australian centre for grief and bereavement

GriefMatters

Autumn 2009
Volume 12 / Number 1

The Australian Journal of Grief and Bereavement

Contents

Grief Matters: The Australian Journal of Grief and Bereavement
is a listed Department of Education, Science and Training (DEST) Refereed Journal.
See Higher Education Research Data Collection: www.dest.gov.au/highered/research/herdc.htm

PUBLISHED BY
Australian Centre for Grief and Bereavement
McCulloch House
Monash Medical Centre
246 Clayton Road,
Clayton VIC 3168
Freecall 1800 642 066
Telephone: (03) 9265 2100
Facsimile: (03) 9265 2150
Email: griefmatters@grief.org.au
URL: www.grief.org.au
ABN 22 038 903 478
Reg. No. A0032503K

ISSN 1440-6888

COVER
Blue Window,
Diane Diederich.
© iStockphoto, 2003

Eye to Eye Graphic Design
Phone: (03) 9885 0955
Email: design@eyetoeye.com.au
www.eyetoeye.com.au

Editorial

Christopher Hall

B.Ed, Grad.Dip.Adol. & Ch. Psych, MA, MACE, MAPS, FAIM, CT

Director
Australian Centre for Grief and Bereavement
Monash Medical Centre
246 Clayton Road
VIC Australia
Email: c.hall@grief.org.au

The means of our dying clearly impacts upon the grief experience of survivors. The broader social system with its cultural, linguistic and religious discourses shape the private and public experience of grief. This is particularly evident in deaths such as those by suicide, which have been variously viewed as a sign of criminality, weakness, madness, heroism, sinfulness and rationality (Kastenbaum, 2008; Murray, 2000).

A substantial body of research has demonstrated that coping with a significant others' suicide can be an exceedingly difficult experience, with survivors being at an elevated risk for a number of adverse psychological and social outcomes (see review by McIntosh, 2003). These impacts include significant levels of impairment in daily activities, depression, guilt, anxiety, prolonged and complicated grief, traumatic distress and suicide (McMenamy, Jordan & Mitchell, 2008).

This edition of *Grief Matters: The Australian Journal of Grief and Bereavement* considers the experience of suicide bereavement and appropriate clinical responses to the plight of the bereaved. Drawing on the clinical and research experience of three research-practitioners these authors draw upon their considerable clinical experience and contemporary research evidence to provide a unique lens through which to understand this complex phenomenon.

The paper by Jordan provides guidelines for clinicians who provide grief counselling for suicide survivors. Following a review of the research on the impacts of suicide and interventions, Jordan examines a range of interventions for survivors including the importance of contact with other survivors as a crucial part of the healing process.

Sands considers suicide bereavement in the context of meaning-making and the grieving person's relational world. Her tripartite model of suicide grief provides a framework for considering the interaction between the relationship with the self and the development and adjustment of the relationship with the deceased. Using the metaphors of *Trying on the shoes, Walking in the shoes and Taking off the shoes*, Sands explores the process of engaging with the intentional nature of the death, through reconstruction of the death story to a repositioning of the suicide and pain in the deceased's life.

The final paper by Flynn draws upon her extensive experience in coordinating an innovative suicide bereavement program in Victoria. This paper addresses the impact of suicide on identity, considers the experience of failure, the impact of stigma, the search for explanation and meaning, the impact on social and family networks and the particular challenges suicide bereavement represents for young people.

This issue of *Grief Matters* will further our understanding of the unique issues confronted by those bereaved through suicide. I join with the contributors to this edition in the fervent hope that we will increasingly see methodologically sound and clinically relevant studies, which will encourage more sensitive and effective responses to those bereaved by suicide.

References

Kastenbaum, R. (2008). Grieving in contemporary society. In M. S. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe (Eds.), *Handbook of bereavement research and practice: Advances in theory and intervention* (pp. 67-85). Washington, DC: APA.

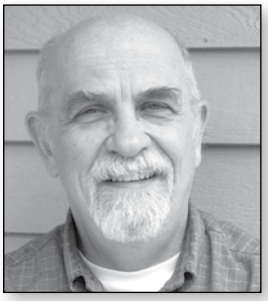
McIntosh, J. L. (2003). Suicide survivors: The aftermath of suicide and suicidal behavior. In C. D. Bryant (Ed.), *Handbook of death & dying: Volume one: The presence of death* (pp. 339-350). Thousand Oaks, CA: Sage Publications.

McMenamy, J. M., Jordan, J. R., & Mitchell, A. M. (2008). What do suicide survivors tell us they need? Results of a pilot study. *Suicide and Life-Threatening Behavior, 38*(4), 375-389.

Murray, A. (2000). *Suicide in the Middle Ages: Vol. 2. The curse on self-murder.* Oxford, England: Oxford University Press.

Christopher Hall

Editor



After Suicide: Clinical Work With Survivors

John R. Jordan
Ph.D.
Private Practice
10 Exchange Court
– Unit 401
Pawtucket, RI – 02860
USA
Email: jjordan50@aol.com

Abstract

The death of a loved one to suicide can be devastating. This article provides guidelines for clinicians who provide grief counselling for suicide survivors. Reviews of research on the impact of suicide and interventions to ameliorate that impact are briefly described. Next, the range of interventions for survivors is discussed. The article concludes with a discussion of the recovery tasks that are faced by most survivors, and some clinical interventions that may be of use in facilitating the healing process.

After Suicide: Clinical Work With Survivors

The experience of losing a loved one to suicide can be devastating. First-person narratives by suicide survivors (the term for people who are grieving the loss of someone to suicide) and empirical studies testify to the fact that this loss can have a life-altering impact on people. Recent reviews document the many sequelae of suicide in the lives of survivors (Cerel, Jordan, & Duberstein, 2008; Jordan, 2001, 2008; McIntosh, 2003; Range, 1998; Sveen & Walby, 2008). For example, many studies have found that survivors experience high levels of guilt after a suicide (Miles & Demi, 1991; Reed & Greenwald, 1991; Saarinen, Viinamäki, Hintikka, Lehtonen, & Lönnqvist, 1999), as well as intense feelings of rejection and abandonment by the deceased (Bailley, Kral, & Dunham, 1999; Reed, 1998; Sveen & Walby, 2008). Survivors may also experience increased relational strain and avoidance from family members and friends as a result of the general social stigmatisation of suicide (Cerel, Jordan, & Duberstein, 2008; Cvinar, 2005; Dyregrov, 2003; Kaslow & Gilman Aronson, 2004; Range, 1998; Sveen & Walby, 2008). As with other sudden, violent deaths, suicide survivors may also be more at risk for developing trauma reactions (Currier, Holland, Coleman, & Neimeyer, 2008; Knieper, 1999; Miyabayashi & Yasuda, 2007; Murphy, Johnson, & Lohan, 2002; Murphy, Johnson, Wu, Fan, & Lohan, 2003) and complicated or prolonged grief disorders (Melhem et al., 2004; Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004; Mitchell, Kim, Prigerson, & Mortimer, 2005). Perhaps most tragically, there is also compelling evidence that exposure to suicide attempts or completions by other people, particularly family members, increases the risk of completion in survivors (Agerbo, 2003; Agerbo, Nordentoft, & Mortensen, 2002; Brent & Mann, 2006; Crosby & Sacks, 2002; Qin, Agerbo, & Mortensen, 2002). This elevated risk holds true even for people who are not biologically related to the deceased, such as peers who lose a friend to suicide (Brent et al., 1996; Brent et al., 1993) or spouses who lose their partner to suicide (Agerbo, 2005), suggesting a role-modelling effect that is over and above any shared genetic predisposition to psychiatric disorder or suicide among family members. Taken together, this evidence suggests that suicide survivors are a population at significant psychological risk, and therefore worthy of special clinical attention.

Given this data, the relative lack of attention to interventions that might be of help to survivors is both surprising and disappointing. Jordan and McMenamy (2004) and McDaid, Trowman, Golder, Hawton, and Sowden (2008) have recently reviewed the available evidence base for interventions specifically designed for survivors. Both reviews have come to similar conclusions about the inadequate state of our knowledge about how to help survivors. Only a small number of interventions specifically targeted towards suicide survivors have been investigated. Moreover, most of these studies suffer from significant methodological weaknesses, including a lack of control or comparison groups, non-randomised assignment of participants to groups, the use of outcome measures that are poorly validated, and low statistical power due to small sample size. In general, the studies did show a modest positive effect for the intervention, but both reviews concluded that there is little empirical foundation for recommending particular interventions for survivors. This mirrors the larger body of research on interventions for general bereavement, which have generally been shown to have a small effect size, and only moderate effect sizes for high risk and/or treatment seeking individuals (Currier, Holland, & Neimeyer, 2007; Currier, Neimeyer, & Berman, 2008; Forte, Pazder, & Feudtner, 2004; Jordan & Neimeyer, 2003). Given this paucity of evidence-based interventions, the remainder of this article will be drawn from the clinical experience of the author in working with many suicide survivors over more than 35 years, coupled with reference to selected empirically supported interventions that have relevance for work with survivors. It is this author's fervent hope that the number of methodologically sound and clinically relevant studies of this population will increase rapidly in years to come.

The Range of Options for Survivors

Recent research with survivors has supported the importance of contact with other survivors as a crucial part of the healing process (Dyregrov, 2002; Grad, Clark, Dyregrov, & Andriessen, 2004; McMenamy, Jordan, & Mitchell, 2008). Contact with other survivors seems to reduce the strong sense of isolation, stigma, and shame experienced by many survivors. It contributes to a feeling of being understood by peers who are empathically attuned to the distress of survivors. Contact with other survivors also provides a reference group by which survivors can gauge the normality of their own reactions, and allows for an exchange of effective coping strategies (e.g., dealing with the holidays). Lastly, contact with other survivors offers role models of people who have, in fact, survived the trauma and been able to rebuild their lives, a key source of hope for new survivors.

Contact can occur in a variety of formats, the most common being organised bereavement support groups. These groups may be led by survivors or mental health professionals, and appear to be growing in number around the world as suicide becomes less stigmatised. In addition, survivors may have access to services that provide outreaching support to very new survivors. These typically include trained survivor volunteers and/or mental health professionals who visit the newly bereaved at home. One of the best known of these programs[1] has recently published data demonstrating the dramatic ability of the service to help survivors access additional services more quickly and with greater follow-through (Cerel & Campbell, 2008). Based on an outreaching Active Postvention Model (Campbell, 1997; Campbell, Cataldie, McIntosh, & Millet, 2004), such programs show great promise in helping new survivors link with "veterans" who are further along in their mourning.

Lastly, a newly emerging form of contact is the internet. Activities may include participation in online support groups, survivor list-serves and message boards, and one-on-one email correspondence. A recent survey of bereaved survivor parents (Feigelman, Gorman, Beal, & Jordan, 2008) found that the online groups provided significant support for participants, who noted that the increased availability of the groups was particularly helpful. The study also found that users of the internet resources were more distressed and estranged from their social networks than participants in face-to-face groups. One possible explanation for this finding would be that survivors may turn to the internet for support when their social networks fail to provide them with the support that they need.

In addition to contact with other mourners, many survivors report a benefit from contact with a mental health professional, most frequently in the form of individual grief counselling (Dyregrov, 2002; McMenamy et al., 2008; Provini, Everett, & Pfeffer, 2000). Individual therapy allows for a careful assessment of risk factors for the development of prolonged grief disorder, depression, PTSD, and suicidality in the survivor. It also provides a psychological "attachment figure" who helps with the difficult tasks of re-regulating and reorganising one's life after the trauma of suicide. A skilled and "survivor informed" counsellor can also help with the intrapsychic meaning-making and interpersonal re-alignments that are a common part of the healing process for many survivors (Sands, 2008).

In addition to group and individual services, bibliotherapy and becoming an "activist" may have beneficial effects for survivors. Reading the personal accounts of other survivors (Alexander, 1991; Wrobleski, 2002) as well as books written for lay people by mental health professionals (Baugher & Jordan, 2002; Myers & Fine, 2007) can be useful. Similar to face-to-face contact, reading about the experience of others helps mourners to normalise their experience and learn skills for coping. Bibliotherapy has the added advantage of being private and available at the survivor's schedule, thereby allowing the mourner to "dose" their confrontation with the loss. In contrast, becoming an "activist" in suicide prevention or postvention efforts brings the bereaved into direct contact with the community of survivors. Activism incorporates the important principle of honouring the life of the deceased by working to create something "redemptive" in the tragedy, while also becoming a better person oneself. This principle of "benefit finding" has been found to be a key component of meaning reconstruction after the death of a loved one (Gillies & Neimeyer, 2006; Holland, Currier, & Neimeyer, 2006), as well as posttraumatic growth (Calhoun & Tedeschi, 2001). Activism also allows for a form of symbolic atonement that may be of help in ameliorating the intense guilt that can accompany a suicide loss.

Recovery Tasks and Clinical Goals for Survivors

The concept of recovery tasks that the bereaved need to accomplish in order to integrate a loss into their life trajectory has been used as a way to understand the mourning process by grief theorists (Rando, 1993; Worden, 2009). The same concept can be applied to the psychological work that suicide survivors must do in order to come to terms with the loss of a loved one to suicide and to rebuild their lives. This next section identifies tasks that survivors often need to face, and also identifies the goals that clinical work with survivors can help to facilitate.

Containment of the Trauma

Suicide death frequently involves some degree of violence in the manner of death. The fact that a loved one has "self-murdered" (the literal Latin root of the word suicide) is a psychological violation that leaves survivors with many of the same feelings and reactions seen after a homicide. These include shock, disbelief, and horror at the manner of death and the suffering of the deceased as they died. It is likely that many suicide survivors will experience at least some degree of clinical traumatisation, and the chances of developing full-blown Acute Stress Disorder or Posttraumatic Stress Disorder are increased if the survivor witnessed the suicide or saw the death scene. Symptoms of ASD or PTSD include recurrent and intrusive reliving of the experience with sensory experiences (visual images, smells, sounds, etc), emotional numbing or loss of emotional control, difficulty concentrating, physiological dysregulation (difficulty sleeping, under- or overeating, etc.), irritability, and attempts to avoid being triggered into the hyperaroused trauma state. Unfortunately, grief counsellors who may not be familiar with PTSD often overlook trauma symptoms. There are a number of pharmacological and psychosocial treatments that have been developed for PTSD (see: Foa, Hembree, & Rothbaum, 2007; Shapiro & Forrest, 2004; Yadin & Foa, 2007), and clinicians should always assess and provide treatment for trauma symptoms when present, or refer to practitioners who can provide appropriate interventions for the survivor.

Creation of a Survivor Narrative and Meaning-Making from the Death

For most people, suicide is an inherently frightening and mysterious form of death. It violates the assumptive world of the survivor, meaning the beliefs the survivor "takes for granted" about themselves, their relationships with other people, and their world (Kauffman, 2002; Sands, 2008). A hallmark of suicide bereavement is an intense need to make sense of what has happened, why it happened, and who was "responsible" for the death, so that a sense of coherence in the world can be restored (Jordan, 2001, 2008). Accordingly, survivors often need to conduct an "investigation" into the state of mind of the deceased and the factors that led to the suicide. This includes an accounting of the survivor's own perceived responsibility for the death and their perceived failure to prevent the suicide. Put differently,

survivors need to conduct their own personal "psychological autopsy" (Jordan, 2008). It is important for clinicians to recognise and support this effort, rather than opposing it as irrational guilt or pathological rumination. The goal over time is to help the survivor educate themselves about suicide and its causes (and by extension, psychiatric disorder). They must put into realistic perspective the multi-determined factors that contributed to the death, as well as the realistic limitations on their own power to control the outcome. This inquiry can be an arduous one for survivors, and cannot be rushed. Instead, the survivor should be supported in seeking any and all information that seems relevant to gaining a better understanding of the suicide. The mourner can also be supported in sorting through the "data" to create a picture of the state of mind of the deceased, and realistically assessing what, if anything, the survivor could have done differently. Guilt (or anger at someone else) about the suicide needs to be dealt with through a combination of gentle consideration of the "evidence", development of a realistic and balanced understanding of what contributed to the suicide, correction of common cognitive errors and "magical thinking" (e.g., believing that what one can see in hindsight should have been obvious before the suicide [Goggin & Range, 1985]), and sometimes, taking actions that help to atone for one's perceived mistakes. Atonement can take the form of trying to become a better person or of activism in helping others in a way that honours the life of the loved one. The repair of the survivor's assumptive world is a complex and difficult process involving making sense out of what initially is experienced as a senseless death (Sands, 2008). The use of narrative approaches to bereavement and trauma can be of great assistance for survivors in this process (Neimeyer, 1999, 2001). These techniques might include keeping a journal (Neimeyer, van Dyke, & Pennebaker, 2008; Pennebaker, 2003), narrative and expressive forms of retelling the story of the death (Rynearson, 2001; Shear, Gorscak, & Simon, 2006), and other types of therapeutic interventions that facilitate meaning making and a restoration of the psychological coherence that has been lost through the trauma of suicide (Neimeyer, 2006a, 2006b, 2006c; Neimeyer, Herrero, & Botella, 2006).

Learning To Dose Exposure to the Loss/Trauma

The Dual Process Model (DPM), a new model of the grieving process, suggests that recovery in bereavement entails oscillation between confrontation with the loss (Loss Orientation) and avoidance of the loss in order to focus on the adaptive challenges involved in living without the deceased (Restoration Orientation) (Stroebe & Schut, 1999). In essence, the DPM implicitly suggests that survivors must learn to "dose" their exposure to the loss. Mastery involves gaining/regaining regulatory control over the physiological, emotional, and cognitive sequelae of the loss. Thus, survivors must be willing to sometimes move "towards" the triggers that confront the mourner with the death and its implications for the mourner (e.g., visiting the grave, dealing with the belongings of the deceased, telling others the story of the death, visiting the scene of the suicide, etc.). At other times, the survivor must be able to compartmentalise and avoid these triggers in a way that allows respite from the pain and adaptive restoration of functioning (e.g., distracting oneself from thinking about the deceased and the details of the death, engaging in novel activities and pursuits). Both of these activities involve skill sets that must be acquired by the deceased, and both can be greatly facilitated by the assistance of an experienced grief counsellor.

Managing Changed Social Connections

Suicide often disrupts the social connections of survivors, both within their family and with their larger social network (Cerel, Jordan, & Duberstein, 2008; Jordan, 2001). There is evidence that suicide survivors generally receive less social support than survivors of other types of losses (Farberow, Gallagher-Thompson, Gilewski, & Thompson, 1992; Range & Calhoun, 1990; Range, 1998; Thompson & Range, 1992). This may be a result of the general ambiguity about the norms for social interaction after a suicide. Members of the survivor's social network are often uncertain about how to be of help because of the stigmatised nature of suicide, as well as the fear of making the survivor feel worse. Hence they may avoid discussing the suicide, or avoid contact all together with the survivor. Conversely, survivors may be expected to "explain" the death in a way that does not happen after death from natural causes (Range, 1998). In addition, a subset of the people may overtly condemn the suicide and/or blame the family for contributing to the suicide. Lastly, suicide survivors may "self-stigmatise" and isolate themselves, assuming that others will be judging them for the suicide (Séguin, Lesage, & Kiely, 1995; Van Dongen, 1993). Learning to navigate in this changed social reality requires the learning of complex skills around responding to unhelpful responses from other people, deciding when and with whom to be open about the details of the suicide, and learning to elicit support from others who wish to help, but are uncertain about how to do so. Again, a skilled grief counsellor can be instrumental in facilitating the acquisition of these new social skills on the part of survivors.

Repair and Transformation of the Bond with the Deceased

The field of thanatology is moving beyond the once widely held belief that successful resolution of grief necessitated the withdrawal of psychological energy from the deceased. Replacing that idea is the recognition that many mourners continue a psychological bond with the deceased (Klass, Silverman, & Nickman, 1996). Recent research suggests that there may be both adaptive and maladaptive ways of continuing this bond (Field, 2006a, 2006b). Thus, the task for most mourners is more one of transforming the attachment to the deceased, rather than relinquishing it. With regard to suicide bereavement, however, this task is likely to be more problematic. Suicide is frequently experienced as a rupture of the relationship with the deceased, not simply because of their unavailability through death, but because the suicide is perceived as an act of rejection, abandonment, and/or betrayal on the part of the deceased. This may engender strong feelings of anger (*How could they do this to me?*) or unworthiness in the survivor (*Why was I not enough to make them want to stay with me?*). While some attempt to deal with this perceived abandonment by psychologically cutting off all emotional ties with the deceased (most frequently after the suicide of a partner or spouse), it usually proves difficult to do. Instead, survivors can often benefit from doing symbolic "repair work" on the relationship, in a manner that bears some resemblance to repair work after other relational betrayals such as marital affairs or family estrangement. The work involves expressing to the deceased the feelings of anger and hurt the suicide has created, as well as finding a way to make peace with or even forgive the deceased for leaving.

Appropriate techniques range from letter writing to the deceased, guided imagery conversations, "empty-chair" enactments, and graveside rituals. Clinicians can play an important role in suggesting, guiding, validating, and bearing witness to this important relational repair work on the part of the survivor.

Memorialisation of the Deceased

As mentioned above, suicide survivors frequently feel a need to "investigate" the suicide and develop a narrative of the factors that led to the death. However, a normal aspect of mourning after any type of death is the creation of what has been called a "durable biography" of the deceased (Walter, 1996). This refers to a coherent narrative of the life of the deceased, the chronology of important events and accomplishments in that life, and an evaluation of the "type" of person they were, particularly with respect to their moral character. Development of this narrative often involves soliciting and incorporating the stories about the life of the deceased from the social network of those who knew the individual. As with so many aspects of suicide, this task is made more complicated by the mysterious and stigmatised nature of suicide deaths in most societies. After a suicide, both the survivor and others in their community may feel that the only important fact about the life of the deceased was the manner of their death. It is central to the recovery process of survivors that they review and put into perspective the entire life of the deceased, not simply the end of that life. This allows the survivor to construct a "durable biography" that honours the positive aspects of the life of the deceased, and combats some of the shame and feelings of failure that may attend a suicide death. Clinicians can actively encourage the survivor to cultivate memories of the deceased through a review of biographical material (photographs, videos, etc.) and participation in the sharing of memories and stories about the deceased with others. Some survivors find it valuable to literally construct a biography of the life of the deceased through work on photographic collages, edited versions of family videos, and written narratives of the deceased. Likewise, much of the involvement in suicide prevention or postvention that some survivors pursue is motivated by the need to remember and honour the loved one. All such activities can be an important component of the healing process for survivors, and should be encouraged by clinicians who work with them.

Restoration of Functioning and Reinvestment in Life

Sanders (1999) has noted that the bereavement trajectory of most mourners involves a turning point in which the mourner decides on some level to continue with and reinvest in their own life, despite the loss of the deceased. Sands (2008) has developed an elegant model of the path for many after a suicide by describing the process of initially identifying with the psychological mindset of the deceased, and then gradually relinquishing that identification to reclaim their own sense of self as separate from the suicidality of the deceased. Instead, the survivor reaffirms their own commitment to their own living and life. This process is difficult and subtle, because in a very real sense the deceased has served as a role model for one pathway by which deep psychological pain can be resolved, i.e., suicide. A significant number of the suicidally bereaved also wrestle with the viability of this option for themselves, given the pain they are enduring and the prospects of life without the deceased. The process of dis-identification with the deceased and rebuilding of reasons to go on living is a major healing task for survivors, one that involves working through all of the previous tasks listed above. It goes beyond a simple restoration of functioning or "getting over" the loss, and instead encompasses the complex work of making meaning out of the suicide, making peace with its reality, and finding renewed purposes for one's own life (Sands, 2008). Clinicians who work with survivors can be of enormous help in this healing process, primarily by serving as a sojourner or "expert companion" with the survivor on their difficult journey (Tedeschi & Calhoun, 2003), and by bearing witness to the transformation that recovery requires of the survivor. When this is accomplished, the result can be posttraumatic psychological growth in the survivor, and with it a renewed sense of hope tempered by hard-won wisdom about the simultaneous impermanence and preciousness of life (Calhoun & Tedeschi, 2001; Tedeschi & Calhoun, 2008).

1 The LOSS Team at the Baton Rouge Crisis Intervention Center in Baton Rouge, LA

References

Agerbo, E. (2003). Risk of suicide and spouse's psychiatric illness or suicide: Nested case-control study. *BMJ: British Medical Journal, 327*(7422), 1025-1026.

Agerbo, E. (2005). Midlife suicide risk, partner's psychiatric illness, spouse and child bereavement by suicide or other modes of death: A gender specific study. *Journal of Epidemiology & Community Health, 59*(5), 407-412.

Agerbo, E., Nordentoft, M., & Mortensen, P. B. (2002). Familial, psychiatric, and socioeconomic risk factors for suicide in young people: Nested case-control study. *BMJ: British Medical Journal, 325*(7355), 74-77.

Alexander, V. (1991). Grief after suicide: Giving voice to the loss. *Journal of Geriatric Psychiatry, 24*(2), 277-291.

Bailley, S. E., Kral, M. J., & Dunham, K. (1999). Survivors of suicide do grieve differently: Empirical support for a common-sense proposition. *Suicide and Life-Threatening Behavior, 29*(3), 256-271.

Baugher, R., & Jordan, J. (2002). *After suicide loss: Coping with your grief*. Newcastle, WA: The Sturbridge Group.

Brent, D. A., & Mann, J. J. (2006). Familial pathways to suicidal behavior: Understanding and preventing suicide among adolescents. *New England Journal of Medicine, 355*(26), 2719-2721.

Brent, D. A., Moritz, G., Bridge, J., Perper, J., & Canobbio, R. (1996). Long-term impact of exposure to suicide: A three-year controlled follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*(5), 646-653.

Brent, D. A., Perper, J. A., Mortiz, G., Allman, C., Friend, A., Roth, C., et al. (1993). Psychiatric sequelae to the loss of an adolescent peer to suicide. *Journal of the American Academy of Child & Adolescent Psychiatry, 32*(3), 509-517.

Calhoun, L. G., & Tedeschi, R. G. (2001). Posttraumatic growth: The positive lessons of loss. In R. A. Neimeyer (Ed.), *Meaning reconstruction & the experience of loss*. (pp. 157-172). Washington: American Psychological Association.

Campbell, F. R. (1997). Changing the legacy of suicide. *Suicide and Life-Threatening Behavior, 27*(4), 329-338.

Campbell, F. R., Cataldie, L., McIntosh, J., & Millet, K. (2004). An active postvention program. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 25*(1), 30-32.

Cerel, J., & Campbell, F. R. (2008). Suicide survivors seeking mental health services: A preliminary examination of the role of an active postvention model. *Suicide and Life-Threatening Behavior, 38*(1), 30-34.

Cerel, J., Jordan, J. R., & Duberstein, P. R. (2008). The impact of suicide on the family. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 29*, 38-44.

Crosby, A. E., & Sacks, J. J. (2002). Exposure to suicide: Incidence and association with suicidal ideation and behavior: United States, 1994. *Suicide and Life-Threatening Behavior, 32*(3), 321-328.

Currier, J. M., Holland, J. M., Coleman, R., & Neimeyer, R. A. (2008). Bereavement following violent death: An assault on life and meaning. In R. G. Stevenson & G. R. Cox (Eds.), *Perspectives on violence and violent death*. (pp. 177-202). Amityville, NY: Baywood Publishing Co.

Currier, J. M., Holland, J. M., & Neimeyer, R. A. (2007). The effectiveness of bereavement interventions with children: A meta-analytic review of controlled outcome research. *Journal of Clinical Child and Adolescent Psychology, 36*(2), 253-259.

Currier, J. M., Neimeyer, R. A., & Berman, J. S. (2008). The effectiveness of psychotherapeutic interventions for bereaved persons: A comprehensive quantitative review. *Psychological Bulletin, 134*(5), 648-661.

Cvinar, J. G. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care, 41*(1), 14-21.

Dyregrov, K. (2002). Assistance from local authorities versus survivors' needs for support after suicide. *Death Studies, 26*, 647-668.

Dyregrov, K. (2003). Micro-sociological analysis of social support following traumatic bereavement: Unhelpful and avoidant responses from the community. *Omega: Journal of Death and Dying, 48*(1), 23-44.

Farberow, N. L., Gallagher-Thompson, D., Gilewski, M., & Thompson, L. (1992). The role of social supports in the bereavement process of surviving spouses of suicide and natural deaths. *Suicide and Life-Threatening Behavior, 22*(1), 107-124.

Feigelman, W., Gorman, B. S., Beal, K. C., & Jordan, J. R. (2008). Internet support groups for suicide survivors: A new mode for gaining bereavement assistance. *Omega: Journal of Death and Dying, 57*(3), 217-243.

Field, N. P. (2006a). Continuing bonds in adaptation to bereavement: Introduction. *Death Studies, 30*(8), 709-714.

Field, N. P. (2006b). Unresolved grief and continuing bonds: An attachment perspective. *Death Studies, 30*(8), 739-756.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences: Therapist guide*. New York: Oxford University Press.

Forte, A. L., Hill, M., Pazder, R., & Feudtner, C. (2004). Bereavement care interventions: A systematic review. *BMC Palliative Care, 3*(3).

Gilles, J., & Neimeyer, R. A. (2006). Loss, grief, and the search for significance: Toward a model of meaning reconstruction in bereavement. *Journal of Constructivist Psychology, 19*(1), 31-65.

Goggin, W. C., & Range, L. M. (1985). The disadvantages of hindsight in the perception of suicide. *Journal of Social & Clinical Psychology, 3*(2), 232-237.

Grad, O. T., Clark, S., Dyregrov, K., & Andriessen, K. (2004). What helps and what hinders the process of surviving the suicide of somebody close? *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 25*(3), 134-139.

Holland, J. M., Currier, J. M., & Neimeyer, R. A. (2006). Meaning reconstruction in the first two years of bereavement: The role of sense-making and benefit-finding. *Omega: Journal of Death and Dying, 53*(3), 175-191.

Jordan, J. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior, 31*(1), 91-102.

Jordan, J. (2008). Bereavement after suicide. *Psychiatric Annals, 38*(10), 679-685.

Jordan, J., & McMenamy, J. (2004). Interventions for suicide survivors: A review of the literature. *Suicide and Life-Threatening Behavior, 34*(4), 337-349.

Jordan, J., & Neimeyer, R. A. (2003). Does grief counseling work? *Death Studies, 27*(9), 765-786.

Kaslow, N. J., & Gilman Aronson, S. (2004). Recommendations for family interventions following a suicide. *Professional Psychology: Research and Practice, 35*(3), 240-247.

Kauffman, J. (2002). *Loss of the assumptive world: A theory of traumatic loss*. New York: Brunner-Routledge.

Klass, D., Silverman, P. R., & Nickman, S. L. (1996). *Continuing bonds: New understandings of grief*. Philadelphia: Taylor & Francis.

Knieper, A. J. (1999). The suicide survivor's grief and recovery. *Suicide and Life-Threatening Behavior, 29*(4), 353-364.

McDaid, C., Trowman, R., Golder, S., Hawton, K., & Sowden, A. (2008). Interventions for people bereaved through suicide: Systematic review. *British Journal of Psychiatry, 193*(6), 438-443.

McIntosh, J. L. (2003). Suicide Survivors: The aftermath of suicide and suicidal behavior. In C. D. Bryant (Ed.), *Handbook of Death & Dying. Vol. 1* (pp. 339-350). Thousand Oaks, CA: SAGE Publications.

McMenamy, J. M., Jordan, J. R., & Mitchell, A. M. (2008). What do suicide survivors tell us they need? Results of a pilot study. *Suicide and Life-Threatening Behavior, 38*(4), 375-389.

Melhem, N. M., Day, N., Shear, M. K., Day, R., Reynolds, C. F., III, & Brent, D. (2004). Traumatic grief among adolescents exposed to a peer's suicide. *American Journal of Psychiatry, 161*(8), 1411-1416.

Miles, M. S., & Demi, A. S. (1991). A comparison of guilt in bereaved parents whose children died by suicide, accident, or chronic disease. *Omega: Journal of Death and Dying, 24*(3), 203-215.

Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer-Stephens, M. (2004). Complicated grief in survivors of suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 25*(1), 12-18.

Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer, M. K. (2005). Complicated grief and suicidal ideation in adult survivors of suicide. *Suicide and Life-Threatening Behavior, 35*(5), 498-506.

Miyabayashi, S., & Yasuda, J. (2007). Effects of loss from suicide, accidents, acute illness and chronic illness on bereaved spouses and parents in Japan: Their general health, depressive mood, and grief reaction. *Psychiatry and Clinical Neurosciences, 61*(5), 502-508.

Murphy, S. A., Johnson, L. C., & Lohan, J. (2002). The aftermath of the violent death of a child: An integration of the assessments of parents' mental distress and PTSD during the first 5 years of bereavement. *Journal of Loss & Trauma, 7*(3), 203-222.

Murphy, S. A., Johnson, L. C., Wu, L., Fan, J. J., & Lohan, J. (2003). Bereaved parents' outcomes 4 to 60 months after their children's death by accident, suicide, or homicide: A comparative study demonstrating differences. *Death Studies, 27*(1), 39-61.

Myers, M. F., & Fine, C. (2007). Touched by suicide: Bridging the perspectives of survivors and clinicians. *Suicide and Life-Threatening Behavior, 37*(2), 119-126.

Neimeyer, R. A. (1999). Narrative strategies in grief therapy. *Journal of Constructivist Psychology, 12*(1), 65-85.

Neimeyer, R. A. (2001). *Meaning reconstruction & the experience of loss*. Washington, DC: American Psychological Association.

Neimeyer, R. A. (2006a). Bereavement and the quest for meaning: Rewriting stories of loss and grief. *Hellenic Journal of Psychology, 3*(3), 181-188.

Neimeyer, R. A. (2006b). Narrating the dialogical self: Toward an expanded toolbox for the counselling psychologist. *Counselling Psychology Quarterly, 19*(1), 105-120.

Neimeyer, R. A. (2006c). Re-storying loss: Fostering growth in the posttraumatic narrative. In L. G. Calhoun & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research & practice*. (pp. 68-80). Mawah, NJ: Lawrence Erlbaum Associates Publishers.

Neimeyer, R. A., Herrero, O., & Botella, L. (2006). Chaos to coherence: Psychotherapeutic integration of traumatic loss. *Journal of Constructivist Psychology, 19*(2), 127-145.

Neimeyer, R. A., van Dyke, J. G. & Pennebaker, J. W. (2008). Narrative medicine: Writing through bereavement. In H. C. W. Breitbart (Ed.), *Handbook of psychiatry in palliative medicine* (pp. 454-469). New York: Oxford.

Pennebaker, J. W. (2003). Writing about emotional experiences as a therapeutic process. In P. Salovey & A. J. Rothman (Eds.), *Social psychology of health* (pp. 362-368). New York: Psychology Press.

Provini, C., Everett, J. R., & Pfeffer, C. R. (2000). Adults mourning suicide: Self-reported concerns about bereavement, needs for assistance, and help-seeking behavior. *Death Studies, 24*(1), 1-19.

Qin, P., Agerbo, E., & Mortensen, P. B. (2002). Suicide risk in relation to family history of completed suicide and psychiatric disorders: A nested case-control study based on longitudinal registers. *Lancet, 360*(9340), 1126-1130.

Rando, T. A. (1993). *Treatment of complicated mourning*. Research Press: Champaign.

Range, L. M., & Calhoun, L. G. (1990). Responses following suicide and other types of death: The perspective of the bereaved. *Omega: Journal of Death and Dying, 21*(4), 311-320.

Range, L. M. (1998). When a loss is due to suicide: Unique aspects of bereavement. In J. H. Harvey (Ed.), *Perspectives on loss: A sourcebook* (pp. 213-220). Philadelphia: Brunner/Mazel.

Reed, M. D. (1998). Predicting grief symptomatology among the suddenly bereaved. *Suicide and Life-Threatening Behavior, 28*(3), 285-301.

Reed, M. D., & Greenwald, J. Y. (1991). Survivor-victim status, attachment, and sudden death bereavement. *Suicide and Life-Threatening Behavior, 21*(4), 385-401.

Rynearson, E. K. (2001). *Retelling violent death*. Philadelphia: Brunner-Routledge.

Saarinen, P. I., Viinamäki, H., Hintikka, J., Lehtonen, J., & Lönnqvist, J. (1999). Psychological symptoms of close relatives of suicide victims. *European Journal of Psychiatry, 13*(1), 33-39.

Sanders, C. M. (1999). *Grief: The mourning after* (2nd ed.). New York, NY: John Wiley & Sons, Inc.

Sands, D. C. C. (2008). A study of suicide grief: Meaning making and the griever's relational world. PhD thesis. University of Technology, Sydney, Australia. http://hdl.handle.net/2100/777.

Séguin, M., Lesage, A., & Kiely, M. C. (1995). Parental bereavement after suicide and accident: A comparative study. *Suicide and Life-Threatening Behavior, 25*(4), 489-498.

Shapiro, F., & Forrest, M. S. (2004). *EMDR: The breakthrough therapy for overcoming anxiety, stress, and trauma*. New York: Basic Books.

Shear, K., Gorscak, B., Simon, N. (2006). Treatment of complicated grief following violent death. In E. K. Rynearson (Ed.), *Violent death: Resilience and intervention beyond the crisis* (pp. 157-174). New York: Routledge/Taylor & Francis Group.

Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies, 23*(3), 197-224.

Sveen, C.-A., & Walby, F. A. (2008). Suicide survivors' mental health and grief reactions: A systematic review of controlled studies. *Suicide and Life-Threatening Behavior, 38*(1), 13-29.

Tedeschi, R. G., & Calhoun, L. G. (2003). *Helping bereaved parents: A clinician's guide*. New York: Brunner-Routledge.

Tedeschi, R. G., & Calhoun, L. G. (2008). Beyond the concept of recovery: Growth and the experience of loss. *Death Studies, 32*(1), 27-39.

Thompson, K. E., & Range, L. M. (1992). Bereavement following suicide and other deaths: Why support attempts fail. *Omega: Journal of Death and Dying, 26*(1), 61-70.

Van Dongen, C. J. (1993). Social context of postsuicide bereavement. *Death Studies, 17*(2), 125-141.

Walter, T. (1996). A new model of grief: Bereavement and biography. *Mortality, 1*(1), 7-25.

Worden, J. W. (2009). *Grief counseling and grief therapy* (4th ed.). New York, NY: Springer.

Wrobleski, A. (2002). *Suicide survivors: A guide for those left behind* (3rd ed.). Minneapolis, MN: Suicide Awareness Voices of Education.

Yadin, E., Foa, E. B. (2007). Cognitive behavioral treatments for posttraumatic stress disorder. In L. J. Kirmayer, R. Lemelson, & M. Barad (Eds.), *Understanding trauma: Integrating biological, clinical, and cultural perspectives* (pp. 178-193). New York: Cambridge University Press.

A Tripartite Model of Suicide Grief: Meaning-Making and the Relationship With the Deceased

Diana Sands
PhD., M. Ed., Dip. Psych., B.A.

Director
Bereaved by Suicide Service,
Salvation Army
University of Technology
Sydney

Centre for Intense Grief,
Level 4,
234 George Street,
Sydney, NSW, 2000
Fax: (02) 9251 8855
Email: dianasands@
bereavedbysuicide.com.au

Abstract

This paper considers suicide grief in the context of meaning-making and the grieving person's relational world. Specifically, the paper focusses on the interaction between the relationship with self and the development and adjustment of relationship with the deceased, and increased vulnerability to suicidal ideation during these processes. These relational issues are considered within the theoretical and research context of a Tripartite Model of suicide grief. The model outlines a process of adaptation, from engaging with the intentional nature of suicide, through reconstruction of the death story, to repositioning the suicide and pain of the deceased's life. The metaphors of *Trying on the shoes*, *Walking in the shoes* and *Taking off the shoes* are used to illustrate and discuss different dimensions of the grief process.

A Tripartite Model of Suicide Grief: Meaning-Making and the Relationship With the Deceased

Suicide bereavement can be understood as a special case of grief, with complex meaning-making issues that challenge the development, nature and adjustment of the continuing bond or relationship between the bereaved and the deceased. Research has identified an increase in intensity and duration of grief reactions in suicide grief, and a significant clustering of distinct themes related to challenges to the bereaved person's assumptive world, psychosocial processes, health issues, depression, work and family functioning that can complicate the bereavement process (Brent, Moritz, Bridge, Perper, & Canobbio, 1996; Jordan, 2001; Jordan & McMenamy, 2004; Murphy, 1996; Murphy, Johnson, Wu, Fan, & Lohan, 2003; Range, 1998; Worden, 1996). Those bereaved report less social support and feelings of rejection and stigma within both family and community (Attig, 1996; Centre for the Advancement of Health, 2004; Cerel, Jordan, & Duberstein, 2008; Range, 1998; Range & Calhoun, 1990). The essential difference between a suicide death and other types of death is that the death is not the result of natural causes, accident or homicide; it is a self-inflicted, intentional act by the deceased, and this distinction tends to define the content of grief themes, familial disruption and psychosocial process issues that eventuate.

Rubin, Malkinson and Witztum (2003) suggested that one of the main sources of trauma occurs "when the previous representation ... of the deceased is shattered by the self-volition of the death" (p. 668). Anger and abandonment themes found in suicide bereavement can be understood as a response to feelings of profound hurt and betrayal of the fundamental relational pact of trust (Clark, 1995; Wertheimer, 1991). Research suggests that bereaved families struggle with the antecedent conditions to the death, fears for the safety of other family members, secrets, self-blame and a range of issues that silence communication within the family and affect grieving processes (Cerel, Jordan, & Duberstein, 2008; Linn-Gust, 2001). Jordan (2001, p. 95) explained, "suicide is an unusual form of mourning experience, because losing a loved one to suicide may elevate the mourner's own risk for suicidal behaviour and completion". Many researchers have reported an increased risk of developing grief complications in suicide bereavement, with the attendant risk of suicidal ideation and behaviour (Brent et al., 1996; Currier, Holland, & Neimeyer, 2006; Kim, Séguin, Therrien, Riopel, Chawky, & Lesage, 2005; Latham & Prigerson, 2004; Mitchell, Kim, Prigerson, & Mortimer, 2005; Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004; Runeson & Asberg, 2003).

Challenges to Meaning-Making in Suicide Grief

A starting point for the research by Sands (2008) discussed in this paper is the proposition that meaning-making processes are activated to help individuals to make sense and coherence of events that disrupt existing meaning structures (Janoff-Bullman, 1989, 1998; Neimeyer, Prigerson, & Davies, 2002), and that self-narratives play a central role in this process (Neimeyer, 2001; Neimeyer, Prigerson et al., 2002; Neimeyer & Levitt, 2001). Meaning-making is a complex, relational, ongoing process that is central to grieving and fundamental to the conceptualisation of grieving in current theories of grief (Davis, Wortman, Lehman, & Silver, 2000; Martin & Doka, 2000; Nadeau, 1998, 2000, 2001; Neimeyer, 2000a, 2000b, 2000c, 2002; Silverman & Klass, 1996; Walter, 1996). Ayres (2007), as the narrator in his film based on his experience of his mother's suicide, captured in a few poignant words the struggle provoked by suicide grief:

> If everyone has one story that defines and shapes who they are, then this is mine ... Most of all, this story is about my mother. I write it over and over, trying to understand her and all the things that she did. We [my sister and I] never talk about my mother. Neither of us knows what to say. The night my mother died I remember thinking I should cry now, but I didn't. In all these years I've never shed a tear for her. Instead I write about her, bringing her back to life over and over. Trying to understand her, or perhaps to punish her, or just to remember, to feel, to accept, to forgive – to love. (Ayres, 2007)

These words stress the significance of story in making meaning, and how the self-narratives that a person constructs come to define, shape and possibly confine that person. Ayres' (2007) story is about his hurt and confusion about his mother's suicide and his attempts to make meaning. And it is a story about relationships: his

relationship with his mother, with himself and others, and the silence of these issues in his relationships. This research addressed the issues Ayres struggles with: how do the bereaved make meaning and "story" a suicide death in a way that creates the possibility of healing the relationship with the deceased, with the self, and with others?

Neimeyer (1999) noted how a loss event could cause a severe dislocation of the narratives people tell themselves about who they are and their world as they understand it. The process of making meaning cannot be negative; however, the meanings constructed can be negative or detrimental to improved grief outcomes. The influence of meaning-making processes can be tracked in the self-stories or narratives people use to explain life events to themselves and others. This research applied meaning-making as a theory and as an interpretive method of data analysis to increase insight into the construction of relational meaning-making. The ability to make meanings that make sense and find benefit in the death are linked with improved grief outcomes and positive self-growth (Currier et al., 2006; Murphy, Johnson, & Lohan, 2003). However, a suicide death can stretch the limits of the bereaved in making meanings that allow them to integrate the death event. Range (1998) described the search for meaning by those bereaved by suicide, as "emotionally draining ... because they are struggling with existential questions for which there are not ultimate answers" (p. 215). Currier et al. (2006) found vulnerability to complications in grief following a violent death when the griever was unable to make sense of the experience. Neimeyer et al. (2006) found that when there is an inability to make sense of the death and high attachment to the deceased the consequent grief distress increases the possibility of bereavement complications developing.

Challenges to the Relationship With the Deceased in Suicide Grief

The study specifically explored the concept of "continuing bonds", the term formulated by Klass, Silverman, and Nickman (1996) for the postloss attachment of the bereaved to the deceased. This attachment is described in the Tripartite Model (Sands, 2008) as the relationship between the bereaved and the deceased. Current theories of grief allow that continuing bonds and imaginal interactions between the bereaved and the dead are part of a complex process in which the bereaved realign from the living person to a constructed imaginal presence of the deceased, that becomes an ongoing presence in the bereaved person's life (Klass et al., 1996). Boerner and Heckhausen (2003) conceptualised the development of continuing ties with the deceased as a process of transformation that involves both disengagement from the living person and connection or reconnection with a mental representation as the ties with the deceased are transformed. Marwit and Klass (1996, p. 305) noted that the deceased played "an active role in the ongoing lives of survivors", providing a valued role model to the bereaved in their lives. Klass (2006) noted that the relationship or connection with the deceased could be positive or negative, in the same manner as continuing bonds in living relationships can be subject to a variety of pathological elements.

There are multiple storying difficulties in a death due to suicide that influence the development and maladaptive or adaptive nature of the relationship with the deceased. Many researchers have noted the difficulty of making meaning of a suicide death (Clark, 1995; Jordan, 2001; Linn-Gust, 2001; Neimeyer et al., 2006; Wertheimer, 1991). Rynearson (2001) examined his compulsion to return repeatedly to the death event in efforts to make meaning and find a way to live with the intentionality of his wife's death, and observed how the dissonance between the killing action of the deceased and the caring actions of the bereaved destabilises and disrupts the narration of the dying story, creating "a structural dead end that fundamentally complicates retelling" (p. 21). Neimeyer et al. (2006) highlighted concerns for those bereaved that have an intense attachment or bond to the deceased coupled with an inability to make sense of the death. Walter (1996) noted the significance of the "last chapter" about the life of the deceased and its importance for the relationship with the deceased in the ongoing life of those bereaved.

Challenges to the Relationship With the Self in Suicide Grief

This study considered the influence of suicide on the bereaved person's relationship with the self. Current theories of grief emphasise the uniquely personal process of grief for each individual, and recognise that this process involves changes at a fundamental level to the individual's sense of identity and assumptions about their world, and the possibility that these changes can provoke a search for meaning and growth through grief (Attig, 2004; Calhoun & Tedeschi, 1999; Hedtke & Winslade, 2004; Janoff-Bulman, 1998; Landsman, 2002; Neimeyer, 2001, 2002; Neimeyer, Botello, Herrero, Pacheco, Figueras, & Werner-Wilder, 2002). Attig (2004) described this process as relearning the world. Janoff-Bulman's (1989) model of underlying assumptions upon which humans organise their lives offers insight into the challenge that death presents to people's relationship with self and the reverberations of the impact of trauma on their assumptions about their world. Those bereaved by suicide have repeatedly reported their grief experience as a shattering of their sense of self (Barrett, 1989; Bolton, 1986; Jamison, 1999; Lukas & Seiden; 1990; Neimeyer, Botello, et al, 2002). Betrayal of trust is one of many issues with which those bereaved by suicide wrestle (Clark, 1995; DePrince & Fred, 2002; Wertheimer, 1991). In an educational film on suicide, a bereaved child asks, "Why did he do that to me?" (Sands, 2003). How do those bereaved understand the meaning of the death in terms of their relationship with the deceased in ways that are positive for their relationship with themselves? Jamison (1999) addressed the deeply personal meaning of a suicide death, asking, "How can killing oneself, in the context of other lives, ever be seen as anything but a highly personal ... act?" (p. 292). For those bereaved, whose life and love were entwined with the deceased, suicide can be a devastating assault on their relationship with self and their assumptive world.

The Study

The study used a hermeneutic interpretive methodology to analyse audio recorded participant conversations and writings, in the belief that those bereaved by suicide are

the "experiential experts" on the phenomenon of suicide grief. Data analysis generated three central organising themes through which to further interpret data. Data derived from a cross-section of 16 adult male and female participants, all of whom voluntarily attended a suicide bereavement group of 30 hours over three months. Participation in the research was voluntary on completion of the group program. The study included a range of relationships of loss, and participants were between six months to three years bereaved. The study did not consider individual differences but instead constituted a representative cross-section of bereavement group participant data. The group case study method of collecting data provided the opportunity to gather data from an interactive, less structured setting than interviews provide.

The model (Sands, 2008) proposes a tripartite process of adaptation to illustrate the different relational dimensions of the grief process in suicide bereavement (see Figure 1). The multi-directional arrows represent the non-linear nature of grief processes. The first phase of the model is *Trying on the shoes: Understanding the relationship* and is concerned with the bereaved engaging with the intentional nature of a suicide death. A suicide death sends a message to those who care about the deceased, but the message is difficult to decode and understand. The impact of the intentional nature of suicide surfaces in a range of relational themes that saturate group discussions, commonly explored through various forms of "why" questions. The intentional nature of suicide tends to subsume the deceased, and challenges grievers' understanding of the foundations of their relationship with the deceased.

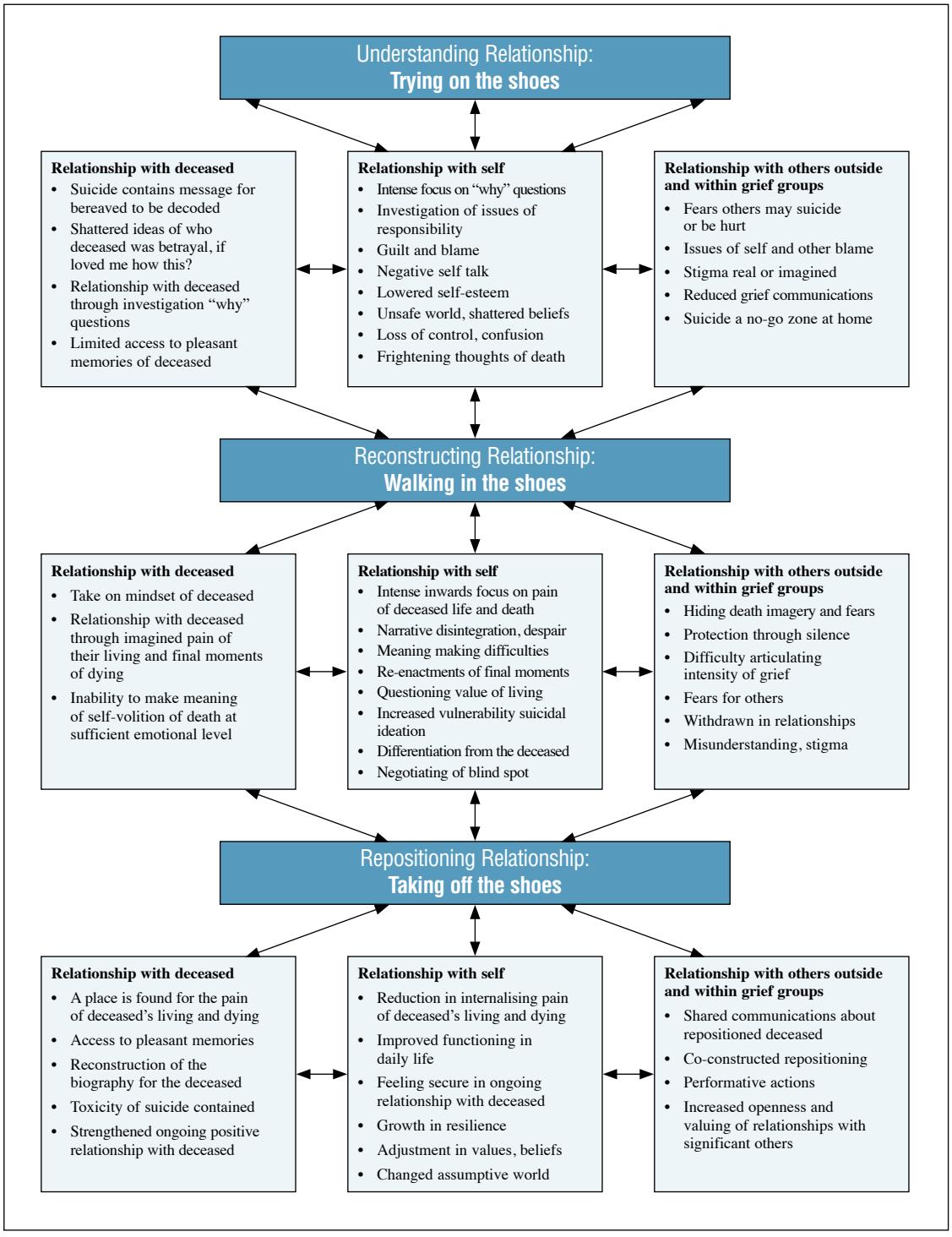


Figure 1. *The Tripartite Model of Suicide Grief*

These questions can be understood as part of an ongoing dialogue that is both internal and external. This paper focusses on the second and third phases of the model, *Walking in the shoes: Reconstructing relationship* and *Taking off the shoes: Repositioning relationship*. Within these sections two relationship areas are covered: the relationship with the deceased and relationship with the self.

Walking in the shoes: Reconstructing relationship

Walking in the shoes: Reconstructing relationship is concerned with reconstruction of the death story and the prevalence of themes that focus on the pain of the life and death of the deceased. Research data suggested that the bereaved constantly either physically or in imagination return again and again to the death scene and the sequence of events prior to the death. Why do those bereaved by suicide do this? The pain of the life and death of the deceased is a major meaning-making challenge for the bereaved. There is a need to understand the mindset of the deceased, and the activity of reconstructing the death story assists the bereaved in meaning-making efforts that facilitate development of the relationship with the deceased and integration of the loss (Rynearson, 2001; Walter, 1999).

Research suggested that during reconstruction of the death story the relationship between the bereaved and the deceased tends to be developed and maintained through the pain and trauma of the deceased's life and death. A bereaved participant explains how thoughts of the deceased lead inevitably to the horror of the death: "It's there every day, I think it colours – it's in every pore of my skin ... I guess 'cause it was so traumatic ... I can't get that vision out of my head." (Sands, 2008, p. 111) The bereaved are vulnerable in reconstruction processes and can become so immersed in walking in the shoes of the deceased and imagining their mindset that they experience similar hopelessness and suicidal ideation. There is significant difficulty in reconstruction efforts because the deceased's death is a statement about not resolving the pain of living; a statement that leaves a message for the bereaved that maybe they will not be able to resolve their pain. Those walking in the shoes of a suicide victim can be drawn into experiencing a challenge to their assumptive world, similar to the challenge that the suicide victim experienced. This is the bereaved at their most vulnerable. It is also possible for the bereaved to stay interminably trapped in ruminating within the mindset of the deceased. To be supported in these meaning-making processes and standing in the shoes of the deceased at the moment of death, to realise that you are different and want to live, can assist navigation of the *blind spot* that is the incomprehensibility at the core of suicide. Navigating the *blind spot* is not about making meaning that is profoundly comprehensive so much as getting to a place of meaning that allows the bereaved to reinvest energy in living.

The excerpt that follows illustrates the nature of both the relationship with the deceased and the relationship with the self. This mother is two years' bereaved and still in the constant shadow, not only of her son's suicide but the dark companionship of her own suicidal fears. She is consumed in thinking about reconstruction questions, "What if?" and questions of intent, "Why?" She connects with him through thinking about "the fact it was suicide". The circumstances of the death remain confused and she continues to struggle with the self-volition of his death. The place she is with her son is the nightmare day he died. In this "surreal" place she cries over the things that she can't change and the things that remain undone. At night she lies in bed praying to die from a heart attack. The quotes in this article described as from "participants" are taken from conversations and writings of study participants in Sands' research (2008).

> *Two years on my world is worse as I think about what if? Why?... But it is not a place where I would do anything but at the same time I pray every night I have a heart attack. I don't know why I'm on this earth ... I ... think about the actual suicide, how and how long did it take, it's too painful ... The fact it was suicide is always there and does stop me moving on ... the pain is still as bad ... it's just a real struggle ... I think about the day [he] was found a lot, any time of day. The events on that day are quite a blur ... I can't understand how [he] could do what he did. I often go there in my mind but still can't come to terms with it ... That day will always remain a nightmare. It seems so surreal ... I wish I could have seen [him]. We weren't allowed to – I wish I had a lock of his hair, I will always just wish ... I just wish I had some insight as to how much pain [he] was in ... you just go on with a part of your heart missing and the suicide issue is just huge.*

The next excerpt is from a mother who is six months' bereaved. The death place is where connection between the bereaved mother and deceased daughter takes place. The mother is drawn back into the death story again and again, struggling with insoluble questions. She tries to sequence and order events. She describes her anguish and confusion about how long it took for her daughter to die and the persistent horror of the visual image from when she found her daughter. At this point the mother walks in her daughter's shoes right up to the moment of death. She fears: "I will end up doing it myself". However, there is differentiation between herself and her daughter: the mother wants to keep herself safe by not knowing too much about hanging.

> *I think about it every day ... Time is skewed ... I'm confused how long it took her to pass away ... To visualise her when I saw her. Pure fear, shock, panic. To think about her being alone: what she was doing and thinking on her last moments on earth? Why would she leave everything and everyone? Her heart stopping, that is horrific, thinking about the actual moment her heart stopped beating. ... Why didn't I hug her and be with her and kiss her ... Why didn't I go in the ambulance with her? Why didn't I go to the hospital morgue and spend time with her there ... The sight of her – so still, not moving ... gone ... Could I have saved her if I tried? How long did she suffer for before she died? What if she changed her mind halfway through but it was impossible to save herself ... I need to know how hanging works and how long it would have taken her to go. I'm scared if I know too much about how to hang I will end up doing it myself.*

In the next excerpt it is important to recognise that this young woman is walking in her father's shoes in order to reconstruct the death event, to help her understand how he could kill himself. Like a forensic investigator, the daughter examines the position of the furniture, the proximity of the post to the hanging spot and the length of the drop. Step by step she moves herself into re-enacting his death. Her conclusion is that "[her] dad did not want to stop or pull out". She reflects that she would try to live, and this is the point of differentiation and adjustment in the relationship with her father. Hard as this knowledge is to accept she tells us this has helped her.

> *All I could think about was what was he thinking at that very moment when he put the rope around his neck, when the last thing he saw was the family portrait in front of him. Did he think of us? Did he struggle? Did he do it then try to pull out? So many questions ... I know if I can't breathe I struggle and try anything to get air ... I had to see if he could get out if he wanted to. Well I know with the fall only a very short one – I know my dad's neck could not have snapped ... No furniture or anything was moved ... Dad hung himself on the start of a spiral staircase. ... I re-enacted my dad's hanging ... I put the chair in the exact place dad kicked it from. Everything was the same. Well I put the rope on and I now know if dad wanted to get out of it he could have, the chair was close enough ... I could put my feet up on and lift myself up. My dad was bigger and a lot stronger ... My dad did not want to stop or pull out – I get much more peace knowing ... so this has helped me.*

The next excerpt gives insight into the bereaved person's relationship with the deceased and how it impacts on their relationship with the self, while inside the mindset of the deceased. For this man his relationship with himself is submerged within his brother's pain.

> *Staring into the middle distance and go into a state of suspension – that's often what might be happening inside. I suppose ... like time stands still, I feel – I feel like that ... space where I am where there is no time where I reflect back and forwards. My brother is there ... the whole – the whole um – the energy is about him and well the sadness that he went and um – trying to feel like I'm connecting ... But that feeling is a way of being with my brother ... there's a lot of sadness and lot of guilt ... I just like to have really given him a big hug but I didn't, I didn't get a chance.*

The last excerpt in this section gives insight into the isolation of the relationship with self. The woman describes how she is haunted by her reconstruction of the violent image of the suicide jump and her relationship with the deceased. Other people are not part of her world. She is alone, maybe too fragile to make it to the future. In fact she feels that she is walking on "that cliff" up to the moment of death. However, she pulls away from the cliff, telling us, "I can't bear to be near the edge of a cliff". This is an important moment in which she differentiates from the deceased and experiences fear and the need to keep herself safe.

> *The violence of her jumping haunts me and I feel I want to shake her. I want to ask her – I want to know what she was feeling ... I feel alone even though I'm surrounded by people ... I'm lost ... I don't really want to do anything ... I feel so fragile, like I am walking on that cliff and to fall off would be the natural progression ... The effort is to pull back and find the energy ... I have withdrawn because I don't have the energy ... to participate. When I think of her I think of the violence, the image of her being airborne, the image of her smashed up body... I can't bear to be near the edge of a cliff ... When I think of how she died I feel physically sick ... I want to throw up and ... Sometimes I dry retch with horror.*

Taking Off the Shoes: Repositioning the Relationship

Research suggested that repositioning themes tend to surface once the bereaved have differentiated from the deceased and negotiated the incomprehensibility of the *blind spot* at the centre of suicide. The bereaved are ready to take off the shoes of the deceased and are no longer intensely focussed on questions of intent and on their reconstruction of the death story. Grieving continues however this shift in focus facilitates adaptation assisting as one participant noted "other layers of subtle grief" to be experienced. During repositioning, the relationship with the deceased adjusts from maladaptive to adaptive as the death event and pain of the deceased's life are separated from more nurturing memories. Repositioning tends to validate the suffering of the deceased but not their decision to kill themselves. Analysis of group data suggested that repositioning importantly assists in re-establishing a sense of order and safety in the world, while also repairing broken trust and increasing personal efficacy. Repositioning narrates difficult meaning-making issues and facilitates positive memories of the deceased. The development of an ongoing relationship with the deceased can occur regardless of whether the bereaved believe in an afterlife or are religious. A mother describes the concept of repositioning and how she is forming an adaptive relationship with the deceased as a valued presence in her life. For this mother the pain in her daughter's life and death had taken over her memories of her daughter, so much so that her living experience of her daughter was, as if she had "never been". But now she is drawing her daughter's essence back into her life.

> *I have made a really conscious effort to have things around me that were hers and that she or I gave her, or she gave me, or things of significance ... I just kind of draw her essence back into my life ... And it's getting there ... you don't stop your relationships with the people that you care about when they are alive so you are not going to suddenly come to a point where you stop developing a relationship with someone that's died. To me it's ongoing and some bits are good and lots aren't good and you just hang onto the good bits but you try and like move on with it.*

To understand the next piece, I refer the reader to an earlier excerpt where this man talked of how he connected with his brother in a pain-filled place in which time was suspended. Now he tells us that his relationship has adjusted and that there are many more

pleasant memories through which he can relate to his brother. This is allowing other subtle layers of grief to be experienced.

> *I have ... learned to step outside of it and see it grow smaller, giving perspective and allowing it to disperse ... rather than clumped into a focus point. Instead the painful feelings are washed through with many more pleasant memories ... there is no point in focussing on the worst point in his life ... I have learned to focus on the rest of his life ... and see the whole picture, not just the bad part ... Good and bad but washed in together ... my emotions have shifted and I [feel] less anger underneath and other layers of subtle grief [are] being uncovered.*

In the next excerpt this person explains the adjustment in relationship with the deceased. The suicide is placed in a time context, that happened "then" but "now we are over here" and the relationship with the deceased has shifted from reconstruction of the death to relating with him as a wise, nurturing guide.

> *I feel so guided by him [the deceased] – and I didn't feel that before ... when you evolve ... you are wiser ... And the way he died, his death that he did it to himself – that feels kind of like, well that just happened then and now we are over here and he is helping.*

When the relationship with the deceased adjusts from maladaptive to adaptive, the relationship with the self improves. The bereaved often report a sense of peace or calm and a decrease in feelings of guilt and blame. Having reached a cognitively complex level in constructed meanings about the suicide, the bereaved can forgive themselves and forgive the deceased for leaving them in that way. This mother explains her belief that her daughter is somewhere "good" and no longer trapped in the death event. Her grief is not dammed up because of the intensity of relating with the deceased through the death story:

> *I no longer feel that my daughter's death was my fault. It's like a great weight has been lifted. I believe she is somewhere good ... I have the strength to go on with life ... Grief is no longer a roller-coaster but more ebb and flow. I am finding a place in my life for her suicide.*

The following words have a redemptive quality, acknowledging the extraordinary resourcefulness and strength needed to reach a place where it is possible to forgive the self. The metaphor of "place" suggests that the pain is contained, no longer seeping over everything.

> *To survive this loss has required every strength, and every ounce of knowledge and experience gained throughout my life ... I never thought I could forgive myself for what happened ... it has found a place within me.*

A mother describes how she has taken down a shrine for her daughter. The relationship is no longer centred on her death. The mother has repositioned the daughter as "part of [the family] again". The expression has an almost organic sense: she is not just with them but part of this family. The continuing relationship with her daughter has the promise of accessing good memories. Her functioning has improved and she is no longer a high risk for suicide.

> *[I am] Calmer, more at peace, and less hard on myself. My daughter has another place no less significant but different in the family ... it isn't the full shrine any more ... I have actually sort of put her back into the family again. Rather than making her stand out and the others around, she is part of them again, and now I feel a lot more at peace with that ... I am working better at work as well, my concentration ... what I was finding it hardest to come to terms with is how do I survive after she is gone. And I am starting to learn that – yeah I can survive, now, but ... I would have been really high on that suicide list. I was not stable.*

In the next excerpt this woman talks of how being able to grieve within the group, to put on the shoes and walk into the "black hole" into which her sister had "disappeared" and find her sister, to bring her "back", have helped her to feel safer. Significantly, she is no longer relating to her sister within the black hole. The relationship has adjusted and she is now able to identify her thoughts, fears and sadness as grief, not as indications of suicidality and mental illness.

> *[I feel] Safer ... I'm not scared anymore that I have a mental illness. I've been able to verbalise the thoughts, images and fears that I couldn't share with anyone else outside this group. I have been able to bring my sister back from the black hole I felt she had disappeared into. I have been able to share my sadness with my family.*

Conclusion

This study applied current theories of grief to the issue of suicide grief, surfacing critical themes in grief group conversations and writings. The group data supported a tripartite model of suicide grief. The model proposes that initially the message of a suicide death provokes the bereaved to engage with questions of intentionality and to *try on the shoes* of the deceased. As the bereaved begin to reconstruct the death story they find themselves *walking in the shoes* of the deceased, trying to make meaning of the pain in the deceased's life and death. These meaning-making activities are relational and challenge the relationship with the self, the deceased and significant others. Analysis identified the prevalence of the bereaved forming maladaptive relationships with the deceased. The intense focus and rumination on reconstruction can increase the vulnerability of the bereaved to suicidal ideation and possible suicide. However, when there is safety and containment that supports the bereaved in reconstruction efforts, they can navigate the incomprehensible nature of suicide and differentiate themselves from the deceased, choosing life. It is important to stress the non-linear nature of these grief processes. As ruminations on the death story lessen, space is created for positive remembering, repositioning, development and adjustment to an adaptive valued relationship with the deceased. In this process, as illustrated in the data, the trust, connection and collaboration developed within the grief group are beneficial. Significantly, the prevalence of relating to the deceased through reconstruction of the death story and the relationship between this and increased suicidal ideation requires further research to determine

how and when these activities shift from effective meaning-making strategies to become active suicidality. It is important to note that the study data derived from group participants who constituted a small sample. It is not claimed that the model and study findings are representative of all people bereaved by suicide. Rather, these findings are put forward to encourage further research into the implications of the model for education and practice issues, and in particular the theory, interventions and outcomes of suicide grief group and counselling programs.

References

Attig, T. (1996). *How we grieve: Relearning the world*. New York: Oxford University Press.

Attig, T. (2004). Meanings of death seen through the lens of grieving. *Death Studies, 28*(4), 341-360.

Ayres, T. (Writer and director) (2007). *The Home Song Stories* (DVD). Australia: Madman Entertainment.

Barrett, T. (1989). *Life after suicide: The survivor's grief experience*. Fargo, ND: Aftermath Research.

Boerner, K., & Heckhausen, J. (2003). To have and have not: Adaptive bereavement by transforming mental ties to the deceased. *Death Studies*, *27*(3), 199-226.

Bolton, I. (1986). *My son, my son: A guide to healing after death, loss or suicide*. Atlanta: The Bolton Press.

Brent, D. A., Moritz, G., Bridge, J., Perper, J., & Canobbio, R. (1996). Long term impact of exposure to suicide: A three-year controlled follow-up. *Journal of American Academy of Child and Adolescent Psychiatry*, *35*(5), 646-653.

Calhoun, L., & Tedeschi, R. (1999). *Facilitating posttraumatic growth: A clinician's guide*. Mahwah, NJ: Lawrence Erlbaum.

Centre for the Advancement of Health. (2004). Report on bereavement and grief research: Centre for the Advancement of Health. *Death Studies*, *28*(6), 491-575.

Cerel, J., Jordan, J. R., & Duberstein, P. R. (2008). The impact of suicide on the family. *Crisis*, *29*(1), 38-44.

Clark, S. (1995). *After suicide: Help for the bereaved*. Melbourne: Hill of Content.

Datson, S., & Marwit, S. J. (1997). Personality constructs and perceived presence of deceased loved ones. *Death Studies, 21*(2), 131-146.

Davis, C. G., Wortman, C. B., Lehman, D. R., & Silver, R. C. (2000). Searching for meaning in loss: Are clinical assumptions correct? *Death Studies, 24*(6), 497-540.

DePrince, A. P., & Freyd, J. J. (2002). The harm of trauma: Pathological fear, shattered assumptions or betrayal? In J. Kauffman (Ed.), *Loss of the assumptive world* (pp. 71-82). New York: Taylor and Francis.

Hedtke, L., & Winslade, J. (2004). *Re-membering lives: Conversations with the dying and the bereaved*. Amityville, NY: Baywood.

Jamison, J. R. (1999). *Night falls fast: Understanding suicide*. London: Picador.

Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social Cognition – Journal of Social, Personality and Developmental Psychology, 7*(2), 113-136.

Janoff-Bulman, R., & Berg, M. (1998). Disillusionment and the creation of value: From traumatic losses to existential gains. In J. Harvey (Ed.), *Perspectives on loss: A sourcebook* (pp. 33-47). Philadelphia: Bruner/Mazel.

Jordan, J. R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior*, *31*(1), 91-102.

Jordan, J. R., & McMenamy, J. (2004). Interventions for suicide survivors: A review of the literature. *Suicide and Life-Threatening Behavior*, *34*(4), 337-349.

Kim, C. D., Séguin, M., Therrien, G., Riopel, G., Chawky, N., Lesage, A. D., et al. (2005). Familial aggregation of suicidal behavior: A family study of male suicide completers from the general population. *The American Journal of Psychiatry, 162*, 1017-1019.

Klass, D. (2006). Continuing conversation about continuing bonds. *Death Studies, 30*(9), 843-858.

Klass, D., Silverman, P. R., & Nickman, S. L. (1996). Concluding thoughts. In D. Klass, P. R. Silverman, & S. L. Nickman (Eds.), *Continuing bonds: New understandings of grief* (pp. 349-355). Washington: Taylor & Francis.

Landsman, I. S. (2002). Crisis of meaning in trauma and loss. In J. Kauffman (Ed.), *Loss of the assumptive world: A theory of traumatic loss* (pp. 13-30). New York: Brunner-Routledge.

Latham A. E., & Prigerson, H. G. (2004) Suicidality and bereavement: Complicated grief as psychiatric disorder presenting greatest risk for suicidality. *Suicide and Life-Threatening Behavior, 34*(4), pp. 350-363.

Linn-Gust, M. (2004). *Do they have bad days in heaven? Surviving the suicide loss of a sibling*. Albuquerque, NM: Chellehead Works.

Lukas, C., & Seiden, H. M. (1990). *Silent grief: Living in the wake of suicide*. London: Papermac division of Macmillan.

Marwit, S. J., & Klass, D. (1996). Grief and the role of the inner representation of the deceased. In D. Klass, P. R. Silverman, & S. L. Nickman, *Continuing bonds: New understandings of grief* (pp. 297-310). Washington, DC: Taylor & Francis.

Mitchell, A. M., Kim, M., Prigerson, H. G., & Mortimer, M. K. (2005). Complicated grief and suicidal ideation in adult survivors of suicide. *Suicide and Life-Threatening Behavior, 35*(5), 498-506.

Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer-Stephens, M. K. (2004). Complicated grief in survivors of suicide, *Crisis*, *25*(1), 8-12.

Murphy, S. A. (1996). Parent bereavement stress and preventive intervention following the violent deaths of adolescent or young adult children. *Death Studies*, *20*(5), 441-452.

Murphy, S. A., Johnson L. C., & Lohan, J. (2003). Finding meaning in a child's violent death: A five-year prospective analysis of parents' personal narratives and empirical data. *Death Studies, 27*(5), 381-404.

Murphy, S. A., Johnson, C., Wu, L., Fan, J. J., & Lohan, J. (2003). Bereaved parents' outcomes 4 to 60 months after their children's death by accident, suicide, or homicide: A comparative study demonstrating differences. *Death Studies, 27*(1), 39-61.

Nadeau, J. W. (1998). *Families making sense of death*. Thousand Oaks, CA: Sage.

Nadeau, J. W. (2000). Family constructions of meaning. In R. A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 95-111). Washington, DC: American Psychological Association.

Nadeau, J. W. (2001). Meaning making in family bereavement: A family systems approach. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequence, coping, and care* (3rd ed.) (pp. 329-347). Washington, DC: American Psychological Association.

Neimeyer, R. A. (1999). Narrative strategies in grief therapy. *Journal of Constructivist Psychology, 12*(1), 65-85.

Neimeyer, R. A. (2000a). *Lessons of loss: Guide to coping*. Clayton, VIC: Centre for Grief Education.

Neimeyer, R. A. (2000b). Searching for the meaning of meaning: Grief therapy and the process of reconstruction. *Death Studies*, *24*(6), 541-558.

Neimeyer, R. A. (2000c). The language of loss: Grief therapy as a process of meaning reconstruction. In R. A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 261-292). Washington, DC: American Psychological Association.

Neimeyer, R. A. (2001). Reauthoring life narratives: Grief therapy as meaning reconstruction. *The Israel Journal of Psychiatry and Related Sciences*, *38*(3/4), 171-184.

Neimeyer, R. A. (2002). Narrative disruptions in the construction of the self. In R. A. Neimeyer & J. D. Raskin (Eds.), *Constructions of disorder: Meaning-making frameworks for psychotherapy* (pp. 207-242). Washington, DC: American Psychological Association.

Neimeyer, R. A., Baldwin, S. A., & Gillies, J. (2006). Continuing bonds and reconstructing meaning: Mitigating complications in bereavement. *Death Studies*, *30*(8), 715-738.

Neimeyer, R. A., Botello, L., Herrero, O., Pacheco, M., Figueras, S., & Werner-Wilder, L. A. (2002). The meaning of your absence: Traumatic loss and narrative reconstruction. In J. Kauffman (Ed.), *Loss of the assumptive world: A theory of traumatic loss* (pp. 31-47). New York: Brunner Routledge.

Neimeyer, R. A., & Levitt, H (2001). Coping and coherence: A narrative perspective. In C. R. Snyder (Ed.), *Coping with stress: Effective people and processes* (pp. 47-67). New York: Oxford University Press.

Neimeyer, R. A., Prigerson, H. G., & Davies, B. (2002). Mourning and meaning. *American Behavioral Scientist*, *46*(2), 235-251.

Range, L. (1998). When a loss is due to suicide: Unique aspects of bereavement. In J. H. Harvey (Ed.), *Perspectives of loss: A sourcebook* (pp. 213-220). Philadelphia: Brunner/Mazel.

Range, L., & Calhoun, L. (1990). Responses following suicide and other types of death: The perspective of the bereaved. *Omega*, *21*(4), 311-320.

Rubin, S., Malkinson, R., & Witztum, E. (2003). Trauma and bereavement: Conceptual and clinical issues revolving around relationships. *Death Studies*, *27*(8), 667-690.

Runeson, B., & Asberg, M. (2003). Family history of suicide among suicide victims. *American Journal of Psychiatry*, *160*(8), 1525-1526.

Rynearson, E. K. (2001). *Retelling violent death*. Philadelphia: Brunner-Routledge.

Sands, D. (Producer and director). (2003). *The red chocolate elephants: Children bereaved by suicide* (DVD film). Sydney: Karridale.

Silverman, P. R., & Klass, D. (1996). Introduction: What's the problem? In D. Klass, P. R. Silverman, & S. L. Nickman (Eds.), *Continuing bonds: New understandings of grief* (pp. 3-27). Washington DC: Taylor & Francis.

Walter, T. (1996). A new model of grief: Bereavement and biography. *Mortality*, *1*(1), 7-25.

Walter, T. (1999). *On bereavement: The culture of grief*. Berkshire, UK: Open University Press.

Wertheimer, A. (1991). *A special scar: The experiences of people bereaved by suicide*. London: Routledge.

Wortman, C. B., & Silver, R. C. (2002). The myths of coping with loss revisited. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 405-429). Washington, DC: American Psychological Association.

Is Suicide Bereavement Different? The Experience of Support After Suicide

Louise Flynn
B.A., B.Ed(Couns), MAPS
Co-ordinator
Support After Suicide
Jesuit Social Services
PO Box 79
Richmond VIC 3121
Email:
louise.flynn@jss.org.au

Abstract

In recent years there has been discussion and debate on whether bereavement following suicide is somehow "different" to bereavement following other types of death. This article explores these issues and brings to the debate the practice experience of Support After Suicide, comprising work with over 500 people. We take the perspective that the experience of bereavement following suicide has particular and complex features that distinguish it from other types of bereavement. This article addresses the impact of suicide on identity and sense of self including: the experience of failure; the importance of being aware of the impact of stigma; the search for an explanation; young people and developmental issues; the impact on the social network and family relationships; and the increased risk of suicide.

Introduction

In recent years there has been discussion and debate around whether bereavement following suicide is "different" to other types of bereavement (Jordan, 2001; Ellenbogen & Gratton, 2001; Bailey, Kral, & Dunham, 1999). This article will explore this issue and bring the five years of practice experience of Support After Suicide to the discussion.

Briefly, Support After Suicide provides direct support in metropolitan Melbourne to those bereaved by suicide in the form of counselling, group programs and, activities for children and young people. The program also conducts education sessions for health, welfare and education professionals on the issues and experiences of those bereaved by suicide. This education component is conducted across rural and regional Victoria. Information and resources are also available to the bereaved and professionals on a recently launched website: www.supportaftersuicide.org.au.

While some of the literature has reached the conclusion that bereavement following suicide is no different to other forms of bereavement (van der Wal, 1989; McIntosh, 1993; Cleiren & Diekstra, 1995, quoted in Jordan, 2001), there is agreement among those who work with the bereaved that there are complex and unique features of bereavement following suicide that distinguish it from other types of bereavement (Knieper, 1999; Clark & Goldney, 2000; Jordan, 2001; Cvinar, 2005).

Why Would it be Different? The Act of Suicide

An important question to consider is: why would bereavement following suicide be different? Sands (2008) points out that the "essential difference between a suicide death and other types of death is that the death is the result of the intentional actions of the deceased …" (p. 47). The loss is not the result of illness, accident, misadventure or murder, but rather it is a self-inflicted, intentional, and deliberate action of the one who has died that has ended their life.

Suicide challenges, even violates, our basic human assumptions about the value of life, of survival and self-preservation (Jordan, 2001). This act of suicide then has numerous consequences for those left behind in terms of how they think about themselves (Cvinar, 2005), how they are viewed by others (Knieper, 1999) and their capacity to receive support (Cvinar, 2005). This intentional, self-inflicted act has a "complex psychological impact" on those left behind (Cvinar, 2005, p. 14).

How is it Different?

Because of the nature of the act, perhaps we can accept that bereavement following suicide will include responses or features that are particular and unique to it. We need to know more about these responses as there is a growing recognition in the literature that bereavement following suicide has the potential for adverse health outcomes including significant implications for mental health (Wilson & Clark, 2004).

Jordan (2001) outlines three thematic areas in which suicide bereavement differs from other types of bereavement. The first thematic area relates to the difficulty with understanding and making sense of the death. One of the ways this manifests is in the question: "Why? Why did they do it?"

The second thematic area is that people bereaved by suicide demonstrate higher levels of guilt, blame and feelings of responsibility for the death than other bereaved people. The bereaved may feel that they caused the death or that they should have been able to anticipate and so prevent it. Also, some in a family or social network may feel that others are blaming them for the death, particularly if a situation such as marital separation occurred prior to the death.

The third thematic aspect outlined by Jordan (2001) is that some people bereaved by suicide experience higher levels of rejection or abandonment by the deceased. For example, the bereaved may feel that there was something wrong with the relationship or that if the relationship had been better they would not have died.

In addition to these thematic aspects, Jordan (2001) described two other significant areas of impact on those bereaved by suicide. These are: the social processes that surround the bereaved, and the impact on the family.

The "social processes that surround the bereaved" refers to the feelings of isolation and stigmatisation that people bereaved by suicide often experience. Concern about being judged or perceived negatively, or that the deceased will be perceived negatively may result in bereaved people concealing the true nature of the death,

preferring to tell others that it was, for example, a heart attack or car accident.

As Jordan (2001) acknowledges, there is considerable evidence that people bereaved by suicide are viewed more negatively by themselves and others. This has serious implications in terms of social support, particularly as: "… interpersonal interaction and social support is frequently different and more problematic after a suicide death than after most other types of loss" (Jordan, 2001, p. 94).

The impact on the family after any death can be profound, however, there is some evidence that suicide has the potential to impact on communication patterns within a family, even when there were no significant issues before. The impact on communication may be a shutdown of communication, the development of conflict, destabilisation of family coalitions and disruption to the relationships that the family has with the larger social network. An additional concern is the increased risk of another suicide. There is evidence that the risk of suicide is increased in those close to the person who died, although it is not yet clear what factors "increase the predisposition towards suicide in a family system" (Jordan, 2001, p. 96).

Other writers in the field of suicide bereavement also highlight these areas as important issues and features of the experience of bereavement following suicide (Clark & Goldney, 2000; Barlow & Morrison, 2002; Ness & Pfeffer, 1990).

It is worth nothing that Wilson and Clark (2004) take a different perspective. They make the point that people bereaved through suicide generally have a higher incidence of predictors of poor bereavement outcome than groups bereaved through other modes of death. This increased risk is not related to the mode of death, but rather is related to the high prevalence of risk factors such as depression, the sudden and unexpected nature of the death, the traumatic nature of the death, and that it is a stigmatised death. They conclude that a suicide "identifies a population at risk of the complications of the grieving process as well as of further suicide" (p. 26). They reiterate that this is a group of people in need of effective care and support.

Whichever view we take, it is important to understand what is happening for those bereaved by suicide. What impact is the death of a loved one by suicide on those left behind? At Support After Suicide in Melbourne, we have supported over 500 people bereaved by suicide in the five years of operation. In this time, we have considered what we have learned from the people we have met and what seems to be creating the most difficulty for them in their grief trajectory. This article highlights the issues we believe have some particular salience to those bereaved by suicide.

The remainder of this article will focus on the impact of suicide on identity and sense of self; the experience of failure; the importance of stigma; the search for an explanation; young people and developmental issues; the impact on the social network and family relationships; and the increased risk of suicide.

These themes are a work in progress and they are not considered to be comprehensive, however, they go some of the way towards describing the practice wisdom developed at Support After Suicide.

These themes and their expression overlap, and provide some insights into the complex, changing, and lived experience of the suicide-bereaved person or family. Importantly, they enhance understanding, which may serve to inform support responses and services.

Identity and Sense of Self

One of the manifestations of grief that may be present in a person bereaved by suicide is the impact on the identity and sense of self. The bereaved person may experience the suicide as directly reflecting on them in some way; that it means something about them. This can be illustrated with the question, (*What does this mean about me?*); there can be a taken-for-granted assumption that the death reflects on and means something about those left behind.

So the suicide can, of itself, undermine a person's sense of self. Essentially, it can lead to a profoundly negative experience of self, identity and worth. One writer referring to the death of her father described suicide as not only a death, but also an "accusation" (Wickersham, 2008). That is, bereaved people can experience the death as very sharply saying something about them. This may also manifest in an acute experience of being rejected or abandoned by their loved one.

This impact on identity may also manifest as undermining the quality of the relationship prior to death. People bereaved by suicide may question if the relationship was as they thought it was (e.g., *I thought we were a close family, why couldn't she tell me she was feeling like this?*), or they may doubt the depth and value of the relationship (e.g., *He must not have loved me to have done this,* or *Why didn't he know I loved him?*).

This undermining experience and loss of confidence can also centre on the particular role-relationship the bereaved had with the deceased. For example, a parent may experience the suicide as a reflection on their parenting capacity; a partner may see it as reflecting on their value as a partner. Bereaved people may come to see themselves as poor parents, unlovable or unworthy partners and this can ripple outward into other relationships and areas of life.

The Experience of Failure

A key aspect of the experience of suicide bereavement that we have encountered at Support After Suicide, closely connected to this attack on identity and sense of self, is that there can be a painful and acute sense of failure. Many of those bereaved by suicide feel they have failed their deceased loved one; in fact the death itself can become "evidence" of the failure and a profound and debilitating guilt can result. This sets up a complex emotional and cognitive experience that is difficult to process as the bereaved's search for meaning and an explanation is undertaken.

Again, a parent, partner, sibling, child or friend can see themselves as having failed the person and the death is "proof", (i.e., *If I'd been a good parent, partner, etc., they would not have died)*. The bereaved person's "failure" has caused a death and this powerfully impacts on their emotional and cognitive experience of themselves and how they think others will see them. One bereaved mother described herself as feeling like a murderer; that she, as a parent, had killed her son and that others would see this and think this about her as well.

Again, this can result in the suicide-bereaved person experiencing a generalised "ripple effect" sense of failure across other areas of their lives. They may begin to lose confidence in social interactions, at work, and ultimately may withdraw from activities.

Stigma

It is important to be aware of the role that stigma plays in the experience of those bereaved by suicide. Cvinar (2005) says that bereavement following suicide is "complicated by the societal perception that the act of suicide is a failure by the victim and the family to deal with some emotional issue and ultimately society affixes blame for the loss on the survivors" (p. 14). One way of understanding the impact of suicide on identity and sense of self is as a consequence of the stigma that surrounds suicide. It is culture and society that affixes blame and responsibility to those left behind and this negative view can be taken up by the bereaved leaving them isolated. As Jordan (2001) says: "It seems plausible that the negative attitude toward suicide in our culture will be mirrored within the survivor" (p. 93). This has significant consequences for social support of those bereaved by suicide.

The Search for an Explanation

The person bereaved by suicide will often be grappling with the question: "Why?". There can be a search for an explanation, to understand the suicide and how it could have occurred. Seeking to find the explanation for the suicide can be accompanied by strong feelings of guilt and/or blame from others, and regret at acts or words of commission, or omission.

Part of this process may involve a person bereaved by suicide (or those around them) developing characterisations of the deceased, which either condemn and criticise or idealise and deem them heroic. For example, it is not uncommon for a person who has died by suicide to be described as selfish, weak or cowardly. Alternatively, they may be characterised as brave or strong for taking their own life. These form part of the effort of the bereaved and those around them to understand what has happened.

This search for an explanation may be a long-term and, at times, relentless and agonising activity that preoccupies the mind of the bereaved. It is important to take time to understand what may have lead to the suicide and avoid simplistic answers. Providing an effective response is compromised by simplistic understandings about suicide, the deceased and those left behind (Dunne, 1992).

Young People and Identity Development

As the family constellation is changed by suicide, the impact on each family member's sense of identity, and their role in the family, can be profound. After meeting with many families, we have considered the prospect that there are particular developmental issues in terms of identity for a young person, particularly when the parent of the same gender has taken their own life. This is important to be aware of when responding to young people.

For example, we can look at the impact on a teenage girl when her mother dies. To remain bonded and close to her mother, she may feel that it includes holding onto the option of taking her own life. To reject this option may be experienced as rejecting her mother, an act of disloyalty. This is complex territory for a young person to negotiate as they work with the developmental issues of identity, autonomy and independence.

Impact on Family and Social Relationships

In line with the work of Jordan (2001) and others, in our work at Support After Suicide, we have encountered the impact of suicide on family and social relationships.

If family members are experiencing feelings of guilt and responsibility for the death, this can have the effect of them withdrawing from one another, while blame and holding others responsible for the death can result in conflict and estrangement in relationships. Unfortunately, we have seen this on many occasions. So, communication between family members can become difficult and complicated. These difficulties are often experienced as additional losses and add to the suffering and distress of bereaved people. Guilt and blame may not be the only cause of difficulty for families; it may also be due to the need of family members to protect one another from pain and distress. Bereaved people may stop themselves speaking about their experience because they believe it will upset others. The research conducted by McMenamy et al. (2008) found that many people bereaved by suicide felt unable to discuss the suicide within their family or to share their grief with one another.

Risk of Suicide

Many of our clients at Support After Suicide speak about a desire to die and some speak strongly about the desire to end their own lives. This is often an expression of wanting to end the pain of grief, feeling that it is too much to bear. It can also be a desire to join with the person who has died. The literature supports the notion that being bereaved by suicide elevates the risk of suicide for those left behind (Ness & Pfeffer, 1990; Krysinska, 2003).

There is also discussion in the literature about why bereavement following suicide elevates the risk of suicide (Clark & Goldney, 2000; Krysinska, 2003). Krysinska summarises the literature by describing four mechanisms that might explain the increased suicide risk of those bereaved by suicide. These are: identification with the deceased, punishment for perceived self-blame, modelling within the family and belief in a family curse (e.g. *I will be next*). As Krysinska (2003) points out, it is likely that an interaction among a range of variables provides the best answer to this question.

One bereaved person told us that suicide had never been an option for her; it was not something she had ever considered. However, following the suicide death of someone close to her, she described how it was now a door in front of her that she could go through. So, where suicide had not been an option before, the suicide of a loved one had presented it as an option for her.

This phenomenon is frightening and difficult for those left behind. Many will be afraid of speaking about suicide to others, children in particular, as they fear this will further increase the risk (see Mitchell [2006] for information on communicating with children following

suicide). Suicide risk assessment as Jordan (2004) recommends is an essential component of working with those bereaved by suicide.

Conclusion

This article addresses, briefly, the perspective that Support After Suicide has developed in terms of the impact of suicide on identity and sense of self including the experience of failure; the importance of being aware of the impact of stigma; the search for an explanation; young people and developmental issues; the impact on the social network and family relationships; and the increased risk of suicide.

While this is not a complete list (issues such as the impact of trauma have not been addressed) it is hoped that this article furthers our understanding of the complex and difficult experiences of those bereaved by suicide. As we know, those bereaved by suicide "may be at risk for a prolonged and complicated bereavement trajectory, one that may be associated with high levels of mental health problems and psychological distress and impairment in functioning" (McMenamy, Jordan, & Mitchell, 2008, p. 384). It is important then to understand the complexity of this experience and how isolation and a lack of understanding and support so often characterise the experience of those bereaved by suicide.

Acknowledgments

The author wishes to thank Martin Ryan and Barbara Friday for their suggestions and feedback on this paper, and to acknowledge the Support After Suicide team: Barbara Friday, Felicity Elkiana, Brendan FitzGerald, Martin Ryan and Jen Trainor for their work with those bereaved by suicide.

References

Bailley, S. E., Kral, M. J., & Dunham, D. (1999). Survivors of suicide do grieve differently: Empirical support for a common-sense proposition. *Suicide and Life-Threatening Behavior*, *29*(3), 256–271.

Barlow, C., & Morrison, H. (2002). Survivors of suicide: Emerging counseling strategies. *Journal of Psychosocial Nursing and Mental Health*, *40*(1), 28–40.

Clark, S., & Goldney, R. (2000). The impact of suicide on relatives and friends. In K. Hawton & K. van Heeringen (Eds.), *The international handbook of suicide and attempted suicide* (pp. 467–484). Chichester, UK: John Wiley & Sons.

Cvinar, J. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care*, *41*(1), 14–21.

Dunne, E. (1992). Psychoeducational intervention strategies for survivors of suicide. *Crisis, 13*(1), 35-40.

Ellenbogen, S., & Gratton, F. (2001). Do they suffer more? Reflections on research comparing suicide survivors to other survivors. *Suicide and Life-Threatening Behavior*, *31*(1), 83–90.

Jordan, J. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior*, *31*(1), 91–102.

Jordan, J., & McMenamy, J. (2004). Interventions for suicide survivors: A review of the literature. *Suicide and Life-Threatening Behavior*, *34*(4), 337–349.

Knieper, A. (1999). The suicide survivor's grief and recovery. *Suicide and Life-Threatening Behavior*, *29*(4), 353–364.

Krysinska, K. E. (2003). Loss by suicide: A risk factor for suicidal behavior. *Journal of Psychosocial Nursing and Mental Health Services*, *41*(7), 34-46.

McMenamy, J., Jordan, J. R., & Mitchell, A. M. (2008). What do suicide survivors tell us they need? Results of a pilot study. *Suicide and Life-Threatening Behavior*, *38*(4), 375–389.

Mitchell, A. M., Wesner, S., Brownson, L., Dysart-Gale, D., Garand, L., & Havill, A. (2006). Effective communication with bereaved child survivors of suicide. *Journal of Child and Adolescent Psychiatric Nursing, 19*(3), 130-136.

Ness, D. E., & Pfeffer, C. R. (1990). Sequelae of bereavement resulting from suicide. *The American Journal of Psychiatry, 147*(3), 279-285.

Sands, D. C. C. (2008). A study of suicide grief: Meaning making and the griever's relational world. PhD thesis. University of Technology, Sydney, Australia. Retrieved 13 March, 2009, from http://hdl.handle.net/2100/777

Van der Wal, J. (1989). The aftermath of suicide: A review of empirical evidence. *Omega, 20*(2), 149-171.

Wickersham, J. (2008). *The suicide index: Putting my father's death in order.* Orlando, FL: Harcourt Publishers.

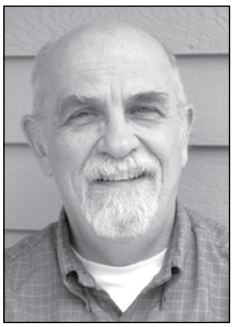
Wilson, A., & Clark, S. (2005). *South Australian suicide postvention project: Report to Mental Health Services, Department of Health*. Department of General Practice, University of Adelaide. Adelaide, Australia. Retrieved 19 November, 2007, from http://digital.library.adelaide.edu.au/dspace/handle/2440/24871

Australian Centre for Grief and Bereavement

The Australian Centre for Grief and Bereavement is delighted to announce that Dr. John R. Jordan will be the 2009 International Educator.

INTERNATIONAL EDUCATOR TOUR 2009

Dr. John R. Jordan, PhD.
Melbourne, Sydney, Canberra, Brisbane and Adelaide
23rd July – 7th August 2009



Dr. John R. Jordan, PhD -USA

The Australian Centre for Grief and Bereavement is delighted to announce that Dr. John R. Jordan will be the 2009 International Educator.

Jack Jordan is a licensed psychologist in private practice in Wellesley, MA, and Pawtucket, RI, where he specialises in working with loss and bereavement. He is also the founder and the Director until 2007 of the Family Loss Project, a research and clinical practice providing services for bereaved families. He has specialised in work with survivors of suicide and other losses for more than 30 years. As a Fellow in Thanatology from the Association for Death Education and Counseling (ADEC), Jack maintains an active practice in grief counselling for individuals and couples. He has run support groups for bereaved parents, young widows and widowers, and suicide survivors, with the latter running for over 15 years.

Jack is the Clinical Consultant for Grief Support Services of the Samaritans in Boston, where he is helping to develop innovative outreach and support programs for suicide survivors. Jack is also the Professional Advisor to the Survivor Council of the American Foundation for Suicide Prevention (AFSP), and a former Board member of AFSP (New England Affiliate) and ADEC. In 2006 Jack was invited to become a member of the International Workgroup on Death, Dying, and Bereavement, and was the recipient of the ADEC 2006 Research Recognition Award. Jack also received funding in 2004 from AFSP to begin a research project on the types of support and services needed by suicide survivors. He has also been working for several years on a research project to develop a new measure to help clinicians identify individuals at risk for complicated mourning.

Jack provides training for therapists, healthcare professionals and clergy through the American Academy of Bereavement, the American Foundation for Suicide Prevention, PESI Healthcare, and the Suicide Prevention Resource Center. He has published clinical and research articles in the areas of bereavement after suicide, support group models, the integration of research and practice in thanatology, and loss in family and larger social systems. He has published in professional journals such as *Omega*, *Death Studies*, *Suicide and Life-Threatening Behavior*, *Crisis*, and *Family Process*. He is the co-author of *After Suicide Loss: Coping with Your Grief*, a book on suicide bereavement for surviving friends and family. He is currently co-editing a new professional book on working with suicide survivors.

TIMES

9.30am – 4.30pm (both days)

COST PER PROGRAM

Standard rate	**$250.00 per day**
Student rate	**$220.00 per day**
ACGB Member rate	**$200.00 per day**

Morning tea, lunch and afternoon tea provided

Registration closes 10th July 2009 (Registration is essential)

MELBOURNE

Conference Centre
Holmesglen College of TAFE
Cnr Warrigal and Batesford Roads
Chadstone VIC 3148
Day 1 – 23rd July 2009
Day 2 – 24th July 2009

SYDNEY

The Vibe Hotel
111 Goulburn Street
Sydney NSW 2000
Day 1 – 27th July 2009
Day 2 – 28th July 2009

CANBERRA

UCU Conference Centre
Building 1
Kirinari Street
University of Canberra
Bruce ACT 2617
Day 1 – 30th July 2009
Day 2 – 31st July 2009

BRISBANE

Mercure Hotel Brisbane
85-87 North Quay
Brisbane QLD 4003
Day 1 – 3rd August 2009
Day 2 – 4th August 2009

ADELAIDE

Ayers House
288 North Terrace
Adelaide SA 5000
Day 1 – 6th August 2009
Day 2 – 7th August 2009

A detailed copy of our Programs and Services 2009 can be downloaded at **www.grief.org.au**

australian centre for grief and bereavement

"Jordan is a consummate clinician, an approachable guy, an experienced trainer and an intelligent advocate and consumer of 'research that matters', being strongly disposed to bridging the worlds of science and practice"

- Robert A. Neimeyer, Ph.D., Department of Psychology, University of Memphis.

PROGRAM 1

21st Century Approaches to Grief Counselling and Therapy

Throughout the past decade a substantial body of research from a diversity of disciplines has combined with clinical practice to advance our knowledge of the bereavement experience, its manifestation, and effective responses to this complex human experience. This day will commence with a review of new perspectives in grief and loss. This workshop will provide an overview of several issues at the cutting edge of bereavement theory. These include the movement to develop a new diagnostic category related to grief (Complicated or Prolonged Grief Disorder), new findings about the role of resilience in bereaved populations, and the rethinking of the role of a continuing bond with the deceased as an important factor in the healing process. It will also examine the recent controversy about whether and for whom grief counselling is helpful. Dr. Jordan will then offer observations about the assessment of complicated grief and the key roles that grief counsellors can play for the bereaved. These ideas will be informed with clinical examples from his practice of grief counselling for over 30 years. The workshop format will include didactic lecture, case discussion, and audio-visual presentation. Dr. Jordan's teaching style emphasises interaction with the audience, and throughout the day, discussion with the audience will be encouraged.

Learning Outcomes:

At the conclusion of this workshop participants will have:

- Enhanced their understanding of recent development in bereavement theory
- Considered the implications of these new developments for the practice of bereavement support
- Enhanced their skills to both identify and treat complicated bereavement
- Reflected on the various roles played by a grief counsellor in the healing process, and the implications of that for their own clinical practice.

"Jack Jordan is one of those experts in the death and dying field who can integrate solid theory with realistic practice. His case examples are useful to practitioners but at the same time he challenges us to question what we think we know and learn new things. He is a skilled teacher and his sense of humor is far from terminal."

- Janice Winchester Nadeau, Ph.D., L.P., L.M.F.T., C.F.L.E., R.N.

PROGRAM 2

Traumatic Loss: Bereavement After Sudden, Unexpected, and Violent Death

Bereavement after the sudden, unexpected, and violent death of a loved one often creates an extraordinarily difficult healing journey for survivors. This type of traumatic loss results in a combination of the trauma and grief responses in human beings. This day will provide an overview and update on what we know about the impact of traumatic deaths such as suicides, homicides, and accidental deaths. The day will begin with a brief exploration of the significant changes in our understanding of the mourning process that are emerging from new bereavement models and research findings. The implications of these new ways of viewing grief for understanding the response to traumatic loss will be discussed. We will also investigate new intervention models that are developing within the fields of traumatology and thanatology that have implications for traumatic loss mourners. General clinical guidelines for working with the traumatically bereaved will be presented. While drawing primarily on the presenter's extensive experience working with survivors of suicide loss, the information presented will have applicability to clinical work with people who have lost a loved one to any type of sudden or violent death. The workshop will be informed by research and clinical experience, and will include the use of didactic lecture, case discussion, audiovisual presentation, reflective writing exercises, and discussion with fellow workshop participants.

Learning Outcomes:

At the conclusion of this workshop participants will have:

- Examined differences and similarities in trauma and complicated grief responses
- Explored prominent psychological themes that are common for individual and survivors of traumatic loss
- Identified risk and protective factors for the development of traumatic grief responses
- Explored several promising new treatment techniques for complicated and traumatic grief
- Incorporated guidelines for work with traumatic loss survivors into their clinical practice
- Reflected upon the impact of work with traumatic loss survivors on clinician self-care.

If you would like to register or require any further information please contact the Australian Centre for Grief and Bereavement on (03) 9265 2100 or email info@grief.org.au

Upcoming Conferences for the Association for Death Education and Counseling

June 21-25, 2011

9th International Conference on Grief and Bereavement in Contemporary Society and

ADEC 33rd Annual Conference

InterContinental Miami, Miami, Florida, USA

April 7-10, 2010

ADEC 32nd Annual Conference

Death, Dying and Bereavement:
It's All About the Story

Hyatt Regency Crown Center
Kansas City, MO, USA

The abstract submission site for this conference has now opened and a call for Concurrent Session and Poster Abstracts has been made. Visit the conference site at: http://www.adec.org/conf/index.cfm

Keynote speakers will include:

Britt Hysing-Dahl, a pioneer within the field of hospice and palliative care in Norway. She is currently a clinical social worker at Bergen University Hospital working with seriously ill and dying patients. She is the CEO of the Norwegian Society Western Norway, CEO of the largest nursing home in Norway and City Counsellor of Bergen.

Thomas Lynch, essayist, poet and funeral director of Lynch & Sons funeral home in Milford, Michigan. He is regularly featured on the op-ed page of *The New York Times*, *The Boston Globe* and *The Times* of London.

Robert Neimeyer, PhD, is professor and director of psychotherapy research in the Department of Psychology, University of Memphis. Prof. Neimeyer is editor of two respected international journals, *Death Studies* and the *Journal of Constructivist Psychology* and a former president of ADEC. The author of over 300 articles and book chapters, he is currently working to advance a more adequate theory of grieving as a meaning-making process.

GriefMatters

The Australian Journal of Grief and Bereavement

Calling for submissions

Grief Matters: The Australian Journal of Grief and Bereavement is looking for articles relating to grief, loss, and bereavement around the following themes:

- Death of a Child or Adolescent
- Death of an Adult Child
- Bereavement in a Palliative Care Context
- Grief and Bereavement and Road Fatalities
- Grief and Bereavement Support in a Group Context
- Traumatic Bereavement
- Grief, Loss, and Bereavement in Relation to Disasters
- Workplace Grief
- Creative Expressions of Grief
- Companion Animal Loss
- Storied Grief: Grief Narratives
- Displacement and Isolation: The Grief of Immigrant, Refugee, and Indigenous Peoples.

These themes are broad and tentatively titled. The editorial board is open to broad interpretations within the Journal's scope. Articles should have a practice/applied focus, be around 3,000 words in length with an abstract of approximately 125 words.

Please email submissions, expressions of interest, and further suggestions for themes to the Journal Production Editor, Natalie Coish, at: **n.coish@grief.org.au**

GriefMatters
The Australian Journal of Grief and Bereavement

australian centre for grief and bereavement

Advertising Rates 2009

Please place a tick in the appropriate box indicating the size of the advertisement:

❑	Quarter page	207 x 74mm	$75.00
❑	Half page	207 x 148mm	$140.00
❑	Full page	207 x 297mm	$220.00
❑	Insert *	207 x 297mm	$250.00

(price inclusive of GST) * Printed and provided by client at client's cost.

Organisation: _____

Contact person: _____

Address: _____

_____

Telephone: _____

Email: _____

Deadline dates for all advertising material:

Autumn issue (published in April)	28 February
Winter issue (published in August)	30 June
Summer issue (published in December)	31 October

Payment details

Cheques to be made payable to the Australian Centre for Grief and Bereavement and posted, along with details of advertisement or copies of insert, to:

Natalie Coish
Journal Production Editor
Australian Centre for Grief and Bereavement
McCulloch House
Monash Medical Centre
246 Clayton Road
Clayton VIC Australia 3168

❑ **Credit Card** ❑ **Bank Card** ❑ **Mastercard** ❑ **Visa**

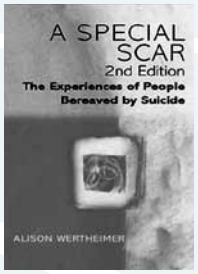
Cardholder's Name _____ Signature _____

Card No. _____ Expiry Date _____

Contact details

Telephone: +61 3 9265 2100
Freecall: 1800 642 066
Facsimile: +61 3 9265 2150
Email: griefmatters@grief.org.au
Web Address: www.grief.org.au

Book Reviews



A Special Scar: The Experiences of People Bereaved by Suicide

Alison Wertheimer (2001)
270pp. ISBN: 978-0-415-22027-9
London, UK: Routledge
AUS $61.00 (inc. GST)

In 1991, Alison Wertheimer interviewed 50 suicide-bereaved individuals of varied ages, backgrounds, and loss circumstances. Using that data, along with her own personal experience of suicide bereavement, she has written an open and frank book that details common issues for survivors of suicide.

She discusses aspects both common and uncommon, highlighting the stigmas experienced by survivors. These include personal issues of grief and practical problems found when dealing with local authorities, such as the police and coroner, counsellors and mental health professionals, as well as other relatives/friends and the wider community. It enlightens the reader, detailing what survivors face in their own words, which is remarkably useful, given (as the book asserts), the stigmatic societal withdrawal of survivors and their reluctance to seek help.

Wertheimer's discussion highlights the universal nature of elements of suicide bereavement, contrary to individuals' common belief that their pain and circumstances are unique.

While it is a great book for counselling and therapy practice, this book is also notable as a resource for non-practitioners. The book is written clearly, without jargon, in an easy to follow format that allows the reader an understanding of suicide bereavement from initial grief (or earlier, if there is previous history of mental illness) through to residual pain many years later.

Notably, anecdotes from participants are handled respectfully, only relevant detail is quoted, and case histories are summarised sensitively and succinctly without sensationalism.

Most of the first edition content remains. Facts made redundant by recent research have been removed, new sections for counselling practice have been added, and other sections updated. Even relevant content that may seem outdated has been addressed with additional commentary.

This amounts to a book that is extremely well researched and suitable for practitioners and academics, as well as survivors, and is a fascinating introduction to anyone interested in suicide bereavement.

Natalie Coish
Journal Production Editor, Grief Matters
Australian Centre for Grief and Bereavement
Clayton, Victoria.

Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications

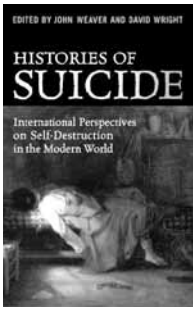
Amy Wenzel, Gregory T. Brown, & Aaron T. Beck (2009)
377pp. ISBN: 978-1-4338-0407-6
Washington, DC: American Psychological Association
US $69.95

The shadow of suicide is often present amidst the clients of those who work with loss and grief, which makes this book a resource and reference of interest. Written by three accomplished suicide researchers and clinicians (including senior author Aaron Beck, renowned for his cognitive approach to depression), *Cognitive therapy for suicidal patients* is a rich source of suicide research, cognitive theory, and therapeutic methods based on 35 years of experience. While the book focusses primarily on work with those who are suicidal and/or have attempted suicide, it should be relevant to any practitioner whose clients struggle with suicide.

There are three sections. Part 1 presents an impressively comprehensive summary of the scientific literature about suicide and suicide interventions, and should be of interest to those seeking a strong evidence base for their suicide-related practice. In Part 2, the cognitive theory underpinning the authors' intervention approach is outlined, followed by descriptions of the intervention's four phases. The authors note that, "for the first time, we present our cognitive model of suicide behaviour, which serves as a blueprint for therapy and research" (p. 10). Work around risk assessment, safety planning, goal setting, cognitive and behavioural strategies, and relapse prevention is detailed. Particularly helpful are examples from the "Janice" case throughout this section, with specific client-clinician interactions that illustrate clearly the cognitive-based work. Also included are such practical tools as a comprehensive suicide risk framework; a safety plan template; examples of "coping cards"; and a relapse prevention protocol checklist. Part 3 examines how the cognitive protocol can be applied with the special populations of adolescents, older adults, and people with substance dependence disorders.

These highly respected authors argue strongly for the efficacy of cognitive therapy in reducing suicidal ideation and the probability of relapse. They offer sound evidence for their approach and clear guidelines for practitioners. For these reasons, this book merits consideration.

Michael Bull
Senior Lecturer
School of Social Work
Flinders University
Adelaide, South Australia



Histories of Suicide: International Perspectives on Self-Destruction in the Modern World

John Weaver & David Wright (Eds.) (2009)
336pp. ISBN: 978-0-8020-9632-6
Toronto, Canada: University of Toronto Press
US $29.95

This book points out at its onset that suicide is one of the leading causes of death, with more than one million suicides in total reported each year. The rate of completed suicides has risen dramatically in the Western world since World War II, particularly amongst young men and aboriginal peoples. This edited book purports to be the first to examine the history of suicide in a range of different international context chapters on countries including France, South Africa, Canada, Japan, Soviet Russia, Peru, and the United States.

The chapters in this book were previously papers at an international conference held at McMaster University in Hamilton, Ontario in Canada in August 2006. This is an interdisciplinary collection from historians, anthropologists, sociologists and health economists. The goal would appear to be to understand suicide in the past, thereby assisting us to unravel its mysteries in the present. Themes that recur across the chapters of the book include the representations of mental illness implicit in suicide, the medicalisation of suicide, disputes among the psychiatric profession about suicide, and the relative frequency of suicide amongst soldiers. The only chapter in the book featuring Australia is the last, which provides a detailed examination of murder-suicide in Queensland from 1890 to 1940.

The editors acknowledge that the history of suicide is often about competition amongst discourses, yet its humanistic aspects are acknowledged in the book including: "... distraught families [being thrown] into the worst sort of financial and emotional maelstrom" (p. 12).

Whilst it is important that those who are assisting those are bereaved by suicide have a knowledge of suicide, its incidence and particularly the multilayered complexity of its causes, this book's detailed and scholarly coverage of the historical background of suicide would only be of peripheral interest to those in helping professions.

Martin Ryan
Former Associate Professor
School of Social Work and Social Policy
La Trobe University, Melbourne
Currently a counsellor/community educator
Support After Suicide, Jesuit Social Services
Richmond, Victoria.

Abstracts

Jordan, J. R. (2008).

Bereavement After Suicide

Psychiatric Annals, 38(10), 679-686.

There are many complex and unique issues surrounding suicide bereavement. This article briefly reviews the literature that discusses the issues faced by suicide survivors, defined here as those people who are significantly and negatively impacted by a sudden death within their social network (family, friends, colleagues, etc.). Several areas of interest are examined, the first of which discusses the impact of suicide, and how it relates to and differs from other types of bereavement. The author compares literature that disagree in their conclusions of whether suicide bereavement does differ from bereavement by other types of death, arguing there is much evidence to suggest that it does differ, despite not always registering on standard psychotherapy measures.

The second of these areas is thematic issues faced by suicide survivors, such as guilt and responsibility; shame, stigma, social isolation and familial relational disturbance; perceived rejection/abandonment by the deceased; trauma symptoms; and complicated grief and suicide ideation.

The third area relates to specific interventions designed for suicide survivors, and argues that there is a dearth of actual studies that have been undertaken; details and compares those studies that have been, and makes recommendations for the future.

The fourth area discussed relates to guidelines for clinicians working with suicide survivors, such as issues of dealing with the family and other survivors of the deceased; as well as instances where the clinician becomes the survivor, when the deceased had been a patient prior to their death.

The author concludes that while not all people who are exposed to suicide will require intervention, evidence noticeably suggests that suicide is still one of the most devastating modes of death. Care professionals need to be aware of the complexities and challenges survivors face, and also need to be extra vigilant when treating this highly vulnerable group. The author argues for more research into current resources for suicide support, and for the development of specifically targeted intervention programs for survivors.

Mitchell, A. M., Kim, Y., Prigerson, H. G., Mortimer, M. K. (2005).

Complicated Grief and Suicidal Ideation in Adult Survivors of Suicide

Suicide and Life-Threatening Behavior, 35(5), 498-507.

This exploratory pilot study aims to examine any association between complicated grief and suicide ideation. Previous research has shown complicated grief to be greater in survivors of suicide than in relation to other forms of death, but no research has been done into how complicated grief factors into suicide ideation in adults. The authors build on previous studies of complicated grief's possible association with suicide ideation that examined young adult survivors of adolescent suicide as well as the elderly and spouse-bereaved.

The study comprised of 60 participants, all of whom were pre-intervention, and had been bereaved by suicide within the previous month. Data was self-reported by the subjects and using the Inventory of Complicated Grief and the Beck Depression Inventory.

First the data was compared to gauge the effect of depression on suicide ideation. Second, the data was entered to compare the effect of complicated grief on suicide ideation. Third, both data relating to depression and complicated grief were entered separately into the model and gauged for suicide ideation. In the last instance, when both were entered simultaneously, even after depression was a factor significant effects of complicated grief on suicide ideation remained; suggesting that complicated grief has an effect independent than that of depression.

The authors also argue their study found no link between previous psychiatric history and complicated grief, contrary to common suggestion.

The authors conclude that after depression is taken into account, participants presenting complicated grief were 9.68 times more likely to be vulnerable to suicide ideation. They call for more research into the association between complicated grief and suicide ideation in adults bereaved by suicide, acknowledging that this particular study was exploratory, and limited by its small, homogenous sample using voluntary participants.

Mitchell, A. M., Wesner, S., Garand, L., Dysart Gale, D., et al. (2007).

A Support Group Intervention for Children Bereaved by Parental Suicide

Journal of Child and Adolescent Psychiatric Nursing, 20(1), 3-14.

Bereaved children of parents who have committed suicide are a neglected special risk group. The authors argue that well-intentioned adult attempts to spare children the trauma of discussing the death circumstances often result in children's need for grief support being ignored after suicide bereavement.

There is evidence to suggest denying children access to grief support at the time of the bereavement is more likely to increase the risk of psychiatric disorders and social problems occurring later in life. They cite a Campbell study in which participants unanimously agreed support during their childhood would have been beneficial.

Drawing on Yalom's work on theoretical group models, the authors offer a theoretical framework for an 8-week support group intervention program tailored specifically for child-aged parental suicide survivors. To emphasise the workability of this model, they discuss its use in an outpatient psychiatric clinic in the US, in the Children's Survivors of Suicide (SOS) Bereavement Support Group.

The group, which comprises of 6-8 children aged between 7 and 13 years, meets for 8 sessions, and each session is focussed on a particular goal, using group discussion and art therapy methods.

The authors discuss the importance and appropriateness of substituting drawing activities for certain adult grief work, as children this age are too young and not emotionally developed enough to be able to fully articulate their emotions and grief processes.

They conclude that group support is particularly useful for children, enabling them to both express their feelings and develop skills to cope with their loss. By comparing to the progress of other children who are similar to themselves, children can learn to understand death as well as suicide specifically. The authors also suggest that future research is needed to evaluate the effectiveness of such programs.

Programs and Services

The Australian Centre for Grief and Bereavement is located at McCulloch House, Monash Medical Centre, 246 Clayton Road, Clayton, Victoria. The Centre provides a range of programs and services to both individuals and organisations. These include:

Consultation and Advice

Centre staff are available for consultation on grief and bereavement issues. These may include advice on program development, staff training, client issues and evaluation. A flexible fee structure has been developed for consultation, which takes the type of organisation into account.

Clinical Supervision

Clinical supervision for those who work in bereavement support is essential. Centre staff are available to take on a limited number of supervisees on a regular basis. Both individual and small group supervision is available for a moderate cost.

Bereavement Counselling and Support Service

The Australian Centre for Grief and Bereavement has a confidential bereavement counselling service which is available to people who have been bereaved through any cause. This service is provided by experienced counsellors participating in advanced training in bereavement counselling. These counsellors are closely supervised by experienced accredited grief and bereavement practitioners.

Counselling appointments can be made by telephone and should be made directly by the bereaved person.

Contact the Bereavement Counselling and Support Service on (03) 9265 2111. The service is located at McCulloch House, Monash Medical Centre, Clayton, Victoria.

Research

The Australian Centre for Grief and Bereavement acknowledges that research is essential in the development of best practice in grief and bereavement education, support and clinical interventions.

The Centre conducts its own research in addition to collaborative national and international research projects.

Referral

The Australian Centre for Grief and Bereavement has a referral database and can put agencies and individuals in touch with private bereavement educators and counsellors. This referral database is comprised of professional educators and counsellors who specialise in grief and bereavement. For referrals to private grief counsellors phone the Centre's Bereavement Counselling and Support Service on (03) 9265 2111.

Education and Training Programs

The Australian Centre for Grief and Bereavement offers quality education and training opportunities for health professionals, interns, students, volunteers and any other individual or agency wanting to incorporate counselling, therapy, support and education into their current work practice.

Membership

Membership of the Australian Centre for Grief and Bereavement offers a range of benefits including receipt of *Connections* members' newsletter (issued twice yearly), *Grief Matters: The Australian Journal of Grief and Bereavement* (issued three times per year), special discount member rate for ACGB seminars, workshops and ACGB products, access to ACGB library for research purposes, discount on most books at Open Leaves Bookshop, free member functions and voting rights at the Annual General Meeting. Membership rates and details are as follows:

2009 Fees

Individual Membership	**$99.00**
Organisational Membership	**$250.00**
Student & Concessional Membership	**$77.00**

The above prices include GST - Australia only

Further information on the Australian Centre for Grief and Bereavement can be obtained by

Telephone	(03) 9265 2100
Freecall	1800 642 066
Facsimile	(03) 9265 2150
Email	info@grief.org.au
Website	www.grief.org.au

Instructions to Authors

The Editor welcomes submissions for publication in *Grief Matters: The Australian Journal of Grief and Bereavement* that match the journal's aims and scope.

Scope

The journal publishes work that encompasses both academic and applied aspects of grief and bereavement.

Grief Matters: The Australian Journal of Grief and Bereavement is published three times a year in Autumn, Winter and Summer. Three research articles appear in each edition and are not to exceed 3,000 words.

It is a condition of publication that papers have not previously been published, nor are currently under consideration for publication elsewhere.

Preparation and submission of manuscripts

In preparing manuscripts, contributors should follow the rules set forth in the *Publication Manual of the American Psychological Association* (5th ed.).

For more detailed information on the submission of manuscripts contact:

The Editor
Grief Matters: The Australian
Journal of Grief and Bereavement
Australian Centre for Grief and Bereavement
McCulloch House
Monash Medical Centre
246 Clayton Road
Clayton Vic 3168
or by Email at: griefmatters@grief.org.au

The Internet

Internet Access

The Australian Centre for Grief and Bereavement has developed a home page for access on the internet, and includes information about the Centre's activities, resources and a range of grief and bereavement information. Entries include information about education activities offered during the current semester, an order form for resource materials available for purchase, details about the Bereavement Counselling and Support Service and information from Bereavement Support Services in Victoria (a list of agencies and organisations which provide free or low cost bereavement counselling, support and services). Direct access is also available from the home page to other grief and loss sites.

The URL for the Centre is: www.grief.org.au

Grief Matters Subscriptions 2009

Individual Subscribers

(i.e. paid for by an individual subscriber for personal use)

Australia

Within Victoria: (includes membership of the Australian Centre for Grief and Bereavement) $99.00

Student/Concessional rate: (details of card number must be provided) $77.00

Outside Victoria: $88.00

Overseas: A$110.00

Libraries and Organisations

(e.g. hospitals, departments, colleges, hospices, companies; paid for by organisation and/or for multiple readership)

Australia

Within Victoria: (includes membership of the Australian Centre for Grief and Bereavement) $250.00

Outside Victoria: $150.00

Overseas: A$170.00

(The above prices include GST - Australia only)

Grief Matters: The Australian Journal of Grief and Bereavement is published three times a year in Autumn, Winter and Summer. All prices are inclusive of airmail postage. Payment must be in Australian dollars and may be made by cheque, money order or credit card (MasterCard, Visa, and Bankcard).

Australian Centre for Grief and Bereavement McCulloch House
Monash Medical Centre 246 Clayton Road, Clayton Victoria 3168
Telephone +61 3 9265 2100 **Freecall** 1800 642 066 **Facsimile** +61 3 9265 2150
Email griefmatters@grief.org.au **Web Address** http://www.grief.org.au