

The Impact of Suicide on the Family

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Abstract. Little research has examined the consequences of a suicide for social or family networks. Because suicide occurs within families, the focus on the aftermath of suicide within families is an important next step to determine exactly how to help survivors. In this article, we review and summarize the research on the impact of suicide on individuals within families and on family and social networks. We begin with a discussion of family changes following suicide. Next, we discuss the effects of suicide on social networks overall and responses of children and the elderly to a suicide in the family. Finally, we identify key issues that remain to be resolved in family survivor research and make recommendations for future studies.

Keywords: suicide, survivor, bereavement

While an individual suicide is often a solitary act, family and friends are almost always left behind to grieve, try to understand the reasons for the death, and learn to carry on with their lives. Only recently have their needs been addressed (Clark, 2001; Jobes, Luoma, Husted, & Mannuzza, 2000), as exemplified by a workshop sponsored by the American Foundation for Suicide Prevention (AFSP) and the National Institutes of Health (NIH; American Foundation for Suicide Prevention, 2004). A product of that workshop, this article reviews and summarizes the research on the impact of suicide on individual family members, family dynamics, and social networks. We begin with a discussion of family changes following suicide. Next, we discuss the effects of suicide on social networks overall and responses of children and the elderly to a suicide in the family. Finally, we identify key issues that remain to be resolved in family survivor research and make recommendations for future studies.

Family Members as Survivors

Before reviewing the literature on the impact of suicide on the family, one must first consider two problems inherent to family research on suicide survivors. First, most studies examine only one type of survivor (i.e., parent, child, spouse) and do not take into account how reactions of family members influence each other and the tone of family communication. Second, the quality of the previous relationships within the family is rarely determined, making it difficult to comment on the specific implications of the death for family relationships and communications in the aftermath of the suicide. In a longitudinal study of parents

bereaved by the sudden violent death (including suicide, accident, or homicide) of their child, Lohan and Murphy (2002) [in refs only Lohan] used the Family Adaptability and Cohesion Evaluation Scales (FACES; Lohan, 2002) to document difficulties with family functioning after a child's suicide. These difficulties included decreases in cohesion (defined as "emotional bonding that family members have toward one another") and adaptation (defined as "the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress"). While few changes in family factors were unique to suicide, the authors hypothesize that families do not actively make changes following a violent death to help the family as a unit effectively cope. Parental functioning may influence surviving family members, especially children at home who may be faced with parents who are less emotionally available to them (Lohan, 2002).

Likewise, in a study of 13 widows whose husbands had died by suicide compared with 13 widows whose husbands had died in accidents, McNiel, Hatcher, and Reubin (1988) found some differences in family communication, support, and intimacy following both types of death. While widows in both groups reported clinically significant levels of symptoms, women whose husbands had died by suicide experienced more guilt and blaming in their families than widows who lost a husband in an accident. (McNiel et al., 1988).

Families with minor children tend to experience a great deal of chronic turmoil and stressors such as marital separation, trouble with the law, or domestic violence prior to the suicide of a parent (Cerel, Fristad, Weller, & Weller, 2000; Shepherd & Barraclough, 1976). However, this degree of disruption is not universal. Cerel et al. (2000) sug-

gested three types of families in which the suicide of a parent had occurred. *Functional* families are characterized by no evidence of preexisting family conflict or psychopathology; the suicide usually took place in the context of chronic physical illness. In *encapsulated families*, psychopathology and conflict was generally observed only in the deceased, not in other family members. In *chaotic* families, clear evidence of psychopathology in multiple family members and/or turmoil prior to suicide was present. Any examination of survivors needs to take into account prior psychopathology in individual family members, along with the specific family and community context in which the suicide occurs.

Impact of a Suicide on Social Relationships

Suicide has the potential to have profound effects on survivors' social networks. Social support after any type of loss appears to be a crucial factor in determining bereavement outcome following any manner of death (Stylianios & Vachon, 1993), and these effects may be more pronounced following suicide (Callahan, 2000; Seguin, Lesage, & Kieley, 1995; Thompson & Range, 1991). Therefore, factors that interfere with the ability of a social group, whether a nuclear or extended family, or a setting such as a school, workplace, or church, to provide support to survivors may have a direct bearing on their mourning trajectory. Compared to individual reactions, there is limited study of the responses of families and extended social networks (Range, 1998).

Perhaps the most deleterious impact of suicide on social networks is the distortion of communicational processes that may occur after the death, particularly around the issue of blame. Suicide is a confusing death. Its causes are complex, multi-determined, and poorly understood. This ambiguity seems to increase the need within a social network to affix blame. Indeed, suicide survivors are judged more negatively than survivors of other types of loss (Range, 1998; Stillion, 1996). They are seen as more disturbed and more deserving of blame for the suicide, and this is particularly true of parents who lose a child to suicide (Range, Bright, & Ginn, 1985; Reynolds & Cimboric, 1988). Blame may be overtly expressed or covertly communicated through nonverbal cues and social withdrawal, straining and even rupturing the cohesiveness of a family or extended social network as survivors blame each other for the death (Barlow & Coleman, 2003).

A second communicational distortion is the development of secrecy around the cause of death. Historically, survivors have been more likely to hide the cause of death from certain members of the family, such as children (McIntosh, 1987), or from people outside the immediate family (Range & Calhoun, 1990). They also report being expected

by outsiders to provide a more detailed explanation of the reasons for the death than in other types of losses (Range & Calhoun, 1990). Long-term effects of secrets in family and other social systems have not been systematically studied, but clinical observation suggests that this may be a major source of dysfunction in family systems, and one that can have long term impacts on the psychological development of all family members, particularly children (Jordan, Kraus, & Ware, 1993; Walsh & McGoldrick, 1991). While suicide is perhaps less likely to be a family secret now than in the past in many industrialized and Western societies, survivors who have recently discovered this secret in the family may also struggle with confronting the secret and giving voice to their experience (Goode, 2003). In developing societies, it is likely that suicide's stigma varies tremendously and, in many places, continues to represent a significant source of distress for many survivors. The issues of blame and secrecy after suicides also contribute to a third form of communicational distortion: Social ostracism and self-isolation by survivors. Suicide has a long history of stigmatization within Western cultures, and the families of suicide survivors were often punished and ostracized by their communities in the middle ages (Colt, 1991; van Hooff, 2000). Shame may make it exceptionally difficult for family and community members to broach the topic of suicide. Most groups' social norms do not prescribe appropriate social responses to a suicide loss, creating awkwardness and avoidance in communications with survivors (Range, 1998; Wagner & Calhoun, 1992). Extended family and community members may also feel the need to protect those most profoundly affected by the death, becoming wary of discussing the suicide out of a fear of reminding the closest survivors of their loss and further upsetting them. Moreover, even when they are not actually avoided by others, survivors may incorrectly expect to be judged harshly by others and thus withdraw from their social networks, a process referred to as self-stigmatization (Dunn & Morrish-Vidners, 1987). Together, these problematic social network transactions may create a cycle of misunderstanding, avoidance, and withdrawal between survivors and their extended networks that only exacerbates the mourning process (Seguin et al., 1995). In recent years, suicide appears to be less stigmatized in many societies than previously. Effects of these recent cultural shifts on survivors remains to be determined.

Survivors often blame themselves for words that were exchanged with the deceased, or for their seeming shortcomings as a parent, partner, sibling, and so forth. Even if they conclude that they were not directly responsible for the death, most survivors seem to struggle with their perceived failure to anticipate and intervene to prevent the suicide. Perhaps not surprisingly, this profound sense of responsibility seems to be particularly pronounced in parents who have lost children to suicide (Range et al., 1985; Reynolds & Cimboric, 1988).

We now turn to a discussion of individual survivors of family death at three different age groups. Each of these

groups of survivors has unique family developmental issues that have not been fully explored by the existing literature. First we review the literature on child survivors, and then we examine the literature on survivors of late life suicide.

Child Suicide Survivors

While there are no estimates of the number of child survivors worldwide, it has been estimated that approximately 60,000 children experience the death by suicide of a relative annually in the United States. The numbers are undoubtedly substantially greater in larger countries with higher suicide rates, such as China or Japan. In addition, 1,900 children/teens in the United States under the age of 20 die by suicide annually, leaving parents and sibling survivors to cope with their loss. In keeping with our focus on families and family relationships, we describe what is known about child survivors of general family, parent, and sibling suicide.

A consideration of how surviving a suicide might affect a child should involve the following *outcome variables*: mental health (e.g., mood disorders, anxiety disorders, suicidal behavior, posttraumatic stress disorder, traumatic grief); emotions (e.g., sadness, anger and guilt); functional problems (e.g., social problems, academic difficulties), and physical health (e.g., onset or exacerbation of disease, physiological changes). The following potential *predictors/mediators* of outcomes for suicide-bereaved children should be considered: demographic factors (i.e., the child's age, sex, and relationship to deceased; family income; race) variables related to the death (i.e., seeing the body at memorial service or funeral, violence of method of suicide, witnessing the suicide or death scene, child's knowledge of the details of the death, time since the loss, anticipation of the death through previous attempts); preloss and postloss family dynamics (i.e., family responses including those of surviving parent), social and community integration (i.e., social network, social support) variables (i.e., participation in support groups or therapy, social support, family responses including those of surviving parent); utilization of informal and formal mental health services (i.e., participation in support groups or therapy); and previous depression and psychopathology.

In a large, nationally representative survey conducted in the United States, 1.2% of adolescents reported a suicide death had occurred in their family in the last year. In regression analyses that adjusted for socio-demographic variables, adolescents in this cross-sectional dataset who had experienced a family member's death by suicide were more likely than those who reported no suicidal behavior in their family to report marijuana use and alcohol misuse, suicidal ideation and attempts, inflicting severe injuries, and emotional distress (Cerel & Roberts, 2005). Clearly the suicide of a family member is associated with risky behaviors in adolescents who are aware of the death.

Each year 7,000–12,000 children in the United States experience the *suicide of a parent*. One would expect that the loss of a parent would lead to more profound effects than the loss of less closely related family members. The available studies have been conducted on children in treatment (Cain & Fast, 1966; Pfeffer, Conte, Plutchik, & Jerrrett, 1980) and community children (Cerel, Fristad, Weller, & Weller, 1999; Cerel et al., 2000; Pfeffer et al., 1997; Pfeffer, Karus, Siegel, & Jiang, 2000; Shepherd & Barraclough, 1976). Early studies suffered from small sample sizes, varying lengths of time between the death and the assessment, and the use of parent-report instead of directly interviewing the child.

Studies of community samples have found no overall differences in suicidal behavior and diagnosable depression in children bereaved from a suicide compared to children bereaved from other types of death (Cerel et al., 1999; Pfeffer et al., 1997, 2000). However, some authors have found that suicide-bereaved children are more likely to be anxious, aggressive, or withdrawn immediately after the death (Shepherd & Barraclough, 1976). Internalizing symptoms (Cerel et al., 1999; Pfeffer et al., 1997, 2000) and problems with school adjustment (Pfeffer et al., 1997) and symptoms of posttraumatic stress disorder (Pfeffer et al., 1997; Cerel et al., 1999) have also been noted. Compared to children whose parent died of cancer, suicide bereaved children experience more depressive symptoms, especially those involving negative mood, interpersonal problems, ineffectiveness, and anhedonia (Pfeffer et al., 2000). When psychopathology in suicide bereaved children has been compared to other bereaved children from all types of death, suicide-bereaved children seem to differ only in an increased level of psychopathology, especially behavior problems, prior to the death and in increased behavioral and anxiety symptoms after the initial few months following the death (Cerel et al., 1999).

Turning to the emotions brought about by the death, a comparison of suicide bereaved children and children bereaved from other causes showed that suicide-bereaved children were more anxious, angry, and ashamed, and that there were no differences in sadness and guilt (Cerel et al., 1999). Suicide-bereaved children also reported less acceptance and relief than children bereaved from causes other than suicide. In another study, two profiles of grief responses were identified: A sad, guilt-laden, and withdrawn response, and an angry, hostile, and defiant response (Cain & Fast, 1966). These profiles may be useful in future research.

Up to 8,000 children experience *sibling suicide* in the United States annually. In the only study focused on child sibling survivors, 25 siblings of 20 suicides were compared to demographically matched controls (Brent et al., 1992). Siblings who had experienced a suicide were more likely to show new-onset depression, the likelihood of which was increased in those with previous psychiatric disorder and a family history of depression and other psychiatric disorders. Other studies have combined survivors of sibling and

parent suicide, making it impossible to comment on the unique experience of sibling survivors in these samples (Pfeffer et al., 1997).

Surviving the Suicide of an Older Adult

Only two research groups, one American and one British, have examined survivors of the suicide of an older adult. Farberow, Gallagher, Gilewski, and Thompson (1992) interviewed 108 surviving spouses of suicide over the age of 55 years (88 women, 20 men) in California from 1982 to 1984. Data were also collected on 199 bereaved spouses of natural deaths and 144 married persons who had not been widowed or divorced in the prior 5 years. The investigators identified potential research participants by searching coroner records, mailing letters to survivors telling them about the study, and then phoning them to see if they were interested in participating. Approximately 35% of the eligible survivors of suicide agreed to participate; interestingly, 25% could not be located due to change of residence.

Data were collected at 2 months, 6 months, 12 months, and between 24 and 30 months postloss. At 2 months, the two bereaved groups were significantly more distressed than the married group; they differed from each other on only one of the 13 outcome variables: the anxiety subscale of the Brief Symptom Index. The authors concluded that there were "practically no significant differences in the mental health and grief reactions within the first 8 weeks after death" (p. 596). Another set of analyses examined changes in social support over the 30 months postloss; analyses were restricted to those subjects with complete data – 71% of the suicide survivors, 89% of the spouses bereaved by natural deaths, and 79% of the controls (Farberow et al., 1992). Whereas the spouses bereaved from natural causes began to appear less distressed by 6 months, suicide survivors continued to report higher levels of grief and depression until after the first year. Survivors of natural deaths reported receiving more emotional support than survivors of suicide; this was especially true at 6 months postloss. The authors speculate that the greater distress reported beyond 6 months in the suicide survivors could be ascribed to their lower levels of social support received postloss, but survivors of suicide may have received less support prior to the suicide as well.

Harwood, Hawton, Hope, and Jacoby (2002) conducted interviews with survivors 5 to 21 months after a relative or friend's death by suicide ($n = 85$) or natural causes. Whereas Farberow and colleagues confined their study to surviving spouses, these authors also conducted interviews with the deceased's friends and other relatives. The investigators approached survivors of all suicides 60 years of age or older between 1995 and 1998 in five towns in the United Kingdom; 46% of the eligible survivors agreed to participate. Of the 100 survivors interviewed for a psychological autopsy study (Harwood et al., 2002), 85 also completed a bereavement interview. Nearly one-third ($n = 27$) of the

suicide survivors believed that media reporting of coroner's inquests were often factually inaccurate or insensitively worded, 42% ($n = 36$) reported problems dealing with the coroner's office, and 15% ($n = 13$) reported problems with the initial police contact.

The authors compared the bereavement responses of 46 suicide survivors with those of a control sample of 46 people bereaved by an older relative, friend, or acquaintance. Analyses of responses to the Grief Experiences Questionnaire (GEQ; Barrett & Scott, 1989) showed that suicide survivors reported greater levels of stigmatization, shame, sense of rejection (feeling deserted by the deceased), and unique reactions (e.g., feeling that the deceased was getting even, a desire to hide the mode of death from others). The groups did not differ in other GEQ subscales, including searching for an explanation, somatic reactions, guilt, responsibility, or self-destructive behavior. When the authors confined the analyses to children of the deceased the only subscale to distinguish the groups was sense of rejection and unique reactions.

Given the paucity of research on survivors in general and specifically on the effect of a suicide on a family, child survivors and survivors of the suicide of an older adult, we focus in the next section on general and age-specific recommendations to move survivor research ahead.

Recommended Questions for Research on Family Units

There continues to be compelling evidence that the subjective experience of grief after a suicide loss is often quite different from other losses (see Jordan, 2001, for a review). In what has now become the seminal work on suicide survivors, Cain's 1972, *Survivors of Suicide*, it was noted that there had been a relative lack of exploration on familial effects of suicide (Cain, 1972). Thirty-five years later, the impact of suicide of a member on family communication and transactional patterns remains essentially unstudied. Moreover, the characteristics of presuicide and postsuicide family functioning that are either protective or risk factors for adverse outcomes are simply unknown. Thus, the need for rigorous study of the phenomenology of survivor experiences in unbiased samples, both at the individual and the family system level, is imperative. The research should be conducted with both quantitative and qualitative methods; the latter is essential for the development of testable hypotheses. Mixed methods will also yield a better understanding of the changes family members, and the family as a whole, experience over time. The research should address several broad questions, including the following: How does the general level of family functioning prior to the suicide impact the bereavement trajectory of individual members? Can common patterns of response in survivor families be identified? What domains are affected-communication pat-

terns, family ritual life, marital relationship, parenting functions, family interaction with the larger community, and so forth? Is the development of secrets, blame, and communication shut-downs around the suicide a marker for either near-term and distal family dysfunction? What are the longer-term family developmental sequelae of the suicide of a parent or child in a family system? What are the cultural, race, and ethnic differences in how families grieve following a suicide and are there commonalities across cultures, races, and ethnic groups? What are the roles of religion and spirituality? How has the church, criminal justice system, and media helped or hindered survivors? Finally, there is also a pressing need for studies that ask survivors themselves what has been of help, or what they feel would have helped had it been available so that interventions can be designed that strengthen the natural coping efforts of families (Jordan & McMenemy, in press).

Recommended Questions for Child Survivors of Suicide in the Family

1. Are there developmental differences in the way suicide has an influence on a child? Is it harder for a child to lose a family member to suicide earlier in development when they cannot understand mental illness and suicide, or later in adolescence after they have developed a relationship with the decedent and may model his or her suicidal behavior as a coping strategy? The overall literature on childhood bereavement is inconclusive on whether early or later loss in childhood is worse (e.g., Cerel, Fristad, Verducci, Weller, & Weller, 2006). Larger studies of child survivors with particular attention to developmental differences will help us understand if systematic differences exist.
2. What happens when child survivors grow up? As suicidal behavior appears to have strong genetic components separate from the transmission of mental illness, child survivors are at risk not only for mental illness but also for suicidal behavior. This risk may be higher for child survivors than for other survivor groups who are not genetically related to the decedent. As children who have experienced suicidal behavior in the family grow into early adulthood when suicide attempts peak, are they at heightened risk for engaging in suicidal behavior? If we believe this to be the case, are preventive interventions needed for child survivors? Should the interventions be universal or targeted? Should the interventions be aimed at children whose family members have engaged in suicidal behavior but have not died by suicide?
3. Does it matter how/if children are informed of the suicide? What is helpful or hurtful for children at different stages of development to know about a suicide? Are there ever times when it is appropriate for a child not to be told the cause of death? What happens if they later discover the truth? When should a child be told? How

much detail is appropriate to tell a child? What is the best way to deal with questions the child has about why the suicide happened? The research to date has not addressed any of these questions.

4. How does a child's family change after a parent's suicide? How do the survivor parent's adjustment and coping abilities influence their child's adjustment? Does social modeling play a role for child survivors?

Recommended Questions for Survivors of the Suicide of an Older Adult Include

1. What is the specific effect of an older adult's suicide on relatives and friends? Only two studies have examined this phenomenon. Both focused primarily on the experiences of grief and bereavement. There is a need to explore other psychological, health (mental, physical), and social effects.
2. In some cases, suicide in older adults may be viewed as a means of controlling the timing of one's death while escaping the prospect of burdening others. For these reasons, many may view suicide in older adults as an "acceptable" solution to a daunting problem. Does the acceptability of suicide deter survivors from believing that they could benefit from intervention? Research on survivors' attitudes toward help-seeking, patterns of health service utilization and treatment initiation would clarify this issue.
3. What are the physical health effects of suicides on older survivors, particularly surviving spouses, siblings, and friends? Although the health and immune effects of stressors have been documented (Seegerstrom & Miller, 2004; Vitaliano, Zhang, & Scanlan, 2003) there has been no research on the physical health consequences of survivorship among older adults. This is unfortunate, as the health effects of stressors may grow more pronounced with increasing age (Kiecolt-Glaser & Glaser, 1999).

Conclusion

Suicide can be a devastating experience for those left behind. While suicidology has perhaps understandably focused primarily on the prevention of future suicides, until recently survivorship has been relatively neglected as an area of study. Because suicide occurs within families, the focus on the aftermath of suicide within families is an important next step to determine exactly how to help survivors.

Individual survivors are at risk for complicated grief reactions, mental disorders, and even future suicides. Thus, research into the experience of survivors and the interventions that may be of assistance to them is an excellent form

of prevention work. To put it succinctly: “Postvention is Prevention” when it comes to survivors of suicide. Although the available literature is a good beginning, much remains to be done before we can really claim that survivors are receiving the help that they need.

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