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Is Suicide Bereavement Different? A Reassessment of the Literature

JOHN R. JORDAN, PHD

The question of whether suicide bereavement is different from mourning after other types of deaths has important theoretical and clinical implications. Some recent literature reviews have argued that the differences may be minimal. In contrast, this article suggests that suicide bereavement is distinct in three significant ways: the thematic content of the grief, the social processes surrounding the survivor, and the impact suicide has on family systems. In addition, problems in the methodology used to compare different bereavement experiences are addressed. Some clinical implications of these conclusions, including the need for homogeneous support groups, psychoeducational services, and family and social network interventions are also discussed.

It would seem obvious that surviving the death of a loved one from suicide is a difficult experience, one that has the potential to produce a markedly different type of mourning process from other types of losses. Certainly, mourning after the suicide of a loved one is often perceived by the survivor to be a very different experience from the losses of other mourners (Alexander, 1991; Bolton, 1983; Wertheimer, 1991). A consensus of clinicians and researchers also indicate that the mourning process after suicide is different and more difficult than mourning after other types of deaths (Clark & Goldney, 1995; Hauser, 1987; Knieper, 1999; Rando, 1993; Range, 1998; Sprang & McNeil, 1995; Worden, 1991). Yet several researchers who have recently reviewed the literature argue that there may be few, if any, empirically documented differences between suicide bereavement and other types of mourning. For example, van der Wal (1989–1990) concluded that "there is no empirical evidence for the popular notion that survivors of suicide show more pathological reactions and a more complicated and prolonged grief process than other survivor groups" (p. 167). More recently, Cleiren and Diekstra (1995) have suggested that "it is unlikely that the symptomatology of problematic adaptation in suicide bereavement differs from that of other types of bereavement" (p. 31). They note that the symptom patterns common in suicide bereavement are also found in other types of traumatic loss, even in some losses due to illness. McIntosh (1993) also reached similar conclusions in his literature review of the more methodologically rigorous investigations where suicide survivors are compared to survivors of other types of death. He suggested four generalizations about survivors: (a) There appear to be more similarities than differences between suicide and other types of survivors (particularly sudden-death survivors); (b) there may be a small number of grief reactions that are different for survivors, but these are not yet clearly established; (c) the course of suicide bereavement may differ over time; (d) but after the 2nd year, the re-

JOHN R. JORDAN, PHD, is the Director, Suicide Grief Support Program, The Trauma Center, Allston, Massachusetts.

Address correspondence to John R. Jordan at The Trauma Center, 14 Fordham Road, Allston, MA 02134; E-mail: jjordan50@aol.com.

actions observed in suicide bereavement seem to show few differences from the mourning trajectory for other types of losses.

What are we to conclude from the apparent contradiction between the perceptions of people who are bereaved by suicide and the clinicians who work closely with them, and researchers who study survivors from a greater distance with the tools of social science? The question has important theoretical and practical implications for caregivers who wish to help suicide survivors. For example, the suicide of a loved one is commonly described as a risk factor for the development of complicated mourning (Rando, 1993), and special clinical services are frequently recommended for survivors (Knieper, 1999). Yet if grief after suicide is not different from other types of bereavement, then there may be little rationale for partitioning out survivors for additional monitoring or specialized interventions. On the other hand, if we can identify what is different about suicide from other losses, yet common to most or all suicide bereavement, we should be able to plan more targeted and effective interventions for this population. This article is written in response to the recent reviews that argue that suicide bereavement is not fundamentally different from other types of mourning. While acknowledging that it shares many elements common to other forms of loss, this article argues that bereavement after suicide is sufficiently distinct to merit additional research and specialized clinical services for most suicide survivors. The goals are to summarize the empirical support for the themes that set suicide bereavement apart from other forms of grief, the distinct aspects of social processes after a suicide, and the differential impact of suicide on family systems. Methodological problems in suicide bereavement research and the clinical implications of the differential bereavement experience after suicide will also be addressed.

THEMATIC ASPECTS OF SUICIDE BEREAVEMENT

Although reviewers such as Cleiren and Diekstra (1995), McIntosh (1993), van der Wal (1989–1990) are correct in noting that the evidence for quantitative differences between suicide and other types of bereavement is mixed, there is also considerable evidence that the qualitative or thematic aspects of the grief may be different after a suicide (Clark & Goldney, 1995; Cleiren, 1993; Dunn & Morrish-Vidners, 1987–1988; Ness & Pfeffer, 1990; Range, 1998; van der Wal, 1989–1990). These special themes of suicide bereavement manifest themselves in three broad areas of grief response. First, numerous studies have found that survivors seem to struggle more with questions of meaning making around the death ("Why did they do it?") (Grad & Zavasnik, 1996; Silverman, Range, & Overholser, 1994–1995; Smith, Range, & Ulmer, 1991–1992; van der Wal, 1989–1990). Because suicide is self-inflicted and violates the fundamental norms of self-preservation, survivors often struggle to make sense of the motives and frame of mind of the deceased. Second, survivors show higher levels of feelings of guilt, blame, and responsibility for the death than other mourners ("Why didn't I prevent it?") (Cleiren, 1993; Demi, 1984; Kovarsky, 1989; McNiel, Hatcher, & Reubin, 1988; Miles & Demi, 1991–1992; Reed & Greenwald, 1991; Silverman et al., 1994–1995). Occasionally, survivors feel that they directly caused the death through mistreatment or abandonment of the deceased. More frequently, they blame themselves for not anticipating and preventing the actual act of suicide (Cleiren & Diekstra, 1995). Third, several studies indicate that survivors experience heightened feelings of rejection or abandonment by the loved one, along with anger toward the deceased ("How could they do this to me?") (Barrett & Scott, 1990; Reed, 1998; Reed & Greenwald, 1991; Silverman et al., 1994–1995; van der Wal, 1989–1990). Of special note is a recently published study that compared suicide, accidental, and expected and unexpected natural modes of death (Bailley, Kral, & Dunham, 1999). This large sample study found convincing empirical evidence for differences between suicide survivors and other types of mourners for all three of these thematic areas, including heightened feelings of respon-

sibility and rejection, greater difficulty making sense of the death, and greater overall grief reactions. It seems evident from these studies that there are qualitative aspects of the mourning process that are more intensified and frequently more problematic for survivors of suicide loss than for other types of mourners. These common themes in suicide bereavement may distinguish it from other losses, regardless of the measured intensity of the grief or psychiatric symptoms. These studies challenge the sweeping and overly simplified conclusions made by some observers that there are few differences between suicide and other types of bereavement (Cleiren & Diekstra, 1995; McIntosh, 1993; & van der Wal, 1989–1990).

SOCIAL PROCESSES SURROUNDING SUICIDE SURVIVORS

The most comprehensive review to date of research on suicide survivors (McIntosh, 1993) did not address the issue of the impact of the social network on survivors. Yet there is considerable evidence that survivors feel more isolated and stigmatized than other mourners and may in fact be viewed more negatively by others in their social network. Research on the social response to suicide has attempted to ascertain whether survivors are perceived in a different and more negative fashion than mourners with a different type of loss. Separate reviews of the literature by Calhoun and Allen (1991) and Stillion (1996), and recent individual studies such as the one by Allen, Calhoun, Cann, and Tedeschi (1993), have generally shown that "individuals bereaved by suicide tended to be viewed as more psychologically disturbed, less likable, more blameworthy, more ashamed, more in need of professional mental health care, and more likely to remain sad and depressed longer" (Calhoun & Allen, 1991, p. 100). Thus there is considerable evidence that the general stigma that continues to be associated with suicide in our society "spills over" to the bereaved family members. It is important to note that these negative attitudes toward survivors may not directly result in differential treatment of survivors by the community. Instead, it is possible that many people genuinely wish to help the survivor but also feel uncertain and uncomfortable about how to provide support (Calhoun, Selby, & Abernathy, 1986; Dunn & Morrish-Vidners, 1987–1988). This awkwardness and hesitation may then be communicated to survivors, and misinterpreted as rejection (Range, 1998).

Beyond the problem of their perception by others, it is equally important to ask how suicide survivors view themselves. It seems plausible that the negative attitude toward suicide in our culture will be mirrored within the survivor. This is an important point, because even if others feel and demonstrate compassion for the mourner, the survivor may assume or fear that others are judging them negatively and therefore withdraw or otherwise act in ways that inhibit social support efforts from others. Dunn and Morrish-Vidners (1987) have referred to this process as "self-stigmatization" (p. 177). For example, Van Dongen (1993) found that suicide survivors worried more about what others really thought of them, felt uncertain about how to act and what to share with others, and believed that community members were likewise uncertain about how to behave around them. Range and Calhoun (1990) found that suicide bereavement subjects felt more pressure than natural death survivors to explain the cause of death and reported that others treated them differently after the death. Strikingly, 76% of those bereaved by accidental death reported that the changes in social interaction were positive in nature, compared with only 27% of the suicide survivors. These authors also report that survivors were the only group that reported lying to others about the cause of death (44% of subjects). Other studies report similar findings (Bailley et al., 1999; McNiel et al., 1988), including the observation that suicide survivors received significantly less emotional support than natural death survivors for their feelings of depression and grief, and confided less in members of their social networks (Farberow, Gallagher-Thompson, Gilewski,

& Thompson, 1992). Wagner and Calhoun (1991–1992) and Cleiren (1993) did not find quantitative differences in the perception of support, though the qualitative (i.e., interview) data of the former suggested that survivors felt pressure to recover faster and that only other survivors could actually understand their experience. Lastly, Séguin, Lesage, and Kiely (1995) found survivor families to be more vulnerable and hypothesized that survivors tended to withdraw from their social network out of shame, causing others, in turn, to pull away out of feelings of frustration and rejection by the survivor. We can summarize these several points about suicide bereavement and social support by noting that there is considerable evidence that suicide survivors are viewed more negatively by others and by themselves. It seems probable that both of these factors operate to interfere with the support process after a suicide (Van Dongen, 1993), depending on the personalities and attitudes towards suicide of the survivor and members of their social networks. Taken together, these studies suggest that interpersonal interaction and social support is frequently different and more problematic after a suicide death than after most other types of loss.

THE IMPACT OF SUICIDE ON FAMILY SYSTEMS

The loss of an immediate member to death almost always has an impact on the functioning of a family system. Unfortunately, when compared with studies of individuals, there is a dearth of research on the differential effects of bereavement (including suicide) on family functioning. Questions such as the impact of death on family communication patterns, conflict resolution, cohesion and intimacy, intergenerational relations, and family developmental tasks have been largely ignored (McNiel et al., 1988). Nonetheless, there is considerable clinical evidence, and at least some empirical data, suggesting that a suicide may be more difficult for the family unit than death from natural causes. This may hold true in several ways.

Family Interaction Patterns

The preexisting interactional patterns of some families in which a suicide occurs may be different from other families, and the suicide itself may contribute to dysfunctional family dynamics. Although by no means present in all cases, there is evidence that families of many suicidal people (particularly suicidal children and adolescents) show more disturbed family interactional styles and increased disruptions of attachments when compared with families without a suicidal member (Brent, 1995; McIntosh, 1987; Moscicki, 1995; Samy, 1995). Adam (1990) emphasized that a dysfunctional family environment can operate as both a predisposing element in the early psychosocial development of suicidal persons and as a precipitating factor in a suicide death. Reviews by Adam (1990) and Blumenthal (1990) have also determined that suicidal adults often show increased rates of childhood physical and sexual abuse, and parental loss or deprivation in their history. Given these consistent findings of elevated rates of family pathology prior to a suicide, it seems plausible that some dysfunctional families might continue to be at the same, or perhaps even greater, risk after the suicide. This risk includes an increased chance of a subsequent suicide of another family member at some future point (see below).

Even when family functioning may have been within a normal range prior to the suicide, there is some evidence that suicide by itself has the potential to warp family patterns and contribute to the development of psychiatric disorder in surviving family members. For example, in a controlled study of the impact of adolescent suicide on peers, siblings, and parents, Brent and his colleagues (Brent, Moritz, Bridge, Perper, & Canobbio, 1996) found higher rates of depression in survivor siblings and mothers

than in controls at 6 months after the death. They also found continuing elevated rates of depression in survivor mothers at one year, and elevated rates of grief in siblings (particularly younger siblings) at 12 and 37 months post death. In an uncontrolled qualitative study, Dunn and Morrish-Vidners (1987–1988) found that twice as many survivors in their small sample reported that relationships with family members (and friends) became more distant after the suicide than reported an increase in closeness. In contrast, when they compared bereavement after suicide, illness, and accident in a small sample, Nelson and Frantz (1996) did not find statistically significant differences in family variables. However, suicide survivor families did show poorer scores in the expected direction on such variables as enmeshment, conflict, and cohesion. McIntosh (1987) noted three themes that may be common in families with child survivors after parental suicide: information/communication distortion (hiding the true circumstances of the death), guilt, and identification with the deceased. The creation of a powerful family secret around the suicide may have devastating longer term effects on the openness of family communication about many emotionally charged issues, leaving the family in a vulnerable position should another traumatic or shame ridden event occur later on (Walsh & McGoldrick, 1991). Jordan, Kraus, and Ware (1993) have also identified several aspects of family interactions that may be affected by the death of a member, including the shutdown of open communication, disruption of role functioning of family members, development of conflict around differences in bereavement coping styles, destabilization of family coalitions and intergenerational boundaries, and disruption of relationships between the family and its larger social network. This group also emphasizes the long-term impact of losses, particularly traumatic deaths such as suicide, on family developmental processes, communication patterns, and the transmission of a family world view to future generations. These "sleeper effects" may make future separations more difficult for the family to negotiate. Jordan and his colleagues (Bradach & Jordan, 1995; Jordan, 1991–1992) have found preliminary empirical support for the negative intergenerational impact of traumatic losses on family systems. Other personal and clinical accounts of the long term impact of loss on families, particularly suicide, have reported similar effects (Treadway, 1996; Walsh & McGoldrick, 1991). Sleeper effects of traumatic deaths such as suicide have received very little empirical investigation yet may be one of the most important dimensions by which suicide deaths differ from other types of losses (Dunn & Morrish-Vidners, 1987–1988).

Heightened Risk for Additional Family Suicide

Suicide bereavement is an unusual form of mourning experience, because losing a loved one to suicide may elevate the mourner's own risk for suicidal behavior and completion (Blumenthal, 1990; Cleiren, 1993; Fekete & Schmidtke, 1996; Lester, 1994; Moscicki, 1995; Ness & Pfeffer, 1990; Roy, 1992). There are at least two possible explanations for this phenomenon. First, interpersonal loss and disruption of attachments from any cause (including, but not limited to, bereavement) appear to elevate the risk for suicidality (Heikkinen, Aro, & Lonnqvist, 1993; Moscicki, 1995). The impact of interpersonal loss appears to be particularly strong when a history of substance abuse is present in the potential suicide victim (Brent, 1995; Murphy, 1995). Reviewing research on the long-term impact of childhood parental loss, Adam (1990) found strong and consistent support for the notion that early parental loss is also associated with later suicidal behavior. Loss has also been linked to increased vulnerability to the psychiatric disorders that may be highly associated with suicidality, such as major depression and anxiety disorder in adults (Brown, 1998; Jacobs, 1999). To summarize, bereavement or interpersonal loss in childhood or adulthood from any cause is a risk factor for increased suicidality, both directly as a proximal precipitant for

suicide and indirectly through the creation or exacerbation of psychiatric illness in survivors.

Beyond the general influence of bereavement, suicide survivors may be at increased risk as a result of familial factors, both genetic and environmental, that may increase the predisposition towards suicide in a family system. There is evidence that genetic factors can predispose people towards the development of psychiatric disorders that are associated with suicide, particularly depression and bipolar disorders (Kety, 1990; Moscicki, 1995). There may also be a specific inheritable biological factor that increases the chances of suicide (Brent, 1996; Roy, 1992). Psychological and family systems variables may also play a role in the familial transmission of suicide. As noted previously, suicide has been associated with family factors such as disorganization and breakup, substance abuse, intrafamily violence, and sexual abuse. The dynamics of some families may also be "suicidogenic," displaying scapegoating, guilt induction, and hostility toward a member that contributes to the eventual suicide (Samy, 1995). To the extent that these dysfunctional patterns contributed to one suicide, they may also increase the suicide risk for other surviving family members. In addition, exposure to suicide, particularly for young people, may increase the chances of suicidality in the exposed person (Blumenthal, 1990; Diekstra & Garnesfski, 1995; Moscicki, 1995). This modeling effect, by which suicide becomes an acceptable "solution" to intrapsychic and interpersonal problems, may have a powerful influence in some families, particularly on children as they develop into adults.

DIFFERENT IN WHAT WAY: METHODOLOGICAL ISSUES IN SUICIDE BEREAVEMENT RESEARCH

There may be a number of ways that some of the unique effects associated with suicide grief are not detected in studies that use conventional methods and measures to assess bereavement outcome. These include the type of research methodology and outcome criteria employed, the other types of losses used for comparison with suicide bereavement, the possibility of relief from some stressors after a suicide, and the longer term versus near-term impact of this type of death.

Categories of Bereavement Outcome Criteria

Most studies of bereavement utilize easily quantifiable self-report measures as outcome criteria for comparing bereavements. These measures typically assess psychiatric symptoms (depression, anxiety, or posttraumatic stress disorder) or global measures of social, medical, and occupational functioning. Although relevant, these are not the only way to evaluate outcome for survivors. Simple quantitative measures of grief may not detect some of the thematic or qualitative differences noted previously, such as the heightened feelings of guilt and preoccupation with the question of why the death occurred. These are more likely to be observed in qualitatively based research methodology that allows research participants to explain their experience to the researcher in their own words (Neimeyer & Hogan, 2001). For example, studies by McNiel and colleagues (1988) and Wagner and Calhoun (1991–1992) both found differences between suicide and other types of survivors in their interview data, but not in their quantitative data.

There is also growing empirical evidence for a distinct form of grief that has been termed traumatic grief (Jacobs,1999; Prigerson et al.,1999). Prigerson, Jacobs, and their colleagues have empirically demonstrated that traumatic grief is a syndrome that is distinct from depression and anxiety (Prigerson et al.,1996), and that is predictive of mental and physical outcome for the bereaved, including suicidal ideation (Prigerson et al.,1997). If this new diagnostic entity holds up after further empirical testing, then standard outcome measures used to assess other psychiatric problems will not be ade-

quate to measure this disorder. To date, no studies have assessed whether suicide survivors differ from other mourners on this important dimension. Nonetheless, it seems likely that traumatic grief is one likely sequelae of a suicide. To summarize, studies that compare suicide bereavement to other types of losses by using only quantitative (as opposed to qualitative) measures, and that assess only general aspects of functioning (as opposed to suicide specific domains) may fail to detect differences that emerge with measures and research methods intended to specifically assess suicide grief. Without these types of studies, we may mistakenly conclude that there are no differences in the mourning process between suicide and other types of losses. With them, we may be able to tease out some of the subtle but important distinctions that have significant treatment implications for caregivers (Bailley et al.,1999).

Suicide versus Other Traumatic Loss

Many of the controlled studies attempting to ascertain whether suicide bereavement is different compare suicide with another type of traumatic death, most commonly accidental death. Several of these studies report that accidental and suicide deaths produce similar types of bereavement reactions, sometimes in contrast to natural death losses (Bailley et al., 1999; Barrett & Scott, 1990; Grad & Zavasnik, 1996; McIntosh & Kelley, 1992; McNiel et al., 1988; Miles & Demi, 1991–1992; Range & Calhoun, 1990; Ulmer, Range, & Smith, 1991). This similarity of response between suicide and other traumatic deaths makes clinical sense and may account for some of the apparent "washing out" in many studies of a distinct effect related to suicide as a mode of death. It is possible that the unique features of traumatic deaths, when present in suicide or in any other traumatic loss, account for much of the variance in bereavement outcome in comparison to natural causes of death. If this is true, then it may be useful to conceptualize suicide as one example of the more general class of traumatic deaths that are likely to be associated with complicated mourning. Accordingly, our research efforts may need to be concentrated on the common characteristics of bereavement after all traumatic death, as well as the unique characteristics of suicide bereavement.

The Relief Effect after Suicide

Cleiren (1993), Grad and Zavasnik (1996), and Reed (1998) all found that many of the suicidally bereaved families in their studies had a long history of problems with the deceased, who often exhibited chronic psychiatric problems, aberrant behavior, and in some cases, previous suicide attempts. Cleiren (1993) noted that these families would most probably show heightened stress (and elevated levels of symptoms), even if the suicide had not occurred. He also observed that relief was as common in suicide survivor families as in those where the loved one had died after a long-term illness. In the same vein, some studies have found that for a sizable number of families, the death of their loved one to suicide was not completely unexpected (Cleiren & Diekstra, 1995; Grad & Zavasnik, 1996). These findings indicate that the families of many (though not all) suicide completers have experienced a difficult and often lengthy ordeal of living with an emotionally disturbed and self-destructive person. In such cases, it seems plausible to suggest that the death of such a member may sometimes reduce the overall stress levels in the family, however painful the loss may be for the survivors. Likewise, if the death was to some extent anticipated (or perhaps feared), this may attenuate some of the shock effects associated with other types of sudden, traumatic deaths. In short, there may be a "relief effect" for some survivors (Calhoun, Selby, & Selby, 1982) that makes the grief a mixed experience of negative emotions, such as guilt, rejection, abandonment, and sorrow, coupled with relief at not having to cope with the destructive behavior of the loved one. Those who experience this relief effect may have a different course of mourning, showing a diminution of stress-related psychiatric

symptoms when compared to families where the prior relationship with the deceased was less disturbing. Symptom levels in this group may be similar to individuals who experience less traumatic losses, masking the impact of suicide on survivors who are more severely traumatized by the death. Again, this seems particularly likely if the criteria used for bereavement outcome are simply self-report measures of psychiatric symptoms. Nonetheless, many of the thematic and qualitative aspects of suicide bereavement, such as heightened guilt and anger at being abandoned, may still be present, even if the death is in some ways a relief. Whenever possible, future research on suicide bereavement should attempt to assess the extent to which the death may have been anticipated by the survivors, and the degree to which the stress levels in the family have decreased as a result of the death. Suicide survivors are probably not a homogeneous group (Bailley et al., 1999), and the relief effect may be one important variable that differentiates survivors from one another.

Time Frame of Research on Suicide Bereavement: Sleeper Effects

Research on bereavement resulting from different modes of death has produced conflicting findings as to whether differences increase or decrease with time. For example, several studies have found that any initial differences due to modality of death disappeared 2–4 years after the death (Barrett & Scott, 1990; Cleiren, 1993; Demi, 1984). These studies would seem to suggest that over time the pattern of mourning from different types of losses tends to converge to a common pathway. In contrast, Thompson, Futterman, Farberow, Thompson, and Peterson (1993) found that the course of mourning for suicide survivors actually diverged from natural death survivors over time, such that suicide survivors took much longer for symptoms to abate and remained higher on some dimensions (anxiety) up to 30 months after the death. Kovarsky (1989) found that although initially being lower than for accidental death survivors, the measured grief intensity of suicidally bereaved subjects stayed the same or even increased over time.

Given this conflicting data, we cannot say definitively whether the longer term trajectory of suicide bereavement is the same or different from that of other types of losses. Echoing this idea, Dunn and Morrish-Vidners (1987–1988) noted that there is a dearth of knowledge about the longer term, existential impact of suicide on survivors. For example, suicide (as well as other forms of trauma) may disrupt the assumptive world or cognitive schemas of survivors about their sense of the safety, efficacy, and personal worthiness (Janoff-Bulman, 1992). The impact of these profound changes in core belief systems on developmental processes in survivors has been largely ignored in empirical suicide bereavement research yet may be a crucial factor that distinguishes this type of loss from more normative bereavement experiences.

CLINICAL IMPLICATIONS

What are the clinical implications of these four points? Are specialized interventions warranted for suicide survivors, and, if so, how would they differ from other types of bereavement services? First, it is probably best to make support services for survivors homogeneous with regard to mode of death. Given the special thematic aspects of suicide bereavement, and the demonstrated stigmatization that many survivors perceive in their social networks, groups limited to suicide survivors seem likely to cohere more quickly and to avoid a replication of the empathic failure that too often occurs for survivors in their larger social networks. Although not always feasible for economic or logistical reasons, whenever possible suicide survivors should be offered the opportunity to interact with other suicide survivors, not just other mourners.

Second, with the elevated risk of suicidality associated with survivorship, management of survivors must include not only

support for their grief but also proactive monitoring of their risk for psychiatric disorders and suicidality. Unfortunately, most bereavement support programs do not systematically monitor the participants' risk for development of these problems. Given the demonstrable link between the suicide of a member and the increase in risk for other family members, it is disappointing that so little research or clinical attention has been paid to postvention with survivors as a potentially effective form of prevention of future suicides.

Third, support services should provide psychoeducational resources that help educate survivors about the nature of suicide and suicide bereavement. Making sense of the suicide of their loved one is a major recovery task for survivors. Compared to other forms of mourning, suicide survivors typically spend much more energy trying to comprehend the reasons for the death, the motivations of the deceased, and the appropriate allocation of responsibility for the suicide. Support services should provide many structured and informal opportunities for survivors to learn more about suicide, and to put the death in a larger perspective. Psychoeducational presentations, reading materials, and discussions with mental health professionals and other survivors can all be of use in this process.

Fourth, support services should target the interface between the survivor and their social network. Because the research suggests that many survivors feel stigmatized and withdraw from friends and family, survivors often need help in dealing with the social aftermath of a suicide. Although many bereavement support services include some discussion of social problems, few programs systematically target this important issue, let alone attempt to intervene directly in the survivor's social network through psychoeducational and network type interventions (Provini, Everett, & Pfeffer, 2000). Discussion of specific coping skills and interpersonal tactics for dealing with stigma and shame should be offered, and interventions targeted directly at the larger social network should be included whenever possible. The latter could include psychoeducational materials and meetings designed to support and educate those who are directly supporting the mourner.

Lastly, although the case can be made that all bereavement services should be directed toward family systems, this seems particularly true for suicide survivors. Given the increased risk of additional suicides, the damaging ramifications for family communication and developmental processes, and the special difficulties of children who lose a family member to suicide, the facilitation of adaptive family emotional functioning throughout the mourning process is crucial. As mentioned previously, effective postvention with suicidally bereaved families may be one of the most important forms of multigenerational prevention available to mental health professionals.

Given the present state of our knowledge, perhaps the fundamental question posed by this article, "Is suicide bereavement different?" cannot be definitively answered at this time. There is a need for additional information about the mourning process in general and suicide bereavement in particular, before targeted interventions for this population can be designed with any degree of specificity. Nonetheless, there is more than enough evidence that suicide bereavement is different from other types of losses to justify the continuing inquiry into comparative bereavement responses. Likewise, there is a great need to develop and test interventions that address the special needs of suicide survivors. Although some general treatment techniques may be of great help to some survivors (Knieper, 1999), there is still almost a complete absence of empirically validated interventions that specifically address the thematic, social, and family system problems noted in this article. Based on the additional knowledge and increased clinical awareness that such efforts will foster, future programs can be designed that provide focused, effective, and compassionate help for survivors as they travel their difficult journey after the death of a loved one to suicide.

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