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**Coping and Meaning Making Following Suicide Bereavement:
Perspectives from Survivors and Practitioners**

Jesse David Henneberry

Thesis submitted to the
Faculty of Human Sciences
In partial fulfillment of the requirements
For the MA degree in Counselling and Spirituality: Individual Counselling

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ABSTRACT

This aim of this study was to gain a better understanding of the experience of suicide bereavement and how coping and meaning making occurs. Additionally, the use of spirituality as a means of coping and making sense of suicide was studied. This is a new area that has been previously unexamined in suicide bereavement research. Using the methodology of transactional phenomenology, the experience of suicide bereavement was studied from the perspectives of those bereaved by suicide, mental health practitioners who work with the bereaved, and a cross-over group of survivors who were also practitioners. Results show that survivors and practitioners are in agreement on many aspects of coping and meaning making following suicide bereavement. However, there are also instances where these groups provided differing insights. Perspectives between groups are compared and several best practices when working with those bereaved by suicide are presented and discussed.

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DEDICATION

I dedicate this thesis to my father, David Francis Henneberry, who passed along his love of music, and taught me the value of education as a means of opening doors to new opportunities. I love and miss you. “Keep your stick on the ice.”

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LITERATURE REVIEW

A. Introduction

In the early morning hours of what was a warm June summer's day I was awoken at 5am by a frantic telephone call from my mother.

"Your father is... dead..." she sobbed. The line went quiet for several seconds, feeling more like several hours.

"What happened?" I asked.

"He did something with a gun. He's ...dead..." she repeated, adding *"I'm at your Grandmother's house. The police left an hour ago. Come home."*

I packed a bag and within the hour I was on a Greyhound bus homeward bound to attend my father's funeral. On the bus, in between what little sleep I could get, I remember thinking, *"What does this all mean?"*
~ Jesse Henneberry, 2009.

.....

"We who lived in concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken from man but one thing: the last of human freedoms- to choose one's attitude in any given set of circumstances, to choose one's own way" ~ Viktor Frankl, *Man's Search For Meaning*, p. 86.

.....

"In many ways, survivors are actively involved and contribute to a better understanding of suicide and its prevention. Suicidology without the involvement of survivors would be poor suicidology. Suicide prevention without survivors would be poor prevention." ~Karl Andriessen, *Can Postvention Be Prevention? Crisis: The Journal of Crisis Intervention and Suicide Prevention*. 30(1) p. 46.

Emile Durkheim (1951) notes that suicide is the fatal outcome of an act which a person directly or indirectly engages in, resulting in the end of his or her life. Suicide has often been called a 'victimless crime' however, as with any death, there are always at least two parties involved- the person who has died, and the person who is now mourning this loss (Colt, 2006, p. 455). Andriessen defines someone who is bereaved by suicide, or a suicide survivor, as "a person who has lost a significant other (or a loved one) by suicide, and whose life is changed because of the loss" (2009, p. 43). While suicide can often be an individual act, its result is anything but isolated. The families of those who take their lives are not only left behind to grieve and carry on, but they are also left with the immense task of comprehending the reason for their loved one's death (Cerel, Jordan & Duberstein, 2008). Any type of death is a tragic thing to have to go through. Regardless of whether a death is caused by suicide, cancer or old age, it will lead to a grieving and bereavement process for those who are left behind.

B. Suicide Bereavement in the Context of General Grief and Bereavement

Robert Kastenbaum (2007) defines bereavement as the process when someone close to us dies, which conveys the idea of a forcible separation, in which an essential and supportive relationship is lost. Regardless of how a person dies there will likely always be a bereavement process for those who are left behind. Bereavement, Kastenbaum says, leads to grief, which he notes as one's painful response to bereavement. While the concepts of bereavement and grief are universal, the process of grieving is very individualistic, often encompassing the survivor's thought patterns, eating and sleeping habits, and generally how they make it through the day. When experiencing the loss of a parent for example, different family members may grieve this loss in different ways. One family member may react in

anger, lose their appetite, and be unable to sleep, while another family member may avoid others, have a greater appetite and sleep more often.

Not only can grief responses differ between individuals, but Kastenbaum (2007) also notes that grief can be further categorized following more difficult forms of bereavement. These further categories include complicated grief, traumatic grief, unresolved grief and hidden or disenfranchised grief. *Complicated Grief* occurs when the bereaved person is unable to move beyond feelings of shock and pain resulting from the loss (Kastenbaum, 2007, p.356). This often happens when an individual who is bereaved suffers a death in which “their reactions involve an intrusive and a distressing set of core symptoms which include yearning, longing for, and searching” (Mitchell, Kim, Prigerson & Mortimer-Stephens, 2004, p. 13). *Traumatic Grief* is an immobilizing response to an often unforeseen and, frequently violent death which is seldom easy to make sense of. Due to the nature of certain deaths, traumatic grief can often manifest into a complicated grief reaction. *Unresolved grief* happens when the resulting loss of a vital relationship is never absolutely resolved. The survivor in this case may move on with his or her life, but he or she will never be the same. Lastly, *Hidden or Disenfranchised Grief* occurs when the grieving process is delayed because the person who is bereaved is deprived of the chance to express their feelings concerning his or her loss. Such grief occurs because the individual either wants to keep their feelings to themselves, believing that such feelings are inappropriate to discuss, or because the individual is not considered “entitled” to such feelings by others (Kastenbaum, 2007, p. 357).

The grief associated with suicide bereavement would likely fit into Katsenbaum’s above mentioned grief subcategories. Suicide bereavement may lead to complicated grief,

traumatic grief, unresolved grief and hidden or disenfranchised grief. For example, a study by Currier, Holland & Neimeyer (2006) showed a link with loss by suicide and complicated grief. In the study 1056 participants who had experienced a violent loss, either to suicide, homicide, or accidental death, completed a survey on complicated grief. The study found that these cases of violent loss led participants to experience higher levels of complicated grief and a lesser ability to make sense of the loss (Currier et. al., 2006). The study concluded by stressing the importance of clinicians being able to help such clients gain greater meaning following violent loss in order to minimize the effects of complicated grief.

C. Suicide Bereavement: A Unique Grief

There is still much debate as to whether suicide bereavement is somehow different from other types of bereavement. Callahan (2000) found in a study of 210 survivors of suicide that there was no difference between suicide bereavement and other types of bereavement; however, many authors say a death to suicide is different from other deaths due to the associated stigma and feelings of guilt.

There has been a long history of a “fear of contagion” that discussing suicide will promote others to kill themselves. Nineteenth century medical literature often reprimanded the press to limit reporting suicide out of this fear. Rather than saying a person hung themselves, for example, a paper may have reported the person “died of a short illness” (Leonard, 2001). Such stigma may still be present today. Cvinar (2005) notes that those who grieve following suicide bereavement experience a unique form of societal stigma associated with suicide. In many cases those bereaved by suicide may be fearful of reporting that their loved one died by their own hand. In a study by Wong, Chan & Beh (2007), 40.6% of 150 survivors of suicide in Hong Kong expressed not wanting others to know the “true cause of

death” (p. 185). Knieper (1999) has also found both a “stigma and avoidance” reaction from others to be the main difference of suicide bereavement. Worden (1991) says that because society stigmatizes suicide, this is correlated to feelings of shame for those who are left to grieve the loss. The result is the “essential isolation” of the person bereaved by suicide with their grief. Feelings of stigmatization of this nature may also contribute to hidden or disenfranchised grief that has been previously mentioned.

Worden (2009) also notes that guilt is a common feeling that the families of suicide victims must deal with. While he notes that guilt is a normal reaction in any death, he adds that in suicide bereavement guilt feelings can be “seriously exacerbated” (Worden, 2009, p.181). Besides increased stigmatization and guilt there may also be heightened levels of depression, and anger in this group of mourners. McMenemy, Jordon & Mitchell (2008) gave a needs assessment survey to 65 adult survivors of suicide. Eighty-four percent of participants indicated a very powerful sadness and longing for the deceased (p. 377). Other common reactions that were reported included high levels of guilt and depression, and moderate to high levels of anxiety, anger, irritability and difficulties sleeping (p. 379). One third of participants also indicated they experienced high levels of shame and stigma. Difficulties also came up in talking about the suicide with family members and friends, feeling isolated from family and friends, and difficulties handling questions from others about the suicide (p. 379). Barriers preventing survivors from receiving support included depression, a lack of information as to where to find resources, a reluctance to ask for help, and a concern over what others would think (p. 381).

Besides feelings of stigmatization, shame and guilt, several studies have found that the overall mental and physical health of suicide survivors is generally poorer following loss

by suicide when compared to those grieving other losses. de Groot, de Keijser & Neeleman (2006) found three months following death, 153 relatives of 74 suicide victims had poorer self reported mental and physical health compared to 70 relatives of 39 natural deaths (p. 418). A Finnish study by Saarinen, Hintikka, Viinamäki, Lehtonen, & Lönnqvist (2000) found that six months after their loss, half of a sample of 104 survivors reported feeling depression and guilt. Additionally, half of the survivors reported a need for professional help, yet only one in four actually sought help. A ten year follow up of this sample found that these suicide survivors experienced greater mental health problems than the general Finnish population. It may be possible that the stigma associated with suicide may act as a barrier preventing survivors from seeking treatment, thus leading to an increase in difficulties in both mental and physical health. Adult mourners of suicide victims are not the only ones to experience difficult symptoms following death- children and adolescents have also been shown to struggle. Compared to control subjects, children and adolescents who are bereaved by suicide have been found to be at a higher risk for developing post traumatic stress disorder, major depressive disorder, and panic disorder (Sethi & Bhagrava, 2003).

With all this in mind, there is a definite need to alleviate the stigma associated with suicide to ensure that the bereaved can ask for help should they feel it necessary. Hall & Epp (2001) note that suicide survivors must acknowledge their pain and both professionals and non-professionals in mental health should be working to ensure that the bereaved can tell their stories and have them normalized (p.75). As barriers to receiving support play a role in how the survivor copes following the suicide, it is necessary to better understand, and make available, the best possible postvention to survivors. Traditional passive models of postvention require survivors to find support on their own, such as being given support group

brochures at a funeral home, or placing ads in the newspaper (Cerel & Campbell, 2008, p.30). Conversely, an active model of postvention provides outreach to the survivor as close as possible following the death i.e. support services, crisis intervention and referrals to all potential survivors at scenes of the suicide (Cerel & Campbell, 2008).

Individuals who receive an active postvention model following loss by suicide have been found to present sooner for treatment, are more likely to attend group survivor meetings, and appear more involved in treatment than those that receive passive postvention (Cerel & Campbell, 2008). Both bereavement specific group work and social group postvention for widowed female survivors of suicide has helped these survivors experience reductions in depression, grief, psychological distress and an increase in social adjustment (Constantino, Sekula & Rubinstein, 2001). This may be due to the fact that if suicide bereavement is related to disenfranchised grief, then any group interaction for survivors (either purely social or bereavement specific) can have healing effects.

Without social support, which can help provide significance for an event, individuals often fall back on themselves when coping. However, to cope in isolation may be an overwhelming challenge (Pargament, 1997). As a result of a lack of social support and a sense of alienation, survivors may be hesitant to discuss or even acknowledge the death with others. Additionally, friends or other relatives of those bereaved by suicide may not know what to say. Often they may rely on the survivor's initiative before offering to help, or talk about the loved one who took his or her life (Pompili, Lester, De Pisa, Del Casale, Tatarelli & Girardi, 2008).

D. Coping Following Bereavement: A Response to Stress

Regardless of the type of death that one is grieving the individual who is bereaved will generally go through some type of coping process to help deal with his or her loss. The bereavement and grieving process for any type of death can be highly stressful, however Lazarus and Folkman (1984) note that such stress often results in a coping process within the individual. In their book *Stress, Appraisal and Coping*, the authors forward their own transactional model of coping. In this model Lazarus and Folkman say that “stress is neither in the environment nor in the person but a product of their interplay” (p. 354). People are not merely passive recipients of environmental difficulties, but can actively shape their environments as a response to stressful stimuli. A particular grief response towards death may be a choice that the bereaved individual can introduce on his or her environment. A person can choose how they react when faced with death, and this in itself can be a means of coping.

From this view, coping is not merely seen as a lifelong pattern of hardwired behavior, nor as a reaction to aversive environmental stimuli, but rather as “a shifting process in which a person must, at certain times, rely more heavily on one form of coping, say defense strategies, and at other times on problem-solving strategies, as the status of the person-environment relationship changes” (Lazarus & Folkman, 1984, p. 142). Under this perspective a person's emotional reactions to an event may be seen as much more fluid and in constant motion with his or her environment. A very important part of this transactional perspective, which allows this person-environment dynamic to take place, is how an individual interprets an event as stressful through a cognitive appraisal (Lazarus & Folkman, 1985, p. 295). Cognitive appraisals are an “evaluative process” which helps determine to

what extent the transaction between the person and their environment is stressful (Lazarus & Folkman, 1984, p. 23). Shortly after the death of a loved one, a person may conclude that the death is extremely painful for them; however a year later they may re-evaluate this same situation and find it to be much less difficult. By constantly re-appraising their environment, the individual can begin to understand its implications on their wellbeing, particularly in terms of what meaning or significance the situation has for the person. This focus on what meaning an event has on the person has major implications for their emotional and behavioral coping responses to his or her environment (Lazarus & Folkman, 1984, p. 52).

E. The Importance of Meaning Making/Making Sense

Taylor (1983) notes that when a person is cognitively adapting following a threatening event, this process has three components: (1) a search for meaning following the experience, (2) an effort to recover mastery over the specific event and more generally over one's own life, and (3) an attempt to reinstate self-esteem (p. 1161). Specifically discussing the search for meaning following a threatening experience, Taylor defines meaning as:

an effort to understand the event: why it happened and what impact it has had. The search for meaning attempts to answer the question, 'What is the significance of the event?' Meaning is exemplified by, but not exclusively determined by, the results of an attribution search that answers the question, 'What caused the event to happen?' Meaning is also reflected in the answer to the question, 'What does my life mean now?' (Taylor, 1983, p. 1161).

Meaning making, or making sense of life circumstances, has been shown to be beneficial in a wide spectrum of studies. Parents of children with Asperger's syndrome have indicated that they have been able to make sense of their child's condition by developing a greater understanding of the disorder through attending conferences, reading, and attending

support groups (Pakenham, Sofronoff & Saminos, 2004). An “ongoing search for meaning” was found in a study of 108 women who experienced prenatal bereavement (Uren & Watstell, 2002, p.279). The ability to make meaning of difficult life circumstances has been shown to be beneficial following stroke (Thompson, 1991), and for victims who are adapting following father-daughter incest (Dollinger, 1986, p. 302). People who were able to find positive meaning after losing or having their homes damaged from a fire were shown to have better coping. Focusing on the positive included “finding side benefits, making social comparisons, imagining worse situations, forgetting the negative, and redefining” (Thompson, 1985, p. 279).

1. How We Make Meaning

Park and Folkman (1997) have expanded on the importance of meaning making in the transactional model of coping, and how a person can have an impact on their environment. The authors distinguish two levels of meaning- global meaning and situational meaning (Park & Folkman, 1997, p. 116). Global meaning broadly includes a person’s basic beliefs, assumptions and expectations concerning the world, which influences perceptions of the past, present, and expectations concerning the future (Park & Folkman, 1997, p.116-117). Situational meaning “refers to the interaction of the person’s global meaning within the context of a specific situation” (Park & Folkman, 1997, p. 121). Following the loss of a loved one, a person’s perceived ability to control his or her world may come into question as the new situation they are faced with may fly in the face of previously held global meanings (Park & Folkman, 1997, p. 121). When a person’s global meaning is disrupted or shaken because of a new situational meaning such as death, meaning making of this incongruent situation may be a way of coping with the loss (Park & Folkman, 1997, p.124). The ability to

make meaning is successful when there is some form of settlement between a previously held global meaning and a new situational meaning. Individuals can either alter their new situational meaning to include it into their previous global meaning, or they create a new global meaning to accommodate their new situation (Park & Folkman, 1997, p.124).

In the case of suicide bereavement, if an individual decides to incorporate their new situational meaning of suicide within a preexisting global meaning that suicide is cowardly or sinful, they may do so by not recognizing the death as a suicide but rather as an accidental death. As such, the situational meaning associated with the suicide does not infringe on their previously held global meaning. Park and Folkman note that this may happen because doing otherwise and acknowledging the situational meaning would violate the person's sense of control. As such, a change to this global meaning is resisted (Park & Folkman, 1997, p. 127). A different route is to change one's preexisting global meaning to cater to the new situational meaning. For example, a preexisting global meaning that suicide is wrong, cowardly and/or sinful, may be changed when a person is actually faced with a suicide of someone they love. Because they are now faced with this personal situational experience, such individuals may no longer have a global meaning that sees suicide as sinful, wrong or cowardly. Instead, they may find new meaning based on the situation of the suicide as a sad end to someone's life who was under a great deal of mental stress. This formulation of a new meaning of suicide may allow for greater personal growth and coping following this loss. It is in this reformulation of global meaning to fit the new situation where there may be the greatest transaction between the person and their environment to reduce stress and to facilitate greater coping.

2. Meaning Making, Grief and Unexpected Loss

Meaning making has been shown to be beneficial in grief work. Neimeyer (2000) notes that an important role in grief work is to “attempt to find or create new meaning in the life of the survivor, as well as in the death of the loved one” (p. 552). Davis, Nolen-Hoeksema & Larson (1998) found that after interviewing family members who were bereaved from the loss of a loved one, those who were able to making sense of the loss and find benefits following the death were “associated with less distress” (Davis, et. al, 1998, p. 561). Similar results were found when the authors interviewed 205 respondents who were family members of palliative care patients. Respondents participated in a pre-loss interview and a six month and thirteen month post-loss interview. Results found that respondents reported benefits following these deaths, including a new appreciation for life, a greater value placed on relationships, and/or a greater sense of strength (Davis, et al., 1998, p. 561). It was found that because respondents were “reasonably certain” that the death of their loved one was impending; there was a very high rate of making sense of the loss (Davis, et al., 1998, 572). The researchers concluded however that their results were limited in that they did not account for unexpected deaths. Such unexpected losses they believe “may importantly influence one's ability to make sense of the loss” (Davis et al., 1998, p. 571).

Unexpected losses, such as those seen in suicide bereavement, can create complex grief reactions. Following a suicide, individuals may continue to ask “*Why?*” questions, often cannot accept the loss and usually show poor adjustment following the loss. “*Why?*” questions may include: “*Why did this tragedy have to occur?*”, “*Why couldn't it have been prevented?*”, and “*Why did my loved one choose to end their own life?*” (Colt, 2006, p.455). As such, it may be extremely beneficial for survivors to make some sense of their loss, yet

this may be exceptionally challenging. Therefore a sudden or unexpected death, such as a suicide, may hinder a survivor's ability to make sense and find any resulting benefit following the loss.

Additionally in unexpected losses, the inability to say good-bye to a loved one prior to his or her death can have major implications for coping and meaning making. A study of 312 grieving adults by Franz, Trolley & Johl (1996) found that the opportunity to say "good-bye" to a loved one prior to his or her death was associated with more positive coping. While 62% of the participants loved one's died a "lingering death" where saying good-bye was possible, 38% of these loved ones died suddenly. In these cases the opportunity to say goodbye was missed (Franz, Trolley & Johl, 1996, p. 154). This may have implications for suicide bereavement as well, as the suddenness of many suicides may prevent survivors from being able to say goodbye to their loved one prior to death.

In what has been discussed so far, there seems to be an underlying assumption that the bereaved individual will actively attempt to find meaning as a means of coping with death in both expected and unexpected losses. However, it should be noted that in certain cases a bereaved individual may not seek to find meaning following a death. In some cases the death of a loved one may result in improved mental health for the survivor because the death may represent the end of a chronically stressful situation (e.g., the person who was dying needed constant care) (Davis, Wortman, Lehman & Silver, 2000, p. 511). As well, John Bowlby's attachment theory states that a bereaved individual may not seek meaning following a death where the "emotional bond" with the person who has died is not valued by the survivor. In such cases there may not be the same need for the bereaved individual to find meaning behind the death (Fraley & Shaver, 1999).

3. Meaning Making and Trauma

While meaning making of life events is beneficial, making sense has also been shown to be very difficult following traumatic experiences. Davis et al. (2000) notes that being able to find meaning when coping with loss is extremely important. Yet, in cases of traumatic loss, finding any satisfactory meaning may be both “painful and fruitless” (Davis et al. 2000, p. 533). For example, college students who suffered a traumatic loss of a parent were found to be considerably more negative in their attitudes about justice, order and predictability within the world when compared to a control group (Schwartzberg & Janoff-Bulman, 1991). A study assessing how children make meaning after their peers were struck by lightning during a soccer game, found the children had greater difficulties answering “why?” questions than compared to “what?” questions (Dollinger, 1986, p. 302). Thus, processing the meaning of life events, and making sense of them, may be more difficult than addressing their content.

While making sense of trauma may be difficult, some believe it is still possible. Viktor Frankl, a Holocaust survivor and psychotherapist, is the founder of *logotherapy*, a type of psychotherapy which holds the core belief that humanity’s principal motivational force in life is to find meaning. Even in great trauma and suffering Frankl says that meaning can still be found. “If there is a meaning in life at all, there must be a meaning in suffering...the way in which a man accepts his fate and all the suffering it entails, the way in which he takes up his cross, gives him ample opportunity- even under the most difficult circumstances- to add a deeper meaning to his life.” (Frankl, 1984, p.88).

From this above description it seems that Frankl’s logotherapy model would fit with Lazarus and Folkman’s transactional model of coping, and Park and Folkman’s meaning

making model. All three models believe that coping successfully with stressful events is a product of the dynamic between the person and their environment. Most importantly, all agree that a person can have an impact on the environment around them, just as much as that environment can have an impact on the person. It is in this back and forth which creates stress, fosters coping, and allows for the search and creation of meaning.

4. Trauma and Growth

Park & Ai (2006) build on Frankl's model as they believe all people have a "will to meaning" which is essential to surviving trauma (Park & Ai, 2006, p.390). They note that while clinical research tends to focus on the negative effects of trauma on individuals, most notably, post traumatic stress disorder, and depressive and/or dissociative symptoms, more recently there has been a greater clinical focus on "stress related growth" as a product of meaning-making following trauma (Park & Ai, 2006, p. 395). For example, in a study of 475 undergraduate and graduate students, Ai, Cascio, Santagelo & Evans-Campbell (2005) found following the September 11th attacks, respondents reported lower rates of anxiety and depression if they had a higher sense of spiritual meaning.

Traumatic events need to be processed, and such processing must eventually involve meaning making. This includes being "emotionally engaged" with the traumatic memory and also "re-framing the trauma in a more acceptable way" (Park & Ai, 2006, p. 395). Failure to find meaning following a traumatic event may create negative circumstances. Boesch, Koss, Figueredo & Coan (2001) found that rape survivors who "blocked out" or "minimized" their memories of a rape had higher levels of post-traumatic stress disorder than

survivors who attempted to reintegrate this traumatic experience into their lives and find some meaning from it.

As traumatic events can often destroy a person's core beliefs about themselves and the world, an ability to revise beliefs to reflect a new "post trauma reality" can help constitute growth (Park & Ai, 2006, p. 396). Park (2004) noted that meaning making following stressful experiences can ultimately lead to positive growth as people make changes that involve a restructuring of their life priorities. This may include spending more time with loved ones, living a healthier lifestyle, having a clearer picture of their own identity, feeling closer to their friends and/or God, having courage to try new things, and appreciating the smaller things in life (Park & Ai, 2006, p. 395).

5. Making Sense of Suicide Bereavement

Jordan (2001) notes that making meaning following suicide can be very difficult for those mourning the loss. He says that because suicide is a death which is self inflicted, it infringes on deep-seated societal norms of self-preservation, and as a result survivors often struggle to make sense of the motivations and drives which lead their loved one to take their life (Jordan, 2001, p. 92). Adding to difficulties of meaning making, those bereaved by suicide often show higher levels of guilt and responsibility, higher levels of feelings of anger, abandonment and rejection towards the deceased, and a heightened risk for their own suicide when compared to other mourners (Jordan, 2001, p. 92-93). Therefore, meaning making or making sense following suicide bereavement may be especially important for the bereaved not just to cope with life without their loved one, but also to cope with life itself. A balance

between the event of losing the loved one and the person's own role in their environment has to be struck.

While meaning making following a suicide is extremely difficult, it may be possible. Begley & Quayle (2007) conducted an in-depth qualitative study where they interviewed individuals in Ireland who were bereaved by suicide. They gained access to this bereaved population by recruiting participants through the *Living Links* support group, a group that provides social support to those bereaved by suicide for up to eight weeks (Begley & Quayle, 2007, p. 27). In total, the authors interviewed eight adult participants- three were males and five were females. All were between the ages of 27 and 72 years old, and all were bereaved by suicide between three and five years. Participants described an ability to make sense of the suicide by reflecting on the "predeath demeanor" of the deceased, and the events leading up to their suicide. However, participants noted it was extremely difficult to make meaning of the suicide as they had to match the "deliberateness of the suicide to what they believed about the world, themselves, and their loved one....The deliberateness of the suicidal act was discrepant with their beliefs about a predictable world." (p. 29). This line of thinking fits with previously mentioned discrepancies between an individual's global and situational meaning. The authors note that meaning making around the suicide was an extremely complex task for participants, which often did not follow a set sequence. Meaning-making for these participants emerged as a result of seeking out the "story" of the death of their loved one and then matching the suicide with the prior beliefs about their loved one. The authors said that this was done out of a need for participants to acknowledge the death while at the same time protecting both the deceased's and the survivor's sense of self during this process (Begley & Quayle, 2007, p. 30). The majority of participants were able to gain some

meaning from the suicide of their loved one by forming the view that their loved one's suicide was an "impulsive act," where the deceased acted out of a mental framework where they felt overwhelmed and believed suicide to be their only choice of action (p. 30). Begley and Quayle conclude their study noting that a "greater understanding of the meaning-making process in suicide bereavement is warranted, while the use of qualitative research designs may be essential if research is to elicit the important details in suicide bereavement" (Begley & Quayle, 2007 p. 32).

F. Spirituality/Religion as a Way to Cope and Make Meaning

Religious and spiritual beliefs represent one way in which human beings create a structure of meaning that gives a sense of order and purpose to their existence and to death (Golsworthy & Cole, 1999, p. 22).

As death approaches us, religious and spiritual beliefs have been shown to be an effective coping mechanism. Religion has been shown to be helpful in coping with depression in elderly men who are hospitalized (Koenig, Cohen, Blazer, Pieper, Meador, Shelp, Goli & DiPasquale, 1992), and as a way to cope with death anxiety (Thorsen & Powell, 1990). Following the death of their partner, older adults have reported that their spiritual beliefs played a significant role in their ability to make meaning from the death (Golsworthy & Cole, 1999). However, "meaning searching" and "meaning discovery" in relation to religious/spiritual views does not always hinge on old age. Meaning making may not occur in adults who reach old age who live a life with a lack of distress, however, it is just as likely that meaning making can happen at a young age due to stressful life events. Thus, the search for meaning in reference to spiritual change does not necessarily reflect a person's chronological age, but rather his or her life events or experiences (Seifert, 2002, p. 64).

Religious coping has been shown to contribute to lower levels of depression following child bereavement (Higgins, 2002), and lower levels of grief in cases of mothers who are bereaved by the sudden death of a child (Anderson, Marwit, Vandenberg & Chibnall, 2005). Spiritual and religious beliefs have also been a way for caregivers of the sick and dying to cope and make greater meaning. Caregivers of terminally ill patients who were able to view their situation as “a means of gaining strength or understanding from God” reported more positive outcomes than those caregivers who saw their situation as a punishment from God (Mickley, Pargament, Brant & Hipp, 1998, p.1).

Often during times of grief, individuals will turn to their beliefs surrounding death for comfort when they are mourning. Death-specific religious/spiritual beliefs, particularly a belief in an afterlife and continued feelings of attachment to the deceased may assist in coping with the death (Benore & Park, 2004). Belief in an afterlife refers to trust in a continued existence of the deceased after his or her passing. This may manifest, among other things, as a bodily resurrection, a placement in Heaven, or as reincarnation (Benore & Park, 2004). Continued attachment refers to the belief that the relationship with the deceased is ongoing, active and may manifest in several ways; including smelling a fragrance, feeling a touch, or sensing a presence (Benore & Park, 2004). Again, due to the sudden nature of many suicides, survivors may feel abruptly cut off from their loved one, making feelings of continued attachment towards the deceased initially unavailable. This is not to say that feelings of attachment may never develop, but rather that this development may take longer. However, in *Dying to be Free: A Healing Guide for Families After Suicide*, the authors devote their last chapter to telling stories from many individuals bereaved by suicide who

have experienced a connection, or continued attachment with their loved one since the suicide (Cobain & Larch, 2006).

Pargament & Mahoney (2005) note that of central importance to meaning making is the ability to engage in sanctification, which they define as “a process through which aspects of life are perceived as having divine character or significance” (Pargament & Mahoney, 2005, p. 183). They note that people can search for the sacred and the divine in any aspect of their life (p. 179). Yet, if a person is faced with a life event where they are unable to do this, or their view of the sacred has been “desecrated” then this will have major consequences for their ability to make meaning out of the event. Additionally, this can have implications for a person’s overall mental, physical and spiritual health (p. 192). If spirituality and religion can help in the meaning making process, then it is likely beneficial to incorporate such views when dealing with suicide bereavement. However, do religious taboos or stigmatizations around suicide act as a “desecration” inhibiting survivors from utilize this aspect of meaning making?

G. Spiritual/Religious Aspects of Suicide Bereavement and Stigmatization

The act of suicide has had different meanings at different points in history. The Greco Roman era viewed suicide as being done out of political motivations resulting in social benefit. This shifted during the middle ages to a more stigmatized view of both the victim and their family (Jacques, 2000). The commonly held Christian view that suicide is a sinful act evolved during the second half of the first millennium A.D. During this time those who killed themselves were commonly refused the right of burial. This view of the suicidal act as a sinful one has also had a direct impact on Western civil law. Many civil codes in the

centuries that followed defined suicide as a criminal act. As such, the surviving family of the person that took his or her life was seen as being responsible for a crime. This often led families to being deprived of their property rights and inheritances (Fine, 1997, p. 50). While such outright stigma is no longer present for those bereaved today, there are still elements of stigma surrounding suicide that exist.

Spiritual or religious traditions surrounding death, such as funerals, that are commonly used to comfort the bereaved in times of grief, may not be as readily available in cases of suicide bereavement. Rituals and customs that surround funerals often help those in mourning to restore order back into their lives. However, in cases of death by suicide, this custom may be complicated with uncertainty. Today, many religious leaders regard the individual who kills him or herself as having suffered from mental illness, rather than having committed a mortal sin. However, suicide is still condemned by most major religions, and as a result, those left mourning this death may not be able to cling to the familiar comforts that religion often provides during times of grief (Fine, 1997, p. 49).

Given the stigmatization surrounding suicide, the bereavement process following such a death may be more complex than what is seen in other circumstances (Cvinar, 2005). In addition to the normal bereavement process, individuals bereaved by suicide may also face heightened grief responses such as shock, anger and guilt (Jacques, 2000). Because of such stigmatization, those bereaved may feel social pressure to become “invisible mourners” due to a lack of community support and an overall feeling of shame surrounding the death (Jacques, 2000). This may be reminiscent of Kastenbaum's previously mentioned hidden or disenfranchised category of grief. Spiritual beliefs of both individuals bereaved by suicide and their surrounding community can play a major role in the coping process following a

suicide. If, for example, a community holds the view that suicide is a sin, individuals within this community who are bereaved by suicide may find that such a belief only adds to feelings of stigmatization (Jacques, 2000). Thus, while a belief in an afterlife for the deceased may be available for an individual bereaved by suicide, it may be counterproductive to coping in such a situation. This may be indicative of Pargament & Mahoney (2005) in that spiritual or religious coping may be less afforded to those grieving a loss of suicide, and as such their ability to make meaning of the death through such channels may be restricted.

H. Mental Health Attitudes Toward Suicide

Much of what has been discussed thus far around suicide bereavement has been from the perspective of the bereaved. While this is important, an understanding of those who work in the mental health system with this population is just as necessary in order to provide better care for survivors.

Professionals within mental health have shown differing attitudes towards suicide prevention. General practitioners, emergency nurses, training psychiatrists and psychiatric nurses who have worked in the community and have had previous training in suicide assessment were shown to have a more positive attitude when working with suicidal patients when compared to similar professionals without such training (Herron, Ticehurst, Appleby, Perry & Cordingley, 2001). Studies have even looked practitioners who have lost a patient to suicide. One study looked at the role of psychiatrists in Thailand who have had a patient who suicides. Over fifty percent of psychiatrists in these cases reported feeling guilt, depression and hopelessness (Thomyangkoon & Leenaars, 2008). Postvention included, the psychiatrists working through these feelings with colleagues and praying or doing “merit” for the dead

patient. Another study noted those therapists who had lost a patient to suicide experienced emotional reactions of “shock, grief, fear of blame, self-doubt, shame, anger, and betrayal,” that nineteen of the twenty-six therapists in the study “saw the patients’ relatives after the suicides” and “in almost all cases the relatives were not critical of them” (Hendin, Lipschitz, Maltzberger, Pollinger Haas & Wynecoop 2000, p. 2022).

Concerning mental health practitioners who deal with suicide bereavement, there has been much discussion in the literature relating to effective therapies for families following a suicide. Solution-focused therapy, for example, has been shown to provide an effective therapeutic approach to helping families bereaved by suicide (de Castro & Guterman, 2008). There has been little research however addressing mental health practitioners’ experiences and opinions when working with those bereaved by suicide. As such, the present study not only hopes to look at the experiences of individuals bereaved by suicide, but also those in the mental health system who work with this population. It is hoped that by looking at both groups a greater understanding of suicide bereavement can be reached so that better care can be provided to individuals following the loss of a loved one to suicide.

PRESENT STUDY

The present research is a qualitative study that takes into consideration the process of meaning making and coping following suicide bereavement from two different perspectives: (1) individuals who have lost a loved one to suicide, and (2) mental health practitioners who work with those bereaved by suicide. The study will also explore the role of spirituality in the process of meaning-making and coping following suicide bereavement. Participants will be asked how spirituality may influence their healing strategies, which is something that is rarely done in mental health research. Park & Folkman (1997) noted that religion and spirituality can be key components in meaning-making at the global and situational level in an individual's coping with significant life stressors. Participants, whether they are bereaved by suicide or are mental health practitioners working with the population, may benefit from this study in that they may discover new coping and meaning making strategies that they did not previously consider.

METHOD

A. Theoretical Model: Phenomenological Approach

The phenomenological approach “describes the meaning of lived experiences for several individuals about a concept or the phenomenon” (Creswell, 1998, p. 51).

Phenomenology has been particularly useful in the human sciences, as it is interested in consciousness in the human experience which seeks the essential essence or “underlying meaning” of a subject (Creswell, 1998, p.52). The central tenants of phenomenology are to determine “what an experience means for the person who has had the experience and...to provide a comprehensive description of it. From the individual descriptions, general universal meanings are derived...” (Moustakas, 1994, p.13).

In this case the phenomenon being studied is suicide bereavement. The “lived experience” of suicide bereavement will be provided first from the lens of the survivor who is left behind and has personal experience, and second, from the mental health provider working with this bereaved population, who is one step removed. As such, it is the researcher’s opinion that the phenomenological approach is an excellent means of researching suicide bereavement as this is a “lived experience” that has been ignored for far too long within the mental health system. A greater objective understanding of suicide bereavement will be reached by looking at these differing subjective experiences (Creswell, 1998, p. 86).

B. Sample

Fifteen individuals participated in this study with a total of twenty one-interviews taking place. Interviews consisted of: (1) eleven individuals who were bereaved by suicide, (2) four mental health practitioners who had worked with survivors, but who had no personal loss to suicide, and (3) six individuals who were both bereaved by suicide and who also volunteered/worked in mental health with other survivors. These six individuals were part of the first group of eleven survivors and were interviewed a second time from the perspective of their professional experience.

Demographic Information

Of the fifteen participants, thirteen were interviewed in Ottawa, ON and two were interviewed in Toronto, ON.

Those Bereaved by Suicide

Of the eleven participants who were bereaved by suicide the mean age of the sample was 49 years old (range 21- 75) and nine were females. Culturally, eight participants identified as having a European Canadian background, one person identified as French Canadian, one participant identified as Russian and one as British. Six participants were single, three were divorced, one was married and one was widowed. All participants reported having attended university or college. Of these, ten participants had earned a diploma, undergraduate, or graduate degree.

With respect to religious affiliation three participants identified as Catholic, two as Protestant, two as Jewish and four identified as having no religious affiliation. Six

participants in the sample said that they did not attend regular religious service, while three stated they attended infrequently. One person reported attending once or twice a month while another reported attending religious service more than once a week. Six participants, reported religion to be slightly important to them, while two participants indicated that religion was not important at all. Two people stated religion was very important to them, while one person noted it was fairly important. Six participants said that spiritual issues were very important to them. Six participants said they were spiritual but not religious, three participants said they were spiritual and religious (one added that they embrace all religions), one participant said that they were neither spiritual nor religious, and one participant wrote his/her own answer of being more spiritual than religious.

The mean number of years since they had lost their loved one to suicide was 13 years (range 3-24). Four participants lost sons, two lost fathers, two lost close friends, two lost uncles and one participant lost a mother.

Of the six people within this group that were also mental health practitioners, the mean number of years for working/volunteering in the mental health system was 10.6 years (range 2-23 years). As well, the mean number of years this group had been working with other individuals bereaved by suicide was 9.5 years (range 2-20 years). Two participants facilitated a twelve week bereavement group for suicide with multiple participants, two participants facilitated a similar group that was eight weeks long, and two participants were a part of a suicide support survivor program assisting individuals and families.

Mental Health Practitioners

The mean age of the four participants who were mental health practitioners working with those bereaved by suicide, but without their own personal loss was 53 (range 37-63 years). Three participants were female. Two participants were married while one was single and one was divorced. Culturally, three participants identified as European Canadian background with one of the three identifying as French Canadian, and the final participant identified as Hebrew. All participants had graduate degrees. Two of these mental health workers reported not attending religious services, while one reported infrequently attending and one reported attending once or twice a month. All four participants rated religion as having different levels of importance to them. Three in this sample rated spiritual issues as important while one rated them as very important. Half of this sample identified as spiritual and religious while the other half identified as spiritual but not religious.

The mean number of years that this sample had worked in the mental health system was 17 (range 9-24), while the average length of time this sample had worked with individuals bereaved by suicide was 12.25 (range 4-25).

C. Procedure

Recruitment for this study began in spring 2009. An advertisement was placed in *The Ottawa Smart Shopper* in mid May which ran for four weeks on a bi-weekly basis (See Appendix 1). This advertisement also appeared on the online edition of *The Ottawa Smart Shopper* for the same time interval. The advertisement looked for individuals to be interviewed who were bereaved by suicide who were over the age eighteen and who were bereaved for a period of at least two years. Two individuals who wished to be interviewed

for the study were excluded for not meeting these criteria. The advertisement also invited mental health practitioners who work with those who are bereaved by suicide.

In addition to the advertisement, participants were recruited for this study through the use of snowball sampling which involves participants informally contacting other individuals (who have experienced the same event of bereavement) about the study.

Interested participants who called the researcher after were told more about the content of the study, the research design, and the possible risks and benefits of being interviewed. This also provided the researcher the ability to screen interested participants to make sure they met the requirements of the study (See Appendix 2).

Interviews took place at the Counselling Centre at Saint Paul University, the subject's home, or a private meeting room, whichever was most convenient for the participant. These accommodations were made due to the sensitive nature of the material being discussed. Prior to the interviews starting, the researcher and participants went over a consent form which all participants signed. This consent contained information on the research design, risks and benefits and their rights as voluntary participants (See Appendix 3).

Interviews were audio recorded and lasted anywhere from 45 minutes to 2.5 hours. Participants were given freedom to discuss their loss to suicide, or work with those bereaved by suicide in the direction of their own choosing. This was especially prevalent when participants were asked about their own personal experience in losing a loved one to suicide. However, while interviews followed a very open format, all participants were also asked structured questions around coping, making sense and spiritual/religious beliefs and coping in reference to their own individual experience. A series of open ended questions were asked

to participants (See Appendix 4). Also, unscripted questions were asked at times to enable participants to elaborate on or clarify their story. Following the interviews participants were asked to fill out a brief demographic questionnaire (See Appendix 5).

D. Bracketing Assumptions

Transactional phenomenologists are anticipated to suspend any bias or preconceptions about what is real in their subjects in order to avoid imposing expectations on the data as it is being analyzed (Creswell, 1998, p. 52). As such, the researcher's assumptions must be identified so as to be set aside or bracketed off aside during data analysis. To this end the following statement is made by the principle researcher and interviewer:

It is assumed by the present researcher that following the loss of a loved one to suicide, those left to grieve this loss will have great difficulties in the task of meaning making, or making sense of the death. Coping (both positive and negative) will be present, but a greater understanding of the "Why?" of suicide will be more difficult to obtain than just the factual "What's?"

Additionally while spiritual/religious coping has been shown to be of importance to meaning making, it is assumed by the researcher that those bereaved by suicide will have greater struggles utilizing such frameworks as a way of meaning making, not only due to the stigmatization surrounding suicide, but also to the taboo nature of suicide in relation to religion.

It is further assumed that mental health practitioners will have less of an understanding of suicide bereavement and the resulting meaning making and coping compared to those who are actually bereaved.

E. Data Analysis

Audio recordings of all interviews were transcribed by the primary researcher. Transcripts were then subject to transcendental phenomenological analysis as outlined by Creswell (1998).

Transcript Analysis:

- a. All of the twenty-one interview transcripts were read over to get a feel for their essence.
- b. Sentences and phrases which directly recounted the phenomenon were pulled out and repetitions in these sentences were eliminated to ensure greater clarity. This resulted in a list of significant statements for each transcript.
- c. Meanings were created for each significant statement. The reason for this was to determine the fundamental meaning of each statement within the framework of the transcript as a whole. A list of fundamental meanings was generated for each transcript.
- d. Themes were derived from each of the formulated meanings and similar themes were grouped together.
- e. Groups of themes that were widespread to *all* or most participants were then included into one list resulting in an exhaustive description of the phenomenon. An exhaustive description of the essential structure of the phenomenon in paragraph form was then written which follows the results section.

F. Peer Reviewer

A peer reviewer was used to provide additional data analysis from an outside standpoint. The peer reviewer read all transcripts independently of the primary researcher and was able to play the role of a “devil’s advocate” by challenging the researcher’s interpretations of data. The peer reviewer also provided support to the primary researcher by listening to the researcher’s thoughts and feelings surrounding data analysis (Creswell, 1998,

p. 202). The peer reviewer analyzed the researcher's hypotheses and gave feedback at each stage of data analysis. The researcher and the peer reviewer met face to face to discuss interview themes from transcripts, as well as corresponded through telephone and e-mail.

The primary researcher and peer reviewer met in December 2009 and spoke for two hours about general themes after both reading over transcribed interviews. During this conversation the peer reviewer provided the researcher with a typed sheet with her initial ideas on interview themes. After reviewing this sheet together both parties were in agreement with all themes listed. The primary research then pointed out one theme that was not on this list which he thought should be. When this theme was mentioned by the primary researcher the peer reviewer was in agreement for its inclusion.

In April 2010 the primary researcher provided the peer reviewer, via e-mail, with a list of significant statements and formulated meanings for all twenty-one interviews. The peer reviewer provided feedback on this document in mid-May 2010, following which, the peer reviewer and primary researcher spoke on the phone for two hours on two separate occasions. The first two-hour block was devoted to discussing themes regarding bereaved participants' interviews, while the second two-hour block was devoted to discussing themes regarding mental health practitioner interviews' and about the peer reviewer's initial feedback. All changes and suggestions that the peer reviewer made at the stage were agreed with by the primary researcher except for one. During one phone conversation of one of the significant statements and formulated meanings, the primary researcher disagreed with the suggestion of the peer reviewer's interpretation of the formulated meaning of one bereaved participant's quote surrounding an experience. The primary researcher felt that the peer reviewer's interpretation of this significant statement did not fit with the overall feel of this

particular individual transcript as a whole. Once the primary researcher spoke of his interpretation of the quote in light of the feel of the individual transcript as a whole, the peer researcher agreed with the primary researcher's interpretation and subsequent placement of interview quote. Additionally at this time, the peer reviewer presented one theme which she thought that the primary researcher could elaborate on, and one new theme which the primary researcher did not previously consider. After receiving this feedback from the peer reviewer, the primary researcher agreed with both suggestions and incorporated them into the results.

In early June 2010 after careful consideration of significant statements and formulated meanings, the primary researcher sent another document via email regarding the final themes based on transcript interviews. After reviewing this document the primary researcher and peer reviewer were in agreement of all results presented.

RESULTS

The Results section is divided into three main parts. Part A describes themes based on interviews with the eleven individuals bereaved by suicide. Part B describes themes from interviews with the ten mental health practitioners. Part C describes themes from the cross-over group of individuals who were both bereaved by suicide and mental health practitioners.

Finally an exhaustive description of the experience of suicide bereavement will be provided based on these differing perspectives.

A. INDIVIDUALS BEREAVED BY SUICIDE

The following themes were found in interviews with those bereaved by suicide. Following this list each will be explored in greater detail.

1. Feelings Associated with the Loss of a Loved One to Suicide

- (a) Shock;
- (b) Confusion, disbelief and misunderstanding;
- (c) Guilt.

2. Issues Surrounding Making Sense of Suicide

- (a) Suicide makes no sense;
- (b) The unanswered question of “why?”
- (c) Letting go of the “why?” question;
- (d) Acceptance of the suicide as a choice;
- (e) An inability to tolerate life difficulties.

3. Talking About the Experience of Loss by Suicide

- (a) The best way to cope;
- (b) Peer support: sharing with others who have loss by suicide;
- (c) Not talking/isolation;
- (d) Stigmatization: an additional barrier to talking openly;
- (e) Greater compassion and humanism.

4. Additional Coping Methods

- (a) Family;
- (b) Maladaptive behavioral coping: emotional blanketing, drugs, alcohol and anger.

5. Spiritual Issues

- (a) God;
- (b) Struggling with or rejecting religious/spiritual beliefs;
- (c) Rejection of religious stigmatization;
- (d) Continued attachment.

6. Changes in Relation to Self and Others

- (a) Less judgmental, greater compassion;
- (b) Greater life perspective;
- (c) Heightened awareness of suicidal ideation in others.

1. Feelings Associated with the Loss of a Loved One to Suicide

(a) Shock

Many participants appeared very emotional and upset during the beginning of these interviews when asked to tell about their experience with suicide bereavement. Most described a moment-by-moment narrative leading up to finding out about their loved one's suicide. Five participants noted feeling shock after finding out that their loved one had taken their own life. This seemed especially true when the suicide was unexpected.

Um...It was such a shock There was no warning. He wasn't ill. He didn't appear to be depressed.

...And it was a surreal, surreal experience...you know...when I arrived...ahhhh...and they told me that he had shot himself...like I mean you go into instant shock...and ..and there sitting at the kitchen table, and he's in the basement still I find out.

*

Um, how did it affect me? Ah, shock (*laughs*)...Um, I never understood what shock was before...I think I'm still in shock...

*

I was around, between the ages of eight, nine, ten...And um, my father committed suicide at that point (*clears throat*). As I recall it was certainly shocking. I think for any child of that age.

I don't think I was aware it was a suicide until probably a year after the fact. I was just told that he had died, and I didn't really discover how, or the fact it was a suicide until a bit later...Did I go through two types of shock? The initial shock of the death, and then another one on the discovery of suicide?

*

And it was really shocking because I remember . . . I came home and it was on the answering machine. So my mom and I were in the kitchen and we saw that we had a message. So we pressed play, and it was my Aunt um . . . she just kind of blurted it out, um that he took his life.

*

It was such a shock to everybody. We had an open coffin because nobody believed that he was dead. . . . In this case it was a shock because we didn't understand it. And we still don't.

In cases where the bereaved participant expected the suicide of their loved one, because there had been multiple past attempts, there seemed to be less or even no feelings of shock. This is shown in the following narratives of a woman who lost her uncle, and a mother who lost her son. Both spoke of the pain, suffering and torment that their loved ones endured on a daily basis when they were still alive.

...an uncle of mine that I was privileged to come to know because of the experiences that occurred. Um, that one was kind of expected because he had twenty-five attempted suicides throughout his life.

Uh, so it was a question of time with him. I think the majority of his brothers and sisters had come to that conclusion. I got to know his life story which was a very, very sad story from the, from a young age. It was somebody that truly suffered. Uh, was truly in pain every single day.

But uh, when it came his time to pass, it was a little bit of a shock.

*

I think I was in a very different position than the majority of people. At least . . . that's my understanding, because . . . [my son] lived a very tormented life . . . he had started talking about ending his life when he was five-years-old . . . From the time he was nine 'til the time he died when he was nineteen. So over that ten-year period . . . umm . . . he was hospitalized almost every year, at least once. And . . . I lost count, but according to his calculations, he had had ahh . . . about thirteen suicide attempts. So the whole idea the he was going to end his life wasn't, was not really a shock.

(b) Confusion, Disbelief and Misunderstanding

Other participants did not mention shock, but rather feelings of confusion, disbelief and misunderstanding when they found out that their loved one had taken their own life. This is shown in the following narratives of a father who lost his son, and a daughter who found her mother after she had died.

I remember when I was first told about this, and a policeman came to the door. It happened, my son was in Toronto. And, (*quick breath out*) I think it was, in disbelief at first because . . . I couldn't imagine. I've never been able to understand how anybody could get that low that they could take their own life.

*

Um, so I found my mother. And when I found her it was just kind of like...I knew that she was dead, but, um...it didn't really hit me at that point that she had taken her own life. It was really confusing at the time.

(c) *Guilt*

The majority of participants identified guilt feelings in relation to their loved one's suicide. Guilt was particularly strong in cases of parents who lost a child to suicide. Two mothers who both lost their sons spoke of a great guilt they had. There was also a feeling of failing their children which was tied to this guilt.

Because I kept thinking for years I had such terrible guilt because as a mom, I should have known if it's *my* son. I should have seen it. I should have seen all those signs coming. Um, and I didn't.

*

I know that...it's not *my fault*...because I did the best I could...And...he knew he was loved...but I still know that I failed him.

A father who lost his son twenty-five-years ago described an almost all-consuming grief, and also noted strong feelings of responsibility for his son's suicide which was mentioned on several occasions. These feelings of guilt and responsibility seemed to be very raw in the interview.

...after that immediate thing of taking care of getting things organized, there was an incredible guilt... You know, of, how could any father let his child take his life?

...I felt, this is my fault. That blaming your wife, anything else...that I could have saved this.

...But I do carry um, this feeling that I am the parent of a person who felt that life was no longer worth living. And I suppose that's guilt you know, that's the part that's guilt.

A woman who also lost her son spoke more generally of the grief experience that many parents feel after losing a child to suicide.

So I think parents who lose a child by suicide have that added variable to it that most other people don't have. And, and um, and I think that is one of the hardest pieces for anybody. Coming to grips that you couldn't have prevented it. And I really do believe that, that when a person's mind is really dead set, that that's their answer to their pain. Then there's probably next to nothing...we could maybe prolong it.

Participants also noted a general feeling of guilt which was tied into the idea that they could have prevented their loved one's suicide. This presented in "what if?" questions and scenarios in which the survivor noted thinking that if they would have taken a different course of action then the suicide could have been prevented. Four participants showed this with the following statements.

Cause when the person leaves it leaves you with a lot of guilt. What could I have done differently? What did I miss? What didn't I see? And it leaves you with all these questions and the guilt.

*

...I think that when anybody dies there's always guilt. "*I wish I had done, I wish I had said ..*" That's natural and normal. I think with a suicide it's worse because everybody feels that if they had said the right word, if they had been there at the right moment, if they had...you know all the ifs. So I think that we have all this, we take all this on to ourselves.

*

The divorce was...the divorce was terrible, it drags out...Um...I still in a way am really annoyed at the lawyers who kept it going because I thought, '*If this was settled six months ago he might still be alive.*' However, God knows what else might have happened. He might have done it anyway...

*

...my regret is I know he didn't call me that night because he knew I would have tried to talk him out of it.

Participants also stated guilt feelings arose when they started to feel better sometime after the suicide. Two participants described being caught off guard when they realized they were beginning to live again and not think of their loved one's suicide. They noted this led to additional feelings of guilt. This is seen in the following narratives of a daughter and a mother.

Um...when you start to feel a little better you start to feel guilty. You think, like there's something wrong with you (*laughs*).

Like what kind of mother am I? I always loved music, and stuff like that. And even after [my son] died I had the music on in the kitchen. But a lot of times I would be crying because music stirs me a lot. And the first time there was something on and I was dancing to it, I was shocked. You know?

*

I remember the seventh year, no, the sixth year, I forgot the day she died. And I remembered three days after, and I felt *so* bad that I forgot. But then I started thinking, '*No, this is good that I forgot the day she died because I remembered her birthday.*' But I wasn't counting down the days, you know, as much. It was amazing...kind of liberating for me.

While this woman did mention the guilt associated with forgetting the anniversary of her mother's death, she also noted it to be 'liberating' that thoughts of her mother's suicide are not as all-consuming as they once were. While forgetting the anniversary of the loved one's death and starting to feel better may lead to additional feelings of guilt, with time these occurrences may also allow the bereaved to carry on with their lives and not be so wrapped up in the huge guilt that is related with suicide.

Four participants noted coping with guilt and feelings of responsibility for their loved one's suicide by viewing it as an act that had nothing to do with them. One person noted that it was an act that they ultimately had no control over, while others mentioned it as a selfish act.

This was not a feeling of selfishness that was out of anger or bitterness towards the loved one, but rather out of compassion. They came to see the act as selfish, but that it was OK for their loved one to be selfish since the suicide took away the person's pain and suffering. Looking at it this way appears to have diminished feelings of guilt and responsibility to do with the suicide because it allowed them to see the suicide as something beyond their control.

You can't control what people do, and when you're dealing with somebody that's suicidal you have to come to understand that it has nothing to do with you. You know, you didn't influence their decision.

*

I recognize that it's possible for somebody to be in so much pain and they just don't see an out. This is an out, this is the door...um, I do believe it's selfish in some ways because it causes so much pain. But, you know having said that, I think it's OK to be selfish that way if someone is experiencing so much pain. Sometimes you know that selfishness is OK.

Another participant had a different spin when she talked about selfishness. She noted that it would be selfish on the part of the bereaved to have expected their loved one to have continued living rather than take their life. She noted that one cannot expect a suicidal person to live for others and framed this as almost a "reverse" selfishness.

Then you think of the selfish acts. Why didn't they want to live for me? Why didn't my mother want...why wasn't I enough, you know?

...And, um, somewhere in your psyche, to just try on some primal level to tell yourself that it's not about you. Because if it was about you, you know they'd probably still be alive, because you're more than worth living for. It's just they were just overcome by whatever it was. And on top of everything else too, um, you can't expect someone to live for you, because that's selfish...um, this is what I've come to the conclusion to, that you can't expect someone to live for you. That's selfish, and what's their quality of life?

Again this seems to help the bereaved with the strong guilt feelings and feelings of responsibility that are associated with suicide by seeing the death as an act that had nothing to do with them.

A mother who lost her son to suicide described watching a videotape that he left for her and her family after his death. In the video he addressed the family and explained his reasons for taking his life prior to his suicide. She noted that he researched suicide extensively before taking his life; particularly issues that those left behind are faced with following suicide. In this narrative she describes what he had to tell the family about guilt, feelings of responsibility and control, and the idea of selfishness.

And on the video tape, it was interesting...he said his research told him that one of the things people go through is that they start to feel guilty. Like what could I have done differently, what could I have done? Umm, why didn't I know this? Blah, blah, blah, blah, blah. Or, why didn't I do something to stop it? Etc, etc.

And on the videotape, at that moment if I remember correctly, he like even leaned closer into the camera and he said, "*I need to tell you something really important.. this isn't about you It has nothing to do with you...It is a purely selfish act* "

...I think he was so one-hundred percent dead on. He kept saying, "*Suicide has nothing to do about you, and it's totally to do about me, and I'm about to do what is a purely a selfish act I'm doing it for me* " And on the video he said, "*I know it's going to cause you pain, but I'm going to be selfish.*"

... And then I say you know [my son] was so clear. And it was funny because he was so emphatic, the way his body was too. I can picture it now as I'm showing you...he leaned into the camera (*leans forward*), "*This is not about you.*"

2. Issues Around Making Sense of Suicide

(a) Suicide Makes No Sense

The majority of participants noted that on one level there is an inability to make sense of their loved one's suicide. Many noted being unable to make sense of the suicide both initially and presently. This inability to make sense appears to be linked to the grief of their loss, as if a part of them cannot let it go.

Initially? There was no sense. I...what kept coming to my mind was an old Marty Robbins song, "*This time Lord you gave me a mountain* ". (*crying*) And that was all I could think of. ..

*

I don't know how I made sense of it. Um...I think...probably what sort of occurred was I did have family around to try and make it easier.

*

I didn't [make sense]. Honestly...I think, initially, initially that day, I think my parents were sitting down and we were trying to figure out all the details. Trying to put the pieces together, but we had no information really. I think we were just busy with making the arrangements for the trip so that we could leave, and not really be thinking about the suicide.

*

There weren't a lot of ways to make sense of it initially...So there weren't a lot of ways for me to make sense of it. I just sort of tried to throw myself into understanding about what happens, and what you go through, and...reading maybe about depression or I guess suicide in general.

*

No...I couldn't. I still don't. It still doesn't make any sense to me.

*

I cannot take my son's death and say that happened for a reason.

*

Any death is tragic. Any young death is even more tragic. But a suicide...is altogether a different death... because it didn't need to happen. It didn't need to happen.

You know, as I said, a car accident that would be a tragic death. And all the parents and friends and people would mourn that person. I mean it doesn't make the mourning any less. It's just is not as senseless. It seems to be a senseless act somehow...to me.

(b) The Unanswered Question of "Why?"

The majority of participants said that following the suicide of their loved one they were left with the question of "why?" Making sense of suicide may be so hard because this question so often remains unanswered. Some people described this "why?" question as something that stays with them for years because they cannot ask this of their loved one this directly.

Suicide is a very haunting kind of grief because you never really know why, and that haunts for years.

*

And I wanted to know "why?" Every day. Like you know, everyday. "Why did he do this?" You know, what was it in his life that was so terrible? And there was no answer.

*

Um...I think after I realized it was suicide, I think the curiosity or the wanting to find out why, or what occurred.

*

And then later when we were there it felt like it was an investigation. Honestly it felt like it was a detective story. We were trying to figure out, you know, why, and how?

...But there were so many questions that just remained, that we could not answer. Um, the question "why?" obviously does not get answered, right?

One participant who lost her friend to suicide described the “why?” question she had following the death, and the struggles that came with it remaining unanswered.

... It was a very, very violent death in my view... Like if there are different ways in which people would take their life, you know, it was not one of the less violent ways per se... non-violent means. So, it was trying to understand why she chose that particular means, or why she did that. ... So I struggled with those last few moments of what her life must have been like. You know, and what it would have taken to do that... knowing her.

She adds the difficulties in not being able to ask her friend directly “why?” she took her life.

... You know, you just want hear what that person must have felt right? And you can't get that. You'll never get that. Right, like I wasn't with her at that last day with whatever she went through, so it was hard for me to even have those pieces.

While the majority of participants spoke of this unanswered “why?” the mother whose son left a videotape addressing his family prior to taking his life, noted not being plagued by this question. In the interview she noted he spoke about this question of “why?”

... one of the things in his tape that he started in the very beginning part of the tape was... that the thing that was the most difficult, other than losing somebody that you love from suicide, was that people were always left with questions unanswered. And he didn't want us to have questions unanswered. And so he researched to find out what were the questions that most people ask afterwards, and he wanted to address those questions with us.

And one of the things that he said on the videotape which... which was really true, and my two daughters and I both said it's so true, was that he said “For those of you that are close to me” ummm, no, he said “One of the key questions most people ask is why?” And he said “But for those of you that are really close to me, I don't think that you'll be plagued with the question of why And in my case it's not why but, why did it take so long until I finally did it?”

In this case it seemed not to be a question of “why?” but a question of “when?” This above case is quite unique as this son specifically addresses his loved ones about his feelings of suicide in such a compassionate way. This was the only case where something of this nature was mentioned.

(c) *Letting go of the “why?”*

While many participants noted wanting to find answers to the question of “why?” many also indicated that there came a point when they stopped asking this question and accepted there will always be unanswered questions in relation the suicide. Many also spoke of accepting that fact that they may never make full sense of their loved one's suicide.

And you know, you have to pick that person apart, because your mind won't rest until you have some kind of answers to put it to rest and just accept.

...I'm comfortable with not having to make complete sense of it. You know, I spent a long enough time trying to make complete sense of it...and it's that relief.

Making sense of suicide seems to be a necessity, yet one that may never occur.

There's still always questions left unanswered as to how they can do that. Such as with their children present in the house, which occurred in one case...You, you just come down to accept it as an individual thing. Some people are fighters, some people are not fighters.

*

Yeah...I think to a point we've given up You know, as a family we've given up with the question of "why?" to try and make sense of it. We just left it. Let it be.

...Or maybe answered it to the best of our ability. You know, came up with our own version of saying, 'Well you know, I guess he was so lonely and hopeless that he came to this decision.' But really that's our story.

*

And I think that people that are left behind would find comfort knowing that their husband had cancer for example, and that they'd done everything possible, and he still passed away. And they could let that go. But, if he took his life...why did he do that? You know? I think it's always a big "why?" And it goes on. It never stops...for me. I don't know about others. And you know, I always...at the, at the time and I still do it, I find myself still saying these same words, "*The bottom line is, he's gone.*" So, it doesn't matter. The fact is he is no longer with us. And I...that was the only way that I could find...I could let it go.

*

...It's having to accept something you don't want to accept. The first thing in Al Anon. You have to accept the unacceptable.

(d) Acceptance of the suicide as a choice

While participants may let go of the question of "why?" and accept that there may be no answers to make full sense of the suicide, many also described a process of accepting the suicide as a choice that their loved one has made.

You have lost somebody who was special to you and somebody that was loved. Do not be embarrassed or anything else. Nobody knows the circumstances or the reasons. This was somebody you loved. You still love them. And they must have been really desperate. Do not blame them. I've been angry at [my son] for some of the choices, but...that's life. We make choices.

*

I mean it's an act, it's a choice. It's what someone chooses to do in their life, um...so that's kind of how I saw it. I didn't see it in a good way or a bad way, or anything else. It was an experience where people get to a place in their life where things are not going right, or whatever it is that's occurring, or what they're going through causes them to lead to that place.

*

Because when it comes down to any suicide, I think it comes down to accepting the choice that person made. And you are not responsible for the choice that person made in any way...

*

I myself will always be content in any scenario that I did my best. That I was the best human being that I could be. That you know you just have to accept their choice and go from there.

(e) *An inability to tolerate life difficulties*

Although the majority of participants noted great difficulties in fully understanding suicide, they seemed to make partial sense of their loved one's suicide by saying it was related to an inability to tolerate something difficult in their life. Suicide happened when things in their loved one's life such as their pain, depression or suffering became too difficult to handle. It is a way of not wanting to feel and to end emotional pain. It is a last resort in response to overwhelming and ultimately intolerable aspects of life. This is seen in the following five statements.

Well there was something that he didn't want to feel. And it was through not feeling that I believe that led him to this. There was something he didn't want to feel, many things. I don't know. There were things he wasn't allowing himself to express and feel fully, emotionally.

*

...I, I really don't think he felt he had the strength. Um...he told me one time that the depression, he said, at one time he had a job, he had his car, he had a motorcycle. You know he had a good life. And he said it just takes over.

... (long pause)...I think it's wound up in the fact that I understood why he did it. So then I guess in that sense it made sense to me. It wasn't um...he's not suffering anymore.

*

I think it has to be a last resort. I think people who do suicide; it has to be an extreme sense of desperation. Which is something that, you know I think we've all experienced despair, and desperate times so certainly I think I can empathize to a degree.

*

I think she might have been molested also when she was younger. She had drug problems, alcohol problems, um...she was a psych nurse too, so she knew how to hide the signs too that she needed help. And, no one around her was smart enough to understand that she was hiding the signs. She had tried rehab several times. She was having seizures too when she was coming off of the alcohol, and I guess it just got too much for her.

*

But going back to [my close friend]. Um, she had bi-polar disorder, she had lost her husband in 1985 to cancer, and she had two young boys...she was a fun loving person. When she was up she was really up, and when she was down she was pitiful. And, um, very embarrassed about being so down... Well, it was bound to happen eventually because she was not stable. Even with medication she was not stable. . But it was something you'd have figured was quite possible down the road...when she just couldn't handle anything more.

While the above examples by the participants shed some light onto what they thought the suicidal person was going through prior to ending their life, again this is only a partial explanation as most were left with the inability to make complete sense of the suicide. All but one person noted these partial explanations. Again, this is the case of the mother whose son left her the videotape addressing his family.

As compared to the other interviewees, this mother was able to say unequivocally that her son's intolerable pain was the reason for his suicide based on conversations she had with him while he was still alive. Because of such conversations this mother did not have the "why?" question that other bereaved participants had. She knew her son's reason for taking his life because he made it clear to her which is something that the other participants from this study did not have prior to their loss.

I know he said it over and over again to me, was *"When I reach that moment, when the pain is really too much"* . . .and he said, *"You know you've seen me, the pain is there almost all the time. But when I reach that moment where I say 'Absolutely...no more' that's what I'll do"*

And I really have come to believe, rightly or wrongly, that that's what happens for everybody who ends their life by suicide. It's at that moment that they no longer can tolerate the pain. Like that it's so severe to them now that that's it. It has to stop.

3. Talking About the Experience of Loss by Suicide

(a) *The Best Way to Cope*

Ten of the eleven participants noted that talking with others whom they trusted to be the best way to cope with the suicide. Whether it was talking to friends or family, talking and talking soon after the suicide occurred seemed to be very helpful.

Um, talking to people that I really trusted. You know, just ah, letting them know what was going on and how I felt. Um, just, that I felt ashamed and that it was my fault. That there was something that maybe I could have done to prevent it. And then just reassuring me that I could not have done anything differently.

*

We spoke about it (*snaps fingers*) from the day it happened. We told everybody. It was mentioned during the...you know it was talked about during the funeral and the wake. It was never something we hid...

*

I (*laughs*) the only thing I could really suggest is to talk about it.

*

Um, I think talking, talking to friends that I did have. Um, you know, and you know what's funny, I would say touch, actually as well. That was important. I don't know why but that was a big thing.

*

And I will tell people. Another thing that helps for me as well is just being able to share it.

*

I don't know for everybody, but for me talking is the most important. There's also a tendency to want to isolate. I didn't do that. I pushed myself not to do that. But I was very careful of who I pushed myself to be around when I was doing that.

(b) *Peer Support: Sharing with others who also have a loss by suicide*

Many participants cited their experiences with others who have also experienced loss as a result of suicide within the context of suicide bereavement groups as being extremely beneficial in terms of coping. Four participants reported going to suicide bereavement groups following their loss and could not speak highly enough of them.

Finally...I had never met someone else who had lost to suicide other than my family, so I was like "Whoa! That happened to you too! And that happened to you!"

*

It's not that, you know I need to feed off their grief or anything like that; it's just helping to listen to somebody. It's such a tremendous thing to help me cope, and I learned all sorts of things to help me cope, and ways that I never would have been able to come up with myself, you know? *(laughs)* And hearing other peoples' coping mechanisms within the group...

*

It was enormous...enormous for coping ..It gave us the understanding of grief and what we can expect, and that it's healthy, and there are others, and we're not alone. And on, and on and on and on .with direct experience. Not with just one voice, but with many voices. It's like having nine therapists, but they're not giving you therapy.

*

So when I first went to the bereavement group I didn't want to say anything. I just looked around me and I was like, "OK, there's people here. I'll let them talk "

So I started and I was like...I lost my mom to suicide, she hung herself. And then it just kind of went *(makes crashing sound)*. Then I went on. I was guilty and filled with shame and embarrassment So that kind of just all came out I really focused on the guilt and shame part of it, and how I felt really embarrassed. And they helped me through that.

One woman who lost her uncle noted the benefit of peer support through talking to a friend individually who had also lost a loved one to suicide.

I was talking to the friend and I didn't know much about his family, so I asked about his dad. And he said, "My dad died of an accident." And it was the way he said it. Like I can't even tell you what it was, but I just knew...that it was suicide. And I asked gently. And both of us told our stories. Like he had said, he had never told anyone. It was really recent and he was keeping it to himself. So it's almost me being a survivor made it OK to ask about that because I knew that there was something shared.

Another woman who lost her son also noted the benefit of previous therapy that kicked in and helped her after her son took his life.

And, my husband had a bit of a drinking problem so of course I got involved with Al Anon, which...*(laughs)* saved my life. I swear to God when [my son] died everything I had gotten in the Al Anon meetings just clicked. And, you know, the biggest one was keep the focus on yourself. Keep the focus on yourself. You have to; you know...some people would say, "How could you do that? That's a terribly selfish thing to do " But the bottom line is I'm here.

(c) *Not talking about the suicide/Isolation*

The majority of participants noted that isolating themselves and not talking about the loss of a loved one to suicide was a very poor form of coping. Two participants noted not wanting to talk about the suicide for fear of burdening or traumatizing others if they did bring it up which also lead to isolation.

...I don't think I was doing very well. Like at first you don't really see it necessarily, but I think it took a few months before I was really...I had no energy. I didn't want to do anything. I was at home sort of held up for a while...but I don't think I was doing very well, because I didn't have anybody to talk about it emotionally.

*

I think just in isolating myself initially, unconsciously, probably wasn't helpful. Um, so in a sense I should have reached out sooner maybe.

*

And I think that's where the biggest tragedy comes ..the biggest pain for people is in the not talking about it.

*

...people don't like to bring this up. And oddly enough there are times when I'd like them to have brought it up. You know I think if he'd been killed in a sports accident or something, or even a boating accident, they still don't like to talk about death...but they wouldn't have been quite so reluctant...And, I...(short sigh) I don't have a lot of, well I have a few people I consider quite close to me, two or three. But I don't want to bring it up. I don't want to load them with it.

*

I was experiencing lots of flashbacks and really kind of vivid scary memories...and so, how did I cope? You know, the thing that I found really hard is that I did not feel that I could talk to anybody about it... for me I knew what I needed to cope was to actually talk about it. But for some reason I was unable to. And I know part of it was I felt that I did not want to traumatize somebody else by telling them the details, but I felt like I needed to tell the details, right? So I wanted to talk about it, but I couldn't talk about it.

(d) *Stigmatization- An additional barrier to talking openly*

Many participants noted a societal stigma around suicide as is shown in the following narrative.

I think in society as a whole there's definitely stigmatization. I think people are embarrassed about it. I think people that have experienced loss by suicide...um...are very reluctant, most people, to, to openly talk about it. I think there's a huge difference between grieving the loss of anybody, of a loved one, versus grieving a loss of a loved one because they died by suicide.

Two participants noted being wary of talking about the suicide because they were unsure of what another person's reaction would be.

With strangers absolutely because I did not know how they would react to that. And you know I have had reactions thinking, people saying "You know it runs in the family" or whatever. Yeah, so that's definitely part of it. I was unsure of the reaction I was going to get. Especially, this is culturally, at the funeral they said that he had died of a heart attack. Because the stigma is so strong in Russia that my parents wanted to just kind of protect that.

*

I guess...well...it made me really ashamed I guess, and um,...skeptical of the world. Ah, for a long time whenever someone asked me how my mom died I would say a car accident, or cancer. Never suicide, because the reactions were so, so varied. Um, everything from shock, to disgust, to embarrassment. So I just avoided it all together.

While there was a belief that stigmatization around suicide does exist, three participants noted not being affected by stigmatization because they either did not buy into, or failed to notice it.

...you know what, I guess for me I didn't give a shit. I really didn't care. I don't know maybe if I lived in a small town or just...I don't know if I would have cared. He was my son. I don't give a shit what anybody else thinks. I know him. I know what he was. I knew what he was going through. You wanna stigmatize me for that because I was his mother? Well then it's your loss.

*

I found the idea of the stigma more interesting than feeling actually somehow ashamed about it.

I think there was a period where I didn't tell people, and if it did come out, I wouldn't state it necessarily with pride, but with defiance. As in, "Yes my father committed suicide. What of it?" You know, almost as a challenge.

*

I didn't feel that stigma. But certainly you can get a room very silent (*laughs*)...you know, if you say, well...

"I love him and I lost my son."

"Oh, my goodness was he ill?"

You know for somebody that I just meet...And it's like, "Yes he was. He was *mentally ill*." That then leaves a huge silence. And then if I add, "He chose to end his life" most people don't know how to respond.

...you know, we can recognize it out there that there is society's stigma, but if you don't embrace that stigma it doesn't affect you.

Two other mothers reiterated this last example that most other people do not know what to say when suicide is brought up in conversation. This can be a very difficult conversation for survivors to have.

Travelling is very difficult... I love meeting people. I love talking to people... Every time, "Oh, do you have any children?" He was my only. And I won't lie. I won't say no. I will never deny, because being a mother was very important to me. ... So there are things that are difficult.

*

When [my son] died and people would ask me how many children I had, if I said two, the natural question would follow, "Oh boys or girls?" And I would say one of each. "Oh, where are they now?" And then, when they found out that [my son] had died by suicide, or died period, the next question was, "How did he die, an accident?" And I would say, "No, by suicide." And then there would be dead silence... if you said my son died in an accident, they'd say, "Oh, I'm so sorry." And that would be all. But if you say, "My son died by his own hand..."

(e) *Greater compassion and humanism*

Participants recognized a need for more compassion towards those who suicide. In the following narrative a mother who lost her son describes a conversation the two had about suicide shortly before he took his life. The mother, reiterating her son's words, calls for greater compassion towards the person that ends his or her life.

Umm, and so, the, the week or two weeks before he actually died he had had a conversation with me one evening where he said to me, "I want to ask you a question, hypothetically speaking now. If you had a really, really close friend, somebody that you've known for a long time .. somebody that you really cared for deeply.

And that person came to you and said, 'I have some news and not all of it is really good.' And that the news was that they had an illness umm, that was going to create a tremendous amount of pain, and that they were going to be in an absolute painful state. And that the really bad news about all of that was that the disease was not fatal, in and of itself. So that the person would have this illness and disease that would just get worse and worse as they got older " And he said, " And if the person then said to you, 'I don't want to live like that, I don't want to live in this constant pain, and that they have no cure for it, nothing...and I want to end my life.' And he said, "Mom, what would you say to your friend?"

And I couldn't answer him because I knew what he was trying to get me to say. And so I said to him, I mean because we had such an open relationship... I sort of smiled because I knew what he was trying to get me to do. And I said to him, "I'm not going to answer that, because I know what you're trying to get me to say. And I can't say that, to you."

And he said, "Well that's just it, because you can't say it to me, because I'm your son. But I know that you are one of the most compassionate people I know in this world. And I know that if it was your best friend you would be saying, 'I understand.'

And I said, "I can't answer that."

... And then he hugged me and I hugged him, and... that was the end of that conversation.

Not only is greater compassion towards the suicidal person needed but greater compassion and humanism towards all aspects of suicide is important. One survivor noted that by having greater compassion and humanism towards those who take their lives, and those who grieve these losses, this can hopefully lessen the stigmatization felt by both groups significantly.

The humanistic approach. That's what's needed.

4. Additional Coping Mechanisms

(a) Family

Two participants noted that their family support system was beneficial in terms of coping with the suicide.

Yeah, certainly some family members um, I think closed ranks and got closer. Um, which is certainly a positive effect of what had occurred.

Um, you know, I'm still close to my family so...I think its support and coping. I have a fairly good support system there.

*

I thought the daughter, she's going with the mother. And after all the dust had settled, she said she wanted to come and stay with me... And I thought 'I've got to learn how to run a house.' I've got to cook and look after my daughter and pick her up after school and so on. That helped, because I thought, "I've got to do this!" I mean if I'm gone, or I go bananas, uh, or sit in the corner, who's going to look after her?

(b) Maladaptive Behavioral Coping

Participants noted maladaptive behavioral coping, specifically using emotional dulling particularly through drug and alcohol use, or feeling angry following the suicide. Several participants admitted to previously using these methods to help them cope but found they were not helpful.

Well, I think when people start to drink heavily or smoke pot, or...those sorts of things, drugs and alcohol...when they become excessive, which happens often when people are grieving, and they don't even know why. Umm...and that's related to any type of loss. It's emotional blanketung. It's a...you do it because you don't want to feel.

*

Um...drugs. Drugs, yeah....a lot of drugs. And uh, anger, heavy metal music. Um, writing, shitty poems (*laughs*). Questioning, being angry. Um, being closed off... Initially it was drugs. I want to forget about this...

*

I used to drink... And I was not a very good drinker. So I wouldn't feel good, I'd go home and go to bed and I wouldn't feel good the next day. Um, so I was never a heavy drinker on a day-to-day basis.

*

Being angry is not a positive....Resentment, cause I resent that [my friend] wasn't there for me when I went through my cancer battle.

5. Spiritual Issues

Participants noted both positive and negative aspects of religion and spirituality in terms of dealing with suicide bereavement, including issues with God, general views on religion, views of the afterlife, religious views that stigmatize suicide, and spiritual rituals and beliefs of continued attachment to their loved one.

In general participants noted being much more spiritual as a means of coping with suicide than turning to organized religion. No one mentioned turning to any specific organized religion for comfort, but were much more comfortable accessing spiritual resources and/or practices on their own. One of the ways people turned to spirituality was their communication with God.

(a) God

Participants expressed both turning to God prior to their loved one's suicide and struggling with views of God afterwards. In the next two narratives, two mothers recalled how they spoke to God before their sons killed themselves to end their loved one's suffering.

I do remember saying, "If you, if there really is a God, now is the time to prove it to me and take him out of his pain. And either, you find some medication that can stop this craziness for him, or you allow him to figure out a way to peacefully end his life."

...And so the comfort I have, whether I believe in an actually God or not, is still up for...grabs, even though somehow I guess somebody answered it (*chuckles*). But the comfort I have is that I know the...I really believe strongly he's no longer in that pain.

*

I prayed to God at night. I would pray when I got into bed, asking him to guide us...

I'm not sure where I learnt this from, but, you take the person you're concerned about, and you wrap them in something. And I chose a flannel blanket. Um.....(long silence)

...(takes a deep breath out)...this was before he died. And I wrapped him in the flannel blanket (crying) and I handed him to God...and...I said, "You guide "

So when [my son] died I think God said it was OK (crying).

While these participants noted talking to God prior to their loved ones' suicide and now believing that their loved ones were no longer suffering after their death, others had more struggles with their views of God in relation to suicide. Two participants noted struggling or abandoning their beliefs around God following the suicide. One participant also noted anger towards God following the suicide. Two participants described having difficulties understanding the suicide as God's will, and that possibly other people could do this for some comfort, but that they could not.

Um, I struggle with God. Why? You know, God is supposed to take care of everybody. God, the bible states, "If you live by my word you will have happiness." Mmmm...God's not there for the people I know, and they're not bad people. And why, why would God, why would God do something...like in that fashion, where he just dragged him on for fifty-two years?

*

...but I don't know, suicide it kind of destroys beliefs in God. You know, how could someone take this away from me? How could God let suffering exist in the world? How could, you know, someone's problems get so much that they just are destroyed by them?

*

Well I stopped going to church because I was mad at God. Uh, or a higher being, if you have a higher being in your life. Um...I didn't go to church for a long time.

*

I knew that (sighs) I didn't want to get down on my knees and pray to God and say "You know I don't understand this but it's your will." A religious person can do these sorts of things. I definitely couldn't do that.

*

But the one part I found hard was that they were explaining it during the funeral and sort of the subsequent timing initially that, you know, it was a choice that God had a hand in doing. There were explanations that only God could understand. Or they were making sense of it in terms of their own religious views, whereas for me that didn't make any sense whatsoever.

(b) Struggling with or rejecting religious/spiritual beliefs

Three participants also noted struggling or rejecting religious/spiritual beliefs following the suicide. They were either religious/spiritual before the suicide and abandoned these beliefs afterward, or they were not religious prior to the suicide and remained so

afterwards. Two participants noted feeling unsupported by what they felt were predominantly Christian views that spoke against suicide and took up more agnostic or atheistic beliefs, while another rejects the Catholic views against suicide.

It was a habit of mine even as a young man before I converted... to be in the middle of a huge city in the afternoon, its hot...I'd just go in a church and sit down and get away from it all. Um, but I did think, after my son's suicide, "*You know, this is all hocus pocus* "

Um...why...we're put on earth with a free will, sure. But you know some of us are tested beyond our ability to cope with it. Is that fair?

*

Oh, it changed everything for me. Um...I went from being agnostic I guess to being atheist.

*

...when I was older you hear about suicide within the Catholic faith and how it's a big no-no, and certainly that's...it didn't concern me because I think I have more agnostic, almost atheistic viewpoints.

One woman who lost her friend noted while such religious stigma may not be intentional, it still exists.

I guess there is a lot of negative stigma...But you know, it's interesting, you often hear how the people who commit suicide, they're buried in more remote, or obscure portions of a cemetery, or something like that even. And it's odd because that's the case with my friend. I don't even think it was intentional, but when you go there and look at it and you kind of see where you are and stuff, you kind of have to wonder.

While there were some who struggled with religious and spiritual beliefs, two participants noted having good experiences with their priests who presided over their loved one's funerals which were both Catholic services.

Um...we had, he was cremated. We had a service in the chapel. Um...there was, they had a father [x] that they worked with, And he didn't get back to me until the morning of the memorial, so in the meantime I called father [y] thinking, "Oh my gosh! There's going to be nobody there." Anyways, (*laughs*) they both came. But, um...father [x] was wonderful! He spoke to me for maybe half an hour. And when he got up to speak he had an essence. He was wonderful.

*

One thing that I experienced with [my friend's] funeral was that it was a Roman Catholic burial which once upon a time would have been shunned by the church, and that the priest was very open in talking about suicide, and he actually talked to the young crowd that was there, And I thought that was very helpful, because it's not as much of a hush, hush issue, we have to hide issues. It's opening the lines of communication because it's addressing the truth that suicide does happen. That was nice to see that the church was finally turning around.

While a dialogue may be opening between religion and suicide, still, these two above examples seemed to be the exception as many spoke of feeling unsupported by religion following their loss by suicide.

(c) *Rejection of Religious Stigmatization*

Others spoke more of a direct religious stigma towards suicide and religious beliefs of the afterlife, which also made those bereaved feel unsupported. Most participants noted rejecting such religious views, for example, those seen in Christianity that view suicide as a sin which results in the person going to hell. Regardless of whether participants were religious, spiritual or neither, many believed that their loved one had ended their pain and were now at peace. Of those who did mention a belief in God, all referenced a belief in God that accepted their loved one after their death. One participant who believed that suicide was a sin still believed that God would accept her loved one in the afterlife.

Well at the beginning it was instantaneous. I mean, he's with...he's OK now. He's safe. He's moved on to...I read one book about suicide and I didn't like what the guy said. He said people who commit suicide are...they don't go to hell, but they don't...I don't know, but I didn't like that. I thought, "You don't have much understanding." Because people who take their own lives are very ill. This is not something you do out of spite. You're sick. Now maybe people's reasons for getting there might be because they're angry, but it's not something you do lightly.

*

Oh, no doubt...he's in a better place and someday I'll be there with him.

*

Certainly I don't have much belief in certain religious tenants against suicide, or the consequences of it. And that probably puts me off, um, certain religions, or those parts of the religion. Um, which may have made me in the end shy away from organized religion.

*

I guess what I believe, and this is totally not in sync with the Orthodox Church, but I don't believe in hell and heaven. I believe there is an afterlife for everybody and it's a good afterlife. So there isn't an idea that if you sin then you go here. So I guess when it comes to a suicide, I don't believe that my uncle has gone to a bad place because of what he did. I believe that we all go to the same place, and it's a good place. It's a positive place. So maybe in that sense it does, in terms of coping I don't feel...that oh he's gone to hell, because that's not about what I believe, and I never did. I don't believe in it...I believe that he has gone to a good place.

Three had a view of God as accepting the loved one who suicides. The move towards a loving image of God seemed to help survivors to retain a human view of the deceased.

Um, and I don't know if religion really helped or not because it did, it scared the shit out of me. You know, like? It just made me more angry too... That she was in hell. That she was Satan's minion and was suffering. So, what was she supposed to do? She was supposed to continue suffering on earth and hope eventually it would eventually get better?

You're saying that she killed herself in vain. And now I'm without a mom, and she's still suffering and she got tricked into thinking that she would be alleviated from the suffering. But you're telling me that she's just somewhere else suffering...like, how dare you say that. It's ridiculous. So...um, I think that, it just made me rebel against um, Catholicism.

So, um, but I know it was a decision of hers, but it hasn't really been eased over, the whole Christianity thing. Its underneath all that, under the pity, it's your cardinal belief that she's in hell because she committed the only thing that God can do, is give and take life. So she took her own life, like sticking her middle finger up at God and the punishment for that is you're going to hell. I just don't I don't agree with that.

...It's not like she was sticking her middle finger up at God, she was kind of trying to get to God faster sort of. You know, as like bypassing all of the bullshit to get there, and God would have accepted her either way.

*

Um, and I have my religious caring about it if you will...because suicide is a sin, according to religion. But this man who was completely and utterly dedicated to God, and the church his entire life, I doubt that God would have turned his hands on him, you know coming to the doors of heaven.

*

Uh, well, it is not a sin. It is not a sin...because we have a loving God, and so if a person is in that heightened state of mental instability, and emotional instability...and really have...lost the light at the end of the tunnel, um...then they basically want to go to a safe place. So they take their lives. And that, that to me can't be equated as a sin.

(d) Continued Attachment

Four participants noted a felt presence from their loved one following the suicide which gave a sense of comfort and knowledge that their love one was safe.

And I have always all my life, since I was a kid, had this affinity with butterflies. Umm, and my kids knew about it. I love butterflies. I love the whole idea of metamorphosis and change in life... And...I had said to [my son], "When I die...I will come back as a butterfly, and you watch for those butterflies because I will be there to give you a sign."

...And then, his response to me was, "Well I'm going to be dying before you so I will come back as the butterfly, so I will be the one...and you'll be the one that'll have to watch for butterflies." And I believe that happened... I mean butterflies were appearing everywhere, and around me.

*

We put the tobacco in and it's...going, and smoke comes up. And it comes towards me, and it comes over me. And then it goes towards the lake....It was wonderful. I felt at that moment I had to let go, because if I didn't let go I was stopping him from going... I felt that he smudged me. He was...it was symbolic. OK. The smoke was symbolic. Symbolism is very important.... He came once more to me and then left.

Here it seems the act of smudging eased the feelings of grief, and was a ritual that evoked a felt presence helping this mother to let go of her son.

There's a big tree in front of where his gravesite is and one bird showed up, and then another. And by the time I left there were like ten birds in this tree going, "Yap, yap, yap, yap!" So it was just to me little signs that you know, he's OK. And he knows you came, and he's happy you came.

*

...so as I read I realized that sometimes the bed would shake a little bit. Well people had told me that Ottawa is built on a, a...what do you call that? (*laughs*)...a stretch which sometimes is given to earthquakes. Anyway...well this isn't an earthquake.

So then I said to the oldest boy, "Have you had a visit from your mom?" He says, "Every night I'm getting really tired of it "

And I said, "Well you know what? She's been shaking my bed."

"OK" he says.

"We have to talk to her, and tell her that we are managing the best we can. And we would really like her to depart a little farther."

So, one night I sat there and I talked to her. The bed stopped shaking. And, she came back occasionally after that but not as persistently. And what she needed to know...she came...it was interesting; she knew when the young one was in trouble, and...that's when the bed would shake.

*

For example, [my son] his whole life, from the time he was a little boy, he was going along and he'd say, "Oh, that light's going to go out." And it did. And we used to laugh about it, saying that he could, you know, make bulbs burn out. Well after he died, you have no idea how many light episodes happened (*laughs*) to both myself and my daughter.

One night [my daughter] and I were talking on the phone. I lived in [x] so I'm on a different hydro system than she is. She lived in [y], so, we were two different things. And I said, "Goodness" we were talking about [my son], "my lights are flashing on and off."

And she said, "Mine are too." And it was only later that we realized that we're on two different hydro systems. It would be very unlikely that they...and it only lasted for a few minutes and then it stopped...It was [my son]. I'm quite convinced. ...It's comforting. It's comforting. They're still around. Like I believe that spirits are still around. And I think I've believed that probably my whole life. Absolutely!

Three other participants noted the importance of preserving continued attachments with their loved ones who suicide by keeping their loved one's memory alive. This included remembering them on special occasions and doing special rituals for them. Here the bereaved noted that the person who dies deserves to be remembered, that they existed and were important.

Oh yeah! For sure. Every day. Oh yeah. Like it's going to be ten years this Christmas, and I still miss her like crazy. And it's still the same. And I still laugh about things that we did and look at pictures....I write to her. I write poetry for her...

...I visit the cemetery. Uh, that's the other way that I have. That's the other way I have to connect to her... Yeah, um...well, I did a lot of remembering...And doing celebrations in terms of like celebrating her birthday and having small remembrances.

*

I remember the little things she used to do, and I try to make a point to keep doing them... she used to sing songs about animals. She had a song about her cat called Boo so I made a, to the song Whinnie the Pooh, so I made new one, we have a new cat called Olive, so I made up a song for Olive that's to the tune of Whinnie the Pooh... Um...I don't want to be...sorry this is a...hard (*tearing up*)...um (*laughs*)...I don't want to be the only one that remembers her. So um, yeah I try to make it a point to having everyone exposed to her, you know? And I don't want to have her forgotten.

I tend to think like on her birthday and on the day she died, that I might be the only one that remembers that this person ever existed, so I want to make that a daily thing...because she existed and she was important and she deserves to be remembered. So yeah, I tried to do that.

*

Ah, yeah Um in bizarre little rituals in my own way actually. Um, for years, uh, I used to wear a bottle opener which was his. It was like a piece of led, into a bottle opener that he had on his, as a key chain. And I wore it around my neck for probably ten years. And one of these rituals that I've had was in the theatre oddly enough, um, before going on I would sort of actually hold it as a tassel and kind of do my own personal prayer to him. Uh, every, before a performance. It was a ritual for theatre as well, but in an odd way an attachment to my father.

I think it gave me strength and gave me confidence. I think it was the whole idea that he was looking over me. Uh, and asking for his strength and his help. Um, plus I was about to do something I enjoyed and took pride in, and perhaps there was a need to have him, in some way or another, be a part of that.

Three participants noted lighting candles as an important ritual (sometimes spiritual) to remember their loved one who suicided. One woman who lost her uncle to suicide describes the process of lighting a candle in church for him, and the conflicting message she has been told about lighting candles in memory of those who suicide in her family's Orthodox religion.

When I have those moments when I'm really missing them, or feeling like there's a big hole, I have a little ritual, which is a little angel candle. So I'll light the little angel candle...you know, spiritually wishing them well by lighting the little angel candle. Hoping [my friend's] way gets lit, and because if he's stuck in the darkness then let the little angel light his way. Um, when death occurs suddenly I light my little candle because to me that a, that little angel candle means a lot to me and I light it on all of their anniversaries. So, you know the anniversaries of their deaths never go...

*

... I just, I like to light the candle. That's the only kind of spirituality that I have at the moment. It's weird that I totally reject this religion, but I go and I light two of those damn candles. Um, still, you know and it helps me. It really, really does... I just say a little thing and, for some odd reason they can hear me all of a sudden when I light that candle.

*

So when somebody dies by suicide, again in Orthodox religion, you should not light a candle for them. And that's something we do. I don't know if it's practiced in other religions. But what we do is we go to church and we light a candle for somebody who has passed away. And that's something I've done as a child even, you know, I don't really follow any other traditions. But that's something I'll do. If I'm in an Orthodox church wherever in the world that may be, I'll often light a candle for my grandparents, for my other uncle.

And I actually did not know that you should not light a candle for somebody who committed suicide. And I did. After he had died there was a point where I went to church and I did. And it was only later that somebody said that to me. It was my Aunt who had said, "Maybe you shouldn't." So that's kind of the struggle. You know it's weird on one end the church says you know you shouldn't. But I mean, why? This is stupid. So there's a little that's strange, uncomfortable.

6. Changes in Relation to Self and Others

(a) Less Judgmental, Greater Compassion

Four participants noted being much less judgmental of others and having greater compassion following the suicide. One man noted being less judgmental and that this was a good thing, however his being this way was not worth losing his son.

I think perhaps I'm kinder. I try to be more sensitive to people's feelings. I, I don't think...anybody goes through any life changing experience that they don't come out the other side a better person.

*

...my spirituality is changed to be...less judgmental I guess.

*

I'm not, I don't think I'm quite as judgmental as I used to be. When I'd see something on TV, (*coughs*) where you'd see people smoking drugs or something on a street corner. Well my immediate reaction was get a life, pull your socks up go to school, do something. I'm still somewhat like that, but I tell myself now, what circumstances put them there. It's not always necessarily all their own weaknesses or failures. Something drove them there.

So I think I'm more tolerant than I was which is a positive thing. Not worth going through this to be a little bit more positive.

*

Getting to know people's stories going through it...that's what made me change growing to compassion, better understanding of people not wanting to live.

(b) Greater Life Perspective

Two mothers noted greater feelings of personal growth and new life perspective that would not have occurred without the suicide of their sons. In this first narrative a mother notes how she has become less angry and anxious after losing her son to suicide.

Oh! *(laughs)* Drastically! All the stuff I had taken for granted, or believed in, or, or just took at face value...felt different. I'm sometimes amazed when I get angry about some stupid government thing, and I think, well... *(laughs)*. Because I was a very *(makes growling noise)* you know? I had lots to say, and I had opinions and so on. And now on most anything *(laughs)*, I mean I still have, I just don't...It's gotta be really important now in order to...Not much really phases, I just don't give a shit about most of it *(laughs)*.

Sort of like, don't sweat the small stuff, and it's almost all small stuff sort of thing. It's...a... *(sigh)*...I find in life, unfortunately the biggest growth is in death.

Another mother recalled receiving letters following her son's suicide where those who wrote to her told her how she had positively affected them. Such affirmations brought greater meaning to her life and would not have occurred without her son's death.

As a result of [my son's] death I got to know what most people never hear in their life. That somehow, you and your presence in this world made a difference to somebody else's life.

And usually those are the kind of things that are said when somebody has died, and the person that's dead doesn't really hear them.

[My son's] death allowed me to hear that my life had meaning.

(c) Heightened Awareness of suicidal ideation in others

Two participants noted that they have a greater awareness and ability to notice the signs of suicide when interacting with others.

I've taken a number of courses in suicide prevention and I am very aware of looking for signs...

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It has shifted the way I interact with other people...I think I'm a lot more sensitive to cues of somebody having suicidal thoughts, suicidal ideation. A lot more sensitive to that... I'm not scared to ask the question.

B. MENTAL HEALTH PRACTITONERS

A total of ten interviews were completed with mental health practitioners who had experience working with individuals bereaved by suicide. Six of these participants were part of the first group of survivors who were interviewed about their own personal experience. All six were interviewed a second time concerning their professional experience as bereavement facilitators with others who are bereaved by suicide both individually and in groups. Additionally, one facilitator also had previous experience working as an individual counsellor with someone bereaved by suicide.

Four other mental health practitioners were interviewed, including a psychologist, a social worker in an emergency department, a hospital Chaplin and a member of a post-suicide debriefing team. These participants had no personal loss to suicide but were asked about their experience in working with those bereaved by suicide. In the interviews the following themes emerged:

1. Emotional Responses

- (a) Shock;
- (b) Anger;
 - i. at the system;
 - ii. at the loved one;
- (c) Guilt;
- (d) Child death and guilt.

2. Issues Around Creating Meaning Following Suicide

- (a) Difficulty integrating;
- (b) Meaning is an individual process;
- (c) Asking questions that are often unanswerable;
- (d) Helping survivors accept that they may never make sense of suicide.

3. Addressing Spiritual Issues

- (a) Address religious and spiritual issues when the client bring this up;
- (b) Belief in an afterlife creates hope;
- (c) Need to accept the mystery.

4. Practitioner Environments

- (a) An environment conducive to talking;
- (b) An environment that is empathetic to pain and suffering;
- (c) A non-judgmental environment that views suicide as a choice;
- (d) An environment of emotional processing;
- (e) Exploring both positive and negative continued emotional attachments.

1. Emotional Reactions

(a) Shock

When working with individuals bereaved by suicide, three mental health practitioners mentioned the shock that survivors go through and how this affects the timing of interventions that they provide. The shock that someone experiences following suicide may make them quite immobile to treatment early on, yet once this shock subsides treatment may progress.

A social worker in a hospital emergency room noted the shock she witnessed among families immediately after they receiving the news their loved one had died by suicide. This professional had the role of liaising between the bereaved family and other hospital staff.

...we would certainly sit with them, try to process some of the shock ...of the whole situation. If they want to see that person then we would be preparing them for what they are going to visually see when they view the body.

...everybody reacts very differently. Except most of the time it's shock.

We've had people faint. We've had people, um, start vomiting, we've had people that just start screaming uncontrollably. Um, and it's just being with them, and making sure we just, you know, giving that time so that they can absorb and let those feelings out, and then go on from there.

She continues that very early on a survivor's shock may prohibit them from understanding that their loved one has taken their own life.

...sometimes they're not ready to absorb that and to detach from that person. And you know there's that whole bit there, "Are you sure that, you know, this person died?" And sometimes that's why sometimes actually for them to see the person and to say goodbye is a really important therapeutic piece. Not for everybody, but for some.

A post suicide debriefing team member describes the difference in shock that people experience based on the time that they receive assistance.

I found quite a difference between if we do go in right after people are so much in shock...they can't express or feel. But if you go back a week or two later, I think then people benefit quite differently from a debriefing.

Shock may play out differently when survivors show for treatment later on in group or individual settings. A bereavement facilitator who also had personal loss to suicide noted varying degrees of shock that she has seen in her suicide bereavement groups.

For some people it might be complete and total shock. They didn't see it coming. ...And then there's other people I think who lose someone, and they've made a previous attempt or attempts...So there's a problem, or there's mental illness, or there's serious hospitalization. You know, dealing over and over with someone in that position, which is hard too. ...And then there's other people too where, they go through a very seriously rough

period in their lives, but nobody recognizes how bad it is, and then there's this act and then they're gone...it's almost shocking too.

A psychologist also describes differences in grief work based on how the bereaved person learns of the suicide and how shock is registered. If someone finds a body this may cause a different shock reaction than if person is told of the suicide from someone else.

Um...if they were working with it from the past, then you would be doing a lot of grief work. Looking at how the suicide affected the person. Um...whether the person saw the actual body. Whether it caused some post traumatic stress disorder, and that they had intrusive thoughts about the person, sort of their whole life long, and couldn't get rid of them, or whether it was...it happened, and they didn't have any contact with the body, but how it affected their life to have their father, to know that their father committed suicide, or their mother.

(b) *Anger*

i. *At the system*

Anger was an emotion that was talked about explicitly by mental health practitioners who noted seeing this in their work with survivors. Many mental health practitioners noted those bereaved by suicide are often angry with the mental health and medical systems for feeling like these systems failed their loved one. Three bereavement facilitators, each with personal loss to suicide, all describe the anger that they have seen their participants express towards the mental health system.

And sometimes, a lot of times, anger. Anger at the system...you know "Why didn't the system do something better?" "Why didn't the medication work?", "Why didn't the doctor see this was coming?" All related to being able to stop it.

*

Yes, very angry about the system. And she wasn't the only one. Once she spoke about that there were others who had lost, tied into the mental health system, and um, felt that it didn't...really serve what their person needed. And that's really hard when you feel you've been let down by what should be a good system.

*

...there were a number of people who had lost someone who had been in the hospital for months and months, if not years, in and out of a system that wasn't helping them at all. And then eventually they killed themselves, or they walked out of the hospital. They had somehow fell through the cracks and died, and that's not acceptable. It's crazy...it just seems that people are being lost in the shuffle.

ii. *At the loved one*

Two mental health practitioners also described some cases where they say the survivor directs their anger at their loved one who suicides. Additionally, one practitioner noted seeing survivors experience anger after initially finding out their loved one had taken their life. This resulted from being unable to comprehend this new situation before them.

And then you get the anger at the person, sometimes. Sometimes people are even angry at the person who died. You know, quite often again it's a selfish thing, "You left me all alone," particularly a spouse. Here I am having to look after everything.

*

Well there's lots of anger at the person who's committed suicide in many ways. They're dealing with all the stages of grief, but anger is one of the big ones. You know, there's denial and there's bargaining...boy are they angry.

*

...and anger. A complete anger that's almost verging on a rage. Just not understanding exactly what happened.

(c) *Guilt*

All mental health practitioners mentioned seeing those who have lost a loved one to suicide struggling afterwards with guilt. Often they noted that while this guilt is unrealistic, at the same time it is very real for those who are bereaved and can be quite immobilizing for them.

So for family members, and then the guilt...is *bad* I think. If the person could come back and tell you it'd be great.

*

I guess a lot of it is related to the guilt, where...where people can become just so guilt ridden where they, um...become quite immobile. So I've certainly seen a number of people that have experience and coped in that way. Or not coped.

*

Guilt is one of the biggest things. "*How could I have not known this person was feeling this way?*" ..

*

I mean, um...they're so immobilized by the event that you're mostly listening and talking to them about their feelings of guilt....On occasion I think you could come across some real guilt if somebody had not really followed up on something they would say they would do in terms of contacting somebody for help. But generally speaking I think the job is to try to help people cope with an unrealistic sense of guilt. Um...which is, although unrealistic, very human to have at a time like that.

Three mental health practitioners also mentioned "what if?" scenarios tied into this guilt.

Um, I think the "what if's" are terrible for people...particularly because connected to suicide is..."What if I had done this differently?" Or, "What if I had been there at this particular moment?" Which...not...most other deaths don't have that kind of connection necessarily. And certainly that whole thing around guilt.

*

They think, *"In hindsight if I'd have known about this, I could have maybe done something."* So they're very, very guilty...especially if the person is extremely close, and they see them on a daily basis.

One practitioner, a social worker in a hospital, noted what if's coming up a lot at her setting when people are just learning about the suicide of their loved one. In this case she notes just listening to the bereaved at this point.

...all the "what ifs" is um, you can't get into too much reality testing at that point because they're so...they're not processing. They're just repeating me and wondering, and questioning uh...and it's just listening to them.

Four mental health participants mentioned a practice which helped survivors combat this guilt is to try to help them understand that they could not read the mind of their loved one who took their life. As such the bereaved could never know what their loved one was truly thinking or feeling and thus they cannot be held accountable for missing the signs of suicide. One participant even spoke of trying to get bereaved participants to shift their view to accepting that one cannot get inside another's head.

And my answer to that, "How could I have not know?" is, "The bottom line is within our society we don't all talk about all of the thoughts that go through our heads...or the feelings that we feel inside."

Um, and sure some people are depressed, so extremely depressed that we see it. And other people have become very, very good at being able to hide it for periods of time. But it doesn't mean that they're not being torn up inside.

*

And sometimes people keep it very, very, very close to their chest that they're thinking about suicide. Can we really observe people that closely in their everyday life to know what they're thinking inside? No we can't. You know, we might have an idea that someone is unhappy, or happy, but as far as the unhappiness, well how far does that go?

*

The shift, the shift is that they realize that they will never know why, because you can never get inside anybody else's head. Um...no matter how close the relationship was. You think you do know what's going on, but not really.

*

They'll say, *"You know, he's been bi-polar...all his life. So we've been expecting this all his life".* ..maybe they accept it....If somebody had cancer you'd say, *"You know, they tried chemo and radiation...and it didn't work and so he's gone."* I don't know if you could do that with a suicide....because you don't know what it was that was in their mind.

(d) *Child death and Guilt*

The theme of guilt following suicide was also mentioned explicitly in cases where mental health practitioners had worked with parents who lost a child to suicide. Practitioners noted being especially attentive to guilt following this type of suicide. Three mental health practitioners noted seeing extreme guilt in the parents that they have worked with who have lost a child.

I think especially of parents who lose a child, a teenager or in their twenties....and don't see the ah...long term life experiences of their child growing up. It's probably very, very sad to lose them; in their prime shall we say?

*

...there was one group that I facilitated in and it was just by chance that all the people had lost...they were all parents and they had all lost a child. And that was probably the most intense groups of all the groups...I think part of it is that it's definitely not the natural order of life as we think it is.

*

I think the worst thing one can experience perhaps is the suicide of one's child....But the amount of guilt that I can imagine myself having, if my child suicided at any age, I would never ever wanna wish that on anyone. It must just be absolutely horrible. And I've seen people, helped people through that. And it's just. .I don't have enough words to describe...the awfulness of something like that. That's just terrible

2. Issues Around Creating Meaning Following Suicide

(a) *Difficulty integrating*

All ten mental health practitioners noted that creating meaning following a loss by suicide, and making sense of suicide is very tough for survivors to do due to the difficulties that come with integrating the event into their lives. This can be due to the shock that accompanies the death, the inability to incorporate the death into their pre-existing life, and the many unanswered questions survivors are faced with following the death.

As such, many mental health practitioners reported seeing those they have worked with struggle with this following their loss. As well, one mental health professional noted that integration of the suicide into the survivor's life may happen more easily on an intellectual level than an emotional level.

But a lot of the time they aren't making sense of it. They're just in such an overwhelmed state of shock that they're just not able to make sense of it.

*

Make sense of the death? Well that it's pretty much a senseless death...

They have to make sense of it. They have to incorporate it or accommodate it into their view of themselves... They can't. They have a hard time doing it at first.... But as time goes on and we talk about it and process it, they understand, you know.

As this psychologist notes, making sense of suicide is an extremely difficult process, and especially early on when the bereaved is in shock, they are likely physically incapable of making sense of the suicide due to the traumatic nature of the death. Often making sense of suicide is a paradox. They have to make sense of that which is senseless.

Oh boy...I wonder if you ever do? (*laughs*)...you know?...I don't think anybody understands the complexity of why people die by suicide. And I think that stays with families...because you wanna know why.

*

...(long pause)...I think, what tends to come out of my mouth at times like that is, "I know that this won't make a lot of sense right now...and it wouldn't make a lot of sense to me either." And I really wouldn't expect them to make a lot of sense of it for a while. And that there will always be an element of it not making a whole lot of sense.

*

...you know there were, seriously, there were a few where they could not make sense of the death because it seemed so bizarre...just out of the blue. They did not know where it had come from. It was just an overwhelming feeling of loss and hurt. So I remember a couple that were kind of like that, and it didn't make sense.

*

...a lot of them don't make sense of it because there's a lot of questions...so many unanswered...pieces of it.

This next narrative, from a bereavement facilitator who also had personal loss to suicide, noted that there are differences in a survivor's ability to integrate meaning of the loss intellectually versus emotionally.

She would understand it intellectually. Emotionally is another thing...

...I'm not sure that we do that. I think we learn to cope with it because we have to. The bottom line is they're gone. I'm not sure that we make sense of it. I certainly haven't.

One bereavement facilitator who also had personal loss to suicide, noted the bereaved may sometimes make sense of suicide by viewing it as a decision their loved one makes outside themselves.

Sometimes the making of sense is that the person wasn't in their...their right frame of mind...wasn't themselves in that decision. And therefore it wasn't even a decision they made, right?

It's a decision made outside of their right selves. So...sometimes that helps make sense of it. Um...sometimes what helps makes sense of it is, for some people because there's been a history of attempts, and there's been more drama around it.

The uniqueness of this process is illustrated in the following quote.

I worked with someone...this person indicated that they were making sense of it by literally...understanding more physically what happened to the person prior to their death. Through coroner reports or through factual evidence, or that kind of thing And I think somehow that appeases people to a certain extent by...giving them a very physical, natural picture, you know?

(b) Meaning is an individual process

Still, other mental health practitioners noted that making sense of suicide is extremely personal. Two bereavement facilitators noted that while survivors want to make sense of the suicide, doing this is an individual process that cannot be given to someone.

I mean, everybody wants to understand why...um, we can't obviously give that to them. I think making sense of it is very personal. It's not something you can really give to somebody.

*

I dunno whether you ever make sense of suicide. It's a very personal thing. A very personal thing. Sometimes it's a spontaneous reaction to some big change, or a loss, or something has happened in a person's life.

(c) Asking questions that are often unanswerable

Mental health practitioners noted that following a suicide there are often many deep unanswered questions such as "why?" and "what if's?" that survivors will ask. These questions also make making sense of suicide very difficult because often they may never be answered. Four mental health practitioners noted this when working with others who have been bereaved.

And yet...in my experience, and hearing other people's stories...I think it's such a very personal decision, that I don't get wrapped up in the "Why?" Um, but families do, and I respect that.

*

And she actually had left a, a suicide note. And it...it certainly explained a lot of how she was feeling. But I think it leaves a lot of unanswered questions. And...um...certainly there's a lot of common threads that go through unfortunately with um...suicide, is the end result of someone's life is that the "what if's" um...he definitely had,

along with other people I've dealt with, with um, family members who have taken their lives by suicide, is ah, the "what if's." And that is the "what if I did this?" or "why?"

*

If somebody dies from cancer, they might esoterically say "How could this happen?" But the suicide is a much deeper kind of, "How could that happen?" ...And I think there's a stronger need to have some kind of an understanding of those answers.

(d) Helping the bereaved accept the suicide without making full sense of it

This was mentioned more by those who had personal loss to suicide and worked in mental health rather than those who did not have personal loss. Five bereavement facilitators/survivors mentioned the importance of helping people not get-caught up in making sense of suicide, but rather accepting their loved one's choice, while only one mental health practitioner with no personal loss (the hospital Chaplin) noted this need for acceptance.

You know, at first you think you gotta know And that at some point you know you have some kind of answers, but then you realize that you're never really going to know certain things. You're never *really* going to have the answers to certain things. And so there comes a point where you, you give up...you give that up, and you come to some acceptance, right?

*

.....*(long pause)*.....I don't know if we ever make sense of the death. That sounds all far too rational *(laughs)* Uh, and I don't know if people make sense of it, as come to...accept it.

*

Sometimes as time passes you kind of get another little clue...uh, and that. But, we try to...we try to keep them focused on not trying to figure out the "why?" But to realize that this has happened, and so now how are they going to cope?

*

This isn't going to make a whole hell of a lot of sense. So I think there's some kind of a...perhaps a need to accept that the world does not always make sense.

*

I mean, someone takes their life and you don't know why, then there's no way of ever making sense of it, because to me there's no...I mean, you can accept it, I guess...we don't have a choice.

A final bereavement facilitator shared her personal experience of working with suicide survivors and seeing them exhaust the process of making sense of the suicide, before being able to truly let it go. She noted that this was an inevitable process that all those bereaved by suicide go through.

...they are really trying to make sense. And this is part of the big reason why it's a separate group too. Uh...because, because the suicide is a choice that the individual makes right? And so they're trying to make sense of *that*. And, like I think I said before, you can't tell them not to. You can't tell them, "Well, you'll never be able to make sense of it." They need to explore all of that before they're able to put it to rest. And I think mostly people exhaust that avenue and then come to acceptance that they're never going to completely make sense of it. And it will only be the sense of...that kind of a, facts of what took place.

3. Addressing Religious/Spiritual Issues

(a) *Address religious and spiritual issues when the client brings this up.*

Eight of the ten mental health practitioners said they addressed religious and spiritual issues in working with suicide bereavement when the client brought up the subject. One participant, a hospital Chaplin did address this dimension as this was based on his vocation. One mental health practitioner noted actively discussing spiritual topics in her bereavement group. All mental health practitioners indicated they would work with what the bereaved individuals felt comfortable sharing about their spirituality or religion. Many also noted not wanting to force their own views on the bereaved. Most noted taking a passive approach where they would follow their client.

Well...again it depends on the client (*laughs*) Um...I don't force my religious beliefs or my own spirituality on any client. They have to let me know where they're coming from, and if their coming from somewhere that's religious or spiritual, they'll let me know. I leave it open enough so that they can actually talk about it.

*

I think when I've talked to survivors if they wish to talk of their faith, or their spiritual life I'll listen for sure. ...If it's mentioned I will work with it (*laughs*)...like anything else.

*

You know what? If it comes up, then yes. If they bring it up and talk about the way they think about it.

*

It does come up. It's only usually when they bring it up.

*

It could be sort of like an option of what they need, in terms of the way they deal with things. I've seen people change also in how they deal with things. They might not be very religious and suddenly things change and they start to re-examine that, and find more meaning and understanding in religion. And you know, look to it a little bit further, you know, to see if they can feel better I think, and find ways to make sense of what happened I guess. If that's how they want to do it...if that's how they want to approach it...yeah.

The following three narratives from bereavement facilitators, each with their own personal loss to suicide, take differing approaches towards addressing spiritual/religion in their suicide bereavement groups. The first two facilitators noted that their bereavement groups do mention spiritual issues with participants, while the third facilitator noted the importance of allowing the group members themselves the right to decide if they want to talk about these subjects.

Ah...they don't understand the haunting grief. And the...and I don't think they understand the spiritual part of it. We don't, we don't push the spiritual or religious part of it at all, because everybody has a different take on that. Um...but we do mention it, and we do talk about it.

*

I really...I don't mind introducing the subject of it, but I really stay out of laying on, "Do this, and this, and this..." because I don't think it's appropriate. ...Grieving is very personal.

*

And spirituality or religion...it can be chosen as a specific topic to really dialogue on. Um...we let the group decide that. And...But it's not something that we bring into the group ourselves unless the group brings it in. So if somebody brings into the group how they coped and they went and that they found that prayer and praying to God...however you wanna describe it, was helpful for them...great. If somebody says, "You know, I don't understand...there is no God." Great, share it....because the goal really, keeping in mind, is to meet the needs of the participants. And to help them through their process. So if there's things that are troubling them, or bothering them, then those are the things that need to be addressed....

Regardless of the differing stances that mental health professionals take on either introducing these subjects themselves or allowing their clients or group members to do this on their own, it seemed very important for practitioners to keep in mind the personal aspect towards grieving in any discussion of religion/spirituality in relation to that grief.

Many mental health practitioners also noted feeling more comfortable addressing spiritual issues, but not issues relating to formal religion. One bereavement facilitator with personal loss to suicide noted this in the following narrative. Once again she seemed to emphasise the importance of the personal aspect to a survivor's spiritual or religious views in relation to their grief.

I do. I don't know if the others do or not. It's a touchy subject. And usually I don't refer to it as a formal religion. I always say, "If you believe in a higher being." Whatever that might be. I frequently will say, I believe in the Angels, if you don't, that's fine.

I have a very strong spiritual belief. So for me it's natural to look for a higher being for help, whatever that may be. And generally speaking I believe that we're supposed to be where we're supposed to be and we are given these challenges, because we're given these challenges for a reason. So for me that's...you know, that's how I believe that is. And you can't instil that in anyone else. They either believe something like that, or they don't.

Religion was seen as both a positive and negative aspect for coping with suicide. One mental health practitioner noted both positive and negative aspects of religious coping at different points in her interview.

I was always appalled by the Catholic Church at the time...and you know, people not being able to be buried, and consecrated. That was a long time ago, but when I was a kid that was still happening. Ah...and what it did to the families not to be able to have rituals...you know?

And years ago, I went to...not prior to this work...but I did go to a funeral of someone who had died by suicide. And the priest talked about it really openly and told everybody there "Be supportive of this family." I thought, "Wow, I wish there were more of you!" (*laughs*), you know?!

A psychologist noted that early on any religious or spiritual beliefs will be of no use to help the bereaved because of the shock they go through following suicide.

It's so traumatic, that whatever belief they have, I usually put on the shelf while they are dealing with it...And a belief, a strong belief in God um, isn't going to make it easier in the beginning. It may make it easier once they've processed the grief. And at the end of the grief, maybe return to the church to get some comfort then, but in the midst of the trauma, in the midst of all the intrusive thoughts, the numbing the dissociation, the self incrimination, the guilt...God doesn't really have a lot to do with playing into it... They're lucky if they can take a breath, uh...during that time.

Because of the difficulties with grieving such a trauma the person may be physically unable of making sense of the suicide and unable to access any spiritual or religious resources, if they have any. This however may come later as time passes and certain beliefs they have may assist in creating hope following the suicide.

(b) Belief in an afterlife creates hope

Many practitioners noted a belief in an afterlife gives hope or comfort to those who have lost a loved one to suicide, and was seen as a positive way to cope.

I think it's comforting. If they believe, it's comforting. Certainly I continue to do that.

*

Hope is going to be a big thing because you're kind of devoid of everything else. Your loved one's been taken away from you, brutally, awfully, with all this guilt. What else could be left but hope? So, belief in an afterlife is hope, isn't it...

Hope that they can move on and that their loved one is a, in a better place...And I can't really know that there is an afterlife. But you see by faith, I can live as if there is one. There is a difference.

*

Mmm...well I would suspect that that must help a lot, because you think, "OK, I'm going to see that person again." I would suspect that would give people a different kind of hope than somebody who doesn't have that belief for sure....There's something less final about it isn't there (*laughs*).

*

Whether you're Christian, Buddhist, Muslim...believe in everlasting life. I think that's basic to all the religions across the board. And if you don't believe in everlasting life and that this person will live on in a different sphere, uh...if I thought the ashes that I bury in the ground was all that would ever remain (*of my husband*) I don't know whether I could live with that. I just consider that to be symbolic. Ashes to ashes and dust to dust.

Two other mental health practitioners noted that more positive spiritual beliefs about the afterlife could help the bereaved in their coping. One mental health practitioner mentioned God, while another mentioned spiritual beliefs as being more comforting for coping than religion in terms of the connection between suicide and hell.

I think people who have expressed a belief in a loving God, and uh, an accepting God...who can see God as having more understanding, not less than we do. Ah...do not then have to worry about some horrible things where their loved one is in the afterlife.

*

I think people who are more spiritual would not have that belief. They would believe more that people have a right to do with their own life what they want. We hope that everybody does a good thing with their life, but um...they wouldn't have that connection between suicide and hell.

One mental health practitioner (both a bereavement facilitator and survivor) noted not having a belief in an afterlife but acknowledged that it could provide comfort for some people. While she did not share this belief in an afterlife, she noted that she personally believes that after a suicide the person is no longer suffering and this helps her when working with other individuals bereaved by suicide.

Yeah...I think that gives comfort to some people. To know that the person they lost is in a better place. And I don't mean in a better place like literally...I mean like literally that they're in a better place mentally. They're not suffering anymore. And it's not like they're suffering from cancer or another type of illness, or whatever it is...which could have been the case too, for example. Um...they're just not living with that pain day in and day out. They're not suffering with the choice, or having problems living their life, because obviously they want to end their life.

...Well again, I don't really have that belief, so it's hard for me to even envision what would happen to someone in an afterlife. Technically I don't have that understanding...but to the same degree, I know that when someone's died and they're gone, yeah, they aren't in that place. They aren't suffering. And they must have been through a great deal of suffering to take that step to end their life. I, I can't imagine what that must be like.

Some also noted a belief in afterlife can cause problems with coping depending what a survivor believes.

I think it can help and it can hinder, depending on what you believe. Cause I think if you do believe that it's a sin and that person is going to go to hell...I would think that it adds to the burden of thinking...you know now you're thinking that they're in hell. Because of that I feel sad for them.

Um...so I think it can burden that way. But I think it can help if you don't believe that it's a sin and they won't go to hell. But if you do believe in an afterlife, then well, you will meet...you know, it's not final. You will get to see that person later, in another world. So I could imagine that it could be helpful that way, but you don't think of suicide as the final...that's it. You know, I will remember and interact with this person again.

*

I think a belief in afterlife, after suicide...gives you hope, can give you hope that that person has (*takes heavy breath*)...has released their pain, right? That...but sometimes people may believe that a belief in afterlife means they're suffering from the fact that they *chose* death.

*

And very often there's still this, still this little myth that this person still won't be given any rest because they killed themselves...I heard it occasionally that somebody is a...um...suicide is a sin according to them, so they can't be buried in hallowed ground and...you know, they're not going to be taken up to heaven very easily if they kill themselves.

...if they think that suicide is a sin, then that person is not going to have a very good afterlife, and it would make them feel even more guilty, right?...That they couldn't have stopped them.

Similar to issues around introducing religious/spiritual beliefs, mental health practitioners took differing routes to discussing afterlife beliefs with survivors by suicide. One woman who was a bereavement facilitator who also had personal loss noted the need to be open to whatever views people bring. She also stated that this helped her when working with others bereaved by suicide.

..(*long pause*)...I think more, it's about allowing people to develop their own beliefs about it. So, being open to the fact that a person can have that perspective that "*Oh they're in afterlife and I know their struggling because...*" allow, being open, supporting someone...Being open to that it is affecting them that way.

So, how that helps me in supporting is...just allowing somebody to take on the belief that they want. Just because it's not comforting them doesn't mean I shouldn't say it shouldn't be that.

Another facilitator with personal loss noted issues of the afterlife can be specifically talked about in bereavement groups. Here this facilitator describes how afterlife beliefs and feelings of continued attachment are shared by many bereaved people who are part of the suicide survivor group she has facilitated. Although she noted this was not a designated topic, many survivors had brought this up with her.

And one of the topics that is interesting in the "Survivor of Suicide" group that has often been touched is after death experience. Sometimes people have said "Oh my God. I have had after death experiences but I've never told anybody because I think that they're going to think I'm crazy."

That isn't necessarily a designated topic per se, um, and...but if group members bring it up...although we have designated topics for each week of the ten weeks, there's lots of room for people to...and people do, because if you're feeling intensely about stuff, somehow it will come out in the ten weeks, regardless of what the topic of the week is.

(c) *Needing to accept the mystery around suicide*

The issues of meaning making and making sense of suicide came up again in discussions of spiritual issues surrounding suicide with two mental health participants. A bereavement facilitator with her own personal loss to suicide and a hospital chaplain with no personal loss both mentioned how the “*mystery*” surrounding suicide makes it especially difficult to make sense of, yet it is also something that can be embraced. Often suicide is a mystery for those left behind, and while there can be some degree of understanding often it is quite limited.

...but I think for most people, um, within the context of a lot of mystery and trusting that there are things that do not make a lot of sense in this world that just aren't right. And you come to a limited degree of understanding. The word limited is always important for creatures; because all we can ever do it is come to a limited understanding....

...trying to help somebody make too much sense out of this, because in a way it sort of, to some extent it kind of has to remain...mysterious to some degree, even though there's things you can understand...like they were depressed.

*

It's a mystery. Well why do we die? “Why do we die?” And then, “Why do you die by your own hand?”

4. Practitioner Environments

(a) *An environment conducive to talking*

Mental health practitioners noted creating an environment which allows the bereaved to talk about the suicide to be paramount for coping. Being emotionally present, empathetic and non-judgemental when listening seemed to be the most important element for allowing this to happen. All mentioned being present and listening to be very important, as there are times where one does not know what to say when there are no answers to be given.

I think it's important to talk things out (*laughs*). So I'm thinking that probably the most beneficial thing is being able to talk.

*

So I do think that by thinking more about it, talking about it and getting maybe some information as well, I think that it helps them maybe understand maybe their own answer as well.

*

My own personal bias is being able to talk about it. And I find that it's helpful to people to kind of be able to share it in a space that is really non-judgmental, and open to whatever feelings they bring up. Because what I've heard people say is that they don't have enough opportunity to talk about it. That their friends, or their family kind of, not to say shut down to it, but they're not necessarily encouraging them to talk. And, participants in the program have shared that they want to talk. They want to be able to talk about it. So I think just having a space that feels safe.

*

...My gosh....(*speaking softly*) to be able to talk about it and have a sympathetic ear with somebody who's not judgmental.

(b) An environment that is empathetic to pain and suffering

Three mental health practitioners noted the importance of understanding the pain that someone bereaved by suicide carries after their loss. It is understanding the pain by having the survivor share it with you, and by listening to them and mutually feeling this pain that leads to better healing.

I think the first one is probably just expressing their pain, because ah...they don't often get a chance to do that...Because even with people, like family...whoever it is...there's always kind of like a wall that comes up. They don't want to hear so much about it. It only goes to a certain level and then that's it, you know?

*

Um...and to share their pain. So I think that's a...and just to be able to listen. There are no answers. You know, and to feel their pain.

This comment, by a post suicide briefing member notes that helping the bereaved find answers is not as important as being present with them and helping them feel their pain. Others noted the need not to help the bereaved make sense of the suicide but to facilitate a process to help them in feeling their pain.

...even if they could make sense of it all I don't think that's really going to resolve it. I think its feeling the pain, and sharing that pain with others. Um, and discovering once again, experiences of life that are nurturing and nourishing.

Additionally three mental health practitioners; a hospital Chaplin, a post-suicide debriefing member and a counsellor/bereavement facilitator/survivor, all spoke of the intolerable pain that the person who suicides goes through, and how they try to talk to the bereaved about this to help the survivor increase their empathy for the pain and suffering of the person who suicides.

...the person did not do it out of anger towards them, although they could have in some cases, but generally speaking it wasn't in anger to them. It wasn't to wound them. It wasn't because they were a bad person, but they

were under more pressure than they could handle and they wanted to get away from the pain. The pain was too much.

*

I guess I've always understood people's pain. .you know, so...I could understand that people would have suicidal thoughts....It's always related to, when you're in excruciating pain...and it's not that you wanna die, it's just...you want the pain to go away

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..and I think with mental illnesses um, we don't always see the extent to which the pain is there, because people have learnt to hide it. Uh, and I think, and not everybody, but a lot of people have been able to hide it and somewhat function And, and we've been often oblivious to the extent that the pain is there.

So I always try to put it in that perspective of, "OK, but what if you could really see it What if that person's pain was as intense as somebody dying from cancer For them, for that person, that's what that pain was Whether we agree or not...it's sort of immaterial...And I guess for me I keep going back and I tell people, "Well, just because you didn't necessarily see it, doesn't mean it wasn't there."

(c) *A non-judgemental environment that views suicide as a choice*

Many mental health practitioners also noted viewing suicide as a choice or option. In some cases practitioners even noted that they would try to help the bereaved consider this perspective as part of their grieving process.

I'm not a very judgmental person. I am not a judgmental person period I guess (*chuckles*) And so, when a person chooses that route...so be it. It is their choice. There's a lot of fallout from it, and feeling of loss.

*

And what I helped the mom realize was, that it was also a choice of the daughter's.

This preceding quote was from a psychologist who noted the importance of helping a family member accept the choice of a loved one's attempted suicide. Others continue regarding accepting the choice of the loved one following their suicide.

And that nobody can drive anybody to it. There's lots of bad things that happen to people. Like really bad things that happen to people, and they don't kill themselves. So, I think it's a whole other thing that's at work that's within somebody that leads them to be able to see it as an option, and then to actually do it.

*

So I think that view has kind of stayed the same, you know, it's like a choice that people make. It's not an easy thing. It's not a good thing. It's a sad thing.

*

You only have so many options. Suicide is really an option I think that needs to be available to people, otherwise you're taking away their most fundamental humanity. I think your most fundamental humanity in many respects has to be the ability to take your own life.

That's different than choosing *to* take it.

The preceding quote, by a hospital Chaplain, gave a very humanistic and compassionate element to this idea of the choice that someone makes when they decide to end their life. He continues in this next narrative.

I see suicide as somebody exercising their power as a human being, to end something that they find intolerable.

...suicide is a sign of someone trying to access some ego strength. As ironically as that may sound....because it's an option. Something they can do when they feel they can't do anything. If you feel you can't do anything else, at least you can do that.

(d) *An environment of emotional processing*

As well as being emotionally present when working with those bereaved by suicide, mental health practitioners noted helping the bereaved emotionally process their experience to be extremely important. This includes validation and normalization of the experience (both individually and in group work), understanding blocks to talking about their loss, and performing rituals following the loss.

Four mental health practitioners noted the importance of validating and normalizing the feelings of the person who is bereaved by suicide in their work with this population. By validating and normalizing the experience of loss by suicide, mental health practitioners are assisting the bereaved person in feeling their grief. Three participants specifically said if the bereaved are able to fully grieve then this will lead to the best coping.

I'd say, you know, "You need to be sad, you need to be angry. You need to do your grieving. It's OK. I'm here...I'll witness it. I'll be here with you while you're grieving."... I don't shut it down.... As far as I'm concerned, anybody that tries to shut it down by cognitively talking them out of it is doing them a disservice. They need to do the grieving. So, doing the grieving will actually help them cope. Not doing the grieving, or talking them out of doing the grieving, or telling them that things will eventually get better doesn't work... They have to go through it. If they don't go through it with you, they'll go through it by themselves or they'll go through it with another therapist (*laughs*). They have to go through it.

*

That you have to feel your feelings....so that's just as important. Not just talk about your feelings, but feel them. So the experience of that is certainly something that is important too when counselling people.

*

...we get people to tell us how they found out about the suicide...how they you know, experienced it when they heard about it. And then we get them to talk about whatever feelings they have about it, and be able to ventilate that.

Seven mental health practitioners noted the importance of group work for emotional processing. All six participants who were bereavement facilitators for survivors of suicide groups with their own personal loss to suicide, and one mental health practitioner without this personal loss, all noted the great importance of group work for this population to cope with their loss. Many times group work can help reduce the isolation survivors feel. Group work was also noted to reduce feelings of stigmatization, to create an environment of safety and mutual understanding, and to help enrich the mutual feelings survivors' may share that may not be processed to the same degree in individual therapy.

...what they thought was that they were going to get support, and what they eventually realize is that they helped others, without doing anymore than what they were doing when they were reaching out for support, right?...They're just asked to express their experience. And then somebody else listening to that can go, "*Oh, wow! I'm experiencing that. Well then, that's not so bad. Somebody else is experiencing that I'm not alone with that.*" So it's a huge benefit.

*

...being able to share your story and hear another person's story...you don't feel as isolated you know...OK well this just happened in my family, and what's wrong with my family that this happened? But you hear stories of normal functioning people and you realize that, hey it happens to people just like me, normal people. So I think that's one thing that it can do, it just takes away that isolation.

*

So I think in a group, people are able to hear other people and, often I've heard people say, "Yeah, you know what? That's true, I've experienced that." But if left to their own devices, they may not have thought of a particular thing.

I think having a group experience is a really important piece, and I think more um, individual therapies should be recommending that for their clients. Um, and it's not necessarily instead of, but it's certainly I think would be very helpful.

One mental health practitioner who did not have personal loss by suicide also noted the importance of group work and sharing in relation to loss by suicide to help facilitate emotional processing.

...Uh, to hear other people support them in their grief. Um, sort of de-pathologizes things when you hear that everybody feels guilty, rather than "Just me, I'm responsible, it must be my fault."

If all ten people in the room feel that way then it's kind of soothing that, you know. You're at least sharing that guilt. Even if it's not legitimate guilt, it's a guilt feeling, you still need to share that I think. You share with people...it had a comforting effect.

Another way to facilitate emotional processing mentioned by mental health practitioners is to understand the blocks to such processing. Two practitioners noted seeing stigmatization around the topic of suicide as a block to processing which leads many bereaved to not talk of their loss because they feel isolated. Such feelings of isolation and stigmatization lead to poor coping, which again points to the importance of fostering an environment where the person bereaved by suicide can communicate openly about their loss. A social worker noted the stigmatization she has seen and how this blocks survivors from processing the loss.

...a lot of people won't want to talk about suicide, because of the stigmatization, the blame. Um...the judgment from the community...and that's really an individual response. They have to do what's right for them. By not really sharing that with people somehow even isolates them even more, because they aren't really able to talk about their true feelings.

She further describes this by commenting on the stigmatization that the bereaved may receive from others.

A very strong stigmatization... for people to kind of question "Why weren't you able to prevent this from happening?" You know, "What was wrong with you?" I think it affects the person's self esteem... But that can profoundly impact individuals... there can be some real culpability, so it's just weighing on that person... I think that really does affect the grieving process and could potentially end in a complicated grief reaction.

A bereavement facilitator with personal loss noted how stigmatization of this topic can make the bereaved unsure of how to talk to others following the suicide.

I think it's just so hidden and people don't feel that they can talk to their best friend about it so openly. You know and um, people have told me, "When people ask me how I am, I'm not too sure how to answer." You know?

A post suicide debriefing member also describes how feelings of stigmatization discourage the survivor from talking about their loss. Often this stigma may cause survivors to choose who they will talk to and this can have negative effects as they receive less support that they need.

You know, you wouldn't think of that if your son died of cancer, you'd be talking, right? And you make sure you can talk to people you can trust. Trust is a big thing. You know, you wouldn't even necessarily think of that in another kind of death, right? But you're going to choose who you're going to speak to after a suicide death I think. So...um...and that's kind of sad too (*laughs*). Because to me you need five times more support by suicide than another kind of death.

Many mental health practitioners also noted that in addition to stigmatization and isolation, other complicating factors preventing the bereaved from emotionally processing the loss of suicide include substance abuse, denial of the death as suicide and unresolved anger. Interestingly many practitioners noted a need to not condemn the person for these chosen ways of coping, but to explore how such coping serves them.

...substance abuse, um...isolation, any PTSD stuff that doesn't get looked at.

*

...alcohol had come up. Coping through that, um, drinking. And in that sense you don't say, "*Oh, you shouldn't do that.*" You explore that...what is that about? And how does the person feel about using that as a coping mechanism? Does it work? What are the downsides, if there are any? And is that a thing that they need to change? And if they say, "Yeah, I'm not too thrilled about it having to have a drink every time I think about it." OK, well what else can you do? So kind of problem solving, and helping them find better, better ways to cope.

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There are some people that don't...actually call it a suicide....It has no...you know, value in telling them, "*Well that's not good*" or, "*That's destructive.*" You know...or "*counterproductive*" or whatever it is. I think that would be more so negative in the sense that we're there to talk about the suicide. So we're happy to be open with them, and they can say whatever they want.

*

And I've seen survivors who are angry, angry, angry twenty years later. And I'm thinking, "Hey who are you hurting?" (*laughs*). The person died twenty years ago, and you're still angry. And what's this doing to your life. So I think some survivors don't cope well, and they have ruined lives in many ways.

*

So, in regards to emotion, which grieving journey is an emotion...it has physical symptoms and emotional symptoms, and those are healthy symptoms. When we look at them, that they shouldn't be felt...so what doesn't serve a person is when they're told that they shouldn't feel how they feel, right? Or they should get over where they at. That's when outsiders are telling you that...that's when that person also sabotages themselves by thinking something is wrong with them for feeling a certain way. And then they reach out for things like medication which don't serve the situation, because it's just blanketing something they need to express, and then it can manifest in the body, and illness, right?

Four mental health participants noted the importance of performing rituals to assist those bereaved by suicide in coping and emotionally processing their loss. Often rituals were seen by practitioners as a way for survivors to express their grief.

....And that can be very simple as writing a letter to the deceased and putting it under the alter cloth. It can be more ritualized in terms of even um...sending the letter up as a burnt offering. Um, going to gravesides. Talking at the graveside. These things can be very, very important. Again, they're part of a larger approach to dealing with death, not just suicide. But they can be extremely important when there's all these unresolved issues that people are looking at and work their way through.

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I think that's improving but I think a lot of the survivors would say even the rituals that we need for grieving...like people talk about something like a wake....ah you know, during the ceremony if they don't talk about it...it's like, part of its denied. You know, no wonder people have difficulty grieving.

*

Um, and some people really struggle with, "Oh I should have..." you know? Residual feelings of, "Oh, I never said goodbye to that person." And sometimes we suggest writing letters to that person and having that opportunity to say what they want to say.

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...we also ask them if there's a way they would like to celebrate that person's life. So often they'll choose something to do...So in a sense it takes something that's very hurtful into something positive, you know, we could plant a tree.

A social worker who worked with families in the ER noted in cases where the bereaved person was able to see their loved one's body, this was important in saying goodbye. It was noted however that this may be rare in many cases for survivors as many people who suicide may not end up in a hospital emergency room. Thus, saying goodbye to a physical body in this situation may be something that is not always afforded to those bereaved by suicide.

...depending on...um, the circumstances, um...our staff are phenomenal in preparing, and putting bandages if there is major head lacerations or different things that respectfully presenting the body. And there's been very rare circumstances that we would discourage someone from a, saying goodbye.

...more so to give them an opportunity to say goodbye...and some people have very strong feelings one way or another in death in general, and even more so sometimes in suicide is that it's either a very strong "Yes I want to see that person," or a very strong "No, I would like to remember the person the way they are."

(d) Exploring both positive and negative continued emotional attachments

Assisting in the bereaved individual's continued emotional attachment toward their loved one who was noted by practitioners to be of extreme importance. Suicide can not only represent a violent way for a person to die, but also an equally violent emotional detachment for those left to mourn the loss. Thus, fostering this continued emotional attachment may be very beneficial.

While participants noted the importance of feelings of continued attachment, some also pointed to negative aspects of continued attachment to their loved one.

I mean people have an emotional attachment whether they believe it or not, um, often, you know. But, I think it can assist. It could also be negative too. It depends. You see people who seem like they're still married to their dead spouse even though they're dead. It limits their life. On the other hand, I think to be able to communicate, uh, things that you didn't get a chance to say, or that you'd like to say now is very important, otherwise they're sort of stuck there. Um, so I've seen great benefit for people articulating, uh, what they want to communicate to the deceased through God. Um, that could be very comforting because they wanted to say this and didn't get a chance.

So that's, that's probably the big one. The other thing is just to, I mean some people believe these people are just looking after them from beyond the grave. All that can be very comforting thoughts...

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People will often say they'll talk to the person all the time too. They talk to them directly....which can be really important but can be hard sometimes. Yeah, I think too people find that they surround themselves with their things. So they immerse themselves with those belongings or those pieces of that person's life.

One participant noted the need for the bereaved to remember their loved one for their life and not have this overshadowed by the way they died.

That because they chose to do *one* thing to end their life, doesn't necessarily mean that it wipes out and eradicates all the other significant things they did with you or in their lives to begging with, or you know, up to that point.

So it's an important spin on keeping that connection....You're remembering them because of their life and everything they were in their life.

C. SURVIVORS WHO ARE ALSO PRACTITIONERS

The following section looks at special themes which arose out of interviews with six individuals who were both bereaved by suicide and who were also mental health practitioners. From this hybrid group the following themes emerged:

1. **Reciprocal Caring: A way to meaning.**
2. **Self Disclosure**
 - (a) As example only;
 - (b) Self Disclosure and Hope.
3. **Facilitator Self Care**
 - (a) Self awareness;
 - (b) Peer Support.

1. **Reciprocal Caring: A Way to Meaning.**

Many noted that having their own personal loss and using it to help others who have had a similar loss to suicide was very enriching. This gave their own loss greater meaning and allowed them to give back to the groups or organizations that helped them when they were initially grieving. Five of the six participants in this group reported this in the following narratives.

It's been very enriching because my, my own personal experience, two times in my life loosing somebody to suicide...And um...and having gone through reaching out for that support myself in a peer support setting. So, now...that's why I came back to the organization to actually help.

...that's the gift that I can help and support others in that experience. Um...would have I preferred not to have had that experience of loss of my dad that way? Well sure. And I did. So the gift is, now I can support others. That's why so many people eventually have an interest in coming and supporting the organization in that manner. That creates this gift back.

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I sometimes resent the idea that I do this (*laughs*) because if I didn't, if I hadn't gone through it in the first place, I wouldn't even be here. Um...that's only a tiny bit of bitterness you know...But I know that it enriches your life in going through it. It doesn't seem like that initially, but I know for me it's brought a lot to my life.

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I'm just glad to be there in the sense of someone to listen to people. Because that's what I got, and I think that was extremely valuable to me.

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Well, um, I think it stems from when you yourself are bereaved...and you get helped from whatever services you take advantage of. And then this great "I need to give back" happened to me. And so I truly wanted to help to return what had been given to me. And that's how it all started. And I think with many people that's how it works.

One woman who lost her uncle to suicide described even greater ability to making sense of her own loss through her experience of helping others.

Or I might share why I'm volunteering, and I'll say "For me what happened was so horrible. But for me I had to make sense of it. And for me making sense of it is trying to work with it, trying to use that experience to help people that are going through it. So that's how I've made meaning from it."

...that it gives meaning to the horrible thing that happened. And the meaning is that it put me in a place where I wanted to...to work with people, and it gives me some advantage because I've been through a similar experience.

2. Self Disclosure

Self disclosure was a very important aspect for survivors who were also bereavement facilitators. All noted the importance for group facilitators self disclosing their own loss to suicide to their group participants. Facilitator self disclosure helps normalize the experience of the bereaved and create a better connection between participants and facilitators. The following narratives by two women describe the first night they meet with those they help, and the importance of self disclosure.

...well the first night is the, probably the most intense and the most difficult, because everybody shares their story.

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Yep. The very first night is tell your story. And the facilitators start off...Yes. It puts you all in the same boat. It takes two to three nights to establish that trust in each other.

Many facilitators also noted that self disclosure is done to build trust and opening with clients. One woman describes a counselling session where one of her clients had discovered prior to this session that her son had taken his life, and the subsequent conversation they had.

...after he discovered that my son had died through suicide, he disclosed that his best friend had died from suicide when he was eighteen. And this was a man that was well into his forties. And that he still carried all kinds of guilt with him, and had never talked to anybody about it.

...and then he said, "Do you, do you carry a lot of guilt?" and "Do you think that when somebody kills themselves do other people end up feeling guilty? Like do you think that's a normal feeling?"

And that just opened up the whole thing. And I know in the end for him, he said he ended up feeling so much better that he had finally talked about it. And I think he gave himself permission to stop feeling guilty, in terms of realizing that it wasn't about him.

Another facilitator noted the importance of self disclosure to create connections.

As a facilitator, yes. And um, all...that is part of the....and actually for every topic, um, the facilitator also discloses, says something. Not a lot...The, the group is not for the facilitator, but it does help to, to um, for people to connect to that.

One facilitator noted the importance of separating out her own experience from that of the participants she is helping.

We learned right off the bat to try to keep as much of our own stories out of the training and...the actual work that we can, because it's not about us. It's about listening to people, participants themselves. So, um, I think the fact that it's become easier for me after all these years, a little bit easier, you know?... Actually it's much easier...um, I think that makes it a more positive way of dealing with someone. So I'm not sitting in it, and I'm not feeling it. I can make a separation.

She adds that self disclosure should be minimal.

It's not um, unheard of, because it enriches it right? So um,...yeah, initially I don't mind telling them, you know I'm the survivor in the pair if that's the case. So again, I just leave it at that.

I'll tell them, I lost my best friend. My best friend killed herself. Or, my very close friend, she took her life. And she was young, and this was the situation. But again I really keep it very succinct. I don't elaborate on things.

(a) As Example Only

All six participants spoke of the need to always preface their self disclosure making it clear that each suicide survivor's experience is different and what has worked for the facilitator for coping may not necessarily work for the bereaved participant.

And I always say, "This was my experience. This doesn't mean that this is how it's going to be for you." But I think sometimes participants will ask what it's like for others. They're curious...

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I always usually indicate that every situation is different. So just because what I went through one thing, it doesn't mean it will be able to explain what they're dealing with. You know I'm happy to share with them the things that I did personally to help myself, but again those are just ideas.

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And I frequently, when I speak to anybody, not just to the group, but if I do a presentation to, to people, um...I always say, "*This is what I did Cause what worked for John doesn't necessarily work for Mary.*"

I don't know that anything is harmful, because you say, this worked for me, so it's always prefaced by a personal, it's me...and other people do that too...

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Because I was never sitting there going, "*Oh, this is what you need to do.. blah, blah,blah, blah..* " What? If you do this everything is going to feel better? I would never do that. But again, often...and I know the other facilitators have said the same thing...because you disclose your own story as well, it allows the participants to feel more comfortable to ask you, "*Did you feel this way? How did you deal with that? Is this feeling that I'm feeling a common feeling?*" Um, so I think that's good...and I think it's been fruitful in a kind of support group that....there's always two facilitators, and I think it's really important that at least one of the facilitators be somebody who has had a direct loss to suicide. I think what it does is it gives a certain credibility.

(b) Self Disclosure and Hope

Three participants mentioned that facilitator self disclosure creates hope in the bereaved participant. Facilitators are models for participants that one day they will be in a better place with their loss and this can help create hope.

Like by them listening to me when I did have, um, made comments or shared how I did, how have I done this? That *that* often gave them hope that they could see me sitting in the room or the group and being able to talk about where my life is now.

That gave them hope that....the intensity of whatever the grief was they were feeling...there was hope that it could be less.

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...so I think it can, we can kind of say, "Yeah, well you know what? I was in a place where I was really hurting long ago and I've gone through a really hard time." So I think it can make them realize that yeah, we're also human. And maybe give them a bit of hope, you know, that we went through this experience and now we volunteer and we're in a different place.

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So...now I can explain to them in a way that this is what happened to me, and this is where I'm at now. And I don't even need to say anything, and often they'll make the connection...like "*Wow, you've come that far that you can now work with other people dealing with it* "

3. Facilitator Self Care

(a) *Self Awareness*

All six participants indicated they have felt triggered at times during the course of their work. When facilitators of bereaved groups self-disclose and recount their own grief experiences, some can run the risk of being brought back to their own experience. Therefore, it is imperative that they be aware of their level of comfort in sharing details of their experience. Triggering may also happen when a participant they are helping is disclosing their own story, so again it is about monitoring their own reactions to hearing another's story.

And although it's been an extended period of time now, sometimes when someone is talking to me it's like...it brings me right back there. And you remember all of those feelings.

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You know it takes me back to what happened to her.

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I think I try to be really aware of what's going on inside of me when I hear their story. My own reaction. Because sometimes you know, I feel that I am having a reaction to whatever they're commenting on. It might remind me of my own experience or, even get triggered by talking about a particular thing.

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You like put on another hat (*laughs*). You go in and go...this is what we're doing. I don't know. It's hard. It's hard because you're constantly reminded. I'm reminded of what I went through every day, so for me it's not...a matter of coming back to it...Like, I don't experience that grief and sadness and pain all the time. I don't feel that at all anymore, it's something that's changed a lot over time which is great.

One woman even spoke of the benefits of remembering her own experience in creating greater empathy.

I remember a gal, nineteen, and her father had just shot himself. And you know, my father shot himself. I wasn't nineteen, I was twenty-seven, but ah...and as she's speaking I was brought back to that experience. Well did it not serve me to be brought back to that experience and be...no actually it probably served me in that call because I even opened my heart more...

Another noted that bereavement facilitators should not self disclose on the topic of unresolved issues to limit being triggered.

In the group there's more disclosure because, when you're facilitating in the group um...you actually, whatever the topic is you model it. So for example, if it was the week where we were talking about unresolved issues, none of the facilitators would spend a lot of time because, we want the time to be there for the participants. But we would model and saying, "Well for me this, you know, the piece of unresolved issue was, blah, blah, blah, blah, blah...and for many other people it's many other things. Who would like to speak first for, you know?"

(b) Peer Support

All mentioned the importance of peer support when working with others who are bereaved by suicide. It is essential for facilitators to debrief with colleagues after each session.

I think as a facilitator if you've experienced it yourself, each and every group that you facilitate also makes everything very fresh again. And certainly one of the things as facilitator of 'Survivor of Suicide' group that I think was very crucial, was at the end of each session the facilitators always met with the coordinator of the program, um...for us to do our own debriefing. And I think that was a really crucial piece.

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And always after the session we stay, sometimes just for a few minutes...sometimes up to a half an hour to debrief.

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...well there's self care, and we support each other as facilitators or as other people. We debrief after. We have a little debriefing session after every support and share night, or the day program, or a closed group night, we debrief.

D. Exhaustive Description of the Experience of Suicide Bereavement

Survivors

Survivors experienced varied emotions following the suicide of a loved one, including shock, guilt, anger, confusion, disbelief and misunderstanding. To begin coping with their response to the suicide, survivors needed to somehow make sense of the suicide. Many were unable to do so both initially and presently because of the many unanswered “why?” or “what if?” questions that they were left with. However, survivors were able to cope with this by accepting that they may never get an answer to their loved one’s reason for suicide, and accepting the choice that their loved one made in taking his or her life. Additionally some survivors were able to make limited sense of the suicide by seeing it as the result of their loved one’s inability to deal with some difficult aspect of life. In one case a survivor who was not shocked, and expected her son’s suicide was not left with any unanswered questions and was able to make full sense of the death as being caused by the immense pain her son was in.

Survivors found that the best way to cope with their loss was by talking about it. Talking in suicide survivor groups with others who had similar losses was particularly helpful in normalizing and validating their loss. Not talking about the suicide was found to be a poor way of coping, and some survivors even isolated themselves because they had fears that talking about their loss would burden or traumatize others. While some survivors noted not feeling any stigmatization, others noted it was an additional barrier to talking openly about their loss. Survivors were also wary of talking about suicide because they were unsure of the reaction that they would get from others. Emotional dulling through the use of drugs and alcohol was also noted as a way that some survivors distanced themselves from their loss, so as not to feel it.

Survivors used much more spiritual means of coping than religious means. Many rejected religious views that stigmatize suicide and see it as a sin. Most viewed suicide as an act to end a person’s pain which put them at peace. Some who referenced God noted that God would accept their loved one after his or her suicide rather than punish them. Still, others struggled with their beliefs around God following the suicide. Many noted having continued attachments to their loved ones either through a felt presence of their loved one giving them a sense of comfort, or by preserving their attachments by keeping their loved one’s memory alive through various rituals and remembrances.

Survivors noted changes in themselves and how they relate to others after the suicide. They were less judgemental, had greater compassion for others and some had a greater life perspective. This included greater feelings of personal growth, and greater feelings of personal life meaning. Additionally, some had a heightened awareness of suicidal ideation in others. A greater ability to recognize the signs of suicide when interacting with others was found.

Practitioners

In their work practitioners saw many emotional reactions from survivors following a suicide, including feelings of shock, anger and guilt.

When working with survivors, and helping them cope with these various emotions, practitioners noted the importance of creating an environment where there is empathy for the pain and suffering of both the suicide survivor and victim, and where practitioners have a non-judgemental attitude which sees suicide as a choice. Additionally it is important that practitioners be emotionally present so that survivors can feel comfortable talking about their loss, and that both positive and negative continued emotional attachments are explored.

In terms of making sense of suicide, practitioners noted that survivors have great difficulties integrating the event into their lives. Often this may be done intellectually, but is much more difficult emotionally. Meaning was also seen as an individual process that cannot be given to survivors but that survivors often ask deep unanswerable questions when trying to make sense of suicide. An important practice is for practitioners to help survivors accept that they may never make complete sense of suicide.

Practitioners did not want to force their own religious or spiritual views on survivors. Most took a passive approach where they followed their clients if this subject was brought up. Others did actively mention spirituality or religion in their work with survivors, but again this was done in a very respectful way that did not attempt to force outside beliefs on survivors. Many noted a belief in an afterlife can comfort survivors, while some also noted it can cause problems for coping if the survivor has more negative views of the afterlife in relation to suicide. Other practitioners noted a spiritual aspect to making meaning. While the mystery of suicide was seen as being something that can be difficult for survivors to make sense of, this was also seen as something that can be embraced.

Survivors who are also practitioners

Reciprocal caring was shown as a way to meaning for survivors who were also practitioners. Many described working with other survivors to be an enriching experience that gave greater meaning to their own loss.

Self disclosure was a very important aspect for these bereavement facilitators. Disclosing their own experiences helped normalize their participants own experiences and also helped create a greater connection between participants and facilitators. Additionally self disclosure was noted to be minimal in some cases to keep the focus on group participants. It was noted of the importance to preface any self disclosure so that bereaved participants are aware that their facilitator's experience and coping methods may not necessarily work for the participant. Self disclosure was also noted to create hope in participants. Facilitators noted that their own example can help their participants see that their grief can eventually reach a better place.

Participants also noted the importance of having self awareness when they are self disclosing to other survivors, so that facilitators can realize when they are being triggered or brought back to their own experience. Being brought back to one's own experience was also noted as important for survivors to have greater empathy when working with others with a similar loss. The use of peer support to debrief following group sessions was also noted as an important practice for survivors who facilitate bereavement groups for others who have lost to suicide.

DISCUSSION

A. Linking Past Research with Current Results

The results of this study contribute to previous literature, and in some cases furthers the discussion of many aspects of suicide bereavement; including meaning making, guilt, stigmatization and both general and spiritual coping.

1. Meaning Making

This study adds to the discussion by Jordon (2001) that making sense of suicide is extremely difficult for survivors. Like in Jordan, many survivors in this study noted having great struggles in trying to make sense of their loved ones' motivations for taking their life. Many in this study noted great difficulties in making sense of suicide both immediately following the death, and up to the present day when the interviews were conducted. Additionally, some survivors noted expecting to never make full sense of the death.

The results from this study also further the dialogue on the process of how survivors make sense of suicide, as started by Begley & Quayle (2007). In their study they describe a process by which bereaved participants ruminate on the events leading up to their loved one's suicide. The majority of participants noted making sense by viewing their loved one's suicide as an act done on impulse. Others made sense by noting that their loved one's life situation was too difficult for them to bear.

Similarly, five participants in this study were able to make partial sense of their loved one's suicide by viewing it as a result of an inability of their loved one to tolerate difficult life circumstances. Additionally, bereaved participants gave interesting insights into the process of how survivors do not make sense of suicide, yet still come to accept it. While

many participants noted an ability to make partial sense of their loved one's suicide, often this did not answer the lingering question of "why?" that most were left with.

Many survivors described a process of never being able to fully answer this "why?" question and as a result they eventually stopped asking it altogether. This allowed them to: (1) accept that there will always be unanswered questions connected to their loved one's death and, (2) accept that they may never make full sense of their loved one's suicide. This means of acceptance of the inability to make full sense of suicide appears to be excellent in terms of helping survivors cope with their loss.

The work of Park & Ai (2006) notes the importance of trauma survivors having a "will to meaning" (p. 390) that is essential to surviving any traumatic loss. Results from this study may also add to the discussion that survivors of suicide may have a "will to meaning" that is exhausted, leading to this additional process of acceptance. As one practitioner who was also a survivor noted, the process of trying to make sense of suicide is one that the survivor must "exhaust" before being able to put to rest.

Colt (2006) noted that individuals who lose a loved one to suicide generally show poor adjustment to this loss when they are unable to answer the question of "why?" Often this causes additional problems accepting the loss. The results of this study furthers this discussion as survivors who are able to drop this "why?" question and accept the many incomplete aspects of their loss may adjust to this loss much better. As such, the results from this study show that the meaning making process is much more detailed and intricate that has been previously shown. In future research it may be wise to not only approach this question of meaning making as, "How do survivors make sense of suicide?" but additionally as, "How do survivors not make full sense of suicide, and how does this influence their process of acceptance of the loss?"

In addition to furthering the discussion of the process of meaning making, results of this study also contribute more generally to discussions of the “why?” question that survivors are left with. In terms of this “why?” question, one participant noted never having a complete answer to her friend’s suicide as she would never have an opportunity to ask her directly why she had chosen to take their life. The majority of bereaved participants reiterated this stance. However, in one case of a mother who lost her son, this participant was not left with this “why?” question. She noted having conversations with her son prior to his death where he told her that he would eventually take his life when the pain that he was dealing with became too much. This was the only case where a survivor described an ability to make complete sense of their loved one’s suicide, while all others described a limited ability to make sense. This contrasting case sheds additional insight into the survivor’s ability to make sense of suicide when this “why?” is not a factor, and furthers the discussions already put forth by Colt (2006) and Dollinger (1986) that may take for granted this “why?” question as a given following suicide or other traumas. As well, it was assumed by the researcher in the methods section, that this “why?” questions would be particularly troublesome for survivors. While this was the case for the majority of participants, this above mentioned case notes the importance of not assuming that all survivors will have such difficulties.

Additionally, this study contributes to the body of knowledge concerning mental health practitioner’s views and opinions concerning suicide bereavement in their work with individuals bereaved by suicide. Previous research regarding mental health practitioners has focused on the attitudes of practitioners who work with suicidal patients (Herron, Ticehurst, Appleby, Perry & Cordingley, 2001), effective therapies for dealing with suicidal patients (de Castro & Guterman, 2008), and feelings of practitioners following the suicide of a client

(Thomyangkoon & Leenaars, 2008, and Hendin, Lipschitz, Maltzberger, Pollinger Haas & Wynecoop 2000).

This study interviewed mental health practitioners about their views of making sense of suicide. Six of ten participants were bereaved participants themselves and again reiterated the importance of acceptance of the inability to make full sense of this type of death. Two practitioners also noted the importance of accepting the mystery of suicide in helping survivors come to terms with a suicide while not making full sense of the death. Additionally survivors, who were also mental health practitioners working with others in suicide bereavement groups, noted making greater meaning of their own loss through their work in these groups. Many noted it was meaningful to them to be able to facilitate such groups and give back to the organizations that helped them when they were initially grieving. As such, this may challenge previous work by Davis (1998) who noted that making sense of traumatic losses can be both “painful and fruitless.” While the majority of participants could not make full sense of their loss, several did find some benefit out of their experience in helping others with similar losses. Three of the six suicide survivors, who were also bereavement facilitators, also noted that through their own self disclosure in these groups, they were able to provide hope to others survivors. In such cases these losses may be painful, but they can hardly be described as fruitless.

2. *Guilt*

This study also adds to and furthers the discussion put for by Worden (2009) who noted that feelings of guilt are significantly more intense following suicide bereavement. Results from this study agree with Worden (2009) as feelings of guilt and responsibility were not only show in survivor “what if?” scenarios, and present when survivors began to feel

better, but that guilt was also shown to be exceptionally strong in three cases of parents who lost their children to suicide.

Often these parents struggled with the fact that they could do nothing to save their child's life. Mental health practitioners who were interviewed also agreed that parental guilt following suicide adds to the already aggravated guilt that survivors experience. Results also add to the discussion of guilt as both survivors and mental health practitioners noted ways of coping with guilt. Survivors noting the importance of distancing themselves from feelings of guilt and responsibility by seeing suicide as a choice that their loved one made that they had no part in influencing. Conversely mental health practitioners noted trying to get survivors to cope with guilt by realizing that they could not know what their loved one was thinking or feeling prior to taking their life, and thus should not hold themselves accountable.

3. *Stigma*

Results of this study also confirm the work of Cvinar (2005) who noted that suicide survivors experience a unique form of societal stigma associated with their loss. Cvinar said that in many cases the bereaved are apprehensive of reporting that their loved one died by their own hand out of fears of how others would react.

In two cases, bereaved participants noted being fearful of reporting that their loved one's had taken their lives due to not knowing the reaction that they would get from others upon disclosing this information. Other participants noted not disclosing their loved one suicided out of different fears that doing so would cause harm to the individual they were talking to. A father who lost his son noted being fearful that he would be burdening another person by disclosing this information, even though he did want to talk about it and wished others would be more proactive in bringing up the topic. A woman who lost her uncle was

afraid of talking to others for fear that the details would traumatize the listener, even though she stated knowing that she needed to talk about it. As well, two mothers noted feeling stigma from others when they disclosed their child's suicide. They stated that often the person they were talking to did not know how to respond. Still, three other participants noted not being affected by the stigma at all, adding yet another layer to this topic. Additionally stigma was also noted by mental health practitioners as a block to emotional processing which they should be aware of when working with survivors.

4. Coping

Hall & Epp (2001) noted all those in mental health who work with suicide survivors must acknowledge the survivor's pain and help them normalize their experiences of loss. Practitioners in this study reiterated these findings. This included such things as understanding the bereaved's pain, allowing the bereaved the space to talk about their loss to facilitate emotional processing, and recognizing the role that stigma can play as a blockage to emotional processing. Additionally, practitioners noted the importance of getting the survivor to develop greater empathy for the pain and suffering that their loved one must have been under prior to taking their life.

Survivors also said that simply talking about their loss was one of the best ways of coping. Connected to this was the use of peer support groups that gave survivors a comfortable place to talk about their loss with others who have gone through a similar experience. This was noted by four bereaved participants as extremely important for coping and as well by six mental health workers. Group work with other survivors diminishes stigma, lessens feelings of isolation, and helps to normalize grief. These results are consistent with the work of Constantino, Sekula & Rubinstein (2001) who found female widowed

survivors particularly benefited from group work. Results add that group work is helpful to many other survivors of suicide and not only limited to those who have been widowed.

Additionally the use of group work for coping with loss by suicide may also be of great benefit as it may fit with Lazarus and Folkman's (1984) transactional model of coping. As previously noted, this model says that the stress following suicide bereavement is a product of the interplay between the person and their environment. The transaction in this case being that the person, after having lost a loved one to suicide, is in an environment where they feel incapable of fully talking about their loss.

It seems that group work was so effective for survivors because the group fostered the creation a new situational environment where the stigma associated with the suicide was gone and the bereaved were finally free to talk openly about their experience without fear of reprisal or judgement from others. Additionally this group work may also fit with Park and Folkman's meaning making model (1997). The global meaning that suicide is wrong and cannot be talked about seems to be trumped in this group environment where all individuals experience the same loss and situational meaning of suicide. Thus, it makes sense that survivors recalled such great experiences of peer support with others who were similarly bereaved to helping normalize and reduce feelings of isolation in their grief. Group work, as noted by one mental health practitioner, "de-pathologizes" many false notions that surround suicide. In the group setting, if everyone feels guilty or angry, then this is normalized and it may be quicker to process the grief and feelings associated with the suicide than if the individual is left to their own devices. This notion of group work may also fit with Viktor Frankl's logotherapy, which states that survivors can choose to be a part of an environment that fosters better care for suicide bereavement, as participants indicated doing.

5. *Spiritual Coping*

Previous literature has noted that religious stigmatization has been, and continues to be, a negative factor in coping with suicide (Jacques, 2000; Fine, 1997). Inabilities to access spiritual resources following a life changing event, or having such attempts “desecrated” by others has also been shown to make coping and meaning making more difficult (Pargament & Mahoney, 2005). Results from this study suggest that religious stigmatization, while acknowledged by survivors, was not a factor in “desecrating” a survivor’s ability to access spiritual aspects of coping. Many survivors noted dismissing any religion, or aspects of religion, that views suicide as a sin and places the person who takes their life into an afterlife of hell. Many who spoke of rejecting these stigmas also adopted the spiritual view that their loved one was in a good afterlife where their pain was ended and they were now at peace. Some even mentioned a belief in a compassionate God that would be accepting of their loved one into a good afterlife regardless of their decision to take their own life.

Such spiritual beliefs may add to the work of Mickley, Pargament, Brant & Hipp (1998) who found that caregivers of terminally ill patients had greater coping when they viewed their situation as having more understanding from God. Similarly, survivors who viewed God as being more understanding and accepting of their loved one’s suicide may have an additional spiritual coping resource. The rejection of religious stigmatization in place of a more compassionate and spiritual view of the person who suicides may again show use of Park and Folkman’s meaning making model (1997). As many participants reject global religious meanings that suicide is a sinful act, many additionally replaced this with spiritual meanings (acceptance or peace in the afterlife) that fit the survivor’s situation following their loss by suicide.

Additionally, results add to the discussion of Park & Benore (2008) who noted that death specific religious beliefs, such as a belief in an afterlife and continued attachments, can be very important in helping the bereaved cope following the death of a loved one. As the majority of survivors in this study noted either rejecting religion, or aspects of religion that stigmatize suicide, results of this study may add that survivors may access a belief in an afterlife and a feeling of continued attachment not in an inclusively religious way, but in a way that is more spiritual to accommodate their loss by suicide. Many survivors noted feeling some sort of continued attachment to their loved one. Some described this as a felt presence while others noted physically carrying out rituals, such as lighting candles or having personal remembrances, to feel continually attached to their loved one. Mental health practitioners, on the whole, also reiterated the benefits of survivors who experiencing continued attachment, either through a felt presence or through engaging in rituals of remembrance as a way of coping following their loss.

B. Best Practices When Working With Bereaved Persons

While results from this study further what has already been written with regard to suicide bereavement, results also add a new element of best practices when working with those who are survivors of suicide. These best practices can not only be seen in the results of interviewed practitioners, but also in the results of what survivors noted to be most important in their experience. The next section will focus on the best practices that have resulted from interviews. Best practices will be looked at in terms of what each group (bereaved, practitioner, and cross over group) deemed important for survivors of suicide. These best practices will then be compared and contrasted between groups.

1. From the Perspective of Survivors

In interviews with survivors, participants gave great insight into their struggles, and what hinders and helps their healing.

(a) *What survivors see as their struggles*

The results from the interviews with the eleven bereaved participants show many great struggles that follow the loss of a loved one to suicide. Shock was shown to be a great struggle, especially early on when a person initially found out their loved one killed themselves. Of the five participants who noted shock, all described their experience with suicide to be totally unexpected. In these cases shock was described as instant. After loss by suicide, feelings of shock can also stay with a person long afterwards. In one case, a mother who lost her son noted still being in shock as she spoke in the interview, some eight years after his death.

Two other participants cited less or no shock in cases where their loved one attempted suicide multiple times. In these cases, interviewees spoke of seeing their loved one's pain and suffering every day. Such circumstances may have helped reduce feelings of shock as suicide was expected. For the majority in this sample however, shock was a product of suicide that they struggled with. Two other participants struggled with confusion, disbelief and misunderstanding upon initially learning of their loved one's suicide. There was a total inability to comprehend the situation before them so early on after learning of the suicide.

The guilt that those bereaved by suicide felt was also another struggle that was noted by many participants. Participants spoke of "what if?" questions and scenarios tied to their guilt feelings. They would often feel a great deal of responsibility for the loved one's suicide, and often spoke of these "what if?" scenarios as remunerating in their mind as actions they could have taken that would have saved the person's life.

Guilt also appeared strongest in three interviews with parents who had lost their children to suicide. There seemed to be a feeling of failing their children as parents blamed themselves for missing the signs of suicide that would have prevented the deaths. These feelings of responsibility tied to guilt were seen by two mothers and one father who all lost their sons.

Guilt, especially in relation to the feeling of responsibility for a child's suicide, was noted by one mother (who had also lost her son) as an additional struggle for parents to come to grips with the fact that they could not have prevented the suicide. She noted that perhaps parents can prolong their child's suicide if they know it may be a future possibility, however preventing anyone's suicide is just not possible. Therefore coming to grips that they could not have prevented the death is something that many survivors may struggle with, yet this is a struggle that is particularly difficult for parents. Participants also noted that guilt was a large struggle when they started to feel better after some time had passed following the suicide. This was seen in two cases.

Survivors also had great struggles with making sense of the reasons their loved one took their life. Making sense of the reasons for their loved one's suicide was a struggle both initially following the suicide and, in many cases, right up until the present when the interviews took place. This inability to make sense of the suicide also seemed to inhibit survivors from letting go of the loss to some degree.

A great deal of struggling with making sense came out of the inability of survivors to get a clear answer as to "why?" the suicide occurred. This question was often unrelenting, and haunted survivors as they ruminated it over and over again in their minds. Often this was such a difficult struggle because, as one participant noted, the survivor is unable to ask their loved one this question directly because they are dead.

In only one of the eleven participants who were interviewed was the survivor not plagued by this unrelenting question of “why?” This was the mother whose son left her and her family a videotape prior to taking his life. The mother also disclosed she and her son had a very open relationship and would talk about his views of suicide when he was still alive. She noted that she was not plagued with this “why?” question because he told her it was because of his pain that he would eventually take his life, at the point which this pain became too much.

This case seems to be the exception to the rule when compared to the other ten cases of suicide bereavement. In the other ten cases, the bereaved did not mention speaking to their loved about their views of suicide prior to their deaths. As such, they were left to question why this happened.

While the majority of participants were much more comfortable turning to spirituality over religion as a means of coping following suicide, some participants also noted great struggles with spiritual and/or religious beliefs following their loved one’s suicide. In particular, some participants noted struggling with their beliefs surrounding God. One participant noted struggling with a belief in God following the suicide of her uncle, one person noted having her belief in God destroyed following the suicide of her mother, and one person noted anger towards God following the suicide of her son. Two participants also described great difficulties in understanding suicide as the will of God for their loved one, adding that it might be possible for religious people to do this but that they could not.

Others struggled with more generally with religious and spiritual beliefs. Two bereaved participants noted struggling with, or outright rejecting religious/spiritual beliefs following the suicide. One participant even noted switching from agnostic to atheist beliefs. Clearly there is great struggle here in terms of religious and spiritual beliefs as a result of

suicide. While two participants noted having good experiences with their priests who presided over their loved one's funeral, this was the minority of participants. One bereaved participant also noted a feeling of stigmatization from the church. Regardless of whether this was intentional or not, she noted it was still present.

(b) What survivors view as a hindrance to their healing

All bereaved participants noted that not talking about their experience of loss by suicide hindered their coping. By not talking many also noted they were isolated in their grief. Two participants noted this tendency to isolate themselves because they thought they would either burden or traumatize others by sharing their stories. Often this tendency to isolate and not talk about their experience of suicide was both a hindrance and a struggle. One man who lost his son noted wanting to talk about his experience more, but at the same time, not wanting to burden others with his grief. The other participant who lost her uncle noted that although she did know that talking about the suicide was important, she did not wish to talk of all the details of the experience for fear she would traumatize others.

Survivors also described a stigmatization around the topic of suicide as an additional barrier to openly talking about their loss which hindered their experience. Two participants noted being wary of talking openly to others about suicide because they were unsure of the reactions they would get from others. Often the bereaved are wary to talk to strangers about the suicide because of past instances of reactions of 'shock' and 'disgust' which lead the bereaved to avoid the topic altogether. However, other participants noted not being affected by this same stigma as they either did not buy into it, did not care what others thought, or did not notice stigma.

Stigmatization as a barrier to openly talking about suicide was also a hindrance in cases where mothers had lost a child to suicide. In two cases, mothers noted great difficulties if they chose to disclose that their child had died. Specifically they noted that others did not know what to say upon finding out their child had died by suicide, and they had a felt that had the death occurred in another way, that condolences would be given.

Another hindrance in dealing with their loss by suicide as described by the bereaved is maladaptive behavioural coping. This was most often seen by emotional dulling through the use of drugs and alcohol. Some participants noted using drugs and alcohol as a way to not have to think about or deal with the associated feelings connected to their loved one's suicide. One person also described feeling angry and resentful towards their loved one for not still being alive to help her through her cancer battle.

(c) *What survivors see as helpful*

While bereaved participants noted great struggles following the loss of their loved ones to suicide, the results of interviews also show that there were many things that survivors found helpful to their healing.

In terms of coping with the intense guilt that is related to suicide, participants noted viewing their loved one's suicide as having nothing to do with them, and that it was a decision that they had no part in influencing. Two participants viewed suicide as an act that those left behind had no control over. This helped diminish feelings of guilt and responsibility. One of these participants noted that the suicide has nothing to do with the bereaved after recalling that her son spoke of this to her and her family on a tape he left following his suicide. On this tape he noted that suicide was a purely selfish act that has nothing to do with those left behind. Another participant did this by viewing suicide as a

selfish act that she had no control over, yet there was a compassionate stance to this view of selfishness, that it was OK for her loved one to be selfish and take his life as this took away the pain and suffering that he was living with. Again this appeared to help in distancing oneself from feelings of guilt and responsibility in relation to the suicide.

Another participant noted reverse selfishness in her own suicide bereavement. She noted previously believing it was selfish for her mother to have taken her life, but later on changed her position, that it was selfish for her to expect her mother to live for her, or anyone else when she was in so much pain. Suicide, she noted, has nothing to do with those who are bereaved by this loss because if it did then the person who took their life would still be alive. Again this seemed to help to diminish guilt feelings.

While the majority of participants noted having great struggles in making sense of the suicide, particularly because they were unable to answer the question of “why?”, many participants noted it very helpful for their coping to have been able to, after some time, let go of this “why?” question and accept that there will always be unanswered questions as a result of suicide. Additionally many participants also expressed the great benefit of coming to terms with the fact that, on some level, the suicide of their loved one may never make complete sense. Acceptance of the fact that they may never make full sense of their loved one’s suicide helped many with their coping. One participant in particular, who lost her father to suicide, expressed the great relief she felt at being able to put her mind at rest after being comfortable with not having to make complete sense of her father’s death. This seems to be a process of making sense of suicide that was of greater depth than seen in those who are only practitioners.

Many bereaved participants also came to accept their loved one’s choice to take their lives and this helped in terms of coping. Additionally five participants noted making partial

sense of their loved ones suicide by seeing it as an inability of the person to tolerate life difficulties, such as not wanting to feel, difficulties with depression, and that suicide is a last resort in responding to a sense of desperation. While making full sense of suicide may not happen, viewing the act as an inability to tolerate life difficulties helped bereaved participants make at least partial sense of the death.

Ten of the eleven bereaved participants noted what helped them most in terms of their coping following suicide was being able to talk about their experience of loss by suicide. Whether this is with friends or family, all noted talking about their experience in a place where they felt safe to do so was of extreme importance in helping them cope. Additionally, four bereaved participants spoke of attending peer support groups as very helpful as they were able to share their own experience with others who had similar experience with loss by suicide. One participant also spoke of peer support in terms of speaking one-on-one with friend who also had lost by suicide to be of great value. By receiving peer support these survivors came to realize that they were not alone in their grief.

Some participants also noted additional help came from their family. One survivor who lost his father to suicide noted that his family 'closed ranks' and got closer following the suicide, and that this connection with his family still remains strong today. A father who lost his son also mentioned family as helpful for coping, noting that caring for his daughter in the aftermath helped him manage.

While many bereaved participants noted struggling and being hindered by the stigmatization surrounding suicide, two bereaved participants spoke of having greater compassion and humanistic views of those who suicide. Based on these interviews, it is the opinion of the researcher that if there were greater compassion and humanistic views after a person chooses to take their life, then the bereaved may be more likely to openly discuss

their loss without fear of stigma or judgement from others. Bereaved participants also spoke of the help they found in spiritual issues as participants were, in general, much more comfortable accessing spiritual resources as a means of coping with suicide than they were by turning to organized religion.

While several participants noted struggling with their beliefs surrounding God following the suicide of their loved one, two mothers who both lost son's to suicide recalled accounts of speaking to God prior to these suicides. One mother noted asking God to help end the suffering that her son was going through, either by helping him end his pain and continue living, or by helping him end his life peacefully. A second mother noted offering her son up to God in an image of wrapping him up in a flannel blanket and asking God to guide. Following her son's suicide she noted in the interview that she thought this was God's way of saying his suicide was OK.

Many participants bereaved by suicide noted it was of great help for them to reject the religious stigmatization that suicide is a sin, particularly seen in Catholicism. Regardless of their views of religion or spirituality, the majority of participants noted rejecting the notion that suicide is a sinful act that results in their loved one going to hell. They said instead that their loved one was now at peace. Of those in who referenced God when rejecting religious stigma, all noted that they saw God as not punishing their loved one for the suicide, but as being accepting and loving. This was extremely helpful as bereaved participants were able to preserve a positive view of their loved one after their death.

Bereaved participants also noted having a sense of continued attachment to their loved one who suicide to be very helpful. Four participants noted a felt presence from their loved one from beyond the grave. In these cases survivors noted such felt presence gave them comfort in knowing that their loved one was safe. Three other participants noted

preserving their own continued attachments to their loved ones by keeping their loved one's memory alive by remembering them on special occasions and doing special rituals for them. Rituals were helpful for these participants because they allowed the bereaved to remember their loved one and make known that they existed and were important. Three other participants noted it was helpful to light candles in memory of their loved one by lighting candles as a way preserve continued attachment to them.

2. From the Perspective of Practitioners

From the perspective of mental health practitioners, results from the ten interviews describe important issues to tackle, and how practitioners should intervene to meet the needs of this bereaved population.

(a) What mental health practitioners deem as important

Mental health practitioners noted anger as an important issue for survivors to deal with following suicide. This included anger at not understanding the situation they are now faced with, anger at the mental health system for failing their loved one, and feelings of anger directed at the loved one for taking their life.

A feeling of survivor guilt was another important issue that mental health providers saw when dealing with suicide bereavement. Practitioners described this guilt as either unrealistic, or immobilizing. Some also noted various "what if?" scenarios tied into guilt feelings. Struggles with guilt were also described by practitioners in relation the death of a child by suicide. Practitioners noted being particularly attentive the guilt they have seen of parents who lose a child this way. Three practitioners spoke of the extreme guilt they have seen in such cases. Issues around making sense or creating meaning were also seen as an important issue by practitioners. They noted how difficult it can be for survivors to integrate

the suicide into their life while making some coherence of it. One practitioner also noted that integration may happen on an intellectual level, but not an emotional level.

Other important issues include understanding the survivor's pain, attending to the best possible emotional processing of this pain, and understanding by practitioners of the blocks to emotional processing. Two practitioners noted the issues of stigmatization of suicide as especially important to be aware of as this can lead survivors to feel isolated and unsafe to talk about their experience and feelings. Other blocks to emotional processing noted by practitioners included substance abuse, denial of the death as a suicide and issues of unresolved anger. Interestingly, as a best practice to these blocks, practitioners noted it is beneficial to not condemn survivors who use these emotional blocks but explore with them how these methods serve them in their overall coping.

(b) How practitioners should intervene

The importance of timing of interventions in relation to shock was of great importance as three practitioners noted that how the survivor experiences shock can affect treatment significantly very early on. Shock can leave survivors quite immobile soon after their learning of suicide, and as such, it may take some time before this shock can be processed with survivors. Practitioners also noted that shock can vary depending on how a person discovers his or her loved one has taken their life. Depending on whether they heard about the suicide by word of mouth, or they actually find their loved one's body, these differing situations can create different types of shock reactions and will influence treatment significantly.

In terms of working with the guilt that survivors feel following the suicide, practitioners noted the importance of getting the bereaved to realize that they are not mind

readers and as such should not feel responsibility for missing any signs of suicide in the loved one. One cannot truly know what someone else is thinking or feeling and as such, survivors should not feel culpable for their loved one's death.

Regarding issues of making sense of suicide, practitioners noted that meaning making following suicide is an individual process, and one which cannot be given to those bereaved. Others noted that one way to make sense of suicide is to help survivors view it as an act that their loved one did outside of themselves, while another practitioner noted working with an individual who made better sense of suicide by actually reading the autopsy report of their loved one and getting a physical picture of what happened to them. Practitioners also noted the importance of allowing survivors the space to ask unanswerable questions such as "why?" and "what if?" which are often associated with suicide. Additionally, with regard to making sense of suicide or making meaning following the loss, practitioners noted the importance of helping bereaved participants accepting the suicide without making full sense of it.

An important issue noted by mental health practitioners is the ability to understand the survivor's pain following this loss. To this end, practitioners noted many important interventions when working with those bereaved by suicide. Practitioners noted understanding the survivor's pain is about listening attentively and mutually feeling this pain with them. All practitioners stressed the importance of emotional presence when working with those bereaved by suicide. This included being compassionate and non-judgemental, and not shutting down their grief but actually giving them the space to do their grieving.

An additional intervention of great importance as noted by practitioners is to help survivors increase their empathy for the pain and suffering of the person who suicides. One practitioner even stressed the importance of trying to get survivors to physically try to

imagining the pain the suicidal person must have been going through prior to ending their life, such as the physical pain seen in a dying cancer patient. Regardless of whether the suicidal person's pain is visible or not, this practitioner noted that it is there nonetheless. Connected to emotional presence of the mental health practitioner is another intervention which allows for the best emotional processing. This included practitioners validating and normalizing the survivor's loss. By doing this and helping the bereaved to really feel their grief connected to their loss is of paramount importance. Fully grieving and processing this loss was also noted as one of the best ways to cope with suicide. The use of group work with other survivors of suicide was also noted as a very important intervention to facilitate fuller emotional processing by creating a safe environment of mutual understanding.

An additional intervention noted by four practitioners is the importance of helping or encouraging survivors to perform rituals to express their grief. Particularly rituals that allow survivors to say goodbye to their loved ones can be helpful as the suddenness of suicide may not allow for such discussions. Assisting in continued emotional attachments was also seen as important by practitioners. Many practitioners noted both positive and negative forms of continued attachments towards their loved one that suicides. One practitioner noted the importance of remembering the person for their life, and not just the way they died. Another important intervention practitioners noted was being non-judgemental regarding the person's choice to take their life and additionally helping the bereaved accept this choice. Many practitioners viewed suicide as a choice or option and would try to help the bereaved consider this perspective as well.

3. Best Practices of Bereavement Facilitators with Personal Loss to Suicide

From the cross-over group of participants who were both bereaved and mental health practitioners, one of the most important issues that was brought up was self care. This was very important because all participants described being triggered at one point or another when working with other suicide survivors. As such, facilitator self care was of the utmost importance. One way that self care was ensured was for practitioners to be particularly attuned to their own self awareness when working with others with a similar loss. This included monitoring their own reactions to hearing survivor stories, and knowing their own comfort in sharing details of their own experience. Additionally, all six members noted another important practice was debriefing with their peer facilitators following the bereavement group.

C. Comparing and Contrasting the Different Perspectives

1. Are Practitioners Targeting what is Important to Survivors?

In many cases mental health practitioners are targeting things that are important to their bereaved clients, while in some cases they are not. One of the most important things that survivors noted to help their coping was simply being able to talk about their loss to suicide in a safe and non-judgemental environment. This is being targeted by mental health workers as they noted that emotionally processing survivor's experiences with suicide is of great importance. Not only is processing this experience with them important, but just as curtail is being emotionally present to enable survivors to open up and fully grieve their loss. Helping the bereaved feel their pain, and creating a supportive environment to do this work is an important task that is being met through normalization and validation.

Additionally, understanding a survivor's blocks to processing their experience is an important aspect that is being targeted. While some survivors noted not being affected by stigma, many survivors noted feeling stigma associated with their experience to suicide that would shut them down to discussing their loss. Some participants noted wanting to talk to others about their loss to suicide but stopped themselves from doing so as they thought they would either be burdening or traumatizing the person they were talking to. Other survivors who did talk about their loss were often put off by the reactions they received from others when they did disclose their loss by suicide. Often survivors were unsure of the reaction they were going to get but, in one case one person noted reactions ranged from 'shock' to 'disgust.' Mothers also noted feeling stigmatization when talking about their children and the ensuing dead-end conversation that would take place when they disclosed that their child took their life. Mental health professionals noted that stigma exists for many survivors and this can be a big block to them fully grieving their loss. Thus, again why mention of practitioners being emotionally present and emotionally processing is so important to facilitate healing.

Both survivors and practitioners also noted emotional dulling, particularly through the use of drugs and alcohol to be another block to processing the loss. Interestingly, practitioners noted not condemning survivors for their choices of using drugs or alcohol, or denying the death of their loved one as a suicide, but to discuss with them how such practices do or do not benefit their coping.

A shock reaction was noted by many survivors upon finding out their loved one took their life, and practitioners again were on the same page, seeing this as an important issue to be aware of that significantly influences the treatment of survivors of suicide.

Survivors and practitioners were in agreement that guilt is an important issue to tackle, yet both groups seemed to have a different way of dealing with these feelings. Many survivors noted being able to distance themselves from strong guilt feelings by seeing the suicide as an act that they had no control over, including seeing it as a selfish act that they were OK with, noting it would be selfish on the part of the survivor to expect the loved one to go on living for them alone, and in one case by hearing from their loved one themselves that the suicide is a purely selfish act that has nothing to do with those left behind now mourning the loss.

Practitioners on the other hand noted combating the guilt associated with suicide by helping survivors realize that no one can truly know what another person is thinking or feeling and thus feelings of guilt, culpability or responsibility for their loved one's suicide are unfounded. In both groups the end result is the diminishment of guilt feelings, yet each seem to get to this end result through different means. Survivors and practitioners were also on the same page with regards the very intense guilt that many parents feel when their child takes their own life.

One of the most noticeable areas where practitioners were not targeting an important element of survivor coping was spiritual issues. In interviews with survivors the majority noted being more comfortable accessing spiritual resources for coping with suicide than compared to formal religious methods of coping. In particular many survivors noted rejecting religious views that label suicide as a sin. Instead many of these survivors said the act of suicide was not a sin and that their loved one was in a good place now in the afterlife. Some survivors even noted a belief in a God that would accept their loved one following their suicide rather than condemn them.

Surprisingly the majority of mental health practitioners (eight of ten) noted not discussing spiritual issues when working with suicide survivors, either individually or in a group, unless their clients brought this up first. Two practitioners who ran suicide bereavement groups noted they did touch on spiritual issues, yet another facilitator, much like the majority of mental health practitioners, noted that if the group (or person) wishes to talk about spiritual issues it would be done under the assumption that if it is important to the survivor, the survivor will bring it up.

While not only noting a rejection of religious views that label suicide a sin, many survivors also noted additional spiritual aspects to their bereavement such as having a feeling of continued attachment to their loved one (whether this be of a felt presence of their loved one that has contacted them, or more earthly aspects of continued attachment such as performing rituals to remember their loved one and lighting candles), and having a belief in an afterlife leading them to believe that they would eventually see their loved one again.

While practitioners noted the importance of performing rituals, and also noted the hope that having a belief in an afterlife can bring, by waiting for survivors to bring these topics up they may be missing key discussions with survivors regarding spiritual coping. Leaving it to the survivor to take the initiative to talk about issues of spirituality such as their views of sin, spirituality, God and acceptance of suicide may be doing a disservice to them. As noted earlier survivors and practitioners both agreed that stigmatization is still a major problem that can create a block to survivors fully grieving their loss. Additionally many survivors in these interviews still noted that religious stigma is present which they reject. Therefore it may be beneficial for practitioners to be more proactive in discussing with survivors their spiritual methods of coping so that this important means of coping does not go overlooked and under processed.

Interestingly some practitioners noted a belief or non-belief in an afterlife can have major consequences for survivor coping following suicide. Some practitioners noted that some survivors may believe their loved one is in hell following suicide still believing the act is a sin, while others noted a belief in a loving God would lead to greater acceptance and less worry about where their loved one is in the afterlife. Yet it is still interesting that these observations can be made yet at the same time practitioners noted on the whole, not wanting to bring up these issues unless the survivor does.

Of great interest was the fact that many bereaved participants noted spiritual issues to be quite important for them in terms of coping, such as rejection of religious stigma, belief in an afterlife, the benefits of continued attachment. However when some of these bereaved participants were interviewed a second time looking at their professional experience in working with others bereaved by suicide, they noted being less likely to bring up such spiritual methods of coping unless their clients did so first.

It is my belief as a researcher that all the benefits of spiritual coping that were noted in interviews would not had been discussed had these questions not been directly asked. Therefore, it may be a great oversight in the healing of those bereaved by suicide by not asking more proactive questions in this area out of the belief that if such issues are important that the survivor will bring them up themselves. Again because of the stigmatization around issues of suicide and religion, a survivor may not bring their thoughts to this on their own and stay isolated not able to access this type of coping in dealing with their grief. Therefore it seems very important for all practitioners to be more proactive in addressing spiritual aspects of coping with individuals bereaved by suicide.

2. Do Practitioners See Things that Bereaved Participants Do Not?

In some cases mental health practitioners touched on issues that they saw when working with bereaved clients that these clients either did not mention, or mentioned very minimally. These included issues of anger, and having negative continued attachments to their loved one. Interestingly mental health practitioners noted that following the suicide of a loved one, survivors are often angry at the situation they are now faced with, angry at the mental health system for failing their loved one and letting them fall through the cracks, and angry at the loved one themselves for choosing to take their own life. Compared with interviews of survivors themselves, anger came up very little. Once where a woman spoke generally about her feelings of anger following her mother's suicide, and once where a woman spoke of being angry at her friend for taking their life and not being there for her during her battle with cancer. Both mentions of anger were very brief. It may be that these were the only cases of anger that came up in interviews with survivors because survivors did not wish to speak ill of their loved ones, however this is an important element of grief that practitioners noted is important to attend to.

An additional issue that practitioners may see that survivors do not is that of negative continued attachments. All those survivors who noted continued attachments to their loved one (either through felt experiences, or performing their own rituals of remembrance) gave positive examples of their continued attachment to their loved one. Conversely, while practitioners noted continued attachments can be positive, some also noted that there are times when these attachments to the deceased can be negative to the survivor's coping. This could include a survivor still feeling married to their dead spouse and thus not moving at all in their grief.

3. Do Survivors, or Survivors who are also Practitioners, See Things that Ordinary Practitioners Do Not?

Because of the direct experience that survivors have with suicide, they may see or approach things differently when working with other survivors of suicide when compared to practitioners without personal loss. This may be true in differing views of the process of making sense of suicide. Survivors and practitioners both agreed that making full sense of suicide often does not happen. Survivors and practitioners also agreed that those left behind are often left with many unanswerable questions such as “why?” Where survivors and practitioners differed however, is that survivors added the additional element of accepting that they may never make full sense of the suicide and let go of this haunting “why?” question. This seemed to be an importance piece in healing to be able to move in their grief.

As noted in the results section, seven mental health practitioners reiterated this notion of acceptance of the survivor in the possible inability to ever make full sense of suicide. However six of these practitioners had their own personal loss to suicide. The seventh, who was a hospital Chaplin, had no personal experience with suicide was the only practitioner out of the four with no personal experience to note the importance of this acceptance in terms of not making complete sense of suicide. These other practitioners who had no personal loss to suicide noted that making sense of suicide is difficult and it likely never happens, but left it at that. As such it may benefit those practitioners who work with suicide survivors, who have no personal loss of this kind, to take a cue from these seven practitioners that while making sense of a loved one’s suicide may not happen, the acceptance of these circumstances may allow survivors to heal much better.

Additionally these same seven participants, six practitioners each with personal loss to suicide and the one hospital Chaplin with no personal loss all noted the importance of

group work for suicide bereavement. This may be an additional stance that all mental health practitioners can take as bereaved participants in this study noted the healing effects of peer support for normalizing, validating and de-stigmatising their loss. As one practitioner who lost her son to suicide noted in her interview, more people in mental health should be recommending that survivors be referred to suicide specific bereavement support groups in addition to any individual therapy they receive.

As well, three survivors who were also bereavement facilitators noted the importance of survivor support groups for giving hope to those newly bereaved by suicide. By having a bereavement facilitator who can self disclose their own experience to suicide to someone who is newly bereaved, this may create hope in the participants that they may one day be further along in their grief like the person who is now leading them.

Restoring hope to individuals following a loss by suicide is very important and may only happen in cases where one survivor can work with another. Therefore those mental health practitioners with no personal loss to suicide could additionally refer their bereaved clients to suicide peer support bereavement programs, not only to help them be exposed to an environment where all present have lost to suicide, and to learn other members' coping strategies, but additionally because and they may be inspired by their group facilitator who was once in their position. This may give them hope that if their facilitator's grief can move to the point that they can help others who have lost to suicide, then their own grief will also eventually shift, and life after the suicide of their loved one will be not as bad as they first imagine it to be.

D. Research Limitations

While bereaved participants gave great insights into their personal experiences with suicide bereavement, since the sample size of this group was only eleven participants, it cannot be considered totally generalizable to every individual who is bereaved by suicide. This was merely a summary of themes found with this small sample. Other themes may emerge as more research is done.

While this sample interviewed was small, nine were females and two were males. Therefore the themes found may be gender biased, leaning more towards the female experience of suicide bereavement. The same could be said of mental health practitioners. Of the ten that were interviewed, only one was male. This may have skewed the results in terms of the feminine mental health view point.

As well, six of the mental health practitioners had worked as bereavement facilitators, while only four other participants worked in different capacities (i.e. social worker, hospital Chaplain, psychologist and post suicide debriefing member). Therefore this sample is not generalizable to the mental health field as a whole as it heavily leans towards those working in bereavement support. However, this can also be argued as being highly advantageous in terms of the population being studied. The majority of mental health practitioners interviewed worked on a daily basis with others bereaved by suicide. So therefore while the sample was skewed it was very informative on the subject matter.

E. Future Research

One interesting aspect to come out of these interviews was the view of some bereaved participants who noted that God would accept their loved one in the afterlife following their suicide. This would be interesting to see researched in the future. Differing attachment styles to God (secure, dismissing, preoccupied and fearful) have shown differing religious coping styles (Cooper, Bruce, Harman & Boccaccini, 2009). Children's attachment to God and overall attachment styles in religious and non-religious homes have been studied (Granqvist, Ljungdahl & Dickie, 2007). It would be interesting to see future research that looks at people who have lost to suicide and how their belief, lack of a belief and attachment style to God influences their coping and meaning making following suicide bereavement. Also, does this attachment or lack of attachment style have anything to do in relation to meaning making/making sense of suicide?

Future research that further looks at how those who have lost to suicide make sense of their loss is also highly valuable. More studies need to address this from both those who have lost to suicide and those who work in the mental health field. Particularly this notion of accepting that making full sense of the suicide may never occur, and being OK with this as a means to further cope, should be further explored as this may be curtail for healing.

Also, it would be interesting to see comparisons of those bereaved by suicide and coping and meaning making strategies of survivors who attend peer support versus those who do individual therapy and outcomes. As well looking at suicide bereavement support groups in greater depth would be interesting. Specifically how participants of these groups coping and meaning making during the beginning of a support group and monitoring any changes as the group progresses.

Comparisons of issues of anger would also be interesting as mental health professionals spoke of anger both at the deceased and towards the mental health system, while only one bereaved participant noted anger at their loved one for taking their life.

Looking at the idea of hope would be great for future research. Three bereavement facilitators who had their own personal loss by suicide, noted that they saw themselves as giving the participants of the suicide bereavement groups they run greater hope. It would be interesting to hear what the participants of these groups have to say about hope and how facilitator self disclosure plays a role in developing this. For example, participants could be given a measurement of hope at the end of each of their group sessions so comparisons could be drawn when the support groups begin and changes could be assessed when the group concludes. Also, another question for future research could be, how do these group members experience their facilitators when the facilitator self discloses their own loss by suicide? Do participants notice when their facilitator is being triggered and being brought back to their own personal experience? If so, what effect does this have on the group participants?

Also research could be done into the efficacy of treatment with a mental health professional with their own personal loss by suicide versus one who has no personal loss, and how self disclosure of this experience effects treatment as opposed to when this is not an issue.

F. Additional Best Practices That Can Be Drawn From This Study

While practitioners who were interviewed gave many best practices for working with survivors of suicide, additional best practices can be drawn from the discussions of survivors.

These include:

1. *Fostering additional environments that are more proactive towards suicide postvention.*

Following a suicide, all individuals that a survivor immediately comes into contact with (i.e. police, funeral homes, and clergy) should be as proactive as possible in supporting a survivor throughout the early stages of his or her loss.

These key players may do this by adopting some of the best practices as noted by practitioners. These may include being attentive to feelings of guilt, trying to understand the survivor's pain, and especially, providing emotional presence so that the survivor can comfortably talk about his or her loss without feeling stigmatized or isolated.

Even if these supportive gestures do not sink in early on because of the shock and trauma that survivors experience, they may lay the ground work in helping a survivor to feel more comfortable in seeking support later on.

In addition to individual therapy, all mental health practitioners who work with survivors of suicide should be promoting and referring these clients to suicide bereavement support groups. These groups were noted by survivors and facilitators to help in the normalization of loss, reduction of feelings of stigmatization and isolation, and also helped survivors learn different coping strategies that they would not have learnt otherwise.

Additionally, there should be greater funding for these groups as they are often run by volunteers, are cheaper for participants to attend than individual therapy (all group members I spoke to noted their peer bereavement groups were free for participants), and they may give greater hope to those bereaved by suicide than will individual therapy alone.

Finally, fostering environments that provide more proactive suicide postvention also requires a change in social attitudes towards suicide.

We all have an ethical responsibility to foster a better environment to survivors of suicide to fully grieve their loss. Suicide should be seen as a type of grief that no longer needs to be hidden or disenfranchised. This begins with greater education of the experience of suicide bereavement. Since the bereaved may be less likely to seek help and rather grieve in isolation, a proactive stance towards openly discussing suicide bereavement should be adopted by the general public.

This will be a very difficult change to make, however it is more likely to be obtained through greater public education about suicide bereavement. This should begin by having greater education about suicide bereavement in any programs that have to do with mental health, especially those that train psychotherapists. Specifically issues of compassion and humanism towards those who suicide and towards those left grieving this loss should be addressed.

Being able to talk about the loss of a loved one after they die is a luxury that those bereaved by suicide may not be afforded due to the stigmatization around this type of grief. This grieving is isolating. This needs to stop, again by having greater compassion.

2. *Greater understanding of the process of how survivors of suicide may, or may not make sense of their loss, especially in regards to acceptance of the loss.*

All practitioners who work with those bereaved by suicide should pay greater attention to the process of meaning making. Specifically, that making sense of suicide is a process of greater depth than has been previously shown. While survivors may make limited sense of their loved one's suicide, they may also never be able to make full sense of this death.

Additionally, practitioners should be aware that while survivors may never make full sense of their loved one's suicide, they may be able to accept it nonetheless.

This is not to suggest that a newly bereaved person be encouraged to drop any possible lingering questions they may have and quickly accept the senselessness of their situation, but rather to suggest to this person early on, that acceptance and making sense of their loss is something very individualistic and it is a process that all survivors of suicide must go through. If practitioners present this idea, and make survivors aware of the process of what others have gone through, this may allow future survivors of suicide to go through their own process of meaning making with greater self awareness.

3. *All areas of mental health should be more proactive in addressing spiritual and/or religious aspects of coping in relation to suicide bereavement.*

This includes not only responding to a survivors spiritual or religious views if they bring them up in treatment, but also for the mental health providers to be proactive in asking a survivors their spiritual or religious beliefs concerning suicide.

As was seen in these interviews many people have varying views on religion and spirituality, but on the whole there seemed to be a rejection of religious views that condemned suicide and viewed it as a sin, and an adoption for many participants of a view of an acceptance of the suicidal individual in the afterlife by an equally accepting and compassionate God. Thus the simple question to be posed to the survivor could be "What does God think of your loved ones choice of suicide?" And work with them on this from there. Or, should the person have a particularly condemning view of religion and suicide, the

practitioner might say, “Some others who have lost to suicide have stated they believe suicide is not a sin and their loved one is no longer in pain. What are your thoughts about this...?” Addressing this topic, much like suicide itself, would be beneficial as it is another aspect that is no longer left silenced. There is no reason that practitioners cannot be more proactive in addressing spiritual views while at the same time keeping in mind the personal aspect of a survivor’s spiritual beliefs that is connected to their grief.

Additionally, if those in religious institutions wish to play a more vital role with suicide survivors, they should take note of how many participants in this sample saw different religions as viewing suicide. People who work within these institutions (religious leaders, clergy) should be more compassionate towards those bereaved by suicide, and be aware of the re-vamped spirituality that many survivors of suicide may take i.e. the acceptance of God, the view that suicide is not a sin, the view that the loved on is not in hell, and the view that the person after taking their life is no longer in pain.

G. Conclusion

This study has sought to better understand the meaning making/making sense and coping process following suicide bereavement. Previous to this study there were very few that explored this topic, and none that could be found addressing spirituality and religious coping.

In interviewing bereaved participants and mental health practitioners many interesting things can be taken away to shed light on suicide bereavement. The shock and guilt that the bereaved face is very intense and often complicates their grief work. Even the act of talking about loss by suicide is, for many, a very painful process. If left to their own devices this pain leaves many who are bereaved to grieve on their own. While some bereaved participants noted not feeling stigmatization, many did. Merely saying their loved one took their life is a difficult process for the bereaved because they may feel that they will be judged from others. Thus, talking about it may be avoided and they may grieve in isolation.

However, talking about their loss to someone they trust was noted as the most important way by the bereaved that they could cope. Mental health practitioners also noted that communication of the loss is of paramount importance so that the bereaved can fully grieve their loss and fully feel all the associated feelings with respect to the loss by suicide in a safe a non-judgemental environment.

Thus it makes great sense that many bereaved participants noted finding this safe environment in peer bereavement support groups, which were run by those who had their own personal loss, and who, by disclosing such loss in a way that also respected their own experience, gave hope to the newly bereaved. These groups, and greater freedom to talk about issues of suicidality should be more greatly promoted.

This study also addressed spiritual and religious aspects of coping, that, to this researcher's knowledge has not been addressed in other studies looking at suicide bereavement. On the whole it seems that many participants turned to spirituality rather than formal religion to cope following suicide bereavement, and when asked openly about the role that spirituality and religion played, a great number of participants noted a re-vamping of spirituality in which God accepted their loved one's choice to take their life and that their loved one was in a good place in the afterlife, rather than a belief that saw suicide as a sin and that punished the person who was now in hell for their suicide. Even more interesting was that many mental health professionals noted that they would only address such issues of religion and spiritual coping only if their client/group members took the initiative and did so first. This may be a great oversight in addressing a topic with the bereaved that could lead to better coping.

Another area of great interest in this study was the process of how people make sense of suicide. There were differences in this topic when looking at those who were bereaved

compared to those who were mental health practitioner. While the two groups were in agreement that making sense is often a paradox, lingering unanswered questions often remain, and acceptance of the suicidal persons choice to take their life is often seen, the major difference noted by those with personal loss to suicide was the acceptance that there may never be an answer to suicide bereavement that makes complete sense. This deeper understanding of suicide bereavement and acceptance of not fully making sense and or meaning from suicide should as well be more greatly promoted.

Finally in all of these topics, one thing that all areas of mental health can do to help those who have lost someone to suicide is be more proactive in postvention. Whether this is in terms of promoting more bereavement groups, letting the bereaved know these groups exist, allowing for a safe and non-judgemental attitude towards the bereaved to promote greater talking of their loss by suicide, and even speaking to spiritual and/or religious aspects of coping that may be being neglected, all areas require more active postvention as this will ultimately inform better suicide prevention so that future generations of those bereaved by suicide will have better quality mental health care, and hopefully a reduction in overall suicides in general. This begins first with greater education concerning all aspects of suicidology.

REFERENCES

- Ai, A., Cascio, T., Santagelo, L. & Evans-Campbell, T. (2005). Hope, meaning, and growth following the September 11th Terrorist Attacks. *Journal of Interpersonal Violence*, 20(5), 523-548.
- Anderson, M., Marwit S., Vandenberg, B. & Chibnall, J. (2005). Psychological and religious coping strategies of mothers bereaved by the sudden death of a child. *Death Studies*, 29 (9), 811-826.
- Andriessen, K. (2009). Can Postvention Be Prevention? *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 30(1), 41-47.
- Begley, M. & Quayle, E. (2007). The Lived Experiences of Adults Bereaved by Suicide. A Phenomenological Study. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 28(1), 26-34.
- Benore, E. & Park, C. (2004). Death-Specific Religious Beliefs and Bereavement: Belief in an Afterlife and Continued Attachment. *The International Journal for the Psychology of Religion*, 14(1), 1-22.
- Boeschen, L., Koss, M., Figueredo, A. & Coan, J. (2001). Experiential avoidance and post-traumatic stress disorder: A cognitive meditational model of rape recovery. *Journal of Aggression, Maltreatment and Trauma*, 4 (2), 211-245.
- Callahan, J. (2000). Predictors and correlates of bereavement in suicide support group participants. *Suicide and Life-Threatening Behavior*, 30, 104–124.
- Cerel, J. & Campbell, F. (2008). 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. & Duberstein, P. (2008). The Impact of Suicide on the Family. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 29 (1), 38-44.
- Cobain, B. & Larch, J. (2006). *Dying to Be Free. A Healing Guide for Families after a Suicide*. Centre City, Minnesota: Hazelden.
- Colt, G.H. (2006). *November of the Soul: The Enigma of Suicide*. New York: Scribner.
- Constantino, R., Sekula, K. & Rubinstein, E. (2001) Group Intervention for Widowed Survivors of Suicide. *Suicide and Life Threatening Behavior*, 31(4), 428-440.

- Cooper, L., Bruce, J., Harman, M. & Boccaccini, M. (2009). Differentiated Styles of Attachments to God and Varying Religious Coping Efforts. *Journal of Psychology and Theology*, 37 (2), 134-141.
- Creswell, J.W. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. London: Sage Publications.
- Currier, J., Holland, J. & Neimeyer, R. (2006). Sense-Making, Grief, and the Experience of Violent Loss: Toward a Meditational Model. *Death Studies*, 30(5), 403-428.
- Cvinar, J.G. (2005). Do Suicide Survivors Suffer Social Stigma: A Review of the Literature. *Perspectives in Psychiatric Care*, 41(1), 14-21.
- Davis, C.G., Nolen-Hoeksema, S. & Larson, J. (1998). Making Sense of Loss and Benefiting From the Experience: Two Construals of Meaning. *Journal of Personality and Social Psychology*, 75(2), 561-574.
- 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.
- de Castro, S. & Guterman, J.T. (2008). Solution-focused therapy for families coping with suicide. *Journal of Marital & Family Therapy*, 34(1), 93-106.
- de Groot, M.H., de Keijser S. & Neeleman, J. (2006). Grief Shortly After Suicide and Natural Death: A Comparative Study Among Spouses and First-Degree Relatives. *Suicide and Life Threatening Behavior*, 36(4), 418-431.
- Dollinger, S. (1986). The need for meaning following disaster. *Personality and Social Psychology Bulletin*, 12(3), 300-310.
- Durkheim, E. (1951). *Suicide*. New York: Free Press.
- Farley, R.C., & Shaver, P.R. (1999). Loss and bereavement: Bowlby's theory and recent controversies concerning "grief work" and the nature of detachment. In Cassidy, J. & Shaver, P.R. (Eds.), *Handbook of attachment theory and research: Theory, research, and clinical applications* (pp. 735-759). New York: Guilford.
- Fine, C. (1997). *No Time to Say Goodbye. Surviving the Suicide of a Loved One*. New York: Broadway Books.
- Frankl, V. (1984). *Man's Search for Meaning*. New York: Pocket Books.
- Frantz, T., Trolley, B. & Johll, M. (1996). Religious aspects of bereavement. *Pastoral Psychology*, 44(3), 151-163.

- Golsworthy, R. & Cole, A. (1999). Spiritual beliefs and the search for meaning among older adults following partner loss. *Mortality*, 4(1), 21-40.
- Granqvist, P., Ljungdahl, C., & Dickie, J. (2007). God is nowhere, god is now here: Attachment activation, security of attachment, and god's perceived closeness among 5-7 year-old-children from religious and non-religious homes. *Attachment and Human Development*, 9(1), 55-71.
- Hall, B. & Epp, H (2001). Can Professionals and Nonprofessionals Work Together Following a Suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 22(2), 74-78.
- Hendin, H., Lipschitz, A., Maltsberger, J., Haas, A.P. & Wyncoop, S. (2000). Therapists Reactions to Patients' Suicides. *American Journal of Psychiatry*, 157(12), 2022-2027.
- Herron, J., Ticehurst, H., Appleby, L., Perry, A. & Cordingley, L. (2001). Attitudes Towards Suicide Prevention in Front-Line Health Staff. *Suicide and Life-Threatening Behavior*, 31(3), 342-347.
- Higgins, M.P. (2002). Parental bereavement and religious factors. *Omega: The Journal of Death and Dying*, 45(2), 187-207.
- Jacques, J.D. (2000). Surviving Suicide: The Impact on the Family. *The Family Journal*, 8(4), 376-379.
- Jordan, J.R. (2001). Is Suicide Bereavement Different? A Reassessment of the Literature. *Suicide and Life-Threatening Behavior*, 31(1), 91-102.
- Kastenbaum, R.J. (2007). *Death, Society and Human Experience*. (9th Ed.) Boston: Pearson Education Inc.
- Knieper, A. (1999). The survivor's grief and recovery. *Suicide and Life Threatening Behavior*, 29(4), 353-364.
- Koenig, H.G., Cohen, H.J., Blazer, D.G., Pieper, C., Meador, K.G., Shelp, F., Goli, V. & DiPasquale, B. (1992). Religious coping and depression among elderly, hospitalized, medically ill men. *American Journal of Psychiatry*, 149 (12), 1693-1700.
- Lazarus, R.S. & Folkman, S. (1984). *Stress, Appraisal and Coping*. New York. Springer Publication Co.
- Leonard, E. C. (2001). Confidential Death to Prevent Suicidal Contagion: An Accepted, but Never Implemented, Nineteenth Century Idea. *Suicide and Life-Threatening Behavior*, 31(4), 460-466.

- McMenamy, J.M., Jordon, J.R. & Mitchell, A.M. (2008). What do Suicide Survivors Tell Us They Need? The Results of a Pilot Study. *Suicide and Life-Threatening Behavior*, 38(4), 375-389.
- Mickley, J.R., Pargament, K.I., Brant, C.R., & Hipp, K.M. (1998). God and the search for meaning among hospice caregivers. *The Hospice Journal*, 13(4), 1-17.
- Mitchell, A.M., Kim, Y., Prigerson, H.G. & Mortimer-Stephens, M.K. (2004). Complicated Grief in Survivors of Suicide. *Crisis: The International Journal of Crisis Intervention and Suicide Prevention*, 25(1), 12-18.
- Moustakas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks, CA: Sage.
- Neimeyer, R.A. (2000). Searching for the meaning of meaning: Grief therapy and the process of reconstruction. *Death Studies*, 24(6), 541-558.
- Pakenham, K.I., Sofronoff, K. & Saminos, C. (2004). Finding Meaning in parenting a child with Asperger syndrome. *Research in Developmental Disabilities*, 25(3), 245-264.
- Pargament, K.I. (1997). *The psychology of religion and coping: Theory, research, practice*. New York: Guilford Press.
- Pargament, K.I. & Mahoney, A. (2005). Sacred Matters: Sanctification as a vital topic for the psychology of religion. *The International Journal for the Psychology of Religion*, 15(3), 179-198.
- Park, C. L. (2004). The notion of stress related growth: Problems and prospects. *Psychological Inquiry*, 15(1), 69-76.
- Park, C.L. & Ai, A.L. (2006). Meaning Making and Growth: New Directions for Research on Survivors of Trauma. *Journal of Loss and Trauma*, 11(5), 389-407.
- Park, C.L. & Folkman, S. (1997). Meaning in the Context of Stress and Coping. *Review of General Psychology*, 1(2), 115-144.
- Parrish, M. & Tunkle, J. (2005). Clinical Challenges Following an Adolescent's Death by Suicide: Bereavement Issues Faced by Family, Friends, Schools & Clinicians. *Clinical Social Work Journal*, 33(1), 81-102.
- Pompili, M., Lester, D., De Pisa, E., Del Casale, A., Tatarelli, R. & Girardi, P. (2008). Surviving the Suicides of Significant Others. A Case Study. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 29 (1), 45-48.
- Saarinen, P., Hintikka, J., Viinamäki, H., Lehtonen, J., & Lönnqvist, J. (2000). Is it possible to adapt to the suicide of a close individual? Results of a 10-year prospective follow-up study. *International Journal of Social Psychiatry*, 46(3), 182-190

- Schwartzberg, S.S., & Janoff- Bulman, R. (1991). Grief and the Search for meaning: Exploring the assumptive worlds of college students. *Journal of Social and Clinical Psychology*, 10 (3), 270-288.
- Seifert, L.S. (2002). Toward a psychology of religion, spirituality, meaning-search, and aging: Past research and practical application. *Journal of Adult Development*, 9(1), 61-69.
- Sethi, S. & Bhargava, S.C. (2003). Child and Adolescent Survivors of Suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 24(1), 4-6.
- Silver, R.L., Boon, C. & Stones, M.H. (1983). Searching for meaning in misfortune: Making sense of incest. *Journal of Social Issues*, 39 (2), 81-101.
- Taylor, S.E. (1983). Adjustment to threatening events: A theory of cognitive adaptation. *American Psychologist*, 38 (11), 1161-1173.
- Thompson, S.C. (1985). Finding positive meaning in a stressful event and coping. *Basic and Applied Psychology*, 6(4), 279-295.
- Thompson, S.C. (1991). The search for meaning following stroke. *Basic and Applied Psychology*, 12(1), 81-96.
- Thomyangkoon, P. & Leenaars, A. (2008). Impact of Death by Suicide of Patients on Thai Psychiatrists. *Suicide and Life-Threatening Behavior*, 38 (6), 728-740.
- Thorson, J.A. & Powell, F.C. (1990). Meanings of Death and Intrinsic Religiosity. *Journal of Clinical Psychology*, 46 (4), 379-391.
- Uren, T.H. & Watsell, C.A. (2002). Attachment and meaning making in prenatal bereavement. *Death Studies*, 26 (4), 279-308.
- Wong, P., Chan, W. & Beh, P. (2007). What Can We Do to Help and Understand Survivors of Suicide in Hong Kong? *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 28 (4), 183-189.
- Worden, W.J. (1991). *Grief Counseling and Grief Therapy*. (2nd ed.) New York: Springer.
- Worden, W.J. (2009). *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner*. New York: Springer Publishing Company.

APPENDICIES

Appendix 1: Advertisements/Posters for the Study

CALL FOR RESEARCH PARTICIPANTS

Are you an individual who has been bereaved by suicide for **more than two years**, or are you a mental health practitioner who generally works with this population? Would you be interested in being a research participant in our study:

Coping with the Death of a Loved One to Suicide

The purpose of this study is to explore how individuals seek to understand and cope with the death of a loved one (family member, extended family member, spouse, friend) by suicide.

Participants will be personally interviewed on their experience of loss to suicide.

To participate in this study please contact Mr. Jesse Henneberry

This research is supervised by Terry Lynn Gall, Associate Professor, Saint Paul University,

Appendix 2: Recruitment Information (first phone contact)

Research Study: Coping with the Death of a Loved One to Suicide

Hello Mr./Ms. _____

I would like to thank you for your interest in participating in our research study on individuals who have lost a loved one to suicide.

First in order to discern whether you are eligible to participate in this study I have to ask you a couple of questions: 1) how old are you? And 2) how long ago did the suicide take place? It is important that individuals have had some time to cope with their bereavement prior to participating in this study.

The purpose of this study is to explore the experience of individuals who have suffered the death of a loved one to suicide. This study will focus on how individuals cope with and make sense of their loss and specifically what they found to be effective and healing in their process of bereavement. In addition to bereaved individuals, this study will also explore the perspectives of mental health professionals on the impact of suicide and how individuals can best be helped through this process of bereavement.

If you choose to participate, I will arrange for us to meet privately at Saint Paul University to discuss for a personal interview on your experience with suicide. This interview would last a maximum of 1.5 to 2 hours and would be audio-taped. In some cases where I need clarification on some of the issues raised in the first interview, I will invite you back for a briefer second interview (lasting about 30 minutes).

Your participation in this study is completely voluntary. You can refuse to answer specific questions during the interview. As well and most importantly you will be able to withdraw from the project at any time without explanation. If you choose to withdraw, any data collected on your experience will be destroyed.

The benefits from this research play out on three levels. First, you will be provided with the opportunity to reflect on various aspects of your experience. The process of sharing your story with the researcher may be an affirming and comforting experience. Second, information gained from this study could help mental health care providers develop helpful new interventions with bereaved individuals. Third, this investigation may expand our research knowledge and understanding of the nature of this bereavement experience and set the stage for future studies.

You also need to know that because you will be sharing your personal experience, you may feel some emotional discomfort during the interview. If needed, you will be provided with information on appropriate community resources.

All information collected for this study will be strictly confidential and stored at Saint Paul University.

Do you have any questions about this study? Would you like to participate in this study?

Note: In the event that the researcher is invited to present information on the study to an organization or community group, this phone script for recruitment will be tailored to that situation. Specifically, the researcher will first introduce himself and the name of his supervisor, his affiliation with Saint Paul University, the title of the research and the fact that it represents his Master's thesis for the program in Counselling and Spirituality. He will then start the presentation proper at the third paragraph (with the purpose of the study) and end with confidentiality. He will not ask participants to identify themselves at that time but leave some information sheets with contact information with the group. Participants who then call will be screened for the exclusion criteria and reminded of the study information as above.

Appendix 3: Consent Form

Research Study: Coping with the Death of a Loved One to Suicide

Purpose and Design

The purpose of this study is to explore the experience of individuals who have suffered the death of a loved one to suicide. This study will focus on how individuals cope with and make sense of their loss and specifically what they found to be effective and healing in their process of bereavement. In addition to bereaved individuals, this study will also explore the perspectives of mental health professionals on the impact of suicide and how individuals can best be helped through this process of bereavement. Ultimately this research hopes to highlight what factors best help individuals cope with suicide bereavement.

Study Procedure

You will be asked to share your experience in a semi-structured personal interview. This interview will last **no longer than 1.5 to 2 hours**. You will be asked questions about:

1) your experience of the loss of your loved one to suicide, 2) how you coped with this loss, 3) what helped you to understand or make sense of this loss, and 4) whether spirituality or religion played a role in your coping with this loss. You will also be asked to fill out a short questionnaire on demographic information (e.g., age), your sense of spirituality/religiosity (if it applies), and the suicide event (e.g., when in the past it occurred).

You may be asked to attend a second interview that would last **no longer than 30 minutes**. The purpose of this second interview would be to seek further clarification on the thoughts you shared during the first interview.

Interviews will be audio-taped.

Length of Study

This study will be conducted over a period of 12 months.

Possible Risks

Since the interview will address your personal experience with suicide, you may feel some emotional discomfort or distress. Discussion of this stressful event is just part of the interview. We will also discuss positive aspects of how you coped with and understood this loss. If you feel discomfort during the interview, feel free to bring this to my attention. You can stop the interview for a personal break at any time. You can also refuse to answer any question during the interview and this will be respected. You can withdraw from the research project, without explanation, if you feel the need. You need to understand that if you become significantly emotionally upset during the interview I will end the interview and make every effort to assist you in accessing appropriate supportive resources (e.g. Counselling Centre of Saint Paul University, community support groups for bereaved individuals).

Benefits of the Study

Sharing your story and life experience with an attentive listener has the potential to be an affirming experience for you. Furthermore, reflecting on various aspects of your experience may provide a starting point for further reflection and personal growth.

This investigation will expand our knowledge and understanding of the nature of suicide bereavement. Information gained from this study will inform future researchers and mental health care professionals about the best healing practices for bereaved individuals.

Voluntary Participation and the Right to Withdraw from the Study

Your participation in this research is entirely **voluntary** and you may withdraw at any time during or after the interview without explanation. If at any time during or after the interview, you decide that you no longer wish to be part of this study, any data recorded by the researcher will be destroyed.

Confidentiality and Anonymity

All results of this study will be kept confidential. To ensure anonymity, your name will not appear on the audio tapes or the transcriptions. The audio tapes and transcriptions will be identified only by a code number. This consent form will be stored in a locked area separate from the tapes, questionnaires and transcriptions so that your name cannot be matched up to your personal data. Only the researcher, Jesse Henneberry, the research supervisor, Terry Lynn Gall, and a professional transcriber will have access to the audio tapes. The transcriber will not have access to any identifying information such as your name. The transcriber will be instructed to store all material in a locked area until it is returned to the researcher. The audio tapes will be destroyed immediately after they have been transcribed. The transcribed data will be stored in a locked area at Saint Paul University in accordance with ethical guidelines for a period of 5 years after the end of the study and then shredded. In addition to the researcher and the research supervisor, a peer reviewer will have access to the coded transcripts (but not the original audiotapes). This reviewer will be involved only in the analysis of the data and in giving feedback on his or her data analysis to the researcher. No one else (e.g., your agency for mental health workers) will have access to your data.

In the event of publication or public presentations, data will be reported as common themes and descriptions drawn across all participants. If a direct quote is used in publication, all personally identifying information will be removed.

Questions about the Study

This research is being conducted by Jesse Henneberry :
, M. A. candidate in the program of Counselling and Spirituality at Saint Paul University, 223 Main St., Ottawa. This research constitutes Jesse's M.A. thesis. The research supervisor is Terry Lynn Gall, Ph. D., Associate Professor, Faculty of Human Sciences, Saint Paul University (. If you have any questions please do not hesitate to contact us.

Other Rights

If you have any questions about your rights as a research participant, you can contact Ming Zhang, Director of Research Services, Saint Paul University at 613-236-1393 ext. 2213.

Consent

I have read this Consent Form and have had an opportunity to ask the researcher any questions I had about this study. My questions and/or concerns have been answered to my satisfaction and I agree to participate in this study. If I decide at a later stage in the study that I would like to withdraw my consent, I may do so at any time.

A copy of this Consent Form will be provided to me.

Participants Name: _____

Participants Signature: _____ Date: _____

Researchers Name: _____

Researchers Signature: _____ Date: _____

Research Supervisor's Name: _____

Research Supervisor's Signature: _____ Date: _____

Appendix 4: Interview Questions

Sample Questions for Individuals Bereaved by Suicide

1. Please tell me, as much as you are comfortable sharing with me right now, what has been your experience with suicide?
2. How did you make sense of suicide prior to your personal experience?
3. Was this view challenged as a result of this personal experience?
4. How did you make sense of the suicide initially? How did you understand what had happened?
5. How has your experience of suicide shifted your view on the world?
6. How do you make sense of the suicide today? How do you understand it today?
7. What were the primary ways that you coped in the initial aftermath following the suicide?
8. What ways of coping were most helpful or worked best for you? How did they help?
9. What ways of coping were less helpful or made things more difficult to handle?
10. Did your coping change as time passed? If so, how?
11. Did spirituality and/or religion play a role in how you coped with the suicide?
12. Were there any struggles with your spiritual beliefs following the suicide?
13. What impact did the suicide have on your spiritual and/or religious beliefs and activities?
14. Do spirituality and/or religion play a role in how you currently cope?
15. Do you believe in an afterlife? If so, does this belief help you cope with the death?
16. How does this belief in an afterlife help?
17. Do you feel a sense of continued attachment or connection with your loved one?
18. If so, how does this affect your coping with his or her death?
19. What are beliefs, spiritual or non-spiritual, that you have that play a role in how you understand the death of your loved one?
20. What would you say to someone newly bereaved by suicide in terms of their own coping and ability to make sense of what happened to facilitate greater healing?
21. Thank you for taking part in this interview, please feel free to discuss any final thoughts that you may have on suicide bereavement.

Sample Questions for Mental Health Practitioners

1. Please tell me your experience in helping individuals bereaved by suicide.
2. What was your view of suicide prior to working in the mental health system?
3. Has this view changed or ever been challenged since you began working in with individuals bereaved by suicide?
4. How does an experience of suicide shift one's view of the world?
5. In your opinion, what are some of the most effective ways an individual bereaved by suicide can cope with their loss?
6. Are there any instances where coping with suicide bereavement can be negative?
7. How do individuals bereaved by suicide typically make sense of such a death?
8. Are there differences in how individuals make sense initially compared to when time progresses?
9. Do you address spirituality and/or religion in working with individuals who have lost someone to suicide?
10. If so, how do you incorporate spirituality in your work?
11. How can an individual's spiritual beliefs impact on coping and making sense after a suicide?
12. Do such beliefs also benefit you as a mental health practitioner in assisting individuals in these cases?
13. How does one's belief (or lack of belief) in afterlife impact coping after suicide bereavement?
14. How have you (or would you) addressed such concerns when providing assistance to bereaved individuals after a suicide?
15. How does one's belief (or lack of belief) in continued attachment or connection to the deceased impact coping after a suicide?
16. How have you (or would you) address such concerns when providing assistance to bereaved individuals after a suicide?
17. What would you say to someone newly bereaved by suicide in terms of their own coping and ability to make sense of the suicide in order to facilitate greater healing?
18. Thank you for taking part in this interview, please discuss any final thoughts that you may have on suicide bereavement?

Additional Questions for individuals who are both bereaved and who work in mental health:

1. How does your personal experience of loss to suicide benefit others you work with who have also lost to suicide?
2. Are there times when your own personal experience could be negative?
3. How do you make use of self disclosure when working with those bereaved by suicide?
4. How has this self disclosure been positive? Are there times when it has been negative?
5. What does the mental health system need to focus on to provide better care for those bereaved by suicide?

Appendix 5: Demographic Information Questionnaire

1. Sex _____

2. Age _____

3. Marital Status: 1. Single _____ 4. Separated _____
2. Married _____ 5. Divorced _____
3. Common Law _____ 6. Widowed _____

4. Number of children: _____

5a. Last grade completed in public or high school: _____

b. Level of post-secondary education: 1. Some university/college _____
2. Community college diploma _____
3. Undergraduate university degree _____
4. Graduate university degree _____

6. Current Occupation: _____ Hours per week: _____

7. Total Annual Family income: 1. Less than 19,999 _____
2. 20,000 to 39,999 _____
3. 40,000 to 59,999 _____
4. 60,000 to 79,999 _____
5. Greater than 80,000 _____

8. Cultural/racial background: _____

9. Religious affiliation: 1. Catholic _____ 4. Muslim _____
2. Protestant _____ 5. Other _____
3. Jewish _____ 6. None _____

10. Religious service attendance: 1. Not attending _____
2. Infrequently attending _____
3. Once or twice per month _____
4. Once a week _____
5. More than once a week _____

11. How important is religion to you? 1. Not important at all _____
2. Slightly important _____
3. Fairly important _____
4. Important _____
5. Very Important _____

12. How important are spiritual issues to you?
- 1. Not important at all _____
 - 2. Slightly important _____
 - 3. Fairly important _____
 - 4. Important _____
 - 5. Very Important _____

13. To what degree do you consider yourself to be **religious**?

- 1. Not religious at all _____
- 2. Slightly religious _____
- 3. Fairly religious _____
- 4. Religious _____
- 5. Very religious _____

14. To what degree do you consider yourself to be **spiritual**?

- 1. Not spiritual at all _____
- 2. Slightly spiritual _____
- 3. Fairly spiritual _____
- 4. Spiritual _____
- 5. Very spiritual _____

15. Choose **one** of the following statements that best defines your own religiousness and spirituality:

- a) I am spiritual **and** religious _____
- b) I am spiritual **but not** religious _____
- c) I am religious **but not** spiritual _____
- d) I am **neither** spiritual or religious _____

Questions on the bereavement experience:

16. How long ago did the suicide occur? _____ year(s)

17. What was your relationship to the deceased? _____

Additional Questions for Mental Health Practitioners:

18. How long have you worked in the mental health system? _____ year(s)

19. How long have you worked with individuals bereaved by suicide? _____ year(s)