Experiences of Family Members After a Suicide

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Background. Survivors of suicide are the family members and significant others in the life of the person who commits suicide. A recent study by the author explored the life experiences of survivors of suicide, affirmed the severity of postsuicide bereavement, and revealed the critical role of the family physician in intervention.

Methods. Thirty-five adult survivors participated in in-depth audiotaped interviews during the 3- to 9-month period after the suicide death of a family member. Demographic data and the transcribed interview data were analyzed through descriptive statistics and systematic methods of qualitative data analysis.

Results. Subjects stressed the importance of the family physician understanding the nature of their experiences in order to intervene effectively. All survivors experienced profound disruptions in their lives, including changes in physical, emotional, cognitive, and social functioning. Variations among survivors of suicide, based on the survivor's perception of the victim before his or her death, were evident and are illustrated by three case studies. Interventions for the family physician, including specific suggestions from survivors, are proposed.

Conclusions. Survivors of suicide experience a very severe bereavement, yet significant variations exist among their responses. The family physician is identified as the key individual to initiate and ensure follow-up care for this bereaved population.

Key words. Suicide; grief; bereavement; physician, family. *J Fam Pract 1991; 33:375-380.*

I think help should start with the family physician. There should be the concern, the compassion . . . . I don't think that's too old-fashioned a thing to do.—A son, following the suicide of his father

Survivors of suicide, that is, the relatives and friends of the person who commits suicide, are generally viewed as a vulnerable population at high risk for suffering disturbances in physical and psychological functioning. A recent study by Van Dongen[1] explored the perceived life experiences of 35 adult survivors of suicide 3 to 9 months after the suicide death of a family member. An important, serendipitous finding from that research was that the family physician was repeatedly identified as the key individual to initiate follow-up care for persons bereaved through suicide. Subjects also reported, however, that many physicians failed to understand what the survivors were experiencing and seemed uncertain as to how to help the family members postsuicide.

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Methods

Potential subjects were contacted by sending a letter to survivors identified through death certificates, a support organization for survivors of suicide, and through referrals from subjects already in the study. Few difficulties were encountered in obtaining subjects; more survivors volunteered to participate than could be included in the study. Subjects, described in more detail in the recent study,[1] included 25 women and 10 men, ranging in age from 25 to 68 years (mean, 41.7). Nearly half (n = 17) of the subjects were parents of the victim, five were adult children, eight were siblings, and five were spouses of the deceased. Subjects were related to 19 victims of suicide (16 male and 3 female) who ranged in age from 15 to 64 years (mean, 30). Twelve (63%) of the deceased had histories of drug or alcohol abuse, and eight (42%) of the victims had been diagnosed as having severe depression or schizophrenia. All but three of the subjects described their relationship with the deceased as having been close and positive.

Subjects participated in in-depth, audiotaped interviews that averaged 90 minutes in length and were conducted an average of 5.8 months postsuicide. All interviews were done with individual subjects, except in two instances when parents requested a joint session. The

audiotapes were transcribed and analyzed through systematic methods of qualitative data analysis as described by Glaser and Strauss.[2]

Results

Survivors provided new insight into the nature of postsuicide bereavement, particularly that experienced during the early months after the death, and into what factors may result in variations among survivors' experiences. In addition to discussing how the death was currently affecting the lives of the subject and other family members and how it might continue to affect their lives in the future, a recurrent theme throughout the interviews was the question of *why* the suicide had occurred.

Emotional Responses

Subjects universally reported experiencing shock on discovering the body (n = 10) or being otherwise informed of the death (n = 25). They described being stunned and overwhelmed with disbelief. Common emotional responses reported included the affective reactions associated with acute grief, such as crying and yearning for the deceased, as well as feelings of irritation, anger, depression, and guilt. Anger was reported by 31 (89%) of the subjects and was most often directed toward the deceased, the mental health system, God, and the world in general. Anger may have been part of the questioning process, as survivors searched for a reason why the suicide had occurred, believing that someone or something must be to blame.

Depression was reported by 20 (57%) of the subjects. For 11 (31%) of the family members, the depression became even more severe 3 to 5 months postsuicide. Transient thoughts of suicide were reported by five (14%) subjects, and two (6%) subjects indicated that they had even thought of a suicide plan. When questioned by the researcher, however, these subjects denied current thoughts of suicide and noted that a deterrent to suicidal behavior was the awareness of how devastating another suicide would be for the family.

Twenty-one (60%) subjects described themselves as feeling some guilt related to the suicide. In general, feelings of guilt were evident through subjects questioning as to how they might have inadvertently contributed to the death and what they might have missed in terms of recognizing the victim's intent to die.

Physical Concerns

Nineteen (54%) subjects had seen a physician (n = 17) or other health care professional (n = 2) for physical concerns; however, only 7 of the 19 said that the death was discussed during the health care visit. Survivors expected the physician to initiate the discussion, and when that did not occur, they were uncertain as to how to react. Several subjects described the physician as "hurried" and seemingly uninterested in their emotional concerns.

Survivors questioned how the suicide might affect their own future health as well as that of other family members. All subjects reported experiencing some physical symptoms that commonly accompany acute grief. Anorexia, chest discomfort, insomnia, and marked fatigue were the most common complaints. Sleep disturbances were especially troublesome, as survivors repeatedly awoke with thoughts and questions related to the suicide. Eleven (31%) survivors reported exacerbations of preexisting physical illnesses, such as ulcers and other gastrointestinal disorders, arthritis, asthma, cardiovascular conditions, and carcinoma. All subjects attributed their symptoms to stress associated with the suicide.

Cognitive Changes

All subjects, except for those who perceived the deceased as chronically suicidal (n = 7, or 20%), reported experiencing tremendous cognitive dissonance. The fact that a family member commited suicide was in direct conflict with their former beliefs about the victim, their family, and the world in general. They questioned, "How can this be?" This cognitive dissonance stimulated survivors to question their overall belief systems and motivated them to seek information that would help to explain the suicide.

Changes in cognitive functioning were evident through survivors' reports of difficulty in concentrating and making decisions, particularly during the first few days after the death. There were many important decisions to be made related to the care of the body and plans for the funeral and burial. An immediate question for survivors of gunshot suicides was how to deal with the physical aftermath or human residue of the death. They recalled smelling the lingering odor of gun powder and finding tissue and bone fragments of the victim. Most families used a professional cleaning service, but they still found it necessary to clean the area again. Another important decision was whether to see the victim's body. Eighteen (51%) of the subjects saw the victim after the death. Of those who did not, most later wished that they had seen the body because they felt it would have helped them to accept the death.

Twenty-two (63%) subjects described experiencing mental images, dreams, or flashbacks of the death scene as they cognitively struggled to accommodate the reality of the suicide. These were powerful experiences that

often significantly disrupted sleep as well as daily activities. Four (11%) subjects, all women, provided vivid descriptions of recurrent episodes in which they "relived" cognitively, emotionally, and physiologically, the experience of discovering the victim's body. Following these episodes, which lasted 15 to 20 minutes, subjects described themselves as totally exhausted and unable to resume their daily routine.

The Social Context of Grief

Survivors expressed concern about their role as survivors of a suicide. They questioned how they were to behave and what other people thought of the victim and themselves. They were aware of the potentially stigmatizing nature of suicide and were uncertain about whether to reveal their status as survivors and how to answer potential questions related to the death. They described feeling estranged from people outside the family, because they perceived that persons who had not experienced the loss of a family member through suicide could not appreciate their pain. Twenty-four (69%) of the survivors, however, reported experiencing strong social support from others. They perceived that others did care and were concerned about them.

Changes in family functioning were evident postsuicide as subjects described the intense void left by the deceased in the family unit. Lengthy, emotional family discussions were held as family members tried to retrace the victim's actions and understand how the suicide could have happened; yet after the first few weeks, the death was not a major topic of conversation. Survivors explained that concerns related to the suicide persisted, but they hesitated to raise the subject because they wished to avoid burdening other family members who were seen as already emotionally exhausted. All survivors expressed great concern as to how the death was affecting other family members and how the suicide might affect each member's future health and adjustment.

Thirty (86%) perceived that the tragedy had drawn the family together and described their relationship as close or closer than before the suicide. Thirty-two (91%) reported that the family had expressed care and concern about the victim. Only five (14%) subjects recalled major conflicts before the suicide. Survivors' subjective involvement and the recentness of the death may have resulted in inaccurate accounts of family functioning; however, nonverbal interview data suggested that family members were caring and very concerned about one another.

Surviving parents described their relationship with their spouses as positive and mutually supportive. There was no evidence of blaming each other for possibly contributing to the suicide. An increase in marital tension was reported by four of the five married siblings and three of the four married adult child survivors. Two of these subjects had begun marital counseling since the suicide. These siblings and adult child survivors perceived their spouses as concerned but unable to appreciate their feelings. They described themselves as hostile and sometimes even abusive toward their spouses.

Coping with the Death

During the first few days after the death, experiences of shock and denial of the death itself helped survivors to insulate themselves from the harsh reality of the suicide. As time passed, a major theme in survivors' struggle to adjust to the suicide was striving to understand the death and find some meaning in it. They sought out information that would enable them to accommodate the fact of the suicide in their lives. Specific efforts to cope included attending support groups; keeping busy; consciously blocking thoughts related to the suicide; reading about suicide, grief, and mental illness; and discussing their concerns with others.

Subjects reported a slow but discernible improvement in how they felt and functioned as time had passed since the death. Even up to 9 months after the suicide, however, many subjects described incidents in which they suddenly lost their composure and were overwhelmed by a "tidal wave" of thoughts and feelings related to the victim and the death. These episodes were precipitated by "trigger stimuli," such as looking at a picture of the deceased; hearing a favorite song of the victim; or holidays or family gatherings that evoked memories of the deceased. Evidence of beginning to resolve the meaning of the suicide was apparent in comments by survivors that reflected at least some understanding of why the death occurred and a recognition that there were no real answers to the multiple questions related to the suicide.

Variability of Experiences

Although all subjects reported painful experiences postsuicide, the severity of the bereavement experience appeared to be associated with how the survivor had perceived the victim before the death. The most difficult bereavements, characterized by an excessive preoccupation with questions related to the death, were reported by subjects (n = 3) who stated they had had absolutely no warning of the suicide and by subjects (n = 25) who had perceived the victim as troubled and in retrospect could see clues of suicide intent. Subjects (n = 7) who had perceived the victim as chronically suicidal and

thought that a suicide was probably inevitable seemed to experience less disruption in their lives.

Case Illustrations

No Prior Warning of the Suicide

A 45-year-old mother was interviewed 6 months after the suicide (gunshot) death of her 19-year-old son. The victim had been living at home, was employed, and had made plans to attend college. He had had no history of substance abuse, mental illness, or any psychiatric care. His mother reported that absolutely no behavioral or verbal hints of suicide could be identified, despite the repeated efforts by herself and other family members to find such clues.

This survivor experienced a profound upheaval in all aspects of her life. She described prolonged shock, characterized by persistent feelings of numbness and confusion, as she struggled to comprehend the reality of the death. When interviewed 6 months after the death, she reported severe depression as well as strong anger toward the victim for apparently impulsively ending his life. Suicidal thoughts were denied, yet she stated: "I felt so depressed . . . that is, it's hard living like this, and if I should die, then it would be over. And I started to think, 'Is this how [my son] must have felt?'"

Minimal guilt was evident. She explained that she could not have prevented the death because there had been simply no indications of suicide intent. Cognitive dissonance was intense, as the idea of suicide was foreign to the family and inconsistent with how the victim was perceived. She desperately searched for answers to explain the suicide through reading about depression and suicide, talking with other survivors, and reconstructing with other family members the victim's entire life.

She obtained a complete physical examination from her family physician because she feared physical illness due to her extreme emotional stress. She was most appreciative of the efforts of her physician, whom she described as nonjudgmental, sensitive, and a good listener. She explained: "He took me seriously. I think he heard my pain . . . and he seemed to search for some way to explain the death like we have." The physician also suggested further grief counseling, which the survivor and her husband found beneficial.

Clues of Suicide Intent Retrospectively Identified

The subject was a 28-year-old married brother of a 22-year-old male suicide (gunshot) victim who had been living with his parents at the time of his death. The survivor, interviewed 5 months postsuicide, described the deceased as having a 2-year-history of alcohol abuse and irregular employment and a recent depression associated with a breakup with his girlfriend. The survivor had been actively involved in persuading the deceased to accept professional help. Although the victim had refused hospitalization, he had begun seeing a mental health professional before his death. No suicide note was found.

The survivor reported having a profound depression, which interfered with his meeting of many responsibilities at home and work. He reported feeling extreme anger toward the victim for giving up and rejecting the help that the entire family had offered. Anger was also expressed toward a mental health system that made it difficult to secure help for a person who needed help but refused treatment. The anger spilled over into social situations and his marriage. He reported irritability and uncharacteristic verbal abuse toward his wife, whom he acknowledged as being an available target for his anger. He recalled that the victim had made a verbal hint of suicide and described feeling guilty for not somehow preventing the act. He questioned why he had not taken the comment more seriously and whether additional support would have prevented the death.

Although he did not see the body at the scene of death, this subject experienced recurrent waking images and dreams of the victim at the time of death. He said: "All I thought about was him and him putting the gun to his head. I'd wake up at night seeing it. And then, I'd think about what might have been going through his head when he was doing it."

This survivor did go to his family physician, who provided prompt treatment for his complaints of persistent headache and gastrointestinal disturbance. He expressed disappointment that the physician offered no opportunity to discuss the suicide, even though the physician had been previously informed of the death.

Victim Seen as Chronically Suicidal

The subject was the 56-year-old wife of a 60-year-old male suicide (gunshot) victim with a history of alcoholism, severe depression, at least one known previous suicide attempt, and frequent verbal threats of suicide. This woman, interviewed 4 months postsuicide, described her relationship with the deceased as "distant and both good and bad." She recalled her husband's mood swings, violent behavior, and frequent references to wanting to die during the 25 years of their marriage.

Following the suicide, this survivor recalled feeling shocked and a great sense of loss. Typical symptoms of grief, such as crying, sleep disturbances, anorexia, and depression, were experienced for approximately 3 weeks. Some feelings of relief were also evident. She explained:

"It was at the back of my mind that it was going to happen. And when it did, it was a shock, but I felt, 'Okay, he's finally at rest . . . ' I felt relieved that he was finally at peace, because I had done all I could." She denied experiencing cognitive dissonance because the victim was chronically depressed and self-destructive, and a suicide was perceived as probable. She reported being able to maintain her responsibilities at home and work and to resume her social activities early. This subject had not visited her family physician and had felt no need to seek out any kind of supportive counseling. She acknowledged, however, that if she had perceived a need for professional help, she would have consulted first with her family physician.

Discussion

Most survivors of suicide are left with an emotional burden and unfinished business related to the death, plus uncertainty regarding how the suicide could continue to affect their lives. Bereavement research indicates that any sudden death results in more intense grief and is more difficult to assimilate because the death violates the survivor's basic assumptions about the world.[3,4]

Assumptions should not be made that survivors of suicide experiences will vary according to their familial relationship with the deceased. Siblings, children, spouses, and parents of the deceased may all experience extremely painful bereavement. This is consistent with recent research by McIntosh and Wrobleski,[5] who found no difference in bereavement among survivors of suicide based on kinship ties.

The findings lend support to Bugen's model of bereavement[6] and research by Demi and Miles.[7] Bugen proposed that the two dimensions of closeness of the relationship between the deceased and the survivor and the preventability of the death were major predictors of the intensity and duration of bereavement. Nearly all (n = 32) survivors described themselves as emotionally close to the deceased. Survivors who seemed to have the most painful experiences were those who felt the suicide might have been prevented through somehow identifying clues of suicide intent and intervening to stop the death. Subjects who perceived the victim as chronically suicidal reported more "normal" bereavement experiences. Demi and Miles[7] conducted research involving parents surviving the loss of a child through various modes of death and concluded that cause of death alone in not a good predictor of bereavement outcome. Instead complex situational and personal factors may be more influential in how survivors respond.

Survivors of suicide have often been described as stigmatized and social isolates.[8,9] Subjects in this study reported role uncertainty as to how they should behave as a survivor of suicide, but the majority also perceived concern on the part of others and the availability of strong social support. This is consistent with research, which has indicated that the majority of survivors of suicide are not rejected by others.[10,11]

Experts on suicide have emphasized the disturbed dynamics among families before a suicide, and the blaming and scapegoating behaviors after a suicide.[9,12] Data from this study suggest that suicides may well occur within families that appear to be quite healthy. Survivors appeared to be deeply concerned regarding the impact of the suicide on other family members and tried to comfort and protect each other. Descriptions of parents who have lost a child through suicide have indicated a high incidence of marital conflict and mutual blaming behaviors.[13,14] In contrast, parents in this study appeared to have supportive marital relationships. Definite marital strain was evident among adult children and siblings who had survived a suicide. The impact of suicide on this group of survivors may be more significant than has been recognized.

The experiences described by many survivors of suicides are similar to those of posttraumatic stress disorder. Survivors' reports of recurrent and intrusive thoughts about the death, dreams, increased arousal as evident through sleep disturbances and difficulty concentrating, emotional anesthesia, social detachment, and irritability, sometimes even to the point of aggressive behavior, are all representative of posttraumatic stress disorder (PTSD).[15] Descriptions by subjects of flashback episodes in which the survivor relived discovering the victim's body are also consistent with PTSD. However, instead of the characteristic tendency in PTSD to avoid thoughts and stimuli associated with the traumatic event, survivors of suicide seem to dwell on the suicide as they struggle with the question of why the suicide happened.

Suggestions for the Family Physician from Survivors of Suicide

The researcher specifically asked subjects how health care professionals could help the survivor of suicide. Subjects were unanimous in stating that a professional, preferably the family physician, should take the initiative in contacting the family during the first few days after the death. They described this initial overture as the "caring" and "appropriate" thing to do. Only six (17%) subjects were contacted by a health professional (physician or victim's therapist) after the suicide. Survivors expressed amazement and disappointment regarding this perceived lack of caring. They presumed that the family physician or someone on his or her staff must know of the death.

Subjects emphasized that when the family physician sees a survivor of suicide, the physician should inquire as

Table 1. Recommendations for Follow-up of the Survivor of Suicide

1. Be knowledgeable about postsuicide bereavement experiences.
2. Make contact with the family during the first 72 hours. Offer sympathy and a willingness to discuss the suicide and its potential impact on the family. Further contacts at 2 weeks, and 3, 6, and 12 months are also recommended.
3. Be a willing and nonjudgmental listener. Survivors of suicide need your acceptance and compassion.
4. Do not assume that one's familial relationship to the deceased is a good predictor of the severity of grief. Instead, contextual factors, such as whether or not the victim was seen as suicidal, may significantly influence the nature of bereavement.
5. Provide anticipatory guidance to survivors regarding bereavement postsuicide so they will realize their reactions are not abnormal. Be aware that postsuicide bereavement is likely to be prolonged and episodic in nature.
6. Encourage expression of feelings. If medications are prescribed, their use should not interfere with the accomplishment of grief work.
7. Assist the survivors of suicide to gradually understand and accept the death in a way that preserves their own self-worth.
8. Encourage survivors to support each other and utilize the support of friends and relatives.
9. Offer information related to community resources and local survivors of suicide support groups. To locate your closest support group, contact either of the following:

   American Association of Suicidology
   2459 South Ash
   Denver, CO 80222

   Suicide Prevention Center
   184 Salem Avenue
   Dayton, OH 45406

10. Offer a list of postsuicide bereavement references. The following books are highly recommended by survivors of suicide:

   Bloom, Lois A. *Mourning After Suicide*. New York: Pilgrim Press, 1986
   Bolton, I. and Mitchell, C. *My Son . . . My Son: A Guide to Healing After Death, Loss, or Suicide*. Atlanta, Ga: Bolton Press, 1983
   Hewett, J. *After Suicide*. Philadelphia: Westminister Press, 1980
   Lukas, C. and Seiden, H. *Silent Grief*. New York: Charles Scribner's Sons, 1987

to the survivor's feelings related to the suicide, even though a physical concern may have precipitated the survivor's visit. Survivors stressed the importance of the family physician being knowledgeable about suicide and grief, and being comfortable and willing to discuss these topics. *Suicide and Its Aftermath*[16] is an excellent resource for the family physician counseling survivors. In Table 1 the recommendations made by survivors of suicide are summarized, and helpful resource information for the family physician is provided.

Summary

A death by suicide results in a profound upheaval in the lives of surviving family members. Significant changes in emotional, physical, cognitive, and social functioning are commonly experienced by survivors. Contextual factors, such as whether the victim was seen as suicidal, also appear to account for variations among survivors' experiences. Since the family physician has been identified as the key professional to initiate care for this bereaved population, it is essential that physicians have some understanding of postsuicide bereavement and appreciate the concerns of survivors of suicide.

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