the suicide remained a mystery, even decades after the event, and when reasons were provided, they were often cryptic and incoherent, serving only to fuel the bereaved in their search for

answers. In response to the inevitable lack of concrete reasons for the suicide, the suicide bereaved individuals were left to fill in the gaps on their own. In all the cases involved in this study, the bereaved have had to abandon their desire to know exactly what the reasons were, and had to accept that they would have only partial knowledge thereof. However, this acceptance was only possible when the bereaved accounted for the suicide in terms of a divine higher power, or placed the event at the door of some other authority figure. For example, one of the participants (P2) said that, because he was not convinced that his brother had taken his own life, he left it in the hands of the law. Another participant (P4) lamented that she took solace in the fact that her brother would have “made peace” with God before taking his own life. The lack of identifiable reasons for the suicide was therefore compensated for by attributing the event to a higher entity. Interestingly, one participant (P3) attributed his acceptance of the lack of closure to his atheistic standpoint, implying that he was spared the agony of pondering the fatalistic afterlife of his lost one.

In the case of the participant who suspected foul-play (P2), the search for closure may never be fulfilled, because the actual cause of death was not certain.

The Adjustment Process Following Suicide

“...[we would] just get together and talk about it like afterwards, basically trying to help each other handle it better, or get over it, or learn from it. I think that was the best thing I could have done. I spoke about my feelings and I spoke to them, I mean basically just always having their support.”(P1)

“After the event happened...ja we were close, close, whenever we wanted to find out something, we were always together... [when] we had to go and finalise things, we were always together, we always planned this thing together... I would always pick up the phone and consult... we always used to consult each other about it and in that way support each other” (P2)

Participants in this study indicated that they coped with suicide well. In addition to the coping strategies of rationalisation and denial, other external sources of support were highlighted. These included support from the nuclear family members, as well

as from the extended family. However, one participant reported that the suicide was never discussed by his family members, and he therefore received no support from them. Those participants, who viewed their families as close-knit, reported receiving adequate support, while those with family ties that were less strong said that they received minimal family support. This is in line with Jordan's (2001) assertion that families with a history of dysfunction tend to disintegrate after suicide. The consequences of such a lack of family support have not been clearly identified, though it was observed qualitatively that those who did not regard the support available as adequate tended to be more conflicted and defended about the suicide. Talking with close family members was found to be the most utilised method of coming to terms with suicide and thus contributed significantly to the adjustment process.

In general, the participants reported a gradual progression from denial and disbelief, to acceptance of the loss. However, the search for meaning and closure still haunts the suicide-bereaved and therefore seems to make true acceptance almost impossible.

The Social Ramifications of Suicide:

Blaming

“everybody else [asked] ‘why didn’t you spend time with him, why didn’t you see that he was in a really bad place?’” (P1)

“I blame my father for it because I think he acted wrongly there...” (P3)

“...if they can, they take advantage of that person, knowing that that person will never fail them. And that was another aspect which I felt was unfair to everybody - that there are certain members of the family that take advantage that lead to such actions being taken.”(P4)

Common to all of the accounts of the effects of the suicide on family structures was the issue of blaming. Participants either reported being blamed for the suicide, or placed the blame upon other family members. Contrary to what has been noted by other writers such as Seguin and Kiely (1995) however, the blame was, in most cases, directed towards the nuclear family as a whole and not towards individual family

members. This, coupled with the sense of cohesion with which the nuclear families mourned the loss, seems to have had the effect of strengthening the bonds between immediate family members. Only one participant (P3) provided an instance of blame within the nuclear family. Nonetheless, these findings seem to support the general view that suicide has a fragmenting effect on families, particularly on extended families.

Social isolation and stigma

“... basically everybody’s just swept this under the rug.” (P1)

“...people would say he [I] has [have] tendencies of suicide” (P2)

The social stigma attached to suicide differentiates it from other forms of loss (Jordan, 2001). Two of the participants in this study reported that their nuclear families were isolated from the extended family networks because they were blamed for the suicide. In addition, all participants made mention of the fact that suicide is regarded, in their contexts, as unacceptable. This point was especially salient to those who had strong religious affiliations. One participant reported concern about others perceptions of him, saying that he might be regarded as someone with suicidal tendencies due to the fact that his brother committed suicide.

Recommendations from the suicide-bereaved

“I actually think that outside help would’ve really helped back then because everybody was really involved and if we could speak to somebody standing on the outside looking in, then maybe it would have made more sense to me because everybody was in the circle.” (P1)

“Well the support of the family I think is always very good to have, we [are] a big family so I felt that I had that support.” (P5)

The suicide-bereaved, having experienced all of the above-mentioned, had numerous recommendations for others who may find themselves in a similar position. The two main recommendations were:

- Outside help – counselling, either spiritual or psychological
- Communication with family members

Summary of Findings

Participants indicated feelings of guilt, sadness, longing and anger. These feelings often overlapped and were directed mainly towards the deceased. Furthermore, the feelings expressed tended to subside over time, becoming less intense but remained chronic. In addition to the feelings mentioned above, participants were faced with the task of assigning meaning to the traumatic event. Blaming was common in all cases and this usually had the effect of further fragmenting bereaved families. In most cases closure was not possible and the suicide-bereaved had to attribute the event to a divine power or higher authority. In terms of the adjustment process following suicide, those who had described their families as close-knit reported receiving adequate support, while those whose families were more fragmented felt less supported. The process of bereavement was complicated by issues such as blaming (family members), social stigma and social isolation. The suicide-bereaved recommended good family communication as well as external counselling for others who may experience the loss of a loved one due to suicide.

Discussion

The results presented above provide a rich source of information about the process of bereavement after suicide. The main themes will now be discussed and examined in comparison with the literature.

Emotional Reactions to Suicide

The intense longing for the deceased after suicide has not been adequately dealt with in past research. While some would argue that longing to be with, or missing one's loved ones is a universal reaction to all forms of loss, I argue that these feelings are intensified by the act of suicide. The guilt which suicide-bereaved individuals experience has been well documented (Cvinar, 2005; Jordon, 2001, Neary 2000) and it may be that the feeling of having contributed to, or not having done something that could have prevented the suicide serves to intensify feelings of loss and sadness. There seems to be an element of causality that suicide-bereaved individuals in particular struggle with – i.e. an “*if only*” perception of the loss, which contributes to the intensity of the longing for the deceased. Suicide-bereaved individuals, therefore, may experience the longing for the deceased more intensely not only because of the actual loss but the inevitable belief that something could have been done to prevent it. In addition, the act of suicide usually leaves the suicide-bereaved with little or no reason for the act, as well as a dire need to make sense of the state of mind of the deceased (Currier, Holland & Neimeyer, 2006). Thus the actual longing for the physical and emotional presence of the deceased is made more poignant by the longing to find the answers and meaning.

Rationalisation of the event

The aspects of rationalisation, disbelief and denial have not been documented as occurring primarily in cases of suicide but seem to occur in other modes of death as well. However, one could argue that, while disbelief and denial are common to all forms of loss, rationalisation may be more likely to occur after suicide. In other words, it may be more likely that suicide-bereaved individuals, because of the intense feelings of guilt, sadness and anger, as well as the social stigma attached to suicide, attempt to reduce these consequences by rationalising – and thereby reducing – the

suicide completer's actions as a response to something over which he or she had no control.

The Mode of Suicide

The effects of the manner in which the suicide is carried out have not been well documented. The participants of this study all indicated violent means and it is hypothesised that this adds to the intensity of the loss. Other violent modes of death (accidents, for example) have been compared with suicide and the results indicate that outcomes of most sudden and traumatic loss are similar (Dyregrov et al, 2003). However, one could theorise that differences between and within the various ways in which people take their own lives could have an immeasurable effect on the suicide-bereaved, because the chosen manner provides a minute clue as to the mind-state of the suicide-completer. Still, further research into the effects of different modes of suicide is needed.

Feelings towards the Deceased

The feelings towards the deceased in this study seem to support previous research. Suicide-bereaved persons experience guilt, sadness, anger, and regret. One emotional reaction that has not been observed in this study is *relief*. The element of relief has been noted when suicide completers have had a history of alcohol abuse or continued emotional distress (Jordan, 2001; Latham & Prigerson, 2004; Neary, 2000). The absence of feelings of relief in this study could therefore be indicative of the absence of chronic difficulties in suicide completers, or reflect a reluctance to express such feelings for fear of being negatively judged.

The adjustment process

The adjustment process following suicide seems to follow a similar trajectory to other modes of death. All of the participants indicated that with time, their feelings about the suicide, as well as towards the suicide-completer subsided but remained chronic. As with other modes of death, suicide-bereaved families generally tend to get together after the traumatic event and this is viewed as important in coming to terms with the loss. However, not all of the participants indicated family cohesion after the suicide and an assertion that family support is fundamental in terms of adjustment is therefore

questionable. Still, this study seems to support the generally held idea that contact and communication with relatives is an important component of adjustment. Also, because suicide evokes chronic and intense feelings towards the deceased as well as the event, it seems as though adjustment to the loss is a life-long process. While suicide-bereaved individuals may reach a comfortable state of adjustment, they may never reach full acceptance.

Implications for Practice

The findings of this study point to the intense feelings of guilt, anger and regret, as well as the feelings of social isolation that the suicide-bereaved individuals experience. Practitioners aiming to help these individuals should take these factors into account. Due to the fact that suicide affects not only the individual, but the extended family networks as well, holistic interventions are called for. Individual counselling may serve to delineate subjective experiences of individuals, thereby aiding in the process of bereavement. However, the gains made in individual therapy may be negated by the social and familial forces that inevitably accompany suicide. Thus an approach that offers a combination of understanding and insight into the subjective experiences of individuals, as well as systematic integration of each individual's experience into his or her family system, may provide the most effective and sustainable results. Mediated family sessions may serve to help survivors vent and explore feelings towards one another and thus increase family cohesion. For suicide-bereaved individuals who lack strong family bonds (P3, for example), group interventions may be beneficial, since it has been noted that this type of intervention enables the survivor to share similar experiences with others, thereby limiting feelings of isolation (Pietilla, 2002). Practitioners are cautioned not to treat suicide as merely another form of traumatic loss, because, as the findings of this study indicate, the intrapersonal *and* social ramifications of suicide make bereavement following this mode of death a unique experience, distinguishable from other forms of loss.

Limitations of this Study

The sample used in this study was relatively small, due to the difficulty in finding willing participants and this has implications for the generalisability of findings to the greater population. In addition, the participants were all from one particular geographic area and were ethnically and socio-economically similar. Thus the findings cannot be taken as illustrative of suicide bereavement in general. Caution needs to be exercised in the extrapolation of the ramifications of suicide for this particular group of people, given that the sample might not be fully representative. Finally, all the participants had lost a male figure and the bereavement process following suicide may be gendered. While no evidence of difference between the loss of a male or female to suicide exists, readers and practitioners are encouraged to take this factor into consideration, especially with regard to intervention. Further research into this matter is needed.

Summary and Conclusions

Suicide is a phenomenon which inevitably scars family and friends who are left behind in the most profound manner. Unlike bereavement following normal death, suicide-bereaved individuals are left to pick up bits of information that the suicide completer has left behind, and to integrate these into an already frail state of consciousness. In addition to the process of grief that accompanies losing a loved one, suicide-bereaved persons are faced with the devastating task of contemplating the reasons for their loved one's choice to terminate his or her life. This task inevitably requires a reflective process, which leads to intense feelings of guilt. Also, suicide wrecks havoc in social networks, causing familial stress, social isolation, and stigmatisation – all of which spreads the coping abilities of individuals more thinly, and leaves very little in the way soothing the hurt of the loss.

In line with its aims, this study has examined some of the converging themes in the bereavement process following suicide, and it is hoped that this information will aid in the provision of appropriate intervention for the suicide-bereaved. However, the researcher cannot claim to understand the effects of suicide in its entirety, since subjective experiences differ, making absolute conclusions intrinsically difficult. What *can* be categorically stated, is that suicide defies the natural order of life, challenges existential beliefs about death, and shakes the inner worlds of those left behind by contradicting their most deeply held convictions, leaving them to rebuild the very structures that, to them, have been the essence of what it means to be alive.

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Appendix A: Interview Schedule

- 1) Can you describe the time surrounding the suicide?
- 2) How has the suicide touched your life?
- 3) Can you describe your immediate reaction the suicide?
- 4) How did you feel?
- 5) What was the most difficult part for you?
- 6) How do you think you've coped with the loss?
- 7) What might have helped you during that time?
- 8) What feelings did you have towards the deceased?
- 9) How do you feel about the suicide now?
- 10) Are there still aspects of the event that you struggle with? Please explain.
- 11) What feelings do you have towards the deceased now?
- 12) How did your family cope as a unit?
- 13) What kinds of help did you receive?
- 14) What kinds of help would you recommend for others who have lost someone to suicide?
- 15) Is there anything else that you would like to share?

Appendix B – Consent form

Thank you for deciding to participate in this study. Your contribution is truly appreciated. Please note that you might become emotional or upset during the interview, and that this is a normal and perfectly understandable response. If at any time, however, you wish to end the session, please feel free to do so. Also, should you experience any negative feelings after the interview; you are most welcome to contact me to share your experience.

The content of your responses will be handled with the utmost confidentiality. Your identity will be kept private and tapes will be erased at completion of the study.

Please complete the form below:

Name:

Current age:

Names and ages of other family members:
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.....
.....
.....

I, the undersigned, hereby consent to participate in this study. I understand that the information provided will be used for research purposes, and will be treated confidentially. I also give the researcher permission to make use of audio recording equipment during the interview.

Participant.....

Date.....

Researcher.....

Date.....