The impact of events in the immediate aftermath of suicide on family members' bereavement experiences

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The Impact of Events in the Immediate Aftermath of Suicide on Family Members' Bereavement Experiences

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A thesis submitted in partial fulfilment of the requirements for the award of Doctor of Psychology.

Date of submission: 10 March 2005
USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.
Suicide remains a leading cause of death in Australia. Consequently, a considerable proportion of the population is, or will be, bereaved due to suicide. These individuals are referred to as survivors of suicide. Literature suggests bereavement is a significant risk factor for adverse health outcomes. The question of whether or not bereavement after suicide, as opposed to other modes of death, renders individuals more susceptible to enduring and complicated grief reactions remains unclear. Numerous key variables have been found to influence the nature, intensity and duration of the grief process. Variables that are likely to be associated with poor bereavement outcome are considered risk factors. There appear to be a greater prevalence of individual and contextual risk factors leading to complicated bereavement for survivors of suicide, as opposed to those bereaved through most other modes of death. In attempts to limit the potential deleterious effects of bereavement due to suicide, attention has primarily focussed on the role of more distal factors, such as the benefits of support groups. However, trauma-related research and survivors' anecdotal reports emphasise the potential for proximal factors and specific experiences in the immediate aftermath of a suicide to facilitate or complicate bereavement. The impact of such factors remains largely overlooked in the context of suicide, despite representing important and crucial opportunities for secondary prevention efforts with survivors. The initial aims of the present study were to explore participants' experiences in the time following a suicide, determine the existence of any experiences which participants believe to have impacted on their respective bereavement and grieving processes, and to highlight any areas of service provision or support which participants deemed as weaknesses and through which improvement efforts can be directed. A qualitative methodological approach was utilised in this exploratory study. Forty-four bereaved family members participated in a free narrative and guided conversation that focussed on their post-suicide experiences.
In attempts to gain a better understanding of relevant procedural and legal requirements, as well as education and training methods, interviews with a number of relevant service providers were also undertaken. The findings of this study confirm the existence of specific events or procedures, or deficiencies in several definite areas, which survivors believe impacted on their bereavement, or defined as being crucial in exacerbating the traumatic nature of their experience. These include their subjective emotional and mental state following death notification; a poignant paucity of information, guidance and advice during this time; insensitive and inappropriate interactions with others, notably service providers; a number of procedural aspects such as the death notification, and several issues unique to the experience of being a child survivor of a parent's suicide. Recommendations based on these findings include the development of more thorough and informed frameworks to guide future studies, service provision and support services, as well as continued efforts to generate greater insights and understanding into the reactions and experiences of survivors of suicide in the time following their loved one's suicide.
Declaration

I certify that this thesis does not, to the best of my knowledge and belief:

(i) incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;

(ii) contain any material published or written by another person except where due reference is made in the text; or

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Signature: [Redacted]

Date: 10 March 2005
To the memories of

Andrew Nicholas Botha
and
Maureen Grace Botha
4 May 1920 – 3 May 1997

"Too soon, too soon"
ACKNOWLEDGEMENTS

I wish to express my thanks to the following people:

- My supervisor, Dr Lisbeth Pike, for her encouragement, support, guidance and deadlines.
- My associate supervisor, Dr Andrew Guilfoyle, for his patience, wisdom and friendship, and allaying my fears regarding qualitative research.
- My mother, Valerie, for her unreserved faith in all of my endeavours, and whose unconditional love, passion and encouragement (and endless games of internet scrabble and parcels of clippings) have been invaluable in keeping my dream alive.
- My father, Derek, for his love and support, financial assistance, and for always being accessible for advice and perspective.
- My brother, Justin, whose way of life encourages me to venture on wider seas (and for his concerted letter writing attempts over the years).
- Pam, for being my best friend, for keeping me grounded over the last few years, for her tireless and completely biased support for me and everything I do, and for everything else that goes without saying.
- Jay, for endless patience and understanding, for proof reading drafts and providing valuable feedback, and for keeping my life balanced with swims, surfs, sorties into the hinterland, joy, and the endless activities of the “imaginaries”.
- My friends, Lobby, Anna, Sue, Ange, and Nik who have supported me in their various and unique ways over the last few years, and have provided laughter, love, and much-needed good times.
- Nigel, for making this study opportunity possible, and for his faith in me.
- Sandy Phillips, for her generosity and warmth, and for embracing me into her family.
• John Forbes, for his valued advice and his unfailing technical assistance, irrespective of the time of day.

• Gisela Cannon, an inspiring friend whose hospitality at the farm eased the pain of the final write-up stage immeasurably.

• And finally, this study would not have been possible without the involvement and support of the research participants. I feel honoured that they chose to share their personal and very painful stories with me, and I hope that the value of their contributions is realised.
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CHAPTER ONE

Introduction

Over the past few decades there has been a significant increase in international suicide rates, with Australian rates being no exception (Australian Bureau of Statistics, 1999; Brent, Kerr, & Goldstein, 1989; Guyer, MacDorman, Martin, Peters, & Strobino, 1998). Official Australian statistics indicate a 24% increase in the number of deaths attributed to suicide over the ten-year period between 1988 and 1997 (Australian Bureau of Statistics, 1999). In 1998, 2,683 deaths in Australia were classified as suicide. This equates to 33.8% of all registered unnatural deaths. In Western Australia (WA) alone, approximately 270 deaths were registered as suicide in 1998 (Australian Bureau of Statistics, 1999).

A direct consequence of rising suicide rates is the increasing number of individuals bereaved by suicide. These individuals are often referred to as “survivors of suicide” and can include family members, friends, co-workers, teachers, classmates and therapists. Whilst definitions of what constitutes a survivor may vary from study to study, estimated numbers generally range from between five to ten bereaved individuals per suicide. For instance, McIntosh (1993) estimated six individuals will be intimately affected by one suicide, while Lukas and Seiden (1987) estimated that between seven and ten survivors per suicide. Other researchers are less conservative and postulate that the number of affected people can extend to well over twenty (Dunne, McIntosh, & Dunne-Maxim, 1987). In terms of the aforementioned West Australian suicide rates, it stands to reason that the number of individuals affected by the trauma and devastation associated with the suicide of a loved one constitutes a notable portion of the West Australian population.

It is important to note that the term survivors of suicide may be construed as confusing as it fails to clearly distinguish between individuals who were unsuccessful in
their suicide attempt and are still alive, and those who have actually been bereaved by suicide (Clark, 2001; Dunne et al., 1987). However, in the absence of other more appropriate terminology, this is the only term that is in any way faintly reflective of the trauma which the bereaved may endure after the suicide, and throughout its subsequent legacy (Clark, 2001). This current research focuses exclusively on immediate family members as survivors, and explores their bereavement experiences in the time following their loved one’s suicide. As Bolton commented “the real victim, time after time, is not the cold body in the coffin, but the family” (1987, p.36).

Holmes and Rahe (1967) suggested that the death of a spouse or of a close family member can be classified as two of the five most stressful life events. Stressful life events render individuals susceptible to illness and mental health problems (Holmes & Rahe, 1967; McEwen & Stellar, 1993). A wealth of literature supports the assertion that bereavement is therefore a possible risk factor for adverse physical and mental health outcomes (Brent, Perper, Moritz, Allman, Liotes et al., 1993; Clayton, 1990; Helsing & Szklo, 1981). Whilst the loss of a loved one may be a universal human phenomenon, the impact of the bereavement and grief associated with such a loss is highly individualised and complex, and includes numerous interwoven behavioural, psychological, social, spiritual and physiological components (Cowles & Rodgers, 1991; Payne, Horn, & Relf, 1999; Reed, 1998).

The question of whether or not bereavement after suicide, as opposed to other modes of death, renders individuals more susceptible to enduring and complicated grief reactions remains unclear. Support for both arguments can be found throughout the literature (e.g., Bailey, Kral, & Dunham, 1999; Jordan, 2001; McIntosh & Kelly, 1992; Rudestam, 1992). As the field of research expands and becomes more comprehensive however, the role and influence of mediating factors on bereavement outcome is gaining an increasing amount of attention (Parkes, 1985; Stroebe & Schut, 2001; Vanezis &
McGee, 1999). It appears to be not so much a case of simply concluding that bereavement differs according to different modes of death, but rather that a number of key variables influence the nature, intensity and duration of the grief process. Any variables that are likely to be associated with poor bereavement outcome can be deemed risk factors, and need to be considered when addressing and exploring difficulties that arise from grief. Such mediating variables can include relationship, social, historical, circumstantial and personality factors (Parkes, 1985).

Stroebe and Schut (2001) classified these mediating variables as bereavement-specific risk factors, and general risk factors. They referred to bereavement-specific risk factors as those aspects of the bereavement situation or context that influence bereavement impact or recovery. They listed the circumstances surrounding the death as an example of one such factor. General risk factors include those variables that have been shown to demonstrate a positive association with an individual’s health, regardless of their bereavement status, and include social, environmental and personality factors. Stroebe and Schut (2001) divide these further according to those that do moderate bereavement effects (i.e., have a specific impact on bereavement), and those that fail to influence or impact on bereavement, but which have been shown to be positively associated with health in general. An example of a general risk factor which has been positively correlated with the health of both bereaved and non-bereaved individuals, and has been shown to have an additional impact on the bereavement process is a lack of social support (Stroebe & Schut, 2001).

According to Bailey et al. (1999), many of these risk factors, whether bereavement-specific or general risk factors, are more frequently evident in bereavement after suicide, as opposed to death by other means. Clark (2001) corroborated this when, following a review of recent developments in the field of suicide bereavement research, she summarised, “... there is a greater prevalence of risk
Impact of Events in the Aftermath of Suicide

Factors for complicated bereavement in those bereaved through suicide than those bereaved through most other modes of death” (p. 103). Thus, while there appear to be numerous variables that may individually and cumulatively impact on the bereavement experience following a suicide, for the purposes of this study, attention is focussed exclusively on certain specific circumstantial and social factors that are largely unique to the context of suicide.

Williams and Polak (1979) suggested that the interaction between individual factors and the circumstantial factors surrounding the death is the most significant determinant of bereavement reactions. Such mediating circumstantial factors can include: the suddenness of the death, the method of choice, the circumstances surrounding finding the body, the manner in which the family members find out about the suicide, as well as the involvement of strangers in what is a personal and traumatic affair (Parkes, 1985; Stewart, 1999). For instance, sudden and unexpected deaths such as suicide prove to be a greater risk factor for poor outcome following bereavement than anticipated deaths (Lord, 1987; Rudestam, 1992; Sanders, 1999). A reason for this could be that the unexpected nature of the death complicates the process of accepting and adjusting to the loss and the permanence thereof (Raphael, 1985; Wertheimer, 1991). Furthermore, the societal mechanisms whereby sudden and unnatural deaths are dealt with impacts on bereavement responses (Raphael, 1985; Worden, 1982). For example, legal systems are likely to become involved when the death is a suicide. The involvement of such services may bring with them an additional system of psychosocial meaning, particularly that of real or perceived blame, and shame and guilt for the survivors (Raphael, 1985). In addition, survivors are confronted with the initial shock of the news or finding the body, and are then suddenly required to make substantial and significant decisions that have far-reaching ramifications. These include relaying the
news to other family members, seeking out and deciding to keep mementoes, viewing the body, consenting to an autopsy and making funeral arrangements.

The social factors that are important mediators of bereavement outcomes for those bereaved by suicide include: the stigma which remains attached to this mode of death, the difficulties that social and support networks experience when attempting to provide support to bereaved family members, and the perceived isolation and lack of appropriate support which many survivors experience from these networks (Clark, 2001; Jordan, 2001; Reed, 1998). For instance, with respect to the stigma attached to suicide, early research has suggested that one of the primary social conditions surrounding a death which may give rise to complicated grief reactions, is when the case of loss is socially unaccepted, such as in the case of suicide (Dunne et al., 1987). According to Jordan (2001) suicide survivors are viewed more negatively by others and avoidance still surrounds the issue of suicide in our current society. An alternative view is that survivors actually stigmatise and isolate themselves, which makes providing support for them even more challenging (Jordan, 2001; Knieper, 1999). Either way, the results of an inability to access appropriate social support are harmful and potentially devastating to the bereaved who is trying to adjust to the loss of a loved one (Knieper, 1999).

Literature suggests bereavement may be a significant risk factor for adverse health outcomes (Brent, Perper, Moritz, Allman, Roth et al., 1993; Hall & Irwin, 2001; Mor, McHorney, & Sherwood, 1986; Raphael & Minkov, 1999). In attempts to limit the potential deleterious effects of bereavement due to suicide, attention and research have primarily focussed on more distal factors such as the benefits of support groups (e.g., Clark & Goldney, 1995). However, trauma-related research and survivors' anecdotal reports also emphasise the potential for proximal factors and specific experiences to assist or complicate bereavement (Awooner-Renner, 1991; Bloomfield, 1994; Breslau,
Davis, Andreski, & Peterson, 1991; Dubin & Sarnoff, 1986; Jurkovich, Pierce, Pananen, & Rivara, 2000). These may include variables such as the manner in which suicide survivors are informed of the death, the viewing of the body, and the manner of interactions between family and authorities.

In fact, Vanezis and McGee (1999) stated that the grieving process actually commences with the death notification, and Lord (1987) suggested that the specific circumstances of the death notification can significantly affect the bereavement process. Richman (1984) also highlighted the importance of how survivors are dealt with at this time, and went so far as to suggest that events during this time, and the way survivors are dealt with, have a profound and deterministic role in terms of the future wellbeing of survivors.

Any successful attempts to lessen the adverse mental and physical health outcomes of an individual's suicide have far-reaching ramifications, not only in terms of the survivors, but also in terms of the community at large (e.g., cost to the mental health system). Bearing in mind the increased risks for complicated mourning, it stands to reason that "front line responders" (e.g., police, emergency services) can a) be viewed as the first link in support services, b) have a significant influence on the bereaved's grieving process, c) play a valuable role in creating a favourable impression of services, and d) link survivors in with additional support services. In addition, bearing the elevated risk of suicidality associated with survivorship in mind, such events may represent important and crucial opportunities for secondary prevention efforts with survivors (Brent, Bridge, Johnson, & Connolly, 1996; Ness & Pfeffer, 1990). According to Jordan (2001), effective postvention with suicidally bereaved families may be one of the most important and influential forms of multigenerational prevention available.

Thus, knowledge regarding survivors' experiences during this time, with specific reference to those aspects of interactions or processes with others that have
been deemed to impact on the grief process, may serve to limit insensitive or inappropriate reactions, as well as equip authorities and service providers to offer more appropriately tailored interventions and assistance. Service providers may receive comfort in the knowledge that they are acting in the best interests of the survivors and aiding, as opposed to complicating, their healing process. In addition, if those individuals whose task it is to engage with survivors at this time understand how support and compassion can aid the bereaved, they may be less inclined to experience the interactions as a guilt-ridden process (Stewart, Lord, & Mercer, 2000).

Despite the significant impact of such proximal events, relatively little research has addressed survivors' experiences and needs during this time. In fact, an influential study undertaken by Hillman, Green and Silburn (2000), was the first of its kind to focus exclusively on the needs of West Australian survivors of suicide. Whilst the findings of this study were instrumental in increasing awareness about this topic, the authors concluded, "...more work remains to improve the experiences of survivors within the community" (p.22).

In an attempt to address this dearth of knowledge and thus in some way lessen the impact associated with bereavement after suicide, the present study sought to ascertain the existence of any specific events or processes, with particular respect to experiences with service providers, that survivors believe to have impacted on their bereavement experience and subsequent grieving process. The focus was on events in the time immediately after the suicide, and extended until the final significant contact with service providers. Information was obtained through qualitative interviews undertaken with bereaved family members in WA. In an effort to uncover common themes and dimensions in the survivors' experiences, this data was coded and analysed according to principles recommended by several influential researchers in the field of
qualitative research methods such as Strauss (1987), Miles and Huberman (1994), Taylor and Bogdan (1998), and Fischer and Wertz (2002).

The initial aims of the present study were: to explore participants' experiences in the time following the suicide, with particular attention afforded to aspects that are believed to have impacted on their bereavement experience; and to highlight any areas of service provision or support which participants deem as limitations, and through which improvement efforts can be directed.

The aims were thus both exploratory and pragmatic. They were exploratory in that attention was focussed exclusively on the time directly after the suicide, a comparatively overlooked field in terms of research, with attempts being made to obtain representative data from family members regarding the impact of specific experiences. They were pragmatic in the sense that the discovery of significant common themes and experiences may lead to more thorough and informed frameworks to guide future studies, service provision and support services.

Operational Definitions

For the purposes of this study, “survivors of suicide” refer to biological, step or de facto parents, siblings, children and partners of individuals who had died as a result of suicide. “Services or service providers” refer to those organizations and/or government departments that survivors had contact with, whether on a compulsory or voluntary basis, in the time following the suicide. They include emergency response staff, medical professionals, police, government contractors, coronial officials, clergy, and personnel at funeral companies and financial institutions.

The temporal sequence of all events which transpired directly after the suicide include personal experiences, encounters with service providers, and the undertaking of specific legal procedures e.g., the process of verifying the death as a suicide, receiving the death certificate and finalising the deceased individual’s estate. For the purposes of
this study, the temporal sequence was seen to commence from when the participant became aware of the suicide and extended to the last significant contact that family members had with service providers.

**Operational Procedures**

Before proceeding, it is worthwhile to briefly describe the legal procedures that are implemented subsequent to a suicide in WA. This account is based on information gleaned from several telephone and face-to-face interviews undertaken with a Trainer of Recruits from the Legal and Procedural Training Unit, West Australian Police Academy; a Police Coronial Inquiry Officer; and an employee at the Office of the State Coroner. A brief discussion of the relevant training procedures for police in WA is also offered. Any information obtained from other service providers regarding their respective training or procedures implemented is reported on an “as needs” basis where appropriate.

**Standard Legal Procedures Following a Suicide in WA**

In the case of a suicide in metropolitan WA, police attend the scene of the death, make initial inquiries and arrange for the deceased person to be collected and transferred, by someone who is solely contracted to collect the bodies of deceased individuals, to the State Mortuary at the Queen Elizabeth II Hospital. The official death notification is given to the deceased’s senior next of kin by a police officer. Either this officer may be a police officer in general service, or an officer attached to the specialised Coronial Inquiries Section. During the investigation of the case the Police Coronial Inquiry Officers will, among other procedures, undertake an interview with the senior next of kin. Upon completion of the investigation, the Coroner reviews reports of these investigations, and either reaches a conclusion as to the manner of death and sends the family a death certificate and autopsy report, or determines that an inquest should be held. The final report containing the Coroner’s findings is held at the Office of the State
Coroner. Family members have access to this report but are denied copies of it. Further information and detail regarding the above-mentioned procedures can be found in Chapter Six.

Police Training

In terms of the training of police cadets, I attended two separate training lessons that were to cover the procedures of death notification and other relevant death-related procedures. In the first lesson I attended, the instructor spent 15 minutes of a 45-minute lesson on the actual procedure and practise of notifying a family member of a death in the family. This was not specifically related to a death by suicide. The content covered in the second lesson was slightly different, and the actual manner of death notifications or recommendations for such practises, were not covered. I was also informed that in addition to these two theory-based lessons, cadets are exposed to one role-play scenario in which they undertake the death notification procedure with a an actor playing the part of a bereaved family member. Due to time constraints, not all cadets have the opportunity to participate in the role-play, in which case their participation is limited to observing the actions of other cadets. The cadets also undertake a non-compulsory visit to the State mortuary where the process of an autopsy and other related procedures are explained. Sudden deaths, such as a suicide, are investigated by Police Coronial Inquiry Officers. These officers do not have any additional or specialized compulsory training over and above the training that they undertake as police cadets, however they are required to be “experienced officers” (P. Johnson, personal communication, November 27, 2003).

Overview of the Thesis Structure

This thesis is comprised of nine chapters. This chapter introduces the scope and focus of the thesis, and provides a brief overview of the rationale that forms the basis of the thesis. Chapter Two comprises the literature review. This commences with an
attempt to illustrate the number of West Australian family members bereaved by suicide. Firstly, the number of deaths registered as suicide in Australia over an eleven-year period between 1992 and 2002 is reported. Secondly, the proportion of these deaths that occurred in WA is reported, together with the average West Australian family size, calculated for each specific year. This then provides an estimate of how many immediate family members are bereaved by suicide on a yearly basis in WA.

The epidemiological overview is followed by an explanation of several key concepts and a brief discussion of significant contributions from a number of influential theorists in the area of loss and bereavement. As well as highlighting recent developments in the area, this snapshot provides a brief insight into various approaches to understanding the complex and multifaceted phenomena of grief and bereavement.

The impact of bereavement on individuals is then discussed, with particular reference to the deleterious effect it may have on physical, social and psychological levels. Specific focus is afforded to bereavement in the context of suicide, and the question of whether or not suicide bereavement is different to bereavement after other modes of death is addressed. Reasons for apparent inconsistencies in the literature regarding this issue are also examined, and the contributory roles that quantitative and qualitative methodological research approaches may play in these inconsistencies are explored. This is followed by an exploration of the numerous factors and variables that influence or affect bereavement outcome, with specific reference to death by suicide. The rationale and benefits of the study are then discussed, and a statement of the research questions concludes the literature review.

A clear description of the sample population, together with specific demographic information pertaining to the deceased including method of suicide and mental health history, is provided in Chapter Three. The unique benefits of qualitative methodology in a relatively overlooked and sensitive field such as the immediate aftermath of suicide
are also highlighted. In addition, Chapter Three includes a discussion of the methodology utilised in the study. An overview of the major findings is given in Chapter Four. These are reported under the following headings: The Primary Impact on Survivors (includes Subjective State of the Survivor, Information and Guidance, Interactions with Others), Procedural Aspects, Child Survivors, and Survivors’ Suggestions for Improved Practise. Chapters Five, Six, Seven and Eight are dedicated to an in-depth discussion of these findings. Chapter Nine is comprised of the conclusions and a brief summary of research findings. The limitations of the study are also explored and the paper concludes with ideas for the direction of future research. Additional recommendations regarding improvements and amendments to service provision and procedures are proposed and included as an Appendix.
CHAPTER TWO

Literature Review

Epidemiology

The focus of this study is on the immediate family members of suicide victims in WA. Relevant statistics and data have thus been expressly chosen in an effort to most accurately illustrate the proportion of West Australians, specifically immediate family members, who are, or have been, bereaved by suicide. For the purposes of this study, rates are reported as total numbers as opposed to standardized rates i.e., amounts per 100,000. The main reason for this is that standardized rates are often utilized when drawing comparisons between groups e.g., between age groups, cohorts or regions. As West Australian survivors are the focus of this study, I have tried to create an accurate picture of specific numbers of individuals affected and have thus reported actual numbers. My primary aim is not to draw comparisons between groups, but to clearly demonstrate the real extent of the problem as succinctly as possible. Thus, for the purposes of this study, to record rates in a standardized proportion format was deemed inappropriate.

Universally, suicidal deaths tend to be under-reported, therefore caution needs to be exercised when examining most suicide statistics (Statham et al., 1998). Reasons for this trend are numerous. Suicide is generally tainted by the stigma which surrounds it, and the act of suicide is often condemned for social, cultural and religious reasons (Dunne et al., 1987; Vanezis & McGee, 1999). Additionally, the accuracy of suicide statistics is dependent on precise data collection, consistent death certification procedures, and reliable mortality reports, the quality of which varies between countries and can be complicated by numerous factors. Consequently, suicide can be misclassified or incorrectly recorded in official death records, which may result in conservative estimates of actual suicide rates on a global level.
In order to illustrate the numbers of families bereaved by suicide in WA, the following section focuses on West Australian suicide rates within the Australian context, with additional, albeit brief, reference to noticeable gender differences. This is followed by information regarding numbers of West Australian families bereaved by suicide, calculated and tabulated for the period 1992-2002. (An eleven-year time period was chosen in order to provide a context for the more recent suicide rates.)

Table 1

National and West Australian Suicide Rates from 1992-2002

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of suicides in Australia</th>
<th>No. of suicides in WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>2 294</td>
<td>214</td>
</tr>
<tr>
<td>1993</td>
<td>2 081</td>
<td>216</td>
</tr>
<tr>
<td>1994</td>
<td>2 258</td>
<td>217</td>
</tr>
<tr>
<td>1995</td>
<td>2 368</td>
<td>218</td>
</tr>
<tr>
<td>1996</td>
<td>2 393</td>
<td>218</td>
</tr>
<tr>
<td>1997</td>
<td>2 720</td>
<td>255</td>
</tr>
<tr>
<td>1998</td>
<td>2 683</td>
<td>287</td>
</tr>
<tr>
<td>1999</td>
<td>2 492</td>
<td>236</td>
</tr>
<tr>
<td>2000</td>
<td>2 363</td>
<td>261</td>
</tr>
<tr>
<td>2001</td>
<td>2 454</td>
<td>269</td>
</tr>
<tr>
<td>2002</td>
<td>2 320</td>
<td>242</td>
</tr>
<tr>
<td>TOTAL</td>
<td>26 426</td>
<td>2 633</td>
</tr>
</tbody>
</table>


According to the data in Table 1, 26 426 deaths were recorded as suicide in Australia between 1992 and 2002. Of these, 2633 occurred in WA. Furthermore, it is also apparent that over this specific period West Australian rates have made a steady
and consistent contribution to national figures. This suggests that suicide in WA remains a major health concern for both individuals and the community at large.

In Table 2, attention is further drawn to noticeable gender differences in West Australian suicide rates. On average while the rates appear relatively stable over the eleven-year period, they are reflective of a common international trend of higher male than female rates. In fact, the World Health Organization reported that on a global scale males are four times more likely than females to die from suicide (WHO, 1999).

### Table 2

**Number of Suicides in WA according to Gender from 1992-2002**

<table>
<thead>
<tr>
<th>Year</th>
<th>Females</th>
<th>% of Total</th>
<th>Males</th>
<th>% of Total</th>
<th>Total suicides in WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>42</td>
<td>19.63</td>
<td>172</td>
<td>80.37</td>
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<tr>
<td>1993</td>
<td>43</td>
<td>19.91</td>
<td>173</td>
<td>80.09</td>
<td>216</td>
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<tr>
<td>1994</td>
<td>29</td>
<td>13.36</td>
<td>188</td>
<td>86.64</td>
<td>217</td>
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<tr>
<td>1995</td>
<td>39</td>
<td>17.89</td>
<td>179</td>
<td>82.11</td>
<td>218</td>
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<tr>
<td>1996</td>
<td>47</td>
<td>21.56</td>
<td>171</td>
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<tr>
<td>1997</td>
<td>49</td>
<td>19.22</td>
<td>206</td>
<td>80.78</td>
<td>255</td>
</tr>
<tr>
<td>1998</td>
<td>53</td>
<td>18.47</td>
<td>234</td>
<td>81.53</td>
<td>287</td>
</tr>
<tr>
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<td>44</td>
<td>18.64</td>
<td>192</td>
<td>81.36</td>
<td>236</td>
</tr>
<tr>
<td>2000</td>
<td>55</td>
<td>21.07</td>
<td>206</td>
<td>78.93</td>
<td>261</td>
</tr>
<tr>
<td>2001</td>
<td>57</td>
<td>21.19</td>
<td>212</td>
<td>78.81</td>
<td>269</td>
</tr>
<tr>
<td>2002</td>
<td>54</td>
<td>22.31</td>
<td>188</td>
<td>77.69</td>
<td>242</td>
</tr>
</tbody>
</table>


Whilst the data in Table 2 attests to the scope of the problem of suicide, as well as the apparent gender differences, for the purposes of this study a more comprehensive
look at the rates of suicide in WA in conjunction with family size is warranted. Again
rates are reported over the eleven-year period, 1992-2002.

Table 3

**Population, Suicide Rates and Average Family Size in WA from 1992-2002**

<table>
<thead>
<tr>
<th>Year</th>
<th>Population of WA</th>
<th>Suicides in WA</th>
<th>Average West Australian family size</th>
<th>Estimated numbers of West Australian survivors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>1,657,000</td>
<td>214</td>
<td>3.1</td>
<td>663.4</td>
</tr>
<tr>
<td>1993</td>
<td>1,676,341</td>
<td>216</td>
<td>3.1</td>
<td>669.6</td>
</tr>
<tr>
<td>1994</td>
<td>1,701,064</td>
<td>217</td>
<td>3.1</td>
<td>672.7</td>
</tr>
<tr>
<td>1995</td>
<td>1,731,160</td>
<td>218</td>
<td>3.1</td>
<td>675.8</td>
</tr>
<tr>
<td>1996</td>
<td>1,762,733</td>
<td>218</td>
<td>3.1</td>
<td>675.8</td>
</tr>
<tr>
<td>1997</td>
<td>1,807,371</td>
<td>255</td>
<td>3.1</td>
<td>790.5</td>
</tr>
<tr>
<td>1998</td>
<td>1,822,668</td>
<td>287</td>
<td>3.1</td>
<td>889.7</td>
</tr>
<tr>
<td>1999</td>
<td>1,849,733</td>
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<td>3.1</td>
<td>731.6</td>
</tr>
<tr>
<td>2000</td>
<td>1,874,459</td>
<td>261</td>
<td>3.1</td>
<td>809.1</td>
</tr>
<tr>
<td>2001</td>
<td>1,901,159</td>
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<td>3.1</td>
<td>833.9</td>
</tr>
<tr>
<td>2002</td>
<td>1,924,553</td>
<td>242</td>
<td>3.0</td>
<td>726</td>
</tr>
</tbody>
</table>


Figures in Table 3 indicate that in 2002 for instance, 242 deaths in WA were registered as suicide. The average West Australian family size in 2002 was 3.0 individuals. Whilst recognising that a proportion of individuals who suicide do not have any immediate family, and others may have larger families than the State's average, it can be estimated that approximately 726 immediate family members may have been bereaved due to suicide in 2002 alone (242 x 3.0). Furthermore, when looking at the suicide rates in conjunction with average family sizes between 1992 and 2002, this sum
total rises to approximately 8138 bereaved family members over the eleven-year period. A glance at these time-limited statistics serves to provide a partial idea of the ripple effect of one suicide in WA. It would thus appear that a notable proportion of the West Australian population has been, and continues to be, bereaved by suicide.

**Key Concepts**

A direct benefit of the expanding knowledge base in the area of grief and loss, is a greater consensus regarding definitions of many key concepts and terms. It remains a challenge to draw definite distinctions between several of these however, a situation that may have been exacerbated by the fact that early researchers used them interchangeably. It is useful to outline and distinguish between several such concepts that are relevant to this study. They are bereavement, grief, mourning, and normal and pathological grief.

**Bereavement** has been defined as the experiential state a person endures subsequent to the death of a loved one (Sanders, 1999; Stroebe, Hansson, Stroebe, & Schut, 2001; Walter, 1999). It represents the actual state of loss, whereas **grief** refers to an individual’s reaction to being bereaved and can include physiological, social and psychological expressions or manifestations (Stroebe et al., 2001). Weiss describes grief as “...the severe and prolonged distress that is a response to the loss of an emotionally important figure” (2001, p.47). **Mourning** refers to the social acts which are expressive of grief and which are shaped by the practises of any given society or cultural group (Parkes, 1998a; Stroebe et al., 2001; Walter, 1999). It also serves to indicate the process that an individual progresses through while adapting to the loss (Worden, 2003).

A perusal of the literature offers a myriad of terms for what may be construed as **normal grief**. These include healthy grief, productive grief and uncomplicated grief. Such terms aim to describe the range of emotions, expressions and reactions that are common after the loss of a loved one, and do not usually require the assistance of
professional counsellors (Worden, 2003). It is commonly assumed in the psychotherapeutic community that for a small proportion of bereaved individuals some form of therapeutic help or intervention is beneficial, or even necessary, in order to assist with the adaptation to their loss (Parkes & Markus, 1998).

These individuals may be overwhelmed by their intense grief and resort to maladaptive behaviour, or they may remain unable to move forward in the mourning process i.e., their grief involves processes which lead to extensive interruptions in healing (Horowitz, Wilner, Marmar, & Krupnick, 1980). Such grief reactions have also been classified in numerous ways and afforded many different labels including traumatic grief, (Prigerson & Jacobs, 2001); distorted, chronic or inhibitive bereavement (Raphael, 1985); complicated grief (Horowitz et al., 1980); or chronic, delayed, exaggerated and masked grief reaction (Worden, 2003). Notably, and perhaps more accurately, a number of these approaches describe grief reactions on a continuum where one end of the continuum indicates healthy grieving and the other indicates more intense and pervasive reactions (Horowitz et al., 1980). This is in contrast to early research which proposed a simple dichotomy of normal and pathological grief, as defined by the presence or absence of specific symptoms (e.g., see Freud, 1957).

Despite a greater understanding of this phenomenon, Feifel stated, "...the line between healthy and unhealthy grief, at times, can get blurred and difficult to distinguish" (1998, p.3). Reasons for this include the challenge in differentiating between abnormal grief and other disorders. The fact that complicated grief does not have clear diagnostic criteria as it is not a single and exclusive syndrome also complicates matters. Furthermore, there are too many idiosyncratic variables which influence an individual’s grief and thus make it impossible to develop a universal or general cut off (Stroebe et al., 2001).
Irrespective of these semantic challenges, the ability to delineate between healthy and unhealthy grief remains a necessity. From a clinical point of view, it is beneficial to have a broad idea of appropriate and relevant continua as it guides referral and intervention decisions. Furthermore, it is important for bereaved individuals to have an understanding of what constitutes normal grieving behaviour as, according to Walter:

...some are relieved to find that the symptoms they feared were signs of madness are actually normal signs of bereavement. Others, though, who are clinically depressed, are afraid to ask for help because they think it normal to be very depressed after a bereavement (1999, p.165).

Models of Grief

Whilst bereavement, grief and mourning have long been of interest to countless authors, artists and poets, they are comparatively new fields of research (Stroebe et al., 2001). This is ironic in that the bereavement experience is an archetypal one, with most individuals, at some time in their life experiencing the loss of a loved one. In fact, despite the advances in medical research and health care practises, natural disasters, ongoing warfare (including terrorist acts) and epidemics such as AIDS, presently result in large numbers of bereaved individuals. Furthermore, literature consistently suggests bereavement is a significant risk factor for adverse health outcomes (Brent, Perper, Moritz, Allman, Liotus et al., 1993; Clayton, 1990; Holmes & Rahe, 1967; Parkes, 2001).

Despite this, we are yet to develop an integrative theory of grief and bereavement (Stroebe, Hansson, & Stroebe, 1993). The reasons for this are many but primarily stem from the complexity of grief and the multidimensional bereavement reactions that it encompasses. Furthermore, early researchers in the field of grief and bereavement emanated from a wide variety of disciplines including sociology, psychology and medicine. Research questions and findings were often limited to those
specific fields and few attempts were made to integrate diverse findings into a single, comprehensive model (Stroebe, Stroebe, & Hansson, 1993). In fact, Tajfel as cited in Stroebe, Hansson et al. (1993), summarised this aptly when he described the diverse approaches to bereavement in the following manner, "all of us in our various disciplines... are dealing with a common knot of problems seen from different perspectives...." (1981, p.224).

More recently, these early theories and proposals have been subjected to an increasing amount of critical attention and review. Many have been found to be too limited in their scope and focus, while others fail to account for an apparent diversity of outcomes, or explain the differences in peoples’ reactions in response to a loss (Wortman, Silver, & Kessler, 1993). In addition, many seem to construe the experience of bereavement as disrupting an otherwise homeostatic physical and psychological state, a return to which is ideal, attainable and sought after (Stroebe, Hansson et al., 1993). Such approaches fail to acknowledge or give credence to the significantly influential factors such as the meaning of the loss, individual characteristics of the bereaved and the dynamic process of life change (Stroebe, Hansson et al., 1993). Despite this, a number of early theorists' work has been influential in the field of grief and bereavement. While it is beyond the scope of this study to address these in any great detail, it would be amiss to not mention some of the more significant findings that have guided and provided the framework for subsequent research in this area. This brief reflection also highlights the complexity of the phenomena of bereavement and grief as evidenced by the diverse perspectives offered by various theorists. It also serves to illustrate the attempts that theorists and researchers have made in trying to better understand these phenomena, as well as emphasizes the importance of developing an informed understanding of phenomena that can so easily, if misunderstood or inappropriately addressed, have deleterious outcomes.
One of the first models to focus specific attention on the pain and experience of bereavement was postulated by Sigmund Freud in 1917 (Freud, 1957). In this model he laid the foundation for what has become known as “griefwork”, the primary objective of which is the establishment of a new identity in which the lost one is absent. Griefwork is the process whereby the bereaved works through a gradual and challenging process of confronting the loss, accepting its reality, and subsequently relinquishing the libido invested in the lost love object. Mourning is said to have come to a definite end when the bereaved is able to sever their emotional attachment to the lost one in a process called decathexis. The free libido is then reinvested in a new object (Freud, 1957).

Lindemann actually coined the term griefwork and included an additional stage in the process, the forming of new relationships. Furthermore, he suggested that the process of griefwork should be afforded a limited time frame and should be completed within four to six weeks (Lindemann, 1944). Whilst Lindemann was the first person to describe parameters of grieving, many of the factors that he identified as pathological, are now widely accepted as common experiences during grief (Payne et al., 1999).

Bowlby continued to build on Freud’s idea of griefwork, but proposed a four-phase model of grief, based on his own theory of attachment and loss (Bowlby, 1979). He focussed more on the influence of grief on interpersonal relationships, as opposed to the intrapsychic processes emphasised by Freud. He believed that early psychoanalytic approaches were attempts to understand depression, rather than normal processes in response to loss (Raphael, 1985). Furthermore, Bowlby proposed that whilst grief was an extended form of separation anxiety (the general response individuals have to separation from attachment figures), he agreed with Freud’s idea that griefwork entails repeatedly engaging with and confronting the loss in order to accept and reconcile its reality (Bowlby, 1980).
appear to take the role of idiosyncratic and personal variables, which may affect the bereavement experience, into account.

Parkes (1993) also saw grief as a response to the loss of an attachment relationship, however his model addressed some of the earlier theories' shortcomings. Parkes viewed bereavement as a natural psychosocial transition, one which challenges an individual's previously held assumptions about the world. His model accounts for the influence and impact of antecedent factors (such as earlier losses, nature of relationship and attachment, history of mental illness), concurrent factors (such as religion, gender and age), and subsequent factors (including degree and nature of external support) on an individual's bereavement experience (Parkes, 1993). He was also interested in how bereaved individuals form and maintain attachments to both the deceased and others, and proposed that grieving is the "attachment behaviour" that people display as they make the psychosocial transition to re-establish equilibrium in their lives after the loss (Parkes & Markus, 1998).

Like Parkes, Worden (1982) allowed for the continued presence of the deceased in the bereaved individual's life, but saw the grief process as task orientated, with individuals needing to resolve four tasks of mourning before their grief can be reconciled. These are accepting the reality of the loss, experiencing the emotional aspects and ramifications of the loss, adjusting to an environment in which the deceased is absent, and finally, moving on with life while still maintaining some connection with the deceased. In contrast to earlier theories that advocated for the "letting go" of the bond with the deceased, Worden emphasised the change in the bereaved individual's environment after the loss of a loved one and the consequent changes in the relationship with the deceased (Worden, 1982).

Another famous theorist in this area is Elizabeth Kubler-Ross, the founder of the stages of grief theory (Kubler-Ross, 1969). She extrapolated from her work with
terminally ill patients and proposed that bereaved individuals progress through specific stages while coming to terms with their loss, stages similar to those which the terminally ill do as they approach death. Despite her work coming under recent criticism (e.g., Folkman, 2001; Thorson, 1996), Kubler-Ross's approach and model filled a void in the area of work with the terminally ill and is still viewed as a valuable framework from which to work, provided individuals are aware of its limitations (Kastenbaum, 1997; Parkes, 2001).

As is evident from the above, early models of grief and bereavement appear to range in their focus and purpose. Although many of them overlap, some actually appear to be more descriptive of the process of mourning (Worden, 2003). Traditional models of grief can also be viewed as rather prescriptive, an approach which does not account for, or allow for, individual variations or diversity in grief reactions.

In recent years the field of grief and bereavement has gained an increasing amount of attention and scientific scrutiny, and whilst the shortfalls of earlier research have been acknowledged, the more valuable contributions have been incorporated into contemporary approaches (Stroebe et al., 2001). Early postulations of phases and stages have increasingly been viewed as general guidelines in aiding the understanding of the grief process, or indeed the manifestation of symptoms, rather than a prescriptive map, deviations from which symbolize pathological grief or mourning.

According to Parkes (2001), modern theorists appear to concur that the core to grief is embedded in the attachments that we make to people. In addition, the significance of the many diverse factors on the process of assimilating a loss into our existence has also gained justifiable and increasing consideration. In order to continue developing a comprehensive view of the field of grief and bereavement, Parkes stressed the importance of integrating research findings from the fields of loss, attachments, and psychological trauma.
Archer (2001) also offered some excellent ideas on the requirements of an all-encompassing theory of grief. He suggested that any theory should include an explanation of the origins of grief and its evolutionary function, how the process of grief is triggered, as well as possible sources of individual variation within the grief process. Finally, he suggested that any theory should lead to a better understanding of the mechanisms through which bereavement and grief can have a deleterious impact on the bereaved individuals' subsequent functioning (Archer, 2001).

Whilst this is by no means an extensive and in-depth look at all of the predominant theoretical models in the field of grief and loss, a few of the earlier and more influential ones have been mentioned. Irrespective of one's theoretical perspective however, the loss of a loved one through death is considered one of the most stressful, traumatic and painful of all life events (Holmes & Rahe, 1967; McKissock & McKissock, 1991; Parkes, 1985).

**Impact of Bereavement on Individuals**

Support for the far-reaching impact of bereavement is consistent throughout the literature (McKissock & McKissock, 1991; Mor et al., 1986; Parkes, 1985; Payne et al., 1999). Furthermore, both anecdotal and scientific literature suggest that bereavement can be painful and traumatic, and is a significant risk factor for adverse health problems and outcomes (Brent, Perper, Moritz, Allman, Liotus et al., 1993; Clayton, 1990; Ness & Pfeffer, 1990).

These include a variety of serious physical and mental impairments and disturbances such as heart problems, cancer, and symptoms of depressive and anxiety disorders (Clayton, 1990; Sanders, 1999; Zisook & Shuchter, 1993). More recently, Hall and Irwin (2001) found that physiological functioning is indeed altered following a loss, particularly neuroendocrine function, immune system competence and sleep patterns. According to Stroebe and Schut (2001), bereavement can result in extreme
health costs, including more days of disability, increased hospitalization rates, and greater use of medication. They also concurred with earlier findings by Mor et al. (1986), regarding the increased rates of physician visits among the recently bereaved.

Furthermore, bereavement has been shown to increase the risk of both suicidality and general mortality (Birtchnell, 1970; Lichtenstein, Gatz, & Berg, 1998; MacMahon & Pugh, 1965; Szanto, Prigerson, Houck, Ehrenpreis, & Reynolds, 1997). Indeed, with specific reference to bereavement subsequent to suicide, a number of researchers have ascertained that while there is a small but real chance of suicide among the generally bereaved, there is a somewhat higher risk for those who themselves are bereaved by suicide (Cleiren, Diekstra, Kerkhof, & Van der Wal, 1994; Ness & Pfeffer, 1990). This may also be related to antecedent factors that predispose such families to poorer bereavement outcomes however. For example, Seguin, Lesage and Kiely (1995) claimed that the families of suicide survivors are burdened by numerous difficulties such as addiction problems, histories of mental health issues and conflictual family relations. Certain researchers have also noted an increase in family and personal histories of depression and psychiatric illness among relatives of adolescent suicide victims (Brent et al., 1996).

The role of bereavement as a significant risk factor for myriad of adverse health outcomes appears irrefutable. A consensus in the literature also indicates that a number of factors may affect the resolution of a loss. This in turn may increase or decrease the probability of a complicated bereavement reaction or a deleterious outcome in terms of psychosocial morbidity. These factors include the pre-existing relationship between the bereaved and deceased, type or mode of death and circumstances surrounding it, responses of family and social network, time since death, concurrent stress or crises, previous losses and sociodemographic factors (Rando, 1993; Raphael, 1985; Reed, 1998; Stroebe & Schut, 2001; Vanezis & McGee, 1999).
What is perhaps not quite as clear-cut, despite significant clinical and theoretical implications, is the notion that grief reactions may, and often do, vary across various types of losses. Of particular relevance to this study is the contention stemming from a number of clinical and anecdotal reports suggesting that bereavement resulting from suicide is not only fundamentally different from bereavement due to other types of death, but may also be more difficult or complicated (Dunne et al., 1987; Rando, 1984, 1993). Results of initial quantitative studies have either failed to support this, or have produced mixed results (Bailey et al., 1999).

For example, Van der Wal (1989-1990) not only suggested that the grieving process after a suicide is comparable to that of other sudden and unnatural deaths, but also highlighted the apparent dearth of empirical evidence supporting the idea that suicide survivors exhibit a greater incidence of complicated, prolonged or pathological bereavement.

McIntosh and Kelly (1992) sought to determine similarities and differences in the grief reactions among three groups of survivors: suicide, accident and natural death survivors. Participants were administered a set of standardized questionnaires and inventories including the Texas Revised Inventory of Grief, and the Impact of Event Scale. Results of the study led these researchers to conclude that the notion that suicide results in a different or more devastating grief experience, and the widely held idea of special aspects of bereavement in suicide, is unfounded.

A later review of the literature led McIntosh (1993) to again conclude that suicide survivors are relatively similar to other bereavement groups (particularly sudden-death survivors), and whilst there may indeed be a small number of different grief reactions for suicide survivors, these are not yet clearly established. Furthermore, although the course of bereavement after suicide may initially differ to that of other
survivors, after the second year the reactions observed in suicide bereavement seem to show very few differences from the mourning trajectory of other types of loss (McIntosh, 1993).

Interestingly, when one looks to the literature it becomes apparent that the majority of studies that have failed to find any fundamental differences in the grief experienced after suicide, have primarily utilized quantitative methodological approaches, a pattern that has been noted by numerous researchers such as Ellenbogen and Gratton (2001) and Clark (2001). In contrast, the ever-growing body of evidence that supports the idea of such differences is largely qualitative in nature and includes clinical and anecdotal reports from: 1) survivors themselves (e.g., Wertheimer, 1991), 2) those who work with survivors (e.g., Dunne et al., 1987; Payne et al., 1999), and 3) results of public perception studies (e.g., Allen, Calhoun, Cann, & Tedeschi, 1993).

Irrespective of the difficulties inherent in trying to compare the results of studies that have utilised different methodological approaches, several psychological, experiential and social themes do appear to be uniquely associated with a) the act of suicide, and b) the subsequent bereavement process. Whilst these qualitative differences may not necessarily lead to an atypical grief reaction or mourning process, a lack of awareness and sensitivity to such differences may inadvertently complicate the grief reaction. For the purposes of this study, it is useful to explore some of the characteristics of death by suicide that may influence the bereavement process and/or result in specific differences between suicide bereavement and bereavement subsequent to other modes of death.

Albert Cain, a forefather in suicide-related research, was one of the first to suggest that bereavement after suicide is in several ways a unique experience (Cain, 1972). Results of numerous other studies have supported this. For example, Calhoun, Selby and Selby (1982) reviewed the literature on suicide survivors and made three
tentative conclusions. Firstly, suicide survivors experience less social support than survivors of other modes of death. Secondly, they search for an understanding of the death and the deceased’s motivation for the suicide, and thirdly, they experience feelings of guilt more often than those bereaved by other modes of death.

Ness and Pfeffer (1990) also undertook a review of the relevant death-related literature in an effort to demarcate these suggested differences. They concluded that while certain common themes prevail throughout the general bereavement experience, the type of death may indeed affect the psychology of grieving processes, and that a consistency regarding the prevalence of common themes exclusive to each mode of death was clearly apparent. Furthermore, they refrained from disputing the notion that bereavement due to any one mode of death is any more deleterious than to another. Instead they drew attention to the role that specific variables might play in affecting or complicating bereavement after a significant loss. As mentioned earlier, these variables include concurrent crises; premorbid personality of the bereaved; attachment to, and relationship with, the deceased; social support systems and the specific situation surrounding the death (Ness & Pfeffer, 1990).

Additional support for the specific and critical role that characteristics such as expectedness, timeliness and naturalness play in impacting on the bereavement process is evident throughout the literature, with researchers concurring that deaths which are sudden and unexpected tend to impose a greater burden on the bereaved (Cleiren et al., 1994; Parkes & Weiss, 1983; Rynearson, 1987). Reasons for this may include the increased possibility of any "unfinished business" between the deceased and the surviving individual, together with the fact that sudden deaths may shatter one’s mental representation of the world and bring into question one’s belief systems and philosophical ideas. Unnatural deaths, including suicide, are more likely to be
characterized by these elements than are deaths following illness or aging (Parkes & Weiss, 1983).

In a more recent attempt to increase the knowledge regarding psychosocial factors and contextual experiences associated with suicide, and address methodological shortcomings of earlier research, Seguin et al. (1995) compared the bereavement processes of parental survivors of suicide with parental survivors of car accidents. They found that suicide survivors experienced greater feelings of shame and embarrassment than did accident survivors. They went on to state that the effect of shame appeared to be central and distinctive to the experience of suicide bereavement. They suggested that this might in turn influence the way survivors of suicide interact with other people, and the manner in which social support is offered to them. It was also found that suicide survivors indicated trends towards greater perceived stigmatization.

Knieper (1999) supported the idea that survivors of suicide tend to experience a very complicated form of bereavement. She attributed this to the combination of the unanswered question “why”, the sudden shock of the death, and the trauma of possibly discovering or witnessing the suicide. She also highlighted the additional negative impact that inappropriate responses and interactions from service providers and the community may have on the bereavement process.

In a recent study aimed at investigating the influence of suicide on grief, Bailey et al. (1999) grouped 350 bereaved university students according to the mode of death experienced. These were suicide, accident, unanticipated natural, anticipated natural death. All groups were administered a number of identical standardized measures measuring grief reactions (Grief Experience Questionnaire and the Texas Revised Inventory of Grief), as well as one which sought to measure the perceived impact of the death of the known other (Impact of Event Scale). Questionnaires that sought to measure additional aspects of grief as well as the perceived role of mediating variables
in the participant's relevant bereavement experience were also specifically developed and administered. Results of the study supported previous clinical and research findings regarding the differential reactions in the grief processes after a suicide compared to those subsequent to other modes of death (e.g., Ness & Pfeffer, 1990; Seguin et al., 1995). Specific differences included significantly more frequent feelings of responsibility, rejection, and more total grief reactions (as measured by the Grief Experiences Questionnaire Total Grief Reactions scale). In addition, suicide survivors displayed trends indicating heightened levels of shame and perceived levels of stigmatization. In fact, Bailey et al. (1999) found that suicide survivors were more likely than other survivors to tell others that the cause of death was something other than it actually was.

Suicide survivors also reported spending a greater proportion of their time, as compared with participants bereaved by other modes, ruminating about the deceased's motivation and reasons for killing themselves (Bailey et al., 1999). This conclusion supports earlier research by Cleiren et al. (1994) who found that whilst bereaved individuals in general are often preoccupied with the meaning of the loss, this was particularly so for those who had experienced an unnatural, untimely and unexpected loss such as suicide. The notion that suicide survivors are more likely to search for answers and ruminate about the meaning of the loss than are individuals bereaved by other modes of death is well documented (Knieper, 1999; Lord, 1987; Lukas & Seiden, 1987; Wertheimer, 1991).

Further support for a number of the aforementioned findings is offered by Jordan who, following a review of the recent literature, concluded that suicide bereavement is distinct in three significant ways: the thematic content of the grief, the social processes surrounding the suicide, and the resultant impact of suicide on family systems (Jordan, 2001). Firstly, in terms of the thematic content of the grief, Jordan acknowledged that
evidence for quantitative variations between bereavement after suicide and that of other modes of death is inconclusive. He drew attention to the wealth of evidence that highlights and supports the qualitative or thematic differences however, and grouped these differences into three areas: 1) survivors questioning “why”, 2) feelings of rejection, and 3) heightened feelings of guilt, blame and responsibility.

Secondly, Jordan found that the general stigma attached to suicide often permeates bereaved family members and that these survivors often feel more stigmatized and isolated than other survivors. Despite these findings, Jordan drew attention to the apparent dearth of research addressing the impact of the social network on suicide survivors (Jordan, 2001).

The third and final way in which this researcher suggested that suicide bereavement is different to that of other modes of death relates to the impact that suicide has on family systems. After exploring the impact of suicide on family interaction patterns, as well as the relation between suicide and the heightened risk for additional suicides within the family, Jordan concurred with evidence from clinical reports which suggests that bereavement after suicide may be more complex for the family than bereavement subsequent to a natural death (Jordan, 2001).

In summary, all of the above studies suggest that, although the loss of a significant other may stimulate a plethora of responses, feelings of rejection and responsibility are two reactions that clearly distinguish grief associated with suicide from grief resulting from other causes (Bailey et al., 1999; Ellenbogen & Gratton, 2001; Jordan, 2001). Furthermore, the research also suggests that perceived stigmatization and feelings of shame and embarrassment do set survivors of suicide apart from those who mourn non-suicidal deaths (Jordan, 2001).

This stigma surrounding suicide has its roots in the way it was viewed prior to the 19th century when in legal terms it was regarded as a crime, and within the eyes of
the church, a sin. Since the deceased was no longer able to be punished for their transgression, the punishment was enacted upon the family (Knieper, 1999). Appleby (1992) suggested that this stigma stems from societies need to blame or place the responsibility for the suicide on someone, and invariably it is those closest to the deceased who are held accountable. Wrobleski (1985) also highlighted two common and damaging myths associated with suicide: firstly, “nice” people do not take their own lives, and secondly, suicide does not happen in “nice” families. Although these extreme views are no longer embraced by contemporary society, strains and ramifications of such early attitudes do persist. Shneidman supported this when he commented, “it is obvious that some deaths are more stigmatizing or traumatic than others: death by... the negligence of oneself or some other person, or by suicide” (1993, p. 165).

Solomon (1982) viewed the stigma surrounding suicide as being capable of turning the grief process into an extended and contorted one for the survivor of the suicide. Dunn and Morris-Vidners also sought to highlight the impact of such feelings when they stated, “unlike other types of death, suicide causes feelings of stigma, guilt, anger, and confusion strong enough to overwhelm the bereaved, prolonging the grieving process and putting the bereaved at increased psychological and physical risk” (1987-1988, p.175 ). Thus, the “spilling over” of earlier attitudes may result in isolation and stigmatization of survivors, which in turn may provoke or cause complicated grief reactions (Seguin et al., 1995; Wertheimer, 1991).

Feelings of shame and perceptions of being stigmatized may also interfere with how survivors interact with others, and the manner in which social services and support are offered to them (Seguin et al., 1995). It may lead survivors to feel awkward, and cause them to isolate themselves. Consequently, even if the support is present, survivors may report low levels of social support (Seguin et al., 1995). Aforementioned negative attitudes toward survivors may not directly result in differential treatment of survivors
in the community however. Individuals may genuinely want to assist the survivors but are unsure how best to offer their services (Jordan, 2001). This awkwardness and hesitation may then be communicated to survivors and be misinterpreted as further rejection (Seguin et al., 1995).

In Calhoun et al.'s (1982) previously mentioned review, non-bereaved individuals reported finding interactions with suicide survivors to be more stressful and more constraining than interactions with other survivors. Thus, even if individuals feel great compassion for the suicide survivors, they may avoid interactions for fear of doing or saying something they should not, or because they are unsure of the informal "rules" which guide such interactions (Calhoun, Selby, & Abernathy, 1984).

Furthermore, beyond the problem of perception by others, Jordan stated that it is equally as important to ascertain survivors' views of themselves, as any adverse attitude towards suicide in current society may be mirrored within the survivor (Jordan, 2001). Jordan's comments concurred with those of Rudestam (1987) who postulated that any perceived stigmatisation may be the result of the survivor's own projection, and not actually based on fact. This "self-stigmatisation" may result in survivors assuming that others are judging them, and result in them withdrawing further, making support provision even more complicated (Jordan, 2001). Irrespective of the basis of such interactional complexities however, it does appear that personal interaction and social support is frequently more challenging after a suicide than after most other types of loss (Calhoun, Selby, & Abernathy, 1986; Jordan, 2001).

Reasons for Inconsistencies in the Literature

As is evidenced, recent studies seem to be producing more consistent conclusions regarding qualitative variations in the grief process with respect to different losses, however the reasons for earlier contradictory findings are numerous. It is valuable to reflect on the possible reasons for such inconsistencies.
Worden (1982) asserted that the families of suicide victims are often fraught with social difficulties such as abuse and alcoholism. Seguin et al. (1995) also found that, when compared with other survivors, individuals bereaved by suicide tend to have accumulated more psychosocial difficulties prior to bereavement. If this is indeed the case, such a difference in family dynamics and environment may alone predispose family members bereaved by suicide to experience more difficult grief reactions.

The possibility that some survivors experience relief after the suicide of a loved one may also account for a number of the inconsistent findings. Suicide may occur after a long history of mental illness, stress, tragedy and pain and may consequently be viewed as a release for the deceased, as well as generate a sense of relief for the bereaved (Cleiren, 1993; Jordan, 2001).

In studies which have sought to compare bereavement stemming from other types of loss with that from suicide, samples have often included individuals bereaved by sudden and unnatural death (e.g., Bailey et al., 1999; Seguin et al., 1995). Whilst it stands to reason that bereavement after suicide does have a number of qualitative similarities with other sudden and unnatural deaths, such similarities may account for some of the "diluting" of any distinct differences (Jordan, 2001).

The simplest explanation however, is that due to numerous methodological complications, comparative research has yet to fully detect true differences between bereavement across various types of losses (Ellenbogen & Gratton, 2001; Jordan, 2001). Such issues include drawing conclusions from quantitative studies which have mainly assessed general aspects of functioning and have thus failed to uncover some of the suicide specific thematic differences noted previously e.g., the preoccupation with the question of why the death occurred and heightened feelings of responsibility and shame (Jordan, 2001). A number of the conventional research methods used are insensitive to qualitative differences unique to suicide grief and it is consequently, and mistakenly,
assumed that differences in the mourning process between suicide and other types of
losses fail to exist (Ellenbogen & Gratton, 2001; Jordan, 2001). According to Thorson
(1996), qualitative approaches delve into deeper meaning and uncover and ascertain
facets and aspects of the field of study that may never emerge in a study utilizing more
traditional quantitative methods, such as the analysis of a questionnaire. The decision to
utilize a qualitative approach in an attempt to address the aims of the present study was
therefore based on a combination of the above mentioned reasons, together with an
awareness of the unique challenges inherent in this complex and sensitive field of
research. A more detailed discussion regarding the specific benefits of a qualitative
approach for the purposes of this study can be found in Chapter Three.

Factors Affecting Bereavement Outcome Following a Suicide

Despite the inconsistencies in the literature regarding variations in grief
reactions according to mode of death, there appears to be sufficient evidence of such
variations to warrant continued investigations (Jordan, 2001). Bailey et al. (1999)
suggested that in seeking to address the question of differences in bereavement and the
effects of mode of death on grief reactions, future investigations should explore the
more specific components of grief. These consist of the less obvious grief reactions,
processes or unique themes that can, and do, play a significant role in influencing the
course and extent of one's response to the loss. They include the unnatural and
unexpectedness of the death, the context of the suicide, possible withdrawal of usual
social supports and the social stigmatization associated with suicide (Bailey et al.,
1999). It also may include exploring issues such as the fact that mourning rituals that
help facilitate the movement from grief to recovery (e.g., religious ceremonies and
funerals) are often compromised when death results from suicide, and the notion that
individuals bereaved by suicide might never resolve their feelings entirely (Knieper,
In addition to exploring the above mentioned processes and themes, another area which has been deemed influential in the facilitation of the grieving process but which has not been afforded a deserving amount of attention, is the importance of experiences and events that unfold in the time immediately following the suicide. Cleiren et al. (1994) suggested that the period immediately after the suicide is crucial in determining functional adaptation to the loss, with early adaptation being highly predictive of longer term adaptation. More specifically, Dubin and Sarnoff (1986) referred to the important role which authorities involved in the immediate aftermath of a suicide play in the facilitation of a healthy grieving process. Knieper (1999) also stated that a survivor's grief reactions can be compounded or exacerbated by inappropriate responses from the community to the suicide. Trolley (1993) commented that any negative support or involvement from the emergency responders, police, medical examiners, funeral directors and clergy tends to create more isolation between the survivors and the professional world. Invariably these authorities are strangers, intricately involved in what is a very personal and private traumatic event. In the case of suicide, where families may be exposed to the scrutiny and unsolicited involvement of these strangers, the need for tactful involvement becomes even more necessary.

Dunne et al. (1987) remarked that the importance of front line responders (e.g., police and emergency response services), and their manner of interactions with survivors, cannot be overemphasized in terms of the profound impact which they have on the way survivors cope with the bereavement. These include the manner in which the relative or person is informed of the bereavement, official procedures such as finding or viewing the body, and the manner in which the family is subsequently dealt with by authorities (Dunne et al., 1987; Wertheimer, 1991).

For instance, just in terms of the death notification (i.e., being formally or informally notified of the death by a third person), this experience alone represents a
significant, life-altering event for the bereaved (Stewart, 1999). There are few conversations over the course of an individual’s life that have as much impact, or are as significant, as those surrounding a death experience (Jurkovich et al., 2000). The words or phrases that are used to give the bad news, the characteristics of the person who performs the task, the physical environment in which it occurs, all comprise valuable memories of the loss which are never forgotten. In fact, the memories of the death notification event may remain as isolated fragments that preclude an integrated sense of self following the loss (Stewart, 1999).

Front line responders can have a remarkable impact on how people reflect on this major life experience by how they interact with them during their conversations (Jurkovich et al., 2000). The content of such news unquestionably presents numerous challenges that may have deleterious and long lasting effects on a survivor’s adjustment, however the manner in which it is performed significantly affects the extent to which the survivors cope with these challenges (Stewart, 1999). The actual event can be an unsettling scene, which may create bitter memories for all parties (Jurkovich et al., 2000). Understandably, the bereaved does not want to hear the words of a death notification, and their reality and harshness may be overwhelming. In addition, the circumstances of the death, together with the circumstances under which the news of the death are received may be so stressful as to overwhelm the individual (Raphael, 1985). Ultimately however, breaking the news to the family represents a vital opportunity to influence the course, and perhaps the ultimate outcome, of bereavement, and in fact comprises a secondary preventive intervention if the notifiers are sensitive to the immediate needs of the survivor (Jurkovich et al., 2000; Lord, 1987).

In addition to the impact which this news has on the receiver, death notifications can also pose formidable challenges to the varied groups of professionals who perform this difficult but important task (Stewart et al., 2000). Glaser and Strauss (1968) found
that death telling was more difficult in cases of an unexpected or quick death, and
Stewart et al. (2000) reported that suicide was found to be the one of the circumstances
of death that death notifiers experience as most emotionally demanding. Undertaking an
extremely sensitive and difficult task such as death notification with inadequate training
and understanding can leave a notifier feeling helpless, inadequate and powerless
(Stewart, 1999). Education that helps notifiers to respond more effectively and
appropriately to these distressing situations can make the notification process less
traumatic in the short term and ultimately may reduce professional burnout (Stewart et
al., 2000).

Given that specific events and responses from those surrounding the bereaved
can influence survivors' grief reactions, relatively little scientific scrutiny has actually
been paid to survivors' experiences of such events. This is surprising, for as outlined
previously, what happens with and to survivors in the time immediately following the
death can be crucial in determining how well they cope with their bereavement
(Wertheimer, 1991). Parkes suggested that the initial moments following a suicide will
be "...vividly remembered for the rest of the recipient's life..." (1985, p.15).

Thus it seems that a narrow window of opportunity to mediate the responses of
bereaved people to suicide exists, and that the mismanagement, ignorance or
insensitivity regarding the unique impact of specific variables during this time may
significantly impact on the grieving process in an adverse way. The importance of
exploring survivors' experiences during this time, and subsequently raising service
providers' awareness of the potential influence on bereavement of specific experiences
in the period surrounding a suicide, is crucial.

Conclusion

A perusal of the early literature indicates inconclusive findings regarding two
primary questions: a) Is bereavement after suicide different to bereavement resulting
from other modes of death? and b) Is suicide bereavement more difficult or complicated than bereavement stemming from other modes of death? Whilst many quantitative studies have failed to find differences between bereavement according to mode of death, results of more recent, qualitative studies have uncovered specific variations unique to suicide. These include feelings of guilt, rejection, responsibility, shame and being stigmatised. Furthermore, suicide survivors tend to experience more difficulties accessing or acquiring the social support they desire.

Whether suicide bereavement is any more difficult or complicated than other bereavement is dependent on a number of factors. Many variables mediate and influence the bereavement experience after the loss of a significant other. These include the pre-existing relationship between bereaved and deceased, type or mode of death and circumstances surrounding it, responses of family and social network, time since death, concurrent stress or crises, previous losses and sociodemographic factors. It is important to note however that it is not simply the presence of such qualitative differences, but more the lack of attention to, or awareness and acknowledgment of, the interplay of these differences that may lead to atypical or complicated mourning processes or grief outcomes.

In addition, it is also possible to see how events and the manner of interactions in the immediate aftermath of suicide can impact on the bereaved individual’s subsequent grief processes. As much as front line responders have the capacity to aid this process, the potential to cause additional pain and suffering through unintentional insensitivity is also present (Wertheimer, 1991). Dunne et al. (1987) suggest that by being cognizant of their role in facilitation these individuals can initiate processes in the required courses of action that help to cushion the trauma of loss for survivors.

Rando summarized the quandary of differential bereavement experiences when she stated, “although it is always dangerous to compare different losses... it is equally
dangerous not to look at the unique dilemmas posed by specific types of losses and to ignore the distinct needs of mourners experiencing different types of bereavement” (1993, p.4).

Furthermore, by remaining cognizant of the adverse health outcomes related to the bereavement experience, and affording the factors which may mediate the grieving process greater attention, researchers, clinicians and service providers may become more adept at identifying and understanding people at risk of problematic grieving, and organize postvention more effectively (Ellenbogen & Gratton, 2001).

Having reviewed various concepts of bereavement, as well as highlighted the potential for variables during the time following a suicide to impact on a survivor’s grief process, the current study aims to address the apparent dearth in the literature that explores survivors’ experiences and needs in the time immediately following a suicide, and to generate greater insights into the reactions of survivors of suicide by seeking to answer the following questions:

**Research Questions**

1. Are there any specific events or procedures that occurred in the immediate aftermath of a family member’s suicide and which survivors believe in some way impacted on their bereavement experience?

2. Are there any specific aspects of the authorities' or other services' involvement that occurred in the immediate aftermath of their family member’s suicide and which survivors believe in some way impacted on their bereavement?
CHAPTER THREE
Methodology

Overview

A qualitative methodological approach was utilised in this exploratory study in which I sought to describe the experiences of suicide survivors during the time immediately following the death of their loved one. By way of explanation as to why a qualitative approach was utilized in this study, the benefits of qualitative as opposed to quantitative research methods warrant further attention.

The goal of quantitative research is generally to generate incontestable facts and to develop a nomothetic set of cause and effect relationships presumed to generalize across different settings and cultures. In contrast, the goal of qualitative research is more about discovering and exploring the unique and common perspectives of the individuals being studied, ultimately seeking to develop a deeper and richer understanding of a particular or single phenomenon (Neimeyer & Hogan, 2001).

According to Thorson (1996), theory building is a legitimate purpose of qualitative research, and qualitative methodologies, more than almost any other type of methodology, actually have the potential to break new ground, make original observations, reveal how people make meaning of events and provide the foundation for theory construction and development. Qualitative studies can also help uncover ideas which can then be tested and refined using more precise quantitative approaches. Thus qualitative paradigms paint a picture of bereavement which attests to the complexity of what is a multifaceted human phenomenon.

Furthermore, according to Fischer and Wertz (2002), whilst quantitative data can provide critical and valuable information, statistical indicators obtained from quantitative studies do not tell us about the meaning of being a member of a particular community, in this case survivors of suicide, or how it is to be a part of their unique
experiences. As Thorson commented, "not all things worth knowing can be quantified... and this is especially true in the affective domain that is dealt with mainly in the social sciences" (1996, p.179). Whilst qualitative methodologies often rely on the researcher's subjective interpretation, and the descriptive approaches utilized may constrain the extent to which causal explanations for phenomena can be offered, the meaningful and valuable contribution which qualitative research methods bring to the field of bereavement research cannot be overemphasized. Thus the decision to utilize a qualitative approach in this study was largely based on a combination of the unique study aims, together with the above mentioned reasons.

In terms of the current study, attempts were made to determine the existence of any events or procedures, which survivors believed may have impeded, facilitated, or were significant to their bereavement and grief processes. Participants in the study were individuals bereaved due to the suicide of an immediate family member. The other initial inclusion criterion was that the suicide had occurred in WA.

During the process of participant recruitment a number of individuals whose family members had suicided in a state other than WA, approached me with a desire to share their experiences. Despite the explicit inclusion criteria, I believed their participation to be important for their psychological well-being, and that to deny their involvement would have been inhumane and unethical. Ultimately, the aim of the study was to determine specific and subjective events that survivors found to be in some way significant to their bereavement experience. In terms of such experiences, the geographical location of the deceased or participant at the time of death was deemed irrelevant. It was subsequently decided that the relevant data from the interstate sample would be used to supplement that of the local or primary sample.

In relation to survivors' experiences of specific legal and administrative procedures however, I was only in a position to comment on such aspects within a West
Australian context and could not definitively comment on procedures implemented in other states. A number of interstate participants did however have contact with service providers in WA and consequently had pertinent and valuable information to contribute. This offered further support for the inclusion of any relevant interstate data.

The original sample was thus comprised of 44 participants, eight of whom did not meet the initial inclusion criteria. The remaining 36 participants were classified as Sample A. Sample B was comprised of the eight participants who reported on a suicide that occurred outside WA.

The process of data collection comprised the survivors providing a free narrative regarding the sequence of events, and their experiences of the service providers and relevant procedures, in the time immediately following the suicide (primarily the first few days but extending until their last significant contact with service providers). I then utilised the structure and format of an abridged form of the Circumstances of Exposure to Death Questionnaire (CED) (Brent and Moritz, unpublished instrument, obtained from Moritz, personal communication, April 22, 2003), to guide any open-ended, research-related questions (see Appendix E).

The free narrative approach was chosen as, according to Thorson (1996), the fundamental element of qualitative research is narrative, the heart of which is to achieve meaning or communicate a deeper message with a point. Utilising open-ended questions and encouraging individuals to provide such a narrative increases the probability that the research will explore deeper meanings as opposed to the often superficial information that basic quantitative methods may produce (Riessman, 2002; Thorson, 1996). Bearing in mind the nature and aims of the present study, together with the fact that survivors of suicide in WA do not appear to have many opportunities to tell their story and be heard, the benefits of such an approach could not be overlooked.
In addition to the abridged CED, a range of preset mediating questions served as prompts in the event that participants failed to address certain research-related areas of interest (see Appendix F). Repeated evidence of common experiences across interviews resulted in the identification of major themes and concepts. Additional demographic information was also obtained from the participants and included items such as specific demographic details (e.g., age, gender, religion, nature of kinship with deceased), as well as details of the decedents and the suicide (e.g., age, gender, history of attempts and method of suicide) (see Appendix D).

Sample and Decedent Characteristics

Sample A: Participant Characteristics

Sample A was comprised of 36 individuals who represented 30 individual cases of suicide. The participants in Sample A included biological and de facto parents, siblings and children of the deceased, and comprised 27 females (75%) and nine males (25%). This pattern of gender imbalance was also evident in Sample B. Such a pattern may be partially explained by the fact that, when compared to bereaved males, bereaved females have been found to be more expressive of their emotions and are more likely to talk about their loss as a way of dealing with their grief (Martin & Doka, 2000).

More than one family member represented a number of individual cases of suicide. As this research was aimed at ascertaining each individual's experience of the post-suicide events, each individual participant was counted separately due to their unique experiences. Having said that, it needs to be noted that when discussing the characteristics of the decedents, the demographics of those who were represented by more than one family member were not counted more than once. Thus, if one male who suicided by hanging was represented by both his parents, his parents were counted as two participants. In terms of the decedents' characteristics however, he has been counted as one case who died by hanging.
Furthermore, in three instances, one participant represented more than one suicide in their family (one individual had experienced three suicides in the immediate family, and two individuals had experienced two suicides). Again, the respondent for each individual case of suicide was counted separately. For example, I counted a girl who had two brothers suicide as two separate participants and interviewed her accordingly. Her brothers have been counted as two separate decedents.

I initially thought that the greater the diversity within the sample regarding relationship to victim and time lapsed since the event, the richer the data would be. Although attempts were made to recruit participants who reflected a diversity in terms of their kinship relation with the deceased, the majority of participants were the mothers of suicide victims (n=16), followed by fathers (n=5), wives (n=4), sisters (n=5), daughters (n=2), brothers (n=2), husbands (n=1) and sons (n=1).

Whilst it transpired that there were no participants whose relationship to the deceased was classified as that of “step” or “half”, two participants (both from the same biological family and representing the same deceased individual) classified their relationship with the deceased as being “de facto”. In this case, the deceased had immediate biological family members but had resided with the de facto family members for extended periods, and had been living with one of them at the time of death. Apparently, this deceased individual had minimal contact with his biological family and, according to the information supplied, classified these participants as his primary family. Furthermore, the decedent died at the house that he shared with one of the participants.

A significant diversity was evident regarding the amount of time between the family member’s suicide and the research interview. This ranged from between 3 months to 241 months (20 years and 1 month). The average time since the death was 6.72 years (SD= 5.07 years). Interestingly, the fact that in some cases a considerable
amount of time had lapsed between the death and the research participation (in one case up to 20 years), and yet participants were still able to clearly recall and reflect on specific experiences, offers additional support for the long-lasting impact that such events may have on survivors.

Whilst all participants were Caucasian, 11 individuals identified their religious orientation as Roman Catholic, eight as Church of England, six as No Religious Orientation, five as Anglican, three as Jewish, two as Presbyterian, and one as Christian unspecified. All of the participants were over the age of 16 at the time of interview except for one individual who was 15 years and 11 months. This participant's parent completed the consent form thereby allowing the minor to participate in the research.

Sample A: Decedent and Event Characteristics

As evidenced by Table 4, the 30 decedents included 21 males (70%) and 9 females (30%). Ages at time of death ranged from 16 years to 50 years ($M = 31.9$ years, $SD = 10.81$ years). The causes of death included hanging ($n=10$), carbon monoxide poisoning ($n=9$), jumping from high places ($n=3$), stepping in front of a train ($n=2$), overdose ($n=1$), drowning ($n=1$), gunshot ($n=1$) and strangulation by ligature ($n=1$). Prior to the suicide, 18 decedents had previously demonstrated suicidal behaviour, expressed suicidal ideation or had a history of suicide attempts, (whether known to family member at the time of suicide or not). Ten decedents had never shown any form of suicidal behaviour or ideation prior to their successful attempt. Data for two decedents regarding a previous history of suicidal behaviour was unavailable as the relevant participants had no such knowledge regarding this information.
Table 4

Decedent Details–Sample A

<table>
<thead>
<tr>
<th>Decedent</th>
<th>Gender</th>
<th>Age at Time of Death</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>16</td>
<td>Hanging</td>
</tr>
<tr>
<td>2</td>
<td>Male</td>
<td>19</td>
<td>Hanging</td>
</tr>
<tr>
<td>3</td>
<td>Male</td>
<td>19</td>
<td>Hanging</td>
</tr>
<tr>
<td>4</td>
<td>Male</td>
<td>23</td>
<td>Hanging</td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
<td>24</td>
<td>Hanging</td>
</tr>
<tr>
<td>6</td>
<td>Male</td>
<td>25</td>
<td>Hanging</td>
</tr>
<tr>
<td>7</td>
<td>Male</td>
<td>27</td>
<td>Hanging</td>
</tr>
<tr>
<td>8</td>
<td>Male</td>
<td>31</td>
<td>Hanging</td>
</tr>
<tr>
<td>9</td>
<td>Male</td>
<td>42</td>
<td>Hanging</td>
</tr>
<tr>
<td>10</td>
<td>Male</td>
<td>52</td>
<td>Hanging</td>
</tr>
<tr>
<td>11</td>
<td>Male</td>
<td>17</td>
<td>Carbon Monoxide poisoning</td>
</tr>
<tr>
<td>12</td>
<td>Male</td>
<td>17</td>
<td>Carbon Monoxide poisoning</td>
</tr>
<tr>
<td>13</td>
<td>Male</td>
<td>26</td>
<td>Carbon Monoxide poisoning</td>
</tr>
<tr>
<td>14</td>
<td>Male</td>
<td>29</td>
<td>Carbon Monoxide poisoning</td>
</tr>
<tr>
<td>15</td>
<td>Male</td>
<td>31</td>
<td>Carbon Monoxide poisoning</td>
</tr>
<tr>
<td>16</td>
<td>Male</td>
<td>43</td>
<td>Carbon Monoxide poisoning</td>
</tr>
<tr>
<td>17</td>
<td>Female</td>
<td>30</td>
<td>Carbon Monoxide poisoning</td>
</tr>
<tr>
<td>18</td>
<td>Female</td>
<td>33</td>
<td>Carbon Monoxide poisoning</td>
</tr>
<tr>
<td>19</td>
<td>Female</td>
<td>36</td>
<td>Carbon Monoxide poisoning</td>
</tr>
<tr>
<td>20</td>
<td>Female</td>
<td>46</td>
<td>Carbon Monoxide poisoning</td>
</tr>
<tr>
<td>21</td>
<td>Female</td>
<td>46</td>
<td>Carbon Monoxide poisoning</td>
</tr>
<tr>
<td>22</td>
<td>Male</td>
<td>50</td>
<td>Multiple injuries (jumped from height)</td>
</tr>
<tr>
<td>23</td>
<td>Female</td>
<td>40</td>
<td>Multiple injuries (jumped from height)</td>
</tr>
<tr>
<td>24</td>
<td>Female</td>
<td>45</td>
<td>Multiple injuries (jumped from height)</td>
</tr>
<tr>
<td>25</td>
<td>Male</td>
<td>16</td>
<td>Multiple injuries (train impact)</td>
</tr>
<tr>
<td>26</td>
<td>Male</td>
<td>28</td>
<td>Multiple injuries (train impact)</td>
</tr>
<tr>
<td>27</td>
<td>Male</td>
<td>34</td>
<td>Drowning</td>
</tr>
<tr>
<td>28</td>
<td>Female</td>
<td>38</td>
<td>Drug overdose</td>
</tr>
<tr>
<td>29</td>
<td>Male</td>
<td>45</td>
<td>Gunshot</td>
</tr>
<tr>
<td>30</td>
<td>Female</td>
<td>29</td>
<td>Strangulation by ligature</td>
</tr>
</tbody>
</table>
Seventeen decedents had some history of mental health issues at the time of their death. Ten decedents had no known mental health history, and the relevant data for three decedents was unavailable. According to the information available, 13 decedents were either on medication for mental health issues at the time of their suicide, were under the care of a mental health professional (psychiatrist, psychologist or doctor), or had been seen by such a professional within a 24-hour period prior to their death. Five decedents were definitely not engaged with any form of medical or therapeutic assistance or intervention. The relevant details regarding the remaining 12 decedents were unavailable as the relevant participants had no such knowledge regarding this information.

Sample B: Participant Characteristics

Sample B was comprised of individuals who had experienced the suicide of a family member whilst the family member was in Australia, however not in WA. A number of the participants were also residing in a state other than WA at the time of death. Sample B was comprised of eight individuals who represented seven cases of suicide. It included seven females (87.5%) and one male (12.5%). In terms of kinship relations to the deceased, the sample was comprised of mothers (n=2), sisters (n=3), daughters (n=2), and a father (n=1). In one case, two family members from the same family represented one individual case of suicide.

The amount of time between the family members' suicide and the research interview ranged from between 2 years 10 months to 27 years. The average time since the death was 10 years ($SD=8.4$ years). Whilst all participants were Caucasian, three individuals identified their religious orientation as Roman Catholic, three as No Religious Orientation, one as Church of England, and one individual who, despite a Roman Catholic upbringing, now classified themself as “spiritual”. 
Sample B: Decedent and Event Characteristics

As evidenced by Table 5, the decedents were five males (71.43%) and two females (28.57%). Ages at time of death ranged from 17 years to 44 years ($M = 28.14$ years, $SD = 9.99$ years). The causes of death included hanging (n=3), jumping from high places (n=1), overdose (n=1), gunshot (n=1) and laceration of the upper arm (n=1).

Prior to the suicide, two of the decedents had previously demonstrated suicidal behaviour, expressed suicidal ideation or had a history of suicide attempts (whether known to family member at the time of suicide or not). Four decedents had not shown any form of suicidal behaviour or ideation prior to their successful attempt. Six of the decedents had some history of mental health issues at the time of their death. According to the information available, one decedent was on medication for mental health issues at the time of their suicide, was under the care of a mental health professional (psychiatrist, psychologist or doctor), and had been seen by such a professional within a 24-hour period prior to their death. One respondent had no knowledge regarding any of the above information in relation to their loved one.

Table 5
Decedent Details—Sample B

<table>
<thead>
<tr>
<th>Decedent</th>
<th>Gender</th>
<th>Age at Time of Death</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>22</td>
<td>Hanging</td>
</tr>
<tr>
<td>2</td>
<td>Male</td>
<td>23</td>
<td>Hanging</td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>44</td>
<td>Hanging</td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
<td>17</td>
<td>Gunshot</td>
</tr>
<tr>
<td>4</td>
<td>Male</td>
<td>27</td>
<td>Laceration to upper arm</td>
</tr>
<tr>
<td>6</td>
<td>Male</td>
<td>24</td>
<td>Multiple injuries (jumped from height)</td>
</tr>
<tr>
<td>7</td>
<td>Female</td>
<td>40</td>
<td>Drug overdose</td>
</tr>
</tbody>
</table>
Recruitment of Participants

Participants were recruited from two sources. The first source of recruitment included Perth metropolitan and regional support groups catering for bereaved and grieving individuals (e.g., Compassionate Friends). Such organizations were contacted and a number of survivor group meetings attended. The purpose of this was to explain the nature and value of the proposed research and to gain the organizations' support in terms of data collection. Group members who participated in the research also introduced other consenting, bereaved family members to the researcher i.e., snowballing. Kuzel (1992) defines snowballing as the process of identifying cases of interest from people who know which cases are information-rich. Twelve participants in Sample A and one participant in Sample B were recruited in this manner.

The second source of participants was a community sample. Advertisements requesting volunteers for the study were placed at various locations on the Joondalup campus of Edith Cowan University, as well as in the local community newspapers. Twenty-four participants in Sample A were recruited either directly as a result of such advertisements, or through a subsequent process of snowballing. Seven of the participants in Sample B were recruited through these advertisements.

In terms of the community newspaper advertisements, a short article regarding this research project was printed in the three northern suburbs community newspapers that fall under the umbrella of the Wanneroo Community Times. These newspapers were the Wanneroo Times, Joondalup Wanneroo Community News and North Coast Times. The reasons for limiting the choice to northern suburbs papers included time and financial constraints. Furthermore, due to the sensitive nature of this research, it was presumed that individuals living in the northern suburbs, which is also the location of my university, would perhaps feel more comfortable discussing their experiences with an individual affiliated to a familiar institution. Despite this consideration, due to a
snowballing effect from the original newspaper article, eight participants in Sample A and three participants in Sample B did not actually reside in the newspaper catchment area. Recruitment of participants was addressed and conducted on the basis of saturation (Glaser & Strauss, 1967). “Saturation” occurs when there is an obvious and consistent repetition of already described patterns of behaviour or experiences, and thus no new information is uncovered (Miles & Huberman, 1994). Data collection extended for approximately ten months.

Materials

Following the participant’s free narrative regarding their experiences surrounding the suicide, the pre-existing Circumstances of Exposure to Death interview schedule (CED) guided the sequence of the ensuing questions. In its original form, the CED is a 30-item interview designed to assess the bereaved individual’s level of exposure to the suicide. The instrument is divided into four sections: circumstances of death; direct exposure (what was witnessed); indirect exposure (visiting the scene of death, discovery of the body); and events after the death (wake, funeral, contact with family and authorities) (see Appendix E). Whilst the format of this instrument was simply used as a guide for the purposes of this study, in research undertaken by Brent et al. interviewer agreement while using the CED was high (κ= 0.97) (Brent et al., 1992). In a later study, this instrument again obtained high interviewer agreement (κ= 0.80) (Brent, Perper, Moritz, Allman, Liotus et al., 1993). A set of mediating questions, aimed specifically at the survivor’s experience of services during each stage, was also developed and utilised on an “as needs” basis during the free narrative when appropriate, and later in conjunction with the CED (Appendix F).
Procedure

The aforementioned community organizations were contacted and the study was explained to relevant management. Letters detailing the study were then sent to the organizations, and these were handed out at group meetings or to specific individuals (Appendix A). Interested individuals initiated contact with me, whereupon I explained the study in greater detail and arranged to meet with these potential participants. A number of group meetings for survivors were also attended and the research proposal presented to the attendees. In terms of the community sample, advertisements introducing the study were placed in a variety of locations on the Joondalup campus of Edith Cowan University (Appendix G), and in three local newspapers. Interested parties contacted me whereupon I explained the study in greater detail and arranged a meeting time.

At these meetings, participants were given the Introduction Letter which included the conditions of participation e.g., participants will remain anonymous, were free to withdraw at any time, and that support services or some form of follow up could have been offered if deemed necessary (Appendix B). Participants’ permission to tape record interviews was obtained. These tapes were kept in a locked cabinet and were only available to my supervisors and I. The tapes will be destroyed after a retention period of five years, as prescribed by the Edith Cowan University Ethics Research Committee. Participants were also required to complete a Consent Form, after which I administered the Demographic Questionnaire (Appendixes C and D respectively).

Given the exploratory nature of the study and the paucity of previous research in this specific area, a free narrative followed by a guided conversation were chosen as the preferred methods of interviewing. The narrative began with the following open-ended trigger introduction and question:
From what you have told me, (Name of deceased) suicided on (Date). I am looking specifically at your experience of events surrounding and immediately after their suicide. Firstly I would just like you to talk me through and relay as much information and detail that you can remember and are comfortable sharing starting from the moment you first found about (Name of deceased)'s suicide until your last involvement with service providers. Please give particular attention to any aspects which were particularly memorable, or which you perceived to have a helpful or unhelpful impact on your bereavement, both on a personal level (involvement family friends) but also in terms of service providers. What is important is that you start wherever you feel most comfortable. If you want to tell me a bit about (Name of deceased) before we start, that would also be most welcome.

Impromptu open-ended prompts and clarifying questions were used during the free narrative. Subsequent to this, additional questions based largely on the format of the CED interview schedule, together with a set of mediating prompts were used to facilitate the interview process. The CED was utilised as it divides the exposure to the death into four sequential stages and this structure assisted in maintaining direction and focus during the interviews. These questions also served to ensure that similar ground was covered in each interview. The reason for phrasing most questions in an open-ended manner was to encourage participants to use their own voices when reflecting on and reporting their personal experiences and beliefs. Nonverbal cues and other contextual information were also documented through field notes.

The focus was on ascertaining and discovering any common themes in the bereaved individuals’ experiences that they either believe should have been dealt with differently, or that were handled particularly well (i.e., questions linking exposure to subjective bereavement experiences). They were also asked to recall any experiences that they believe in some way impacted on their experience and thus remain vividly remembered, irrespective of length of time between event and research interview. These may have included aspects of administrative procedures, and involvement and conduct of relevant service providers. Bearing in mind there is no guarantee that there will be one definitive interpretation of someone else’s meaning, attempts to limit any
misunderstanding of what the participant was saying and maintain trustworthiness were undertaken. For instance, in order to maintain credibility I aimed to satisfy one of the three criteria of trustworthiness advocated by Guba and Lincoln (1989). Consequently, in order to verify their experiences and my interpretations thereof, and to check for meaning, I filtered, paraphrased and verbally reported back all relevant information offered by the participant. Attempts to satisfy another of Guba and Lincoln's (1989) criteria, that of dependability, is discussed later in the Data Analysis section of this chapter.

These interviews also involved the debriefing of individuals regarding their research participation. Information regarding relevant organizations such as Compassionate Friends and Good Samaritans was offered to participants. Participants were invited to contact me in the week following the interview in order to add to or clarify their stories. All participants also received a “Thank you” letter within a week of their respective interviews.

Interviews extended from between 55-180 minutes. Repeated evidence of similar experiences across interviews led to the identification of major concepts and themes. The data collection stage was terminated when the research participants were reporting no new major themes and it was thus felt that data saturation point had been reached.

In order to gain relevant and accurate information regarding the respective roles and involvement of service providers in the aftermath of a suicide, contact was made with individuals at the Western Australian Police Academy, the Coronal Services Inquiry Section of the police, The Office of the State Coroner, the ambulance provider, and a prominent local funeral company. These contacts were made in order to increase my level of understanding of relevant procedures in WA. They were not for the
purposes of evaluation, but merely to enable me to make informed comments regarding such services and in reference to information offered by participants.

In terms of the Western Australian Police Academy, I attended two separate lessons that were intended to address death notification and related legal and administrative procedures undertaken in the case of an unnatural death in WA. Each lesson was conducted by a different Trainer of Recruits from the Legal and Procedural Training Unit, and was attended by two different squadrons of cadets. The lessons extended for approximately 45 minutes. In addition, I conducted a 50-minute long, in-depth interview with one of these trainers, the purpose of which was to gain additional information regarding the training procedures.

In addition to this investigation, I also contacted the West Australian branch of the ambulance company and held a brief telephone interview with an employee in one of the two Accounts Departments, regarding relevant procedures and practices implemented in the case of a suicide in WA. A brief telephone interview was also conducted with a member of the Coronal Inquiry Section of the WA Police Force. Two telephone interviews and one face-to-face interview was held with an employee in the Office of the State Coroner, and one face-to-face interview was held with an employee at a specific funeral company. Throughout the data collection stage, this particular funeral company was consistently referred to in a positive manner by participants and appeared to be held in high esteem by all survivors who had utilised their services. In addition, an employee of this company had attended a research presentation I had done at the Ministerial Council for Suicide Prevention. An hour-long meeting was held with her, the purpose of which was to gain insight into the general procedures required of funeral companies in WA. This completed the data collection process.
Data Analysis

During data collection it became apparent that not all participants had been exposed to the same service providers, or had experienced identical procedures, or interactions. Whilst numerous significant ideas and dimensions were highlighted, due to relevant researcher constraints (i.e., time and financial), attention in this thesis was only afforded to the more prominent themes. These were themes that were either vigorously endorsed by a large proportion of individuals, or themes that were highlighted as being central to post-suicide experiences.

A variety of ideas and approaches to working with and analysing qualitative data such as those of Glaser and Strauss (1967), Bogdan and Taylor (1975), Taylor and Bogdan (1998), Fischer and Wertz (2002), and Miles and Hubermann (1994) were utilised in this study. In order to make sense of my data I did not exclusively follow or adhere to any one particular model, but instead borrowed from all of these diverse approaches. Having said that, the work of Taylor and Bogdan provided a general framework according to which I approached the data coding and interpretation procedures. Support for the practise of borrowing aspects from different theorists' approaches can be found throughout the literature e.g., Taylor and Bogdan (1998) and Coffey and Atkinson (1996).

All interview audiotapes were transcribed and the data analysed on an ongoing basis as suggested by Miles and Huberman (1994) and Wolcott (2001). The actual data analysis comprised two distinct phases. Firstly, I immersed myself in the data by reading and rereading all transcripts as well as re-listening to a number of the audiotapes. Subsequent to identifying emerging themes, I constructed numerous typologies based on my own classification scheme or general conceptual framework entitled, “Survivors’ post-suicide experiences”. Using these typologies, I was able to make linkages between the various phenomena within this framework such as:
experiences deemed as being influential on bereavement, experiences that had occurred in the immediate aftermath versus those that had occurred in the months following the death, or experiences that were unique or isolated as opposed to those that occurred on a more general level. As a result of this process, theoretical propositions and more applied concepts which had their base in this data, were continually generated. An extensive list of potential categories, based primarily on the manifest content of themes, was thus initially developed. Upon completion of data collection, this list was subjected to a review process, and many of the codes collapsed into fewer, substantive categories. This process provided me with a master list of coding categories and completed the first stage of data analysis.

The second phase of this process involved the coding of the data. During this stage I aimed to develop an analytic thread that integrated the aforementioned major themes, typologies, concepts and propositions, as suggested by Taylor and Bogdan (1998). During the process of sorting the data into the respective coding categories, ongoing attention and efforts to compare specific events and experiences, refine the concepts and properties, and explore the relationships between the categories were made. This process largely replicated the constant comparative method advocated by Glaser and Strauss (1967). Although I did not implement their procedure in its entirety, certain aspects greatly assisted me to simultaneously code, analyse and interpret the data.

The process of data interpretation is based on one's theoretical assumptions (Taylor & Bogdan, 1998). Due to the nature of this research, and the fact that my primary aim was the exploration of survivors’ experiences, I chose not to try to interpret this data according to any one specific set of assumptions. However, for the purposes of this study and the way in which I wanted to be able to draw implications and recommendations from the data, the illustrative narrative was chosen as the most
Impact of Events in the Aftermath of Suicide

suitable form of interpreting and reporting data. In this manner, the data was not translated into any theoretical system but rather served as an accurate and true reflection of survivors' experiences, as advocated by Fischer and Wertz (2002).

The illustrative narrative was drafted according to the coding framework of survivors' post-suicide experiences. The final coding categories within this framework, which were also identified as being the major and recurring themes emanating from the data, were: survivors' mental state; information and guidance; interactions with others (including service providers); experiences of specific procedures; support; children’s perspectives; and survivors’ suggestions. These major themes or categories also incorporated a number of relevant subcategories.

According to the principles inherent in adopting an illustrative narrative form, attempts were made to report each experience as closely as possible to the manner in which it was relayed by the participant, whilst concurrently attempting to generalise such experiences across participants (Fischer & Wertz, 2002). Upon determining the major themes, and placing the data within this structure, additional examples from different cases were included, together with any significantly illustrative excerpts from the transcripts. Throughout this process of data analysis and interpretation, the basic questions that I addressed to the narratives revolved around the participants’ experiences in the sequence of events following the suicide, as well as the perceived impact of all experiences deemed significant to their bereavement and subsequent grieving process.

The themes generated when interviewing participants in Sample B largely coincided with themes generated by Sample A. These similarities emerged naturally from the data and were not the result of forcing a classificatory system from Sample A on the data from Sample B. Any differences in experiences evident between samples, and which were as a result of the geographical variations at time of death, have been
highlighted as differences and reported accordingly. All demographic data was also
analysed and the results presented as descriptive statistics.

By clearly articulating the processes undertaken in this research study, it is
hoped that Guba and Lincoln’s (1989) second criteria for maintaining trustworthiness,
that of dependability, has been met, thus allowing for another researcher to easily follow
and replicate this study, and consequently arrive at similar conclusions.

The following chapter provides an overview of the major themes identified from
the data. An in-depth discussion of each of these themes is presented in Chapters Five,
Six, Seven and Eight.
CHAPTER FOUR

Overview of Major Findings

This study set out to answer the following two research questions: 1) Are there any specific events or procedures that occurred in the immediate aftermath of a family member’s suicide and which survivors believe in some way impacted on their bereavement experience?, and 2) Are there any specific aspects of the authorities' or other services' involvement that occurred in the immediate aftermath of their family member’s suicide and which survivors believe in some way impacted on their bereavement? These questions stemmed from an apparent dearth in empirical research regarding survivors’ experiences of post-suicide events and procedures.

Analysis of the data identified six major themes: The Subjective State of the Survivor; Information and Guidance; Interactions with Others; Procedural Aspects; Child Survivors; and Survivors’ Suggestions for Improved Practise. Examination of these themes identified that survivors did believe that specific events and procedures influenced or impacted on their subsequent bereavement. In addition, deficiencies in several specific areas of service provision were identified by survivors as crucial in affecting the traumatic nature of the experience.

It needs to be reiterated that due to the nature of this study, the impact of such events on participants’ bereavement was not measured per se, but rather participants were asked to reflect on and report events that they believe had some influence on their bereavement experience. It is suggested that experiences which participants found to be either particularly traumatic or beneficial, would consequently have had some impact on their respective bereavement and grieving processes.

In a number of cases, it was difficult to definitively assign an event or procedure to a single class or heading, as on numerous occasions they could feasibly fall under several different categories. Alternatively, in some cases the interactions during the
procedure (i.e., manner of interviewer as opposed to actual questions) were deemed to be undesirable, which in turn may have coloured the participant’s view of the procedure. In looking broadly at the data, the consistency with which themes related to the manner of interactions with others was reported, suggested that this is an influential area worthy of closer scrutiny. A number of specific procedural aspects were also consistently mentioned. Where possible these findings are presented in a chronological sequence, thus mirroring the format that the interview followed.

Although all participants’ stories were unique, numerous common themes emerged, irrespective of their relationship to the deceased. For many participants the suicide of their loved one was their first direct exposure to death. In addition, personal contact with various service providers or related procedures was also a novel experience. Such novelty meant that participants were unsure of their rights and entitlements, or what was required or expected of them in the time following the suicide. Furthermore, upon becoming aware of the death, participants spoke of feeling shocked, confused and bewildered. A dearth of information and guidance, with particular regard to procedural aspects and specific details, was consistently emphasized. It also became apparent that the onus was on survivors to acquaint themselves with such procedures, pursue service providers, and independently seek answers to outstanding questions.

Whilst the impact of several general procedural aspects gained a considerable amount of attention and mention, it was the impact of unsatisfactory personal interactions with service providers, which participants seemed to highlight consistently. This impact of inappropriate or insensitive interactions with others was not limited to service providers however, and was found to be influential irrespective of the relationship between the survivor and the other.
A number of service-specific procedural or administrative aspects were also highlighted. These included survivors being billed by the ambulance service despite a) the ambulance staff not having rendered any services whatsoever as the deceased was already dead when the ambulance arrived, or b) families being informed by ambulance staff that they do not transport dead bodies. In effect then, families were charged for the ambulance attending the scene of the death and leaving within minutes, without having administered any services.

The unsatisfactory manner and nature of questions asked during police interviews, delays in completing the police investigation into the death, as well as being denied a copy of the final Coronial report, were also frequently mentioned. In addition, numerous survivors expressed feelings of disenchantment and disappointment with the lack of follow up from the clergy members who had conducted the funeral. In several cases, unsatisfactory follow up or support from medical professionals under whose care the deceased was at the time of death, notably psychiatrists, resulted in consistent expressions of disillusionment with the mental health system.

A number of non service-specific procedures that were perceived to have impacted on participants’ post-suicide experiences were the death notification, viewing the deceased’s body, being offered the deceased’s personal items and the complicated process of finalising the deceased’s estate. The importance of ongoing and appropriate support for the survivor was also given consistent attention. Participants reported that support from family and friends dissipated after the funeral, a time when it was felt by many to be most needed. In addition, the nature and benefit of support provided by other survivors was highlighted.

Children who had experienced the suicide of a parent offered unique insights into the experiences and distinct issues that confront child survivors. Whilst a perceived lack of information and guidance was also evident in this group, the family was often
seen to impede any of the child's attempts at information acquisition. In addition to procedural facts, children also reported needing or wanting information about the deceased and about related familial issues. It was important for children to be involved in decision-making, and to be seen to have a role in proceedings. The importance of being offered, or choosing several of the deceased's possessions was also highlighted, as was the impact of inappropriate interactions with adults. Based on their experiences, child survivors offered a number of suggestions regarding best practises for dealing with children during the time following the suicide of a parent.

Finally, participants reported on a number of miscellaneous experiences that they found particularly beneficial in the time following the suicide. These were having interactions with service providers who themselves had experienced the suicide of a loved one, the benefit of having service providers or support services attending at the survivors' homes, and the benefit of writing about their individual experiences. Overwhelming consensus as to the benefit of having one person act as an intermediary between all services and survivors was obtained. Due to the favourable experiences survivors reported having had with other survivors, it was recommended that such an intermediary themselves be a survivor, or at least be involved in the training of such officials. This person should be able to give information and guidance regarding all procedures and requirements, and be able to advise the recently bereaved on what to expect on a personal and procedural level.

In reporting on and discussing the findings of this study, it needs to be noted that the individual, environmental and circumstantial variations between participants and their experiences, the different levels at which events were reported on, as well as the unique meanings ascribed to different experiences, mean that at times themes and dimensions may appear somewhat abstract, while at other times appear more concrete and clear-cut. In addition, there were numerous challenges incumbent in reporting on
and discussing such complex data, however it is hoped that by presenting it in a chronological sequence and under a number of broad headings, the essence of the significant themes is suitably reflected.

We start the in-depth discussion of the findings by exploring the impact of certain personal and interpersonal aspects that gained consistent endorsement from the research participants. This is followed by a discussion of specific procedural aspects, and lastly, the experiences of child survivors are addressed. Where appropriate, participant’s verbatim comments are used to support these identified themes and dimensions. Each participant has been identified with a number that appears in parenthesis following his or her respective comments.
CHAPTER FIVE

Primary Impact on the Survivor

*The Subjective State of the Survivor*

When describing their initial responses to becoming aware of their loved one’s suicide, participants consistently cited reactions of disbelief, shock, psychological numbness and feeling stunned by the incomprehensibility of the event. Whilst such reactions are not uncommon (see Chapter Two), literature suggests that the effect of shock is more pronounced when a death is sudden and unexpected (Raphael, 1985; Tedeschi & Calhoun, 1995; Wright, 1991). This feeling of shock was evident throughout the interviews. One participant who having previously experienced the death of her mother and husband to illness commented, “Suicide is different to the other deaths. The unexpected is just so hard to deal with” (42).

However, for many other participants, the suicide of their loved one was their first direct exposure to death. This in itself was a cause of shock. One participant expressed, “It’s the first person I’ve ever seen dead” (27). Others stressed that, “I’ve never actually lost anyone prior to my mother” (23), and “(Name of deceased) was my first dead person. That’s probably why I was more in shock” (21). From the data, it appeared that exposure to a sudden and unexpected death left many participants with a sense of surrealism about the death and uncertainty of how they should behave or respond. In addition to the impact of the sudden and unexpected nature of the death, participants also spoke of their confusion stemming from, and exacerbated by, the novelty of all events associated with the suicide.

Tedeschi and Calhoun (1995) suggested that novel events are more likely to be difficult for us to handle as we cannot bring our experience to bear on unfamiliar encounters. Furthermore, in the case of suicide, social and societal “norms” regarding suicide bereavement may be more restrictive and less clear than the rules or norms for
other types of death (Rudestam, 1992). In this sense, survivors are sensitive to the service providers around them. Reports such as, "You don't know your rights" (2), "You don't know how to behave or anything and that's very difficult" (42), and "I just didn't know what was expected of me" (19) confirmed this. In addition, the unfamiliarity of these experiences may be exacerbated by the fact that strangers (service providers) often immediately surround the survivors. Consequently, the survivor’s experience of grief may initially occur without the immediate presence of those who are usually available to provide support.

Such uncertainties may either be offset by, or compounded by, the survivor’s state of mind after becoming aware of the suicide. The literature suggests that related to the reaction of shock and disbelief, are experiences of acting automatically, without being able to think clearly (Tedeschi & Calhoun, 1995). Worden (1982) also suggested that the crisis of a sudden death frequently renders the survivor unable to formulate coping strategies and unable to process information in a rational manner. This altered state of consciousness or thought patterns in the time immediately following notification of the suicide was one of the most prominent and consistent themes to emerge from the data. A selection of participants’ statements serves to illustrate the commonality of this experience.

Because you’re going through the motions, you can’t think straight. I was like a zombie, I felt like a zombie. I was going through the motions. But also, I know I remember thinking, I had no... I knew things had to be done around the house, like say: the washing, the cooking, the cleaning. But I just couldn’t bring myself to do it. I just had no energy. I just felt completely washed out. Drained. I just felt like things had to be done, but I just couldn’t do it. My body couldn’t do it. I was just like whatever I was doing, it was automatic. But I guess I wasn’t really conscious of what I was doing. Because it is such an emotional time, you can’t always think straight. (1)

I would’ve liked to have (Names of other children) come to say goodbye to him there... but that was all confusing and in that state of mind you don’t think. (2)
I can't remember having showered. I can't remember getting dressed. I must have done sometime or another. I don't think I stayed in a nightie all day. I don't think I could even focus .... (3)

I just didn't think [about whether to view the body or not]. You're so traumatised, you don't think. (12)

You can't think straight. I was like a zombie. I guess I wasn't really conscious of what I was doing during those first few days. (22)

I was all in a daze of disbelief and shock...just going through the motions. (31)

Due to the state of shock, I probably wasn't thinking straight about anything. (41)

In summary it appeared that the sudden nature of the death, the novelty of all associated events, and the participants' varied and individual reactions to the news of the death played an interwoven and complex role in influencing and determining survivors' responses during this time. It is also important to note that due to the unique reactions of survivors to this tragic news, it is difficult to provide any service that either will lessen the shock, or be generically helpful. However, the more poignant issue is that the type and nature of services offered or undertaken appear to impact on the initial reaction or exacerbate the trauma of the shock.

Information and Guidance

Whilst a state of shock and confusion are understandable reactions to stress, this also may render individuals unable to understand or participate fully in the events transpiring around them, disrupting their ability to think and plan coherently, and complicating the simplest decision-making process (Davidhizar & Kirk, 1993). This in turn may leave survivors with regrets about decisions they did or did not make. This was certainly relevant for participants in this study, several of whom noted, "At the time of the death you're in such shock. You're not in any space to be thinking through logically what might be important in the next few days" (39), "I wasn't capable of
functioning or thinking properly” (42), and “When you’re in a traumatised state it’s very hard to have to be practical and to decide on all the stuff that you have to do” (5).

It appeared that participants almost became immobilised by the shock of the event, and either inadvertently but understandably neglected to ask important questions, or experienced difficulty asking for help or for what they needed. As one individual commented, “I think people do want to know, but don’t feel in a state to ask” (2). One participant reported becoming very distressed when her son’s passport and driver’s licence were not returned to her and were destroyed by the office of the Public Trustees instead. When she queried their whereabouts, she was informed that it had been her responsibility to request their return, and because she had not, they were destroyed. On reflection she stated,

When I took that in I had no idea that I could ask for them back. I didn’t think of something like that. ...she said I should have stated at the time but I thought they should have notified me or let me know that I could have stated that I wanted to keep things like that. (27)

The most frequent complaint related to the myriad of unanswered questions and a lack of information and guidance offered by service providers in the time following the suicide. Obviously this paucity of information may also be fuelled by the survivor’s emotional state at the time, together with the fact that the bereaved have seldom had time to prepare for the death, which may further serve to complicate the process of accepting and assimilating such information. Because of these complexities, it is very important for the family to understand and have as much relevant information as possible (Davidhizar & Kirk, 1993). However, participants in this study reported that, “...to my mind there’s a lot of grey areas so it still leaves things up in the air” (10), and “I felt I really needed some answers. It’s like you’ve got to talk now. Don’t keep me
waiting. You’re feeling desperate. You’ve got to know. Please answer my questions” (19).

This lack of information and knowledge may also serve to prolong the grieving process in that survivors do not have all the information they need to enable some form of closure, as evidenced by the comment, “I didn’t have to keep on phoning but I did because I wanted to try and get all the answers, get it all finished and done, it is all part of closure. It’s what I needed” (37).

Individuals who believed they were not offered guidance, or informed of relevant legal, procedural and administrative processes provided consistent accounts, and in some cases were able to reflect on the consequent negative impact.

We weren’t even told about it. We weren’t told anything. Mum got a letter basically saying the Coroner’s report is back and this was like a year afterwards. (14)

Nobody offered, nobody told us where his body was or anything. But even then nobody told them that they could go see their brother. (3)

No one ever told me. I didn’t find out until two years later that I could actually go in and read the report. I didn’t know that. (2)

Nobody told us anything about the whole process that would happen, just that we could deny an autopsy if we wanted…. (41)

Nobody contacted us. My sister found out where he was. We didn’t even know where he’d gone. We just got left with a dead body and they never said anything to us. (8)

You see I’ve never actually lost anyone prior to my mother. I didn’t even know the procedure and I’d never even been to a funeral. (23)

I just presumed the police statement was what I did on the day. I didn’t realise that I had to do another big long interview. They didn’t tell me. (27)

The worst was just not knowing what was going on. It left me feeling even more distressed and helpless. (22)
It is important to note the frequent use of the words *no one* and *nobody*, indicating that not only did participants not have the information or guidance they desired, but that this was further compounded by the fact that they did not actually know who was supposed to be providing them with such information. In a world where we generally have unlimited and easy access to most information, it is easy to see that to suddenly be placed in a position of not knowing what or who to ask, may leave a survivor feeling powerless and overwhelmed. A participant summarised her confusion by stating:

"You see somewhere along the line somebody should have told us about where his body was and what was going on. Now I don't know whether that's the police, the ambulance that take him, who is it? Who's the one that's responsible there? Somewhere that morning somebody should've been able to tell us that we were welcome to go and visit him, and where he was. Believe it or not, we didn't even know where the mortuary was, you know what I mean? Whether it was at Royal Perth, or whether it's Charlie Gardiners. I know now where it was, where it is, but I didn't at the time. (3)"

Interestingly, this lack of guidance and lack of knowledge about who should be providing it, also appeared to be of particular significance for parents who, as a consequence of their spouse’s suicide, needed to manage their bereaved children. Parents in this study drew unanimous attention to the lack of informed guidelines and advice on how best to deal with their bereaved children. Serious long-term implications for both the parent and the child can and did result from such a dearth of information, including parents making child-related decisions that they later came to regret.

"And the other thing, I would've liked for someone to have said, "Do you have other children? Would you like to bring them down to say goodbye to their brother?" Because they didn't see him then for another week, at the viewing and by then he looked like a wax effigy. And I think that was a huge shock to them. I really would've liked to have (Name of deceased’s brother) and (Name of deceased’s sister) come to say goodbye to him there. (2)"
I didn’t know what the best thing to do with my kids was. As it was at the time I had limited contact with them, but I decided to leave them to their own devices. I wasn’t advised either way though. As it turns out, I’ve had no contact with them at all since she died. It’s a big regret for me. I just didn’t know then what the best was. (19)

My boys came with me. I didn’t know what to do with the girls and I didn’t know what would be the best thing. I kind of didn’t want them to come to the funeral because they were so little and I think it would have upset people to see them there. I think it probably would have been helpful for the girls to see him. I think now it would have given them a bit of closure. They still thought he was going to come back. But you don’t get anybody saying what’s the best thing. And you ask people what do you think and they say I don’t know it’s up to you. I just had to make a million decisions in the last few days. I just don’t know what to do. (33)

In one case, a participant was guided in the decision-making by her parents but felt that,

...mistakes were made because of that. The biggest mistake was not taking the children to the funeral. Everything I did they should have done with me and if I did it again what would I do differently? Take the kids. (39)

The impact of this lack of appropriate guidance is not restricted to the death of a parent however, as evidenced by the comment of a mother who was unsure how to best deal with her child whose sibling had died. This quote again serves to highlight the notion that participants had consistently but unsuccessfully sought out someone or had hoped someone would guide them through this time.

I think my daughter wasn’t happy with that in retrospect but we tried to shield her and that was probably the wrong thing to do. Nobody was there to tell us to sort of give us any guidelines. (42)

Support for the notion that a sense of being unable to directly control past or present events exacerbates and compounds the stressful nature of an event, is found throughout the literature (e.g., Janoff-Bulman & Timko, 1987; O'Brien, 1998). Park and Folkman (1997) believe that whilst traumatic events violate people’s sense of control, the stressful nature of such experiences may be actually be alleviated by their attempts
to regain such control. Taylor and Brown (1988) also stated that the illusion of control can buffer the impact of stressful events. Thus, in a case of suicide where a survivor certainly may already feel that the event was out of their control, having no information about what happens afterwards can compound and exacerbate this feeling. From the data it did appear that participants’ thwarted efforts to reassert some form of control over the situation may have stifled their attempts at effective coping behaviour and gaining a sense of coherence and meaning regarding the event. In the present study, the fact that the loved one’s body was taken away by strangers, exposed to unknown procedures, and that the survivors were largely unaware and uninformed about subsequent procedures, was seen to have had a negative impact on the bereaved.

(Name of deceased) had to be embalmed, and to this day... I have a sort of a vague idea of what the Egyptians used to do about embalming, but what did they do to (Name of deceased)? And did they take any of his organs out? Did they put them back in? You know, in the casket. These are the questions I still have that I need to answer for myself. But none of that information was available. I wanted to know what process did they put his body through? I know he’s not there anymore, but what happens to that little body? I’ve been thinking about that lately and I will go to the funeral director and ask them. Because it’s something I want to put at rest. It’s stuff I really need to know. (2)

We were just told he had to have an autopsy because he died. ... but he died because he hung himself. Isn't that obvious? Why did he have to have his brain weighed to find out that he hung himself? I never understood. It gives me the shits. Why do they have to mutilate him after he's dead? I've asked many times, can they find anything in his brain that told him, told me that he was depressed? And they say ‘No, you can't do that.” Well if they can't do that, what do they do it for? What do they take them to bits for? (3)

Maybe if I’d just been kept up to date with what was happening, maybe that would’ve made things a bit easier. I mean I don’t know, but I think it might have, even just a tiny bit. (20)

The data suggested that the need to understand exactly what had happened to their loved one, complete with all relevant details, was of particular relevance. This need for and importance of providing family members with these technical details is
also found within the literature (e.g., Hall & Epp, 2001). Again, the retrieval of such information may allow the survivors to feel more in control of proceedings and events, and this in turn may limit the negative impact of this traumatic event. In addition, learning more about the suicide may aid with facing the reality of the death. Jordan (2001) supports the need for sharing such information with survivors and suggests that service providers should offer many structured and informal opportunities for survivors to learn more about the suicide. The essence of what many participants said in relation to wanting details was succinctly captured in the following few quotes:

...we had to ask exactly where it happened, because I needed to go there. They did warn us that there was a photo there. And I said “No, I want to have a look”. I needed to do that. And there was a photo of him, in the car, which I needed to have a look at because I guess that was his last moment before death. (1)

I was trying to find out at what point she died. It seemed important to me as to what time in that Thursday that she actually died. I just wanted to know what time in that day she wasn’t here. And then it’s quite a few weeks before you get the full results of that autopsy, you know about the contents of the stomach and were there any drugs present and that sort of thing. I wanted to know those things. (7)

...it’s more the details. We were just told basics like the ambulance was rung. I didn’t know that he didn’t die once he had jumped. He was actually alive. I want to know who he was with, when did he get there, what was he wearing, what did he have? There’s all these questions and I think again that will be closure and that’s important.... (16)

I did ring the Coroner’s office once I received the letter to say about their findings on the cause of death, which obviously was multiple injuries, which is all well and good, but it’s not good enough. I need to know more. I think I rang them and said “Look, I need a bit of closure here. I need to know what he had in his system.” (15)

In this instance, the death had occurred in December and the participant had telephoned the Office of the State Coroner in January, however they were closed for vacation. She was told to telephone again in mid February, but the report had not yet been completed. At the time of the research interview in mid March, she had still not
heard from them and summed up her feelings by commenting, 
"...they obviously don't understand. The fact that I don't know the details is still really nagging at me" (15).

Individuals may find the details reassuring as exemplified by one participant, whose son's partner had been present when the son suicided, 
"(Name of partner) told us everything in detail - how he laid, his appearance. I felt comforted" (30). This reassurance may also stem from the fact that, in the case of sudden or accidental deaths, the bereaveds' fantasies of mutilation and destruction are often far worse than the actual damage (Raphael, 1985). Participants alluded to the deleterious impact of such uninformed visions, as well as the benefit of dispelling them once informed of the correct details.

The park where he died was really beautiful. The picture that I had before seeing it was sort of a dirty park with drunkards and homeless people lying everywhere. The picture I was left with was that it was very peaceful. (5)

...he did say with the fall itself, he wouldn't have suffered. He wouldn't have felt anything. It would have been so quick, so painless and that made me feel a bit better to. That was my biggest fear.... (15)

For me personally, I just wanted to know the way it happened...so the image in my mind...I can't tell you what that's like. You go to bed with it and wake up with it. All I could see is him just falling and I can't help him. (18)

It was then that I realized I had misconceptions about where he died because I had not been able to face its physical reality. (30)

One participant had found it valuable to read the statements from the different people who had been present when her son died, and which had been recorded in the investigation reports. She commented:

So, that was good because I dreamt for so long after his death and the dreams were what happened to him, was he flown...that was my memory of him, visions of him flying through the air. Getting hit, or dragged under. That was my big thing. Was he dragged under and mangled? But he wasn't. So that put that to rest. I think for me personally, I would want to know all the details. I know that there were witnesses and I know that people saw it happen. (2)
Turner (1983) postulated that “informational aid” (which includes advice, details, personal feedback and information that may help with understanding) can actually be construed as a form of social support. As mentioned earlier, social support has been found to be instrumental in buffering or reducing the deleterious impacts of exposure to stressful life events (see Chapter Two). Thus, a dearth of informational aid for suicide survivors would surely have the same impact as a paucity in social support would, consequently challenging healthy grieving processes.

In addition to the lack of information and guidance, another problematic area for participants was their experience that the onus was on them to pursue outstanding information. This at a time when they lacked the energy or capacity to make overtures to others, or “... were in no state to be ringing around after people” (6). Reports such as, “It was up to me to phone them, get the answers and follow up actually. I had to ask for all those details though” (15), “I eventually found out what I needed to know from the Coroner’s office, after I had phoned up for the 100th time” (27), and “I was really disappointed because I had to find everything myself” (43) were all too common.

At a time when survivors are confronting the tasks of understanding what has happened and managing the resultant emotional sequelae, when thought patterns may be irrational or incoherent, and when individuals are immersed in a traumatic and novel situation, it is easy to see how survivors may find searching for information and support to be distressing and challenging. This “having to search” may compound the survivor’s feelings of powerlessness and not being in control, which in turn may make the whole experience additionally harrowing.

Besides the search for information and guidance, participants also seemed to experience a pervasive and basic search for meaning regarding the suicide. As one participant said, “I think the only question that is running through your mind at that stage is, Why? Why? Why? Why? Why did it happen?” (1). The literature in this field
suggests that, when compared to other forms of mourning, suicide survivors typically spend much more time and energy trying to comprehend the reasons for the death and the motivations of the deceased (Jordan, 2001; Knieper, 1999; Ness & Pfeffer, 1990).

This search for meaning plays an instrumental role in aiding to comprehend, understand and accept an event (Tedeschi & Calhoun, 1995). Park and Folkman (1997) distinguished between two levels of meaning, namely global meaning and situational meaning. Global meaning refers to people's assumptions about the world, about the self, and about the self in the world. They include assumptions about order, justice and fairness, the distribution of positive and negative events, how benevolent the world is and beliefs about the extent to which we have control over our environment and existence (Park & Folkman, 1997; Tedeschi & Calhoun, 1995). Situational meaning refers to people's interpretations of specific events and experiences within the context of their unique global meanings. Thus, the meaning that a survivor ascribes to a family member's suicide is directly influenced by their unique global meanings. This meaning and interpretation ultimately influences how they react to, deal with and make sense of stressful experiences and events (Park & Folkman, 1997).

The presence of this underlying question regarding the deceased's motives (one that is seldom satisfactorily answered), may mean that the impact of the lack of information and guidance is even more acutely experienced by survivors. Because the questions surrounding the motivation are so pervasive, the need to have answers about those aspects which survivors can have answers to becomes even more crucial. It is therefore understandable how the lack of answers to even the most basic questions can be frustrating and perceived to be an obstruction in the bereaved's grieving process.
Interactions with Others

Inappropriate and Insensitive Interactions

Numerous studies have found that the public may react differently to those bereaved by suicide than to those bereaved by other modes of death, often reflecting more difficulty expressing sympathy, more ignorance about what to do, and more discomfort approaching survivors (Calhoun et al., 1984; Jordan, 2001; Van Dongen, 1993). This may be why participants in this study relayed numerous examples of interactions that they perceived to be insensitive and inappropriate, such as:

Oh you're a tough old wally, you'll get over this. At least your kids aren't giving you any more problems. You oughta see my bloody daughter, she's pregnant now. (3)

Such comments were possibly more keenly experienced, as according to several participants, "You become so sensitive afterwards" (6), and "I reacted to every word that seemed loaded, and at that time, they all did" (12). This increased sensitivity may possibly be compounded by "self-stigmatization", a process whereby survivors assume that others are judging them, which results in survivors misinterpreting others' intentions or comments (Jordan, 2001). Either way, the data was replete with examples of inappropriate interactions which participants found offensive and hurtful. Often even more hurtful were inappropriate comments from service providers who participants believed should have known better. Examples of deficient support or inappropriate comments include those reportedly made by social workers at the Office of the State Coroner who commented, "Steer away from the people who've lost someone twenty years ago and are still grieving" (2), and "It was his choice not to be there so you have to accept that. You've got four sons not just one" (27). A participant recalled getting furious with a doctor who tried to placate her with the platitude, "He's with God now", 
and responded, “I fucking know he’s with God I don’t need you to tell me that” (43).

Participants expressed strong negative emotions in relation to such comments, as did an individual who rang a crisis line, was placed on hold twenty minutes and was then told:

“I’m just so sorry. We’ve got nine calls on hold. I’m going to have to ask you to leave your number and I’ll ring you back”. That’s no good. It’s just no good. I couldn’t believe he said that to me. (7)

The importance of empathic understanding and interactions from others is highlighted by Thoits (1986), who postulated that such an understanding not only validates the distressed person’s reactions, but is also more likely to engender feelings of acceptance on behalf of the empathic helper. Thoits further commented that when distressed individuals are in the presence of others whom they feel display such empathic qualities, they are more likely to focus on the process of grieving and coping.

Extrapolating from this approach then, it can be seen how inappropriate and insensitive reactions from those around the survivor, whether service providers or the public at large, can potentially exacerbate any feelings of rejection which often accompany and stem from a suicidal death. This may consequently thwart survivors’ attempts at a healthy grieving process. Additional support for the impact of inappropriate interactions with specially trained service providers is also evident in the section entitled ‘Mental health professionals’, in Chapter Six of this thesis.

The Importance of Ongoing Support

In terms of support for survivors, it was not just the need for appropriate support that was mentioned, but also the need for timely support, with many survivors expressing a need for ongoing support in the months following the funeral. As previously mentioned, the days following the suicide are characterized by feelings of shock and confusion, an inability to make decisions although needing to attend to
arrangements and planning, and involvement in numerous administrative and procedural activities. It is thus a busy time for survivors, often resulting in their inadvertent avoidance of facing the reality of the death.

I was so busy in probably the first month I just didn’t have time to... I always had to be somewhere, meet someone, talk to someone. I found when that month was over, I had all this time and then it hit me. When I was busy, I didn’t have to feel, I didn’t have to grieve and then all of a sudden I didn’t have any more appointments and everyone goes home and everyone goes back to their families. (15)

The funeral generally serves as an opportunity for others to pay their respects to the deceased, and for many this is the last contact they may have with the bereaved family members. As a couple of participants commented:

...after the funeral is over everyone goes back to their little nests and their lives and what do you do with all this stuff. You feel left behind.... (16)

People were very supportive up until the funeral and the funeral is over and there’s nobody around. ....and so you’re still crying and feeling distraught and they’re not there. I was astounded by that. That I felt really very bad about. (21)

However, the reality of the death often only starts to be felt by the survivor subsequent to the funeral, a period when fewer demands are made on their time and energy. Several participants commented that it was actually during this time that support appeared to dissipate, despite their acute need for it. Comments such as, “After about three or four weeks, unless you’ve got a strong band of friends and family, that’s when you’re left on your own” (2), and “Most people, the first few months they’re there and then they think you should be over it and it doesn’t happen like that. It’s part of you” (27) were common.
Although this pattern may be evident following any death, the consistency with which it was mentioned, together with the complexity of suicide grief and normative perceptions about survivors, emphasize the need for support during this time. The following comments advocate this:

I think you need more support after the funeral than before. They see the funeral as the end of it. They don't see that the people left behind grieving might be for quite some time. You need the support after the funeral. (22)

There is no follow up after two or three weeks. That was it. It was like there wasn't a system in place where somebody knocked on your door after a month and said, "... how are you coping now that things have sunk in?" (25)

In summary, the data suggests that the subjective state of the survivor upon being notified of their loved one's suicide influenced their ability to access the information that they desired. The novelty of particular experiences, the perceived lack of guidance from informed individuals, and the involvement of numerous different service providers, seemed to compound participants' feelings of a lack of control over the situation. In addition, participants suggested that inappropriate and insensitive interactions with others and a lack of ongoing support also had a detrimental impact on the bereavement experience.
In the time following the suicide, participants had interactions and involvements with several different service providers. Not all participants had experiences with all of the service providers however, and in fact, some had no such contact or engagement with services at all. Most of the interactions that did occur, occurred in the process of service providers carrying out their official duties. Whilst it is difficult to distinguish clearly between issues of interaction and those of procedure, participants had much to say about their experiences of such service providers, both in terms of procedural aspects, and in terms of their manner of interaction and conduct. This chapter initially focuses attention on survivors' experiences of a number of procedures that are specific to individual service providers. Participants' accounts of other more general procedures or processes, which are not exclusive to any particular service provider but were deemed to be influential to the bereavement experience, are then explored.

**Specific Procedures**

In focussing on a number of prime procedural areas that participants consistently highlighted, attention is given to the ambulance services, police, contractor, coroner, clergy, mental health professionals, and airline services.

**Ambulance.** Several survivors expressed deep-seated discontent regarding procedures implemented by the ambulance service provider. There appeared to be two issues of primary importance, and whilst both may be individually construed as distressing experiences, I suggest that their joint occurrence qualifies for what many described as brutally inconsiderate and tactless practices.

Firstly, as previously mentioned, for many survivors this was their first encounter with a death, and consequently with a number of the service providers as well. Their knowledge of relevant procedures was thus understandably limited. In the
case where an ambulance attended the scene of the death, survivors reported being affronted when informed that the ambulance would not transport deceased individuals. Whether it was the manner in which this was done, or the fact that these words may have shattered the survivor’s hopes and expectations, or that they may have actually sparked the process of engaging with the reality of the death, several survivors seemed surprised and hurt by this practice, as evidenced by one such comment:

The ambulance arrived but didn’t take his body. That contractor did. I sort of felt that was really cold. That really hurt me because I thought, Okay he’s dead but why ignore him? (27)

Secondly, in addition to the distress that resulted from this news, a mother and sister of a deceased young man were appalled when,

...the ambulance people had arrived and sort of said to (Name of participant), “We don’t take dead bodies”. Then after that, we also got a bill. They sent us this $300 bill. They didn’t even take him, and we sent it back .... (8)

Such an incident would be distressing enough were it an isolated case of an administrative blunder. However, numerous participants spoke of their anguish when they too received a bill from the ambulance company. In an attempt to illustrate the scope of this practice, a selection of relevant comments read:

The next thing I get is them phoning up the bill for the ambulance and I was so mad you know. ...he’s dead you know you didn’t do anything. You left someone who’s dead there and then you send out a bill. You know we had to pay for them to come out and they didn’t do anything. (27)

I remember getting a bill from (Name of service provider). They had called the ambulance but he was already dead and I got this bill for $400 from the ambulance. I wrote back and said I’m not paying. They let it go. If I’d had the money I would have paid it. I didn’t know any better. (33)
We got an ambulance bill...300 and something odd dollars and I wrote back and I said, "Sorry but I'm not paying this bill". They came here and said, "Sorry we can't help you", and went again. We only live half a mile from Fremantle hospital. They never administered medication, they never did anything. ...and we had bills still coming in two years later from (Name of Service Provider). We even had Melbourne ring up. The head office. (36)

They put like credit, you know people who chase you for money.... It was $300 odd...you know 50 odd or something maybe...just the petrol from here to Fremantle you might think about, but I couldn't believe it. They kept on and on and on about it. Trying to get this...and we were not the only ones. A few at our suicide group...there were a couple of others. (38)

Interestingly, such an experience was not location specific and was mirrored by reports from participants who experienced an identical procedure in other Australian States. In this particular example, the administrative procedure is even more inappropriate in that the deceased individual was charged for the ambulance services.

I do remember months later my father got an ambulance bill addressed to her. Not only had they done nothing when they got to our house that night, but it was addressed to her. I remember that was very upsetting for him. (26)

Whilst it would be hoped that this was simply a gross administrative blunder, the fact that two other participants relayed similar experiences would suggest otherwise. A greater number of survivors reported receiving an account from the ambulance company for what was deemed to be non-existent, negligible or limited services rendered however. It would thus appear that this specific course of action is part of the organizations’ national policy of practise, and in the words of a disillusioned parent, "The ambulance administrative procedures sucked. They were very hurtful" (4).

In an attempt to follow up on the issues highlighted by participants, I made telephone contact with an employee at the West Australian branch of this nation-wide service provider. My queries related to the organization’s policies and procedures regarding the billing of individuals for services rendered, as well as the transportation of
dead bodies. I was informed that the company has uniform countrywide policies, that the company is not licensed to transport dead bodies, and that it is standard procedure to bill the deceased's family for the ambulance's attendance, irrespective of any service administered to the deceased. I was also informed, "...if we know there is money attached to the estate, such as private health care or a will, we do pursue the family in order to get the bill paid. If there is no money, we generally let it go" (Employee in Accounts Department, personal communication, August 2, 2004). In the case where the deceased's money is managed by the Office of Public Trustees, the bill is sent to them, or where there are no such funds, or no will, the family is required to provide a Statutory Declaration, attesting to this fact, to the organization, and the bill is nullified.

Police. In terms of police involvement, the two issues highlighted by participants related to the manner in which interviews were conducted, and the nature of the questions asked during such interviews. The police procedure in metropolitan WA following a suicide necessitates at least one interview with the deceased's senior next of kin. The first interview is generally conducted by the original police officers on the scene, and is most likely to be undertaken with the person who found the body, or had contact with the deceased immediately prior to their death. The primary aim of this interview is to collect details regarding the circumstances surrounding the death. In addition to this interview, a more thorough and comprehensive interview is undertaken with the senior next of kin and is conducted by a Police Coronial Inquiry Officer. The aim of this interview is to gain additional information about the deceased in order to assist the Coroner reach an informed conclusion regarding the manner of death. Whilst it is important to remain cognisant of the subjectivity of survivors' perceptions, as well as the potential for heightened sensitivity during the aftermath of a suicide (see Chapter Two), the consistency of negative comments and experiences indicate areas that may benefit from immediate and significant improvement. Interviews reported as poorly
handled appeared to have two overriding features: the nature of the questions and manner in which they were asked left participants feeling guilty and blamed.

The following comments relate to the initial enquiry interview and consistently relate how participants felt interrogated by what appears to be the manner of questioning. Participants went so far as to suggest that they felt like they were actually murder suspects in their loved one’s death, and expressed anger and disbelief about such insinuations, and about how some police continued to relentlessly question the circumstances surrounding the death. Comments similar to the following were all too common:

...and then the police interrogated us. Interrogated me. They were very rude. It almost felt like we were to blame. (9)

I honestly felt like they thought I’d done it. (14)

... he saw me getting distressed about the whole thing because I was bawling my eyes out and he just kept hammering me and I'm like “hang on I'm not on trial. I didn't do anything wrong”. (8)

Survivors often assume responsibility for somehow causing or not preventing a suicide (Ellenbogen & Gratton, 2001; Jordan, 2001). Whilst such assumptions are invariably flawed, experiencing an interview that leaves survivors feeling blamed can only exacerbate this situation, with the risk of additionally deleterious outcomes for the bereaved. As two participants stated, “The interrogation type questions has made a big impact, has stayed with me big time” (8), and “Because we were the last ones in the house with him alive, they made us feel pretty rotten” (3). An elderly mother became increasingly agitated when relating that not only did she feel blamed during the interview, but that the police officer had conducted the interview over the telephone.
The police didn’t come out they rang me on the phone. They never came out. They did it on the 'phone which I thought was a bit tacky. You know nobody was here. I was on my own. They’ve got no idea. I lost my temper with the guy the third time he phoned me. I really felt like I had to defend myself during the interview. The questions were bad enough, really pointed and left me feeling that I was to blame. Then the manner of the guy who was interviewing me. It was just awful. I ended up telling him to get fucked. (44).

A final example serves to best illustrate the potentially harmful ramifications of such an experience. The event was relayed by a participant who stated that, as a result of the interview, she felt entirely responsible for her brother’s death and attributes a subsequent and serious emotional breakdown to the impact of this interview.

I got drilled for two hours... they made me feel like I killed him. I was very angry. They actually started making me think that if I had rung the ambulance straight away my brother would still be here today. But we found out from the coroner that that would not have happened anyway and I spent a good year and a half thinking that. I ended up in a psyche ward and everything else because of that. (14)

In the case of this initial interview, the interviewer’s lack of sensitivity and appropriate interpersonal skills appear to have aggravated an already distressing event. In the second interview however, the interviewer’s manner, as well as the actual content of the questions, appeared to have left survivors feeling distressed and traumatized. Several participants reported similar stories to this mother who believed that,

...the questions were designed to convince them, and convince the Coroner that it was her fault. You know, that it was inevitable that was she was going to kill herself, because not only did they ask me to tell them her mental health history, but they also said to me, “And what was she like as a child? Did you think when she was a pre-school child, that was different to all of the rest of the children? Did she have friends or was she a loner in high school?” All of those questions... I found terribly stressful. I went away feeling I had to make it easy for the coroner to reach the conclusion that she had serious mental problems and that it was inevitable that she was going to kill herself and somehow she deserved to die and if she hadn’t killed herself she would have just gone on suffering. It was very hurtful... (4)
A bereaved wife also relayed feeling pressured by the police to answer questions in a certain way, and told how she felt uncomfortable being alone with the investigating officer in case, due to her state of grief, she was manipulated into answering a question in a particular way.

As mentioned earlier, survivors may be feeling unsure of themselves and that they have little control over the situation, and perceptions of unjust persecution by the police may cause additional strain. In fact, Sheskin and Wallace (1976) found that the contact and involvement of officials and the police actually emphasizes the “differentness” of a suicidal death which in turn creates additional stress for the family. Sadly, the majority of survivors interviewed in this study collectively suggested that the police afford little respect to the relationship between them and their deceased loved one, and that all processes were aimed ostensibly at ensuring a smooth and uneventful administrative procedure for themselves and the Coroner.

It was all just so completely disrespectful. And that was what I think was my most clear impression was…they all just wanted to get rid of this flotsam and jetsam and just pretend, because nobody cared, not one of them. And I loved him. I cared for him. It really hurt. (8)

He (the investigating officer) was such a dickhead. He just didn’t have any empathy. It was one of the first things I noticed. He was just going through the motions. (41)

The far-reaching impact of these unsatisfactory interactions with police is aptly summed up in the following comment:

I just can’t seem to let it go. It’s been 7 years now and I still won’t have anything to do with coppers. The way they carried on that night. It really grates me. When I think back on it now it just makes my blood boil. (12)
**Government contractor.** As previously mentioned, the body of a deceased individual is collected and transported to the State mortuary by an individual who is expressly contracted to undertake this task. This person is neither a member of the police force nor an employee of the Office of the State Coroner, and is contracted for the job following a successful tender. According to an employee at the Office of the State Coroner, contracts are usually awarded for approximately 18 months (D. Dent, personal communication, September 7, 2004). The “contractor” is neither required nor intended to have any contact with the family or other individuals at the location of the body. Furthermore, it appears that the contractor is not formally accountable to any service provider, and there are no procedures that allow for the evaluation and appraisal of their actions. This is even more concerning in that a number of participants did in fact have interactions with the contractor, all of which were deemed to be less than satisfactory.

In two cases, the contractor took more than three hours to attend the scene, which meant that families were left with the body of their loved one in the house. In one of these instances the body was left lying across the entrance to the bathroom which necessitated family members stepping over it when entering the bathroom.

That was probably the most... I mean (Name of deceased)’s death was distressing but that was the most distressing part was you couldn't go anywhere because his body was just there and it just felt wrong to sort of step over him. (37)

Periods before the contractor arrived were reported as disturbingly long for the family, even in cases where the contractor had arrived in a timely manner. Families were informed either by the police or by the contractor that reasons for delays were primarily related to an immediate work-overload. One family member who was told by police that there had been six deaths in the previous hour stated:
I really didn't care how many there had been. For us it was only one, and that’s how we should’ve been made to feel. It felt like (Name of deceased) was just a nameless statistic waiting in line to be collected. (37)

In these instances, the police departed upon completion of the initial interview and the families were consequently left alone with the body of the deceased until the contractor arrived. The insinuation that for service providers this whole process is simply part of their job, while for survivors it is a traumatic time of huge suffering, is noteworthy and was frequently alluded to.

... the guy I actually dealt with said I can’t tell you how many cases we have. Well, I’m not interested in that. I’m interested in my case. I don’t give a stuff what else they have on their plate. (18)

In what is perhaps the most disturbing and horrific account, the contractor arrived late at night to fetch the body of a tall, young man who had died in a small sports car. He had suicided two days prior to being found and his body was therefore stiff and difficult to move. By all accounts the contractor was ill-prepared to remove the body, and had to rely on the help of the deceased’s best friend, while the research participant held a torch to enable them to see. According to both participants who were present when the contractor arrived, the police had left at 18h00 and the contractor arrived at 20h30.

8: The coroner guy (contractor) was about 5 foot 2 tall, and he arrived alone in a station wagon. (Name of deceased) was 6 ft 3...there was absolutely no way in the world that that man could’ve got (Name of deceased)’s body into the station wagon alone. He left me holding a torch because he was trying, he was on the passenger side sort of pushing from one side. (Name of deceased’s best friend) was on the driver’s side trying to get (Name of deceased) out. I just found it unacceptable.
8: I’m holding a torch and (Name of deceased’s best friend) had to get the body out of the car. That’s what I think upsets me the most.

9: (Name of deceased’s best friend) did the lot. He even zipped the body-bag up. I mean it shouldn’t have happened. He (contractor) didn’t say a word. He just honestly didn’t say a word. He just sort of checked out the fact that there was no way in the world he was going to be able to do this, and then just left it up to (Name of deceased’s best friend) to organise. I mean he had to bend the body is what I mean. Without being too graphic he had to force the body out of a very slim space, and the body was stiff... and not smelling very nice. And (Name of deceased’s best friend) did it. I don’t think the bloke even offered (Name of deceased’s best friend) gloves or anything.

The participant who witnessed this unfortunate episode concluded by saying that the whole event took on a nightmarish feel and that she remains haunted by the visions of what happened.

And there was no light, it was an old-fashioned place, there was no light, there was nothing. It was like I said, pouring with rain, freezing cold... and the whole thing took on a nightmarish feeling to it. It was bizarre. At the time, you don’t know what is supposed to happen, but if this is what’s supposed to happen... It’s fucked. It’s just like a bad dream. (8)

The other participant, who was present while these events unfolded, expressed grave concern for the impact which this has subsequently had on the deceased’s best friend.

... and (Name of deceased’s best friend) has got to live with that forever. That’s what I think still really upsets me... the impact it has had on (Name of deceased’s best friend). (9)

*Office of the State Coroner.* Following the lack of information and guidance, the other aspect that received the most consistent commentary from participants, related to specific experiences or procedures of the Office of the State Coroner. As previously mentioned, the Police Coronial Inquiry section undertakes investigations into a suicide. It then provides the Coroner with a comprehensive report that the Coroner uses to assist in reaching a conclusion about the manner of death. During the police investigation, as much information as possible is obtained from those who had some connection or
involvement with the deceased. This may include employers and medical professionals. According to an employee at the Office of the State Coroner, the Coroner usually "allows" for approximately three months for this investigation to be completed, a timeframe that is not always stringently enforced (D. Dent, personal communication, September 7, 2004). The Coroner then examines all reports and either reaches a conclusion as to the manner of death, or decides it is necessary to hold an inquest into the death. Where no such inquest is held, the Coroner's final notification of how the deceased died may still take many months to reach the bereaved family. In one case, "I got a report a year later. It was almost the anniversary to the day I got a report saying that they'd done a tox [sic] screening of his blood and that came almost on the anniversary" (24).

Several participants found this delay in receiving final notification to be inexcusably long. In accordance with the earlier comments about not having information regarding procedures and administrative proceedings, survivors expressed confusion about why they had to wait for so long. This may again compound feelings of powerlessness and a lack of control. In addition, I would argue that an extended length of time between the death and the final notification may serve to delay the survivor's personal closure and grieving process. The act of seeing information in print seemed to assist survivors in facing reality and in assimilating the information, "...that was something that was the best, getting that report, it brought such a lot of closure for me..." (30), and as one participant who had waited seven months before receiving the final report summarised, "It's an awfully long time to wait...you sort of can't finalise anything for yourself until that happens. When it actually came, it hit hard because it's down in writing that it's real whereas that should have come way before" (27).

In addition to delays in receiving this final notification, the data suggested that what appeared to aggrieve survivors even more was the fact that they could not have
copies of the Coroner’s final report. This report contains all the information that the police collect during their investigation, and may thus include any reports written by mental health professionals and counsellors. Bereaved family members may attend the Office of the State Coroner and read the final report, but are denied personal or separate copies. In cases where extremely sensitive or confidential information is contained within the report, this is removed before the families have access to the file (D. Dent, personal communication, September 7, 2004). For many participants the denial of a copy of this report again served to delay or thwart their closure, as well as compound the feeling that they have no rights in the process at all. While there were many comments that expressed participants disdain with this course of action, the following summarise what for many was perceived to be another painfully blunt example of disregard.

They send you a letter to say that you can come in and get the report at the coroner's office. You have to sit in there and read it, which I think stinks. And you're still numb. And my husband and I staggered in there and read it and stayed in there for ages. They were very good, but they don't understand. But since then, about three months ago, it was through (Name of friend), that I met a counsellor at the coroner, (Name of employee)...and she goes...“you can go back and read it all again”. But still, I still reckon we should be entitled properly though to have a copy at least. It's our son, why aren't we? Why is it all done through the Coroner? (3)

The other thing that upsets me and angers me is that I'm unable to get copies of the various reports that the Coroner had. I could go read them, that was fine, but I cannot have copies. Now, it is not about her personal information, it's about, it's a medical report they don't want released to protect themselves from potential litigation. Now, that's just unacceptable. People like myself, all of my reports are available to people because I'm held accountable for the conclusions I reach and the comments I make. What makes them different from the rest of us human beings? I don't suspect that anybody's culpable. What they don't understand is all of those things are like pieces of my daughter. And I want them to hold on to. (4)

They won't let me have anything else, but they did let me have a copy of the suicide note. I was so upset because I felt that everything in that file should have been available to me to bring and put with all my (Name of deceased)'s stuff. I
felt very strongly... and if I'd had one of those little cameras I could have photographed everything. (7)

It's funny. It's like I had full responsibility of my child as she grew up, but the moment she died, she was no longer mine. Almost like she became the property of the State. I think that is what happens, well at least how they see it anyway. The point is, I need closure. I want all that is left of her, and all that relates to her, I want it together. It's the least I can have. This whole thing about not having the final report... it's just a load of bullshit. Fucking painful. It's like such a kick in the face. It's just not right. (18)

Of all the themes verbalized by participants in this study, none was expressed with as much affect as this one. What is also interesting to note is how the participants who reflected on this theme, consistently referred to someone who they perceived to be controlling the situation and responsible for granting permission for certain activities or actions. Terms such as allowed us, let me and granted us access to, all suggest that these participants felt that their actions and rights were determined by a person of power within the relevant organization.

When I queried an employee of the Office of the State Coroner about the policy of limiting access to this report, I was told that the information collected is for the express purpose of assisting the Coroner in reaching an informed conclusion, and not for the benefit of the family (D. Dent, personal communication, September 7, 2004). It goes without saying though that if the reports and details provide the Coroner with information to better understand the situation and circumstances surrounding the death, it may do the same for the family who are invariably questioning the motives of the deceased. It may therefore assist family members in finding answers to questions that may otherwise go unanswered. This was especially evident in a case where a grave error on behalf of the police had meant that a mother did not know of, and had not seen, the suicide note left by her child. The death was totally unexpected and the mother was completely oblivious as to what may have triggered her child to suicide. When informed by a friend that she could have access to the Coroner's report, she found the suicide note
for the first time. Whilst it provided her with many answers, her distress at not being notified of the letter in the first place was clearly devastating.

It was on her computer at work, and her employer had phoned the police, called the police in, they'd taken copies of the suicide note and didn't let me know. I think that was very shocking... somebody, somewhere in that sequence should've been in touch with me. Because if I hadn't gone to read the report, I would never have known. In a way it answered the questions that I'd been asking; "Why did she do it?" It did bring, it took a little while, but it did bring a certain amount of closure to that. I was just devastated that no-one had bothered to let me know about it. (7)

Although I am not suggesting that the report be made available for the purpose of providing bereaved family members with answers to pervasive questions, I am suggesting that this may be one possible benefit of such access. I can understand that the report may contain personal and confidential information that may be painful for those left behind. However, in light of the literature that shows how beneficial it is for sudden death survivors to have information and details regarding the death, and from the responses of the research participants, it seems that the importance and benefit of survivors owning a copy of the Coroner's report warrants an exploration of better ways to deal with this situation.

_Clergy._ Another area in which numerous participants appear to have been disillusioned or disappointed, related to the lack of follow up support from clergy after the funeral. It appeared that survivors had an expectation regarding the manner of interactions and support offered by the clergy, and that when these expectations were not realised, intense disenchantment resulted. From the data, it seemed that survivors had an underlying belief that clergy members, by virtue of their vocation, should have a heightened awareness and sensitivity regarding the needs of survivors. Participants were clearly distressed when this did not eventuate.
...the priest was absolutely useless. He made no contact with us since the day we buried (Name of deceased). He didn't even come round and talk to us. And as a man of the cloth, I think he stinks... Not even to this day, has he been back. I mean, that says a lot for religion, ...when a man of the cloth couldn't even take the time to come and check. Oh, forget them (the Church). They're a lost cause. (3)

We had a minister who couldn't help us because it was beyond her. She'd only been a minister for a few years but she just couldn't handle it. We didn't get any help at all...she wasn't equipped and that is one thing sticks in my mind. It was rather strange that someone who is supposed to have a spiritual background couldn't help us....(10)

I think the priest should contact the family later too. I mean we weren't big church goers but at the same time if they're notified that they're going to be doing the thing or whatever I think it would be nice if they did call round or whatever and say I'm here, do you need any help. In actual fact, I can't tell you what the funeral service was like but a lot of people said that it wasn't nice and he was quite derogatory because he committed suicide. (42)

Whilst a number of participants reported a lack of follow up, this was the only participant who experienced some form of judgement, regarding the mode of death, on behalf of the priest. This was interesting as several participants told how they had actually been anxious and apprehensive about whether or not the Church and clergy would hold a funeral service for their loved one. Comments such as, “I was a bit worried that they may not want to accept him or bury him because of the fact that he killed himself?” (1), and “…my big thing, being a Catholic, was ‘would they accept him?’ because, you know, suicide’s been taboo for so long?” (2) were common. However, despite any early judgemental views within the Church regarding suicide, participants expressed relief upon hearing that this was no longer the case and that, “apparently all that has changed now and they don’t sort of take that into consideration anymore” (3).

Incidentally and ironically, instances of judgement on religious grounds still prevailed in other spheres of life. One participant told of being turned away from a garage owned by a Catholic mechanic when he heard that the engine of the car he was
about to fix had seized while someone had committed suicide therein. Thus, whilst it appears that the Church has in some ways softened or adjusted its views on issues that are relevant in contemporary society, the integral role that it may play in increasing awareness and educating the public about such issues needs to be realised.

_Funeral Company._ The funeral of the deceased serves a number of functions including the disposal of the body and the symbolic separation of the living from the dead (Raphael, 1985). Ultimately, both of these processes, when appropriately carried out, serve to facilitate the bereaved individual’s grief process. With respect to the present data, a variety of funeral-related issues that survivors had found particularly distressing, were mentioned. These issues were largely unique to each individual case thus saturation of the data was hard to achieve. Nevertheless, consensus was attained in relation to a number of positive experiences that a large proportion of participants had with one particular West Australian funeral company. It is worth exploring and discussing these experiences as the aspects that are highlighted by survivors go a long way to developing relevant and valid recommendations for other service providers.

The positive feedback received largely related to the manner of interactions, and the sensitivity and thoughtfulness that the employees of the company displayed. Participants commented on the understanding and caring attitudes, and stated that they were made to feel like the deceased was of great importance to the funeral company. This was in direct contrast to experiences mentioned earlier in this discussion, where survivors stated that other service providers had treated both them and their relationship with the deceased with blatant disregard. However it is consistent with the literature that highlights the comfort experienced by survivors when they perceive that the dead member mattered to the service provider (Raphael, 1985; Stewart et al., 2000). Words such as, “marvellous”, “fantastic” and “absolutely wonderful” were used to describe the type of service that these participants felt they had received.
In addition to the positive manner of interactions, other areas that were highlighted included the fact that the funeral company attended the family in their own home, "...they came to us...that's the difference. We didn't have to hunt them down" (40), and that they paid attention to details and seemingly minor matters that turned out to be very significant for the survivors.

They did all the make-up exactly. They had taken a photograph so they could do that. They had also taken some locks of her hair and just put them in little envelopes. If we'd wanted them they were there for us, and if we didn't that was fine. That was such a nice touch. (7)

Furthermore, survivors appreciated the offer of guidance and suggestions by people who obviously had experience in the field, as evidenced by the following comments:

They're really good. They're just so understanding which is what a funeral director has to be most of all. Just able to tell us how to go about things. (40)

They suggested a freeze, to put like a mural of old photographs to be put on the board. I think that's quite common, I think a lot funeral companies do that. And they suggested a really recent photo that everyone could relate to because (Name of deceased) was always changing her hair, so they had a lovely photograph on the casket. Very special. Not something I would've thought of, but because they are in the business...it just really shows. I really hold on to that. The kindness and thoughtful suggestions. (7)

Finally, the follow-up which this company instituted highlights the void or related deficiencies apparent in other services. In a case where the funeral had to be delayed, an employee rang the family every day until the funeral took place in order to maintain contact. In expressing her thoughts on this, the relevant participant stated, "...she did a really good job. I was actually really impressed with her" (14). This type of follow up had a significant impact on the bereaved, particularly in the case where, "One of the ladies called (Name of employee), was still ringing me up weeks later. It was so..."
touching. I found it very helpful” (7). In another instance, the director of the funeral company also telephoned the family on numerous occasions subsequent to the funeral.

Hearing such positive feedback about one particular company suggests that there is much to be learned and many areas in which other services can improve their manner of service provision. The extent of this company's commitment to issues of best practice can further be evidenced by the fact that it was one of their employees who attended a research presentation which I gave, and in turn invited me to attend their offices in order to gain information and develop a greater understanding of how a funeral company operates.

*Mental health professionals.* As mentioned earlier in this paper, a number of deceased individuals either were under the care of a mental health practitioner at the time of the suicide, or had recently been admitted to, or discharged from, a psychiatric hospital or clinic. In two separate cases, the deceased was denied admission to hospital only hours before their suicide, and in another case, the deceased suicided whilst a patient in hospital. Although this highlights the correlation between mental health issues and suicide rates, it also draws critical attention to the system into whose care we trust our loved ones. Whilst such experiences certainly warrant further attention, they are unfortunately beyond the scope of this study. However, a surprising number of participants also expressed disillusionment and disappointment with mental health practitioners within the mental health system. In reference to the present study, these mental health professionals all happened to be psychiatrists.

I went to see the psychiatrist and I didn't like the psychiatrist that much. For someone in that profession, I thought his attitude really sucked. My sister-in-law, who is also a doctor, says she felt he mishandled the whole thing. (41)

I was so angry, and still am. Angry at the professional people that charge heaps of money to help or are supposed to help you and who don't. (43)
The patient-physician relationship is supposed to be a caring and dynamic one, based on mutual respect and understanding (Glass, 1996; Veatch, 1991). Thus, by virtue of the relationship between a psychiatrist and their patient, it would not be unusual for people to expect a certain level of rapport, and mutual respect and care to exist. This would surely be evident by the actions of such a practitioner should something untoward happen to their patient. This was certainly the expectation of numerous participants who were surprised and hurt when it did not eventuate.

I just would've thought more of them [psychiatrists]. After all, isn’t that what they train for? For all their training, I could’ve done better myself. They had no clue what to do with us afterwards [the family]. (19)

I don’t think he was a good psychiatrist. I didn’t even get a letter from him afterwards. No kind of follow up to see how we were going. Even after my children and I had been to see him. Very disappointing. (41)

The mother of a deceased individual, who had had two treating psychiatrists at the time of her death, did not hear from either of them. Sadly, this was not an isolated experience. In the case where a young man died on a Saturday, his mother telephoned the psychiatrist on the Monday morning and left several messages informing him of her son’s death. She never heard back from him.

I never heard back from the psychiatrist. Never a thing. It made me cross. I was really mad at him and I sort of felt, I felt he should have actually rang me and said, “I’m really sorry this happened”. I was really mad with him. (27)

In this case, the participant greatly appreciated the fact that the nurses who were involved with the care of her son attended his funeral. Several participants mentioned that the treating psychiatrist should have attended the funeral but did not. Attendance at the deceased’s funeral may not only be seen as a sign of respect, but also as a testament
to the doctor-patient relationship, which it is hoped was in existence in the first place. Perhaps what compounded the survivors' disenchantment is that mental health practitioners are realistically expected to exhibit an extraordinary level of empathy and compassion for individuals in distress, and the lack of contact or funeral attendance was experienced as evidence to the contrary.

In addition to the contact from the psychiatrist demonstrating compassion and genuine care, it may also provide the family with an opportunity to gain some answers to the myriad of questions that surround them at this time. Ness and Pfeffer (1990) recommended that health professionals make an active effort to talk with the family, and that such support at this crucial time may have long-lasting benefit for both the family members and the clinician. Raphael (1985) concurred when she stated that talking to the treating doctor of the person who has taken their own life about the mental illness and the state of mind before death can help in understanding the suicide.

Sadly, it appeared that the attitude displayed by many of the psychiatrists reported in this study, was also reflected by individuals in more senior positions in both the local and interstate mental health systems. For instance, the mother of the young man who died in NSW,

... wrote to the Minister for Health in Sydney with a carbon copy with copies of this letter plus the story to the Director of Mental Health in New South Wales and to the community metropole centre, the area centre manager. So I sent that letter ... and I've never heard not a thing from them, not a word. I didn't ask for an acknowledgement, I wished I had of now but not a nothing and that's over a year ago. (30)

In all three instances, the letters were sent via registered mail and thus the participant was assured that they were received by the intended recipient. What is perhaps even more disturbing is that the recipient of one of the letters is a well-known and highly regarded researcher and practitioner in the field of grief and bereavement. This
participant commented that a simple acknowledgment of receipt of such letters would have had considerable meaning for her, as evidenced by the following comment, "I just wanted an acknowledgment of my letter. I didn’t send it for any other reason. Just for some acknowledgment, but I got nothing" (30).

Miller (1980) stated that it is not unusual for survivors to harbour resentment and hostility towards professionals for not saving their loved one. This serves to create barriers between the bereaved and the professional world, which in turn adds to resistance to later intervention. Bearing in mind the potential negative health outcomes resulting from a loved one’s suicide, the importance of professionals creating early trust with the bereaved in order to foster later engagement cannot be overlooked (Knieper, 1999).

Airlines. In two separate cases where the deceased had not died in WA, participants had flown to the location of the deaths. From the data it appears that local airlines have a system whereby flight costs are adjusted for individuals whose flights are necessitated by a familial death. In both of these instances however, this “compassionate fare” was considerably more expensive than the costs of the “red-eye” or “midnight” flight. Both participants appeared to find this practise incongruous and unacceptable. One commented:

I remember booking flights... and (Name of Airline) or (Name of Airline) had compassionate fares of seven hundred and something dollars and yet you could go on the Red Eye flight for $500. So they have this compassionate fare that’s actually higher than a midnight flight. It was just ridiculous and I thought “that’s not very compassionate”. It was pathetic. They know people are in a spot, they know you’re grieving, and they prey on that. It’s really awful. I mean they’re money grabbing scoundrels. There was nine of us going over and there would have been more of us going over if we could have afforded it. I just think it’s completely wrong to be profiteering off people’s grief. Maybe it’s not illegal but it should be. (24)
As illustrated by this statement, the cost of the flights prohibited additional family members attending the funeral. The role that the funeral can play in the facilitation of the grieving process has already been addressed (see Chapter Two). Consequently, it can also be argued that by inadvertently preventing families from having access to each other during this time, their individual grieving processes may be additionally challenged.

**General Procedures**

In addition to these aforementioned procedural aspects, participants also commented on a number of more general and non service-provider specific procedures that they believe to have been influential to their bereavement experience. The following four procedures were consistently highlighted and thus deserve closer attention: the official, or unofficial, death notification; viewing the deceased’s body; retrieving and retaining mementoes of the deceased; and finalising the deceased’s estate.

**Death Notification.** Hearing that a loved one has taken their own life may arguably be the most traumatic news individuals ever hear. As two participants testified, “Hearing the news, being told, it was the worst moment in my life” (43), and “When I heard those words, my world just turned right upside down” (6). The death notification process plays an integral role in orienting the survivor to the death, and invariably symbolizes the commencement of the grieving process, as evidenced by the following comment, “The notification was the first step for me to accepting that he had actually done it” (2). While the bereaved does not want to hear these words and may indeed remonstrate or fight against hearing them, the point remains that the death notification, particularly when delivered in an inappropriate manner, becomes crystallized in the survivor’s memory forever.

In WA, the police are legally required to deliver the official death notification to the deceased’s senior next of kin. In many cases however, the family are aware of the
death prior to this official notification either because they have been notified by someone else or because they themselves found the body. Irrespective of who breaks the news to them, the words of death, the physical setting in which this information is given, and the rate at which information is given to survivors can significantly affect their abilities to understand and assimilate the details of the unfolding tragedy (Raphael, 1985; Vanezis & McGee, 1999).

In addition, a sensitively and appropriately handled death notification not only prevents survivors from being traumatized by the manner in which they learn of the death, but also provides a valuable opportunity for secondary prevention. It assists with making the loss more comprehensible and meaningful for the survivor over the long term, which reduces the likelihood of any bereavement-related problems (Dubin & Sarnoff, 1986; Stewart et al., 2000). In contrast, death notifications that involve incorrect or limited information about the death, occur in chaotic settings, or provide little emotional support, may all compound the survivor’s grief and recovery (Stewart et al., 2000).

Participants in this study commonly reported distress regarding the notifier’s manner, as opposed to the actual notification procedure itself. Words used to describe the notifier’s manner include “abrupt”, “heartless”, “cold” and “flippant”. In one instance, a father received a telephone call from the police at 04h00 and “…the very first thing the guy says is, ‘Could you tell me your son’s dentist?’”(10). Upon querying the need for this information at such an unreasonable hour, the policeman only then informed the father that something unfortunate had happened to his son. Furthermore, in this specific case the deceased’s wife and a friend had notified the police that the deceased was missing. The police had then found his body, returned to the friend’s house, and broke the news to the friend by saying, “He’s not coming back mate. He’s topped himself” (10). In another case, a participant remains disturbed by the manner in
which a policeman at the local police station informed her of her son’s death. She had only gone to the police station to collect his passport as she had recently filed a missing person report, and the police had required a photograph of her son. By the time she arrived, the police had already found his body but the participant had not yet been informed accordingly.

Yeah they’d found him but they didn’t tell me that. It was an old guy and I said who I was and that I’d come for (Name of deceased)’s passport and he looked at me really strangely. I just stood there and he said to me, “You do know that they’ve found young (Name of deceased) and I went “Oh have they? Great”. And he stood there looking at me.... He said, “your husband and (Name of police officer) are on their way back in. Would you like to sit in this little room here until they get here?” I sat on the chair and he stood with his back against the wall just looking at me and I started to feel really uncomfortable and the next thing he said, “you do know that young (Name of deceased) is dead”. That still really gets to me. I still despise the guy for what he did and I just let out this scream...he just stood there. But it was the worst moment in my life. He didn’t care, he honestly didn’t care. (43)

The underlying lack of respect for the impact of the suicide on the family, as well as the relationship and personal dynamics, was also alluded to in the context of being served the official death notification. Whilst this perceived lack of respect was certainly implied in reference to numerous other service providers at other stages in the process, it could be argued that all inappropriate and insensitive interactions, on behalf of those whose job description necessitates constant interaction with survivors, can be perceived as disrespectful and thus additionally traumatic for survivors.

What had happened was that they actually went to his family home first and everyone was at work except for his...like she’s in a relationship now and her boyfriend has two children so the eldest daughter was at home and the police actually said to the daughter, who is 14, we have got news here about (Name of deceased)’s death and she doesn’t even know the man. I think she was actually told through the front door and then they asked where (Name of deceased)’s eldest son was... then proceeded to go to his work. Of course in the mean time the step-sister of his had then gone to my sister-in-law and said “I’ve just had the police here”...so you can imagine my sister-in-law. She’s been told by her step-
daughter that her husband has passed away. Any information like that should be
until that person is there or at least half respectful circumstances. It just seemed
they respected nothing. Just a job to be done... didn't really care about the
niceties in between. (15)

Eight participants were notified of the death over the telephone and all but one
felt aggrieved by this. One of them stated:

Of everything that I remember, the thing that sticks out most was hearing over
the phone. ... it was terrible. I'm sure it's awful however you hear, but it just
seems there must be a better way than over the phone. (18)

Others went on to suggest that hearing such news over the telephone made the whole
experience feel surreal and incomprehensible. In two of these cases, the police had
notified the family over the telephone. This despite an apparent consensus in the
literature suggesting that death notifications should not, if at all possible, be performed
over the telephone (Dubin & Sarnoff, 1986; Vanezis & McGee, 1999). In neither of
these cases did it appear that the police would have had difficulty in arranging for
someone to attend the families' house to perform the notification instead.

Performing a death notification, whether officially or otherwise, will create
stress for almost all notifiers, particularly in the case of tragic and sudden deaths, or in
the case of official notifications where the notifier has little control over the setting and
information is given in unfamiliar surroundings (Clark & LaBeff, 1982; Stewart et al.,
2000). Clinicians and researchers in the field of grief and bereavement are increasingly
recognizing the significance of the death notification process for survivors. In addition,
the value of death notification training for those professionals involved in the process is
also gaining an increasing amount of attention (Stewart et al., 2000). Not only may such
training benefit survivors, but it may also benefit the notifiers who may find this a
distressing and traumatic aspect of their job.
Given that it is a legal requirement in WA for police to officially notify the family of a suicide, I had expected that this aspect of police cadet training to be covered in considerable detail. My experience and observations of training sessions at the Academy suggested otherwise however. The training seemed limited in both time and scope, and on a number of occasions I felt that the comments from trainers were inappropriate and callous. The emphasis appeared to be more on the role or benefit of "black humour" as a coping mechanism utilised by many police officers in this situation. Both trainers provided numerous real-life examples of such humour or experiences. In addition, recruits had many questions that were largely related to best practices for dealing with bereaved family members, and whilst they were provided with written material regarding legal procedures, a lack of any material regarding grief and bereavement, or information regarding issues confronting bereaved families at this time, was clearly apparent.

Bearing in mind that individuals seldom want to hear about the death of a loved one, together with the fact that everyone handles such news in different ways, it is nearly impossible to have one "correct" way to carry out such a procedure. What this data does suggest however, is that there are numerous guidelines and recommendations, based on survivors experiences and suggestions, which may benefit all involved parties. The information offered by participants, together with my experiences of the police training procedures, leads to the postulation that the handling of distressed relatives is an underemphasized part of the work, and one that should gain as much attention as the actual wording of the notification itself.

**Viewing the body.** Viewing the deceased individual's body is one of many significant factors that facilitate the facing of reality (Raphael, 1985). Viewing the body not only affords the survivor the opportunity to say goodbye, but perhaps more importantly it can make the loss real for the survivor. Both of these are important events
in the initial phases of bereavement (Kastenbaum, 1997; Payne et al., 1999; Raphael, 1985).

Whilst no research has actually examined the relationship between viewing the body and bereavement outcome, the results of numerous studies suggest that being allowed to see the body, whether after a natural or unnatural death, has a beneficial influence on the bereaved (Davidhizar & Kirk, 1993; Parrish, Holden, & Skiendzielewski, 1987; Stewart, 1999). Although a small number of participants in this study had viewed their loved one’s body and later regretted it, the overwhelming consensus was that the process of viewing was helpful. In the context of this study, participants all reflected on viewing the body either at the mortuary or at the premises of the funeral company. What is interesting in terms of viewing the body at the state mortuary is that several families had difficulty actually locating the mortuary when they arrived at the hospital. This in itself may compound the trauma of the situation and procedure.

We first went to the wrong place because they were doing building and there were no signs and we didn’t know where to go so (Name of husband) went to find out and I was just sitting there. It wasn’t the emergency section but it was sort of around there and I must have looked a sight because someone asked me what was wrong. So they went to find out about the morgue or find (Name of husband) and then we went in. (16)

... then there are no signs around how to find the mortuary so it was bloody hard to find out where it was. It was dark, it was winter... just made it all that much worse. (41)

I went to the morgue, yeah and God it was difficult to try and find that morgue because there’s no signage. Nothing says this is the morgue. (44)

It seems the old adage of “seeing is believing” can aptly describe participants’ views on seeing the deceased’s body, as evidenced by the following comments:
I needed to see her just to believe it to be true. (7)

…the fact that we weren’t able to see him, because as hard as it to see anybody [dead], you at least know that it’s happened, but with not being able to see anything I still get this feeling that if we go to (Name of town) he’ll still be there. (18)

In some cases, where participants were advised not to view the body, their need to view outweighed the advice. As painful as the reality of the dead body was, it appeared to be a vital factor in consolidating the reality of the loss.

I needed to see her just to believe it, to be true. A lot of people there said we shouldn’t, but I so badly needed to. (10)

I was advised not to see the body but I went. But for me I couldn’t believe it. It helped me grasp what had happened. (39)

In addition to needing to see the body, participants also mentioned the importance of being able to touch the body, or at least being offered the opportunity to do so. Denying survivors the contact they desire with the deceased may have undesirable and long term effects (Awooner-Renner, 1991; Raphael, 1985). Comments from a participant who had been denied access to her son’s body provided support for this statement. In this particular case, the event had occurred more than ten years ago. Procedures for viewing a body at the mortuary have subsequently changed, and individuals do now have access to the deceased’s body. This comment merely illustrated the importance of being offered contact with the body, by someone who was denied it, as well as reiterated how events during this time remain etched in a survivor’s memory.

And he was lying there like on the table, and I wanted to go and touch him but we weren’t allowed to. And I think that was so very, very cruel because as a mother you want to nurture, you want to…. And even though he no longer existed he was still my son…and that was very, very hard. So I think that was
one of the big things that was crucial to me. That, I should've been able to have that choice, to hold him, to say my last goodbyes. (1)

The altered state of death may be frightening when first encountered. The stillness, the absence of response, the lack of breath are all aspects of a dead body which the bereaved may find arresting (Raphael, 1985). Whilst a number of issues regarding the viewing of the body were highlighted, none were as widespread as the impact that the coldness of the deceased's body had on bereaved family members. It seemed that although participants knew on a level that their loved one was dead and that the body would be different, it was the coldness of the body that starkly reinforced this knowledge.

... he was as cold as, and that really shocked me, even though he was dead. (1)

... icy cold. Really very cold. I suppose I might have expected him a bit cool. (11)

... and I went to touch her, and she was cold and I leapt back in fright. (12)

I didn’t expect him to be cold. He looked so peaceful, but then I touched him, and got quite a fright. (19)

... I hadn't expected him to be cold. I wasn't expecting it. My mind knows that he's been in a fridge but somehow you don't connect the two when you go to touch the one you love. I found that very difficult. That first time, the shock is awful. (21)

Really cold. Very, very cold. It's frightening how cold they are. It does stay with you to actually touch someone who isn't warm. (23)

His body, it was just so icy cold. Never forget that, that coldness. (24)

... that really hits you then that they're that cold. They really are dead and that was a horrible experience. It certainly made the funeral harder. (31)

I remember how cold he was, coming out of there it was freezing. That really sticks in my mind. (36)
Several researchers concur that if the deceased’s body is correctly prepared and if a description of the bodies condition is provided beforehand, the bereaved may actually benefit from the opportunity to be with the deceased one last time (Greifzu, 1996; Vanezis & McGee, 1999). It thus seems that the importance of discussing the realities of the appearance of the dead person with the bereaved beforehand cannot be overlooked. Participants endorsed the idea of being warned about the bodies’ appearance, with particular reference to the temperature. By warning the family what to expect, the possibility of being shocked, to the point of causing any additional trauma, is limited.

(Name of deceased) was so cold and maybe to have been given a better idea of what to expect. (21)

There’s no one there saying “Look you should expect this or this”. I wasn’t told anything…. (15)

A participant, whose husband died after the suicide of the participant’s brother, was able to compare the experiences of viewing the bodies, and thus further endorse the idea of being warned about what to expect, and the shock of feeling the coldness of the body for the first time.

I knew he’d [husband] be cold so there wasn’t that surprise element. I knew he’d be cold and I was prepared for it. I didn’t cope with (Name of brother) at all though. (21)

Mementoes. Great distress can be caused by others insensitivity regarding personal property or clothing after a sudden death (Vanezis & McGee, 1999). Personal items may become of tremendous importance and value for survivors. Survivors in this study who were either offered these items or had had them returned to them, expressed
great appreciation for the care that was taken, whereas those who were not, were
distressed by this oversight.

I’ve still got his T-shirt. I’ve got it wrapped up in the cupboard. I don’t think
anyone knows I’ve got it actually but it’s just my little piece of him. I’m very
glad to have even that. (1)

Then after the identification we sat down and (Name of police chaplain) gave
me (Name of deceased’s) watch, and I think his shoes were left. I think it was
his watch and some shoes. Yeah. And he said to me, “Would you like these?
Would you like his clothes?” All that sort of stuff. And I said “No, you can get
rid of the clothes.” But I kept the watch and the shoes. It was so good to be
offered his things. (2)

In most instances this referred to the clothes that the deceased was wearing at the time
of death. Participants who did not have any mementoes reported that retrospectively,
they would have liked something, even if it had been soiled or damaged.

I’ve never seen the pyjamas he died in and I would’ve liked to have them back
because I kept just about everything. … I’ve kept everything of his. I would
have liked them for the smell. (3)

(Name of deceased) had purchased some clothes the day before and he had them
on. He wore them when he killed himself and they disposed of his clothes. We
asked for his clothes and they said, “no we’ve disposed of them because they
were soiled”. They could have just asked, “look the clothes are soiled would you
like us to dispose of them or did you want them back….” (37)

The act of being offered these personal belongings may suggest to the survivor
that the person doing the offering acknowledges the relationship between deceased and
survivor and realises the importance of such items. In addition, the opportunity to make
a choice about such things may empower the survivor who is partaking in what can be
construed as a painful and impersonal process. In the case of soiled clothes,
explanations as to why they are damaged or soiled may be important when returning
such items (Dunne et al., 1987). As with the Coroner’s reports commented on earlier,
these items are often construed as "pieces" of the deceased and the importance of offering the family what is rightfully theirs, cannot be overstated.

**Finalising the deceased's estate.** In most instances in this study, the family was responsible for finalising the deceased's estate. Several issues warrant closer scrutiny, one of which is the challenges which survivors experienced when required to approach institutions or organizations and tell strangers that their loved one had died. For instance, one participant related how devastating it was to "... go into the bank and close his accounts... just having to stand there and say 'my son's dead', was heart wrenching" (2). While telling other people about the death may facilitate the acceptance of reality, this is a further example of survivors having to expose themselves and their private grief to complete strangers.

In addition, the processes involved in finalising an estate can be complicated and daunting for someone who has no experience or knowledge of such procedures. For those who may have had some knowledge about this process, it did nothing to detract from or alleviate the pain and torment of undertaking such a task. In cases where individuals were overwhelmed by the magnitude and complexity of this procedure, such as a participant who after five years had still not "... finalised her estate or anything. I just find it too complicated" (7), resultant delays may serve to further hinder important grief work.

Even when an estate had been "closed" however, it appeared that families either continued to receive correspondence addressed to the deceased from these organizations, or in some instances, companies had continued deducting payments from the deceased's accounts, in one case this continuing for several months. Delays in receiving the official death notification may explain why a few companies continued to contact the family. However, in most cases the apparent barrage of letters was endless.
According to one participant, “I would hate to open up the mail because one letter after the other they just keep coming” (7).

These areas of concern provide clear opportunities for service improvement. For example, bereaved family members may find the whole process less confronting and traumatic if specially trained individuals from relevant financial or insurance institutions attended the home, instead of requiring the family to approach the institution. In addition, it may be beneficial for survivors to either be guided through the administrative procedures, or be offered clear and simple guidelines regarding the steps that need to be followed. To have somebody complete the whole procedure for survivors may in some cases be the ideal, as suggested by the comment, “I would love to just hand it over to somebody and let them do the whole thing, but I don’t know who to do it to” (13)

In briefly summarising this chapter, it appears that due to the nature of a suicidal death, survivors are required to undertake and participate in a number of processes and procedures that are unique to sudden or unnatural deaths. They are also required to interact with various service providers whose involvement is generally not required when a death results from natural causes. Such involvements and procedures appear to have left participants feeling powerless and overwhelmed. According to Tedeschi and Calhoun (1995), a perceived lack of control over events is a particular quality that makes events additionally traumatic. Therefore, whilst the necessity for such administrative and legal procedures cannot be disputed, it is easy to see how these practises, and the meanings that survivors ascribe to them, can have a significant impact on survivors’ bereavement and grief processes.
A number of participants in this study were under the age of 18 years when they experienced the suicide of a parent. A considerable amount of valuable information, unique to this cohort, was discovered. It is beyond the scope of this paper to address such information in the type of detail it deserves, however it would be amiss to not briefly mention a number of key factors that were consistently highlighted. Interestingly, support for the impact or prevalence of these specific factors is also evident in the limited literature regarding children's experiences in the time immediately following the suicide of a parent.

Whilst it is important to remain cognisant of the fact that the consequences of an event occurring in adulthood may be different from those of a childhood crisis, it is interesting to note that many of the children's experiences and issues mirrored those already mentioned by the adult participants. In this case however, it was the parents or adult care givers who thwarted the children's attempts to gain any information, guidance or sense of control over the situation. In a repeat of the pattern discussed earlier, the data suggests the onus was on the children to seek out the information and answers which they required. In addition, when such information was provided, it was often incorrect or intentionally distorted. As one child noted, when querying how her father had died,

... and she said something like some teenagers came in and injected him the night before or some crap. When I found out what actually happened, I remember I got so angry at my mother for lying to me because she should have been straight out and honest with me. (28)

Early researchers such as Cain (1972) found the role of distortions of communication consequent to a parent's suicide to be among the particularly crucial
dimensions of the pathogenic effects of parent suicide. Later research supported this when Jordan (2001) suggested that the communication distortion, or hiding the true circumstances of the death, which is so prevalent in families with child survivors, has devastating long term effects. One participant commented:

...no one had ever said that she'd [mother] taken her own life. I think that was the worst thing about it all...this secret that no one mentioned. I kept it for 20 years. We told everyone she had a heart attack and I think I started believing that too. Then someone I worked with found out the truth and I just cracked. All the years of lies and bullshit just caught up with me. I had to take time off work and that's when I started counselling (26).

Cases of intentional deceit regarding the circumstances of death were contrasted with the experiences of a young girl who had been informed of her mother's death by an ambulance officer. This ambulance officer had told her honestly what had happened, and the manner in which her mother had died. The participant stated that she appreciated such honest interactions, as well as the fact that the officer had a straightforward approach and did not make use of euphemisms when discussing the details of the event.

Participants in this cohort also expressed a need for details about both the event, and the deceased's personal circumstances surrounding the event. As previously mentioned, such information can effectively dispel any myths and fantasies that obstruct the grieving process, as evidenced in the following excerpts:

I started to think people just don't die and mum wasn't old, how did she actually die? My dad wouldn't tell me. The first thing I thought was that she's been murdered.... Eventually he said, "She stepped off a balcony from the top storey of an apartment building," and then just something along the lines of "don't tell your sister yet".... It's something I didn't think about at the time, but later I wondered if she was alive when she jumped. She must have been alive to go to hospital. I had a lot of questions afterwards but at the time I didn't think. I actually thought about that for a long time because she was in hospital when she was pronounced dead so that made me think how did she actually die? The force of the impact, was she actually alive when she hit the ground and died on the
way to hospital or what did they do to try to save her? I started having these dreams...I didn't sleep very well...every time I closed my eyes I'd see my mum falling and I didn't want to go to sleep. (29)

I don't think she was on medication but that's something I've always wanted to ask my father, but never have. There are so many things I want to ask my dad. There's heaps of things I want to ask my dad and this is like 18 years in August. (23)

Many times the retrieval of such information was either blocked because of family dynamics unique to each family, or because parents were wrongly advised on how best to deal with their children or simply not offered any guidance during this time. It is understandable that parents, who are dealing with their own feelings and issues, may agonise over whether to include children or protect them from relevant processes.

However, McLauchlan (1990) suggested that children should not be excluded from the proceedings in the mistaken belief that they need protection as their involvement actually plays a crucial role in helping to facilitate their grief process. Walter (1999) also stated that when parents withhold information or emotionally disappear from their children, they lay the groundwork for later emotional upheaval. Participants who had been excluded from such processes were left feeling that they had had no say in, or influence over, proceedings.

Looking back as I got older it felt like I had no rights. I wasn't consulted, I wasn't consoled, I wasn't asked. I wish someone had at least told me or let me know some of the things I didn't know. (Name of participant), you could have gone to view the body, (Name of participant) you could have gone to the hospital, you could have gone to her flat. None of those things...I could see that would have been a real benefit to me if I had someone to highlight those things to me so that by this time when you're older and you realise these things...it would have been absolutely a different issue. (26)

I'd definitely want to go to her funeral. I'd want to have a say in what happened. It was just little things like I'd want to have an input in how things run like I mean make up and things. It looked absolutely shocking. It didn't look like her at all.... I would've like to have a say in like she was cremated and what they did with her ashes. Little things like that. (28)
I only went to her viewing and I wish that I’d have stayed for her funeral. My family said that it wasn’t safe for me to go. They were saying that I wasn’t up to it in that state and I just pretty much went with their word…. (29)

Participants also stated that they had little or no knowledge regarding the legal or administrative processes that had transpired, and a number of them had no knowledge regarding the existence of a Coroner’s report, or that they could still have access to it.

The impact of inappropriate comments from others was also highlighted, and in a saddening account a young girl who was the eldest of three siblings and whose mother had died was told by an elderly aunt,

“...I’ve heard that you’ve been doing all the washing, keeping the house clean, cooking for everybody. I’m so proud of you. That’s what you’ve got to keep doing. Just look after everybody. Keep doing the washing. We’re very proud of you.” I was 15 you know. So that’s what I did and went on. I never cried. That was the thing. I was just busy doing all the things that had to be done. That was the worst thing to get said to me. She should have said, “it must have been really bad. Do you want to sit down and have a cry?” No one ever said that. (26)

For parentally bereaved children, the impact of a parent’s suicide is a unique blend of the event itself, the individual characteristics of the bereaved child, family and cultural dynamics, service delivery and the social attitudes in which they are all set (Shooter, 1997). Suicide-bereaved children must make sense of their parent’s decision to end their own lives and must deal with the stigma surrounding suicide, in addition to dealing with their own grief. It is often difficult for children to make sense of events unfolding around them. Although it is well known that not all children who experience parental loss go on to develop adult psychopathology, child survivors of suicide are at risk for psychiatric symptoms and social maladjustment (Pfeffer et al., 1997). This risk, combined with the fact that crises that occur during childhood are more likely to be integrated into an identity that is then carried throughout life, suggest that this is an area that would benefit from closer attention. The results of such attention would hopefully
lead to the development of guidelines that focus on issues unique to bereaved children, as well as more supportive and appropriate ways to manage children during this time. Such guidelines and recommendations could have short and long-term benefits for both bereaved families and service providers.

In addition, it appears that there may be some benefit in making one specific individual available to children, whose sole purpose during the time following the parent's suicide is to avail themselves to the needs of the child. Bearing in mind the remaining parent or adult caregiver may not be accessible to the child during this time, a specially trained individual may fulfil the role of both a resource and support person. Children need extra emotional support after a major loss, support that should ideally come from their everyday caretakers. However, parents are often immersed in their own griefwork, as well as various administrative and legal demands, thus the benefit of having a specially trained person available to children during this time is an idea worthy of further consideration. According to one participant:

I didn't know who to ask. There wasn't anyone there for me to ask. I did start asking my dad a lot of things about my mum after she died. It just went on and on and on... but that's people trying to keep me in the dark, don't think I'm old enough or mature enough... a need to protect children is misguided. Keeping them in the dark and keeping things hidden is not really a good idea... I'd rather be gutted knowing my mum hit the ground. If only someone could've just explained this stuff to me and been there for me to talk to, it would've made the world of difference. (29)
CHAPTER EIGHT

Survivors’ Suggestions for Improved Practice

Most participants who reported negative interventions suggested alternative ways of handling the respective situation. In addition, suggestions were also made on the basis of a number of positive and helpful experiences. Whilst the key negative interventions have already been discussed, it would be amiss not to explore some of the primary positive aspects emerging from the data. Ultimately, both kinds of experiences provide a basis for the development of valid and appropriate service improvement recommendations.

Positive Experiences

Bereavement pack. Since October 2001, the Coroner’s Office has distributed a pack entitled “Information and Support Pack for those bereaved by suicide or other sudden death”. The development of this pack was informed by crucial but necessary research into the support needs of families bereaved through suicide (see Hillman et al., 2000). It addresses numerous issues including practical matters, referral information and information about grief and mourning. This pack is sent to family members within days of the suicide of their loved one. Although a number of participants had experienced their loss prior to the development of such a pack, others were able to reflect on its benefits. This pack is presently in the process of being evaluated. However, feedback obtained in this study suggests that it is a valuable and essential form of support. As one participant noted, “I very much liked that folder that the Coroner’s Office sent out, because I found myself for days and days and days afterwards reading everything I could about suicide” (7). Another participant emphasised the benefit of being provided with contact details for relevant support organizations, “...it was great. They had all sorts of different numbers for children, for the adults, for this and that. That’s good to keep” (21). Bearing in mind that numerous survivors suggested that support appeared to
dissipate in the time following the funeral, having a support pack such as this one, ensures that families have access to appropriate support if, and when, required.

**Writing.** During discussions with participants, it also became apparent that a variety of somewhat unconventional coping strategies had been of great benefit during this traumatic time. Such strategies, whilst somewhat idiosyncratic, were often recommended by other survivors, as opposed to health professionals who, as the literature suggests (e.g., Hall & Epp, 2001), may not always be best placed to make such recommendations. One such activity that received consistent endorsement was the act of writing. All participants who recommended this were part of a writing group, formed subsequent to the suicides and with the express purpose of recording the survivor’s personal reflections on the event. Several participants who had participated in this group stated that, despite a lack of previous writing experience, they found the process therapeutic.

Sitting down to write was like a volcano exploding. All this stuff just came out, which otherwise would’ve just stayed inside. It was wonderful. (29)

Writing has been an enormous help and I would recommend it as therapy for anyone trying to cope with grief. (31)

Writing this story was the best thing I ever did. (33)

It may be that an activity such as writing gives a voice to survivors who may not otherwise be heard, or who may not know how to go about expressing themselves in order to be heard. As one survivor noted, “I decided I really wanted to write a short piece that basically vocalised how I felt after it had happened” (41).

Such findings are consistent with the increasing body of empirical evidence that suggests that the disclosure of stressful experience through writing can provide therapeutic benefit for a significant proportion of individuals (Colder & Sharp, 1990; Pennebaker, 1993). In a group of individuals whose voices do not appear to be readily
heard, such as the survivors of suicide, the art of writing may challenge their sense of invisibility, and may also help them to make sense of the event. In addition, the act of writing may facilitate the cognitive integration of such a traumatic event (Lutgendorf & Ulrich, 2002).

This need and desire to express and give voice to their experiences may also be why survivors partake in research such as the present study. Generally speaking, it seemed that participants lacked access to a mechanism for positive or negative feedback regarding their experiences. The development of the Information and Support Pack seemed to be the first undertaking of its kind that really gave a voice to the bereaved, and used their experiences in the development of further guidelines and recommendations.

**Fellow survivors as service providers.** Research suggests that survivors often find that the most helpful and positive support comes from other survivors (Jordan, 2001; Knieper, 1999). Klass and Shinners (1982-1983) actually highlighted the importance of not underestimating the unique kind of support and help that fellow survivors, as opposed to professionals, provide.

Interestingly, the data suggests that this was not only found to be true for general support networks as shall be discussed later, but was also evident in the manner in which service providers, who were themselves survivors of suicide, conducted themselves and their service provision. A particular source of comfort for many survivors was the level of care, empathy and compassion they received from such service providers. Many reported that the difference in level of care and manner of interactions from these providers was clearly distinguishable from providers who had not themselves experienced the suicide of a loved one. Not only did such service providers go to great lengths to limit any additional traumatization of survivors, but they were also able to provide information and specific guidance which was not forthcoming.
from non-suicide bereaved service providers or individuals. For instance, one participant's relatives, who had flown from overseas for the funeral, were quickly processed through passport control, had their luggage collected for them, and were given a private room in which to meet the other family members at the airport. An employee of the airline who had personal experience of a family suicide arranged this. In reflecting on the benefits of this kind of attention and care, the participant commented, “It was the most unexpected kindness. Pretty good isn’t it? Human. He went to a lot of trouble. I think because he had that experience. Amazing, that was amazing” (7).

In another case where a participant’s mother had suicided, his family priest had also actually lost his own father to suicide. The priest provided ongoing support and follow-up in the months after the suicide, and according to the participant, the fact that the priest had personal experience “…really helped because rather than just being from a professional point of view of saying ‘I need to help’, he was really empathetic and that was really helpful” (40). There were other cases of such unique and specialised care offered by bereaved service providers. The benefit of this experience was succinctly captured in a quote from one such participant.

The lady who first came out to the house, she’d actually had her own sister die of suicide, so I really connected with her. She really understood me. She knew how important it was to me to do this right. (15)

In addition to being afforded such unique care, two participants stated that having a service provider who had been through the same thing, meant that such individuals were aware of the need to have questions answered and thus ensured that they were provided with information, or had access to the appropriate channels to obtain this information.
Several participants based their recommendation that the liaison person should also be a fellow survivor on their favourable, and noticeably different, experiences with service providers who were also survivors, compared with those who were not.

The fact that there were a number of cases where the differences in care and attention were so noticeable, suggests that service providers have much to learn from survivors, and that survivors have much to teach the community as a whole. Furthermore, such distinguishable features in manners of interactions not only serve to highlight any deficiencies, but also suggest that survivors should perhaps in some way be involved in providing care to other survivors. It appears that fellow survivors are more acutely aware of the issues confronting the recently bereaved and may thus be well positioned to offer them tailored support.

*Suicide survivor support groups.* While continuing with the theme of the unique type of support offered by other survivors, many of the research participants were members of, or had had experience with, local suicide-survivor support groups. It needs to be noted that in mentioning the benefits of such groups, I am shifting attention away from the immediate impact of different variables. However, the consistent and unequivocal support that the majority of participants afforded these groups, together with the vital role that participants believe group members and membership played in the facilitation of their own grief process, is seen to mitigate this slight digression.

It is difficult to tease apart whether it is belonging to a group or simply being with another person who has had a similar experience, that people find beneficial. Either way, many survivors reported a strong desire to talk with others who had lost a family member through suicide and emphasised the importance and benefit of sharing their experiences with other survivors. Participants regularly spoke of “feeling normal”, “being completely understood” and “not being judged” when reflecting on their experiences with other survivors. One individual related how incredulous he felt when
"... after a year and a bit. I think it was after 14 months I finally felt understood. I couldn't believe there was a whole group of people who understood me" (40). Other survivors also referred to the "inner circle feeling" that they had when speaking with other bereaved parents. This need to talk with other survivors is evident throughout the literature and can be explained from a variety of theoretical approaches. For instance, Festinger's (1954) social comparison theory states that people look to compare themselves with others whom they perceive as being similar to themselves, especially when they lack socially appropriate methods of evaluating their feelings and beliefs. Festinger also predicted that in times of uncertainty, in this case the suicide of a loved one, affiliative behaviours increase as affected individuals seek others' opinions about how they should be feeling or thinking. Through interactions with other survivors, the bereaved can comparatively evaluate their emotional responses, thereby validating the normativeness of their individual grief responses.

The findings of this study, in conjunction with those of other related literature (e.g., Jordan, 2001), highlight the benefit and importance of making support services for survivors homogenous with regard to mode of death. Given the demonstrated stigmatisation that many survivors perceive within their environment, together with the unique thematic aspects of suicide bereavement, it is not surprising that groups limited to suicide survivors cohere quickly and do not appear to replicate the inappropriate and insensitive interactions that all too often occur in the survivors' external environment.

Additional Suggestions

A number of participants independently proposed suggestions that appeared to address several other shortcomings. The first of these was that a single individual from either the police or the Coroner's Office conducts all interviews with the family. In other words, the police officer who conducts the original interview, also conducts all additional interviews and is the only police officer which survivors have any contact
with. A survivor who only had dealings with one police officer throughout her whole experience illustrated the benefit of this:

It made a huge difference to me. We were very fortunate indeed. It just made things so much easier for all of us. I would say it was probably the best thing that could possibly have happened. I mean how do you ever make it right? I mean each particular thing is unique and it’s such a terrible thing and if you then have different people doing it just as a job.... I’m not asking anybody to get emotionally involved but to have the continuity there of one person is probably the most important thing in my view. (32)

On a procedural level, this would mean that either a Police Coronial Inquiry Officer is the first officer on the scene when the police are notified of a suicide, and this officer continues as the investigating officer in this particular case and conducts all the police-related interviews. In the case where other police are the first to attend the scene, they can notify the Coronial Inquiry Officer that the death is a suicide or appears to be a suicide, and the initial interview can be postponed until such an officer can attend the scene. Understandably, this may necessitate increasing the number of police officers allocated to this section, however the benefits which may eventuate from such a measure certainly warrant further consideration.

Another suggestion was having a person who is aware of the special requirements and issues that confront survivors in the days following the suicide, available to the bereaved family. They would serve as a liaison between all services and the bereaved family, and would be accessible to the family at all times. The importance of them possessing and displaying genuine compassion and empathy was also emphasised. These liaison individuals would also be fully aware of all legal procedures and requirements and would thus be in a position to provide the family with answers to procedural questions, additional information about grief and bereavement, and guidance regarding specific issues that may confront the survivor. A selection of participants’
comments attest to the overwhelming support that this suggestion received, as well as the various tasks that such an individual would be expected to fulfil. Whilst some of these are rather lengthy quotes, it was felt that any editing would do them an injustice, and valuable material may have been lost.

I think if someone’s there guiding you through it saying, “Okay this is the next step”. I think that would be helpful. One person I could ring up and say, you know, “How are the police officers doing? Are they okay? And the train driver, did he get my message?” You know, that would be good. (2)

...even when you are first told, there should be some sort of a mediator, someone to help with this stuff. Definitely. Because there’s so many different stages. People don’t understand.... The financial side of it, the preparations. How do you do that when you’re in shock. It’s like you just can’t take another breath. It’s really hard. Let alone listening and understanding. If someone could just be there to advise people ether way.... (15)

I would have loved to have somebody say like a intermediary from the police to be there to answer all the questions. 100% it would have helped me. That would have been marvellous that really would be. If we’d have had some person that could have been there, or if we had access to it if we wanted to, and I think I would have. ...even to be able to be contactable later on when you’re feeling perhaps ready because I know within four, six weeks I was ready for questions to be answered and I’m still waiting because I haven’t actually asked. (23)

It should be the same people who deal with the family however many times they have to go there. It should be up front from the beginning so if the body is discovered by whoever and the police are phoned, I think the police should divert it straight away to that special unit (Coronial Inquiries Section) and then it should be just those people from then on who are there because it is a really shit time. I had a boyfriend killed by a head on collision and I’ve gone through the police coming and telling me stuff and everything and suicide’s different. Even the funeral is different. Every person is questioning what they did. (39)

It would have been helpful at the time if there’d been someone there to say to you “I’ve got all the answers that you might want, like where his body was...?” At the time of the death you’re in such shock. You’re not in any space to be thinking through logically what might be important in the next few days. I think it would have been really helpful to me to have somebody say to me in those first few hours, make maybe two lists, one list was: emotionally, this is how it’s going to be for you, and this is how it’s going to be for your kids, and our research has told us that survivors of suicide afterwards have said that these are the things emotionally they needed to know; and then the other side of the list was the practical things. Here are all the things that are going to have to be addressed in the next few days. Survivors of suicide have said these things, with the asterisk next to them, are the things that are the priority. They’re the things
you’re going to look back on and remember, and they’re the things, as painful as it is now, you need to get your head around it. Maybe this is what you need to discuss with your friends and your relatives because things like the funeral are going to be remembered. Things like viewing the body are going to be remembered, whether you want that memory or not. You might decide now you don’t want to, but in six years time you might be thinking “I wish I’d done that”.

(39)

... at the time they told me there was eight suicides a week in Perth, 11 years ago. Now that number to me would suggest that it would be worth having someone full time whose job it is to point out those things. If not to the victim but at least to the people closest to the victim, and advising them so that those memories are sensible choices and not things that knee jerk reaction, which most of it was for me. (40)

Interestingly, findings of a study undertaken by Finlay and Dallimore (1991) with bereaved parents whose children had died as a result of traffic accidents, murder or suicide, highlighted the benefit which parents found in having one designated person from whom they could ask for help or information about the child’s death. Trolley (1993) also unambiguously offered her support for the benefit of such helpers and the crucial role they play. For several participants the need for this person to be able to assist with legal matters was also deemed important.

I’m no lawyer. I don’t know about red tape stuff. I don’t know about legal, I don’t understand that sort of thing. Most people don’t. It would be so much nicer if you had someone in layman’s terms to explain to ordinary people like us. (16)

... it takes you a while to get things together and legal advice too. I had to go and seek legal advice because I had these people come at me from everywhere saying, “We’re coming to take your house”. It would have been so good just to have somebody actually explain the legalities. It wasn’t until I went to free legal advice, which cost $20.... (33)

Not all participants were unequivocally in support of being supplied with all relevant information however. Thus an idea might be to make the offer of such an access or liaison person, and allow the survivor to decide for themselves. For instance, one participant believed that being left a card and told that they could contact such a
person at any time was sufficient. Another stated that she would have found the
information and details of the death too confronting, and that "...I didn’t want to
acknowledge that it happened and the less information I got about it, the less I had to
deal with it" (24).

A final suggestion addressed the need for service providers, liaison officers, or
employees of companies involved with the deceased’s estate, to visit or attend to
survivors in the comfort and safety of their own home as opposed to expecting survivors
to pursue them. Numerous participants noted that the most helpful service providers
were those who made contact with the family, or came to their home.

I think it would have been good for somebody to come to the house and explain
what happens in the circumstances of suicide. It would have been nice for
somebody to come along and say, “This is what happens in these cases and this
is the procedure and this is the sort of time frame you’re looking at and you have
to contact these people and we’ll help you with if you want to advertise or
whatever”. It would have been good if they had actually come out to the house
though. Obviously I needed help, I never got it. I mean if somebody offers it and
you refuse it that’s fine but I mean to not be offered it at all isn’t good at all. (42)

You have appointments. I found it so stressful just to drive. I feel there should be
a lot more in home services. Personalised services for the bereaved ones. (15)

We need a go between and people to come to you. It would just be so great if
someone could come to you, to your house and not over the phone. I guess it
would just be more sympathetic…. (29)
CHAPTER NINE

Conclusions

In the previous chapters, I have attempted to answer the two research questions by firstly, providing an overview of bereaved family members' post-suicide experiences in terms of specific events and procedures, and secondly, affording particular attention to aspects which participants feel impacted on their bereavement experience in some way. As mentioned earlier, an experience of an event or procedure was deemed to have impacted on the participants' grief if they believed and reported that it had. This final chapter includes a summary of the significant themes explored in the paper and a discussion of the limitations of the study. It concludes with suggestions for future research. These suggestions may assist to fill gaps in the present understanding of specific aspects that influence suicide bereavement.

Summary of Results

The data showed that following a suicide, survivors found themselves thrust into an agonizing personal and sometimes administrative journey, which, because of individual, familial, environmental and circumstantial variables and dynamics, was a unique experience for all involved. The interplay of such variables, together with the fact that the news of a suicide is likely to receive an unfavourable reception from family members, make it difficult to institute a single correct, standard or prescribed manner in which to share such news, carry out any legally required procedures or interact with survivors.

Without controlling for a myriad of variables, it is difficult to determine, with any certainty, the degree to which events or incidents impacted on a survivor's bereavement. However, many participants in this study consistently highlighted certain aspects that they believe made the time following the suicide additionally traumatic, and that consequently impacted on their bereavement response. The majority of these were
related to the lack of information, guidance and advice available to them in the immediate aftermath of the suicide, unsatisfactory and insensitive interactions with others, and a number of specific administrative and legal procedures.

For many, a suicidal death leaves a legacy of unanswered questions, and survivors often embark on a search for a suitable explanation as to why their loved one chose to take their life. Such unanswered questions are believed to be a contributory factor as to why survivors may experience a very complicated form of bereavement (Knieper, 1999). This search for answers is consistent with the experiences of participants in this study but was not limited to instances where the suicide was a complete surprise. In cases where the deceased had a history of suicidal behaviour and thus their death was not totally unexpected, family members also expressed a strong need to understand more about the deceased’s motivation, thus emphasising the prevalence and significance of this issue.

Furthermore, as a result of the suicide, many survivors were exposed to numerous novel experiences including their first personal encounter with death, a dead person, or certain related service providers and legal procedures. The stress related to the unfamiliarity of such events appeared to be exacerbated by the survivor’s state of mind in the time following the suicide. Participants consistently stated that they had felt dazed, confused and in a state of shock subsequent to finding out about the suicide. They were further distressed by the numerous uncertainties regarding their rights and responsibilities, and what was required of them at the time.

Participants also highlighted their need for information and answers, but were unsure whether they had the right to this information, or how to access it. The knowledge of details, such as how the death occurred and the sequence of events leading up to it, was reported to play a crucial role in helping survivors to make sense of events, which in turn may have facilitated their grieving process. The information was
seldom forthcoming or volunteered however, and finding the answers was largely contingent on how actively the survivors pursued them. This pervasive question of the deceased’s motivation may have intensified the need to have access to all available information, as well as to have their questions answered in a satisfactory manner.

Data suggested that many significant decisions needed to be made in the days following the suicide. Considering the survivor’s state of mind at that time, it is understandable that reports of inappropriate and insensitive comments, as well as a lack of informed and empathic support and guidance from those surrounding the survivors, had certainly made the process additionally challenging and painful.

The data also evidenced the many factors that facilitate the facing of the reality of a loved one’s death. These included the actual death notification, viewing the body, the funeral, and finalising the deceased’s estate. Findings from this study suggest that if these experiences are tainted by inappropriate interactions with relevant service providers, or if the procedures are deemed to be intrusive or unsatisfactory, they will impact on bereavement and grief processes. The need for compassion and specialized knowledge of the unique issues that confront survivors in relation to these procedures was also highlighted. Survivors reported being overwhelmed by events, and it was often the seemingly insignificant instances of thoughtfulness, or, alternatively, insensitivity and carelessness that were remembered.

Trolley (1993) stated that inadequate support or involvement from the emergency responders, police, medical examiners, funeral directors and clergy tends to create more isolation between the survivors and the professional world. This is even more important considering the negative mental health outcomes that bereavement can have. Such outcomes make it important for us to understand the intermediate variables that can lead up to these different outcomes, one of which has been shown to be interactions with others. Overall, the content of the survivors’ feedback regarding
interactions with others seemed to relate to the latter’s sensitivity, empathy and interpersonal skills, or indeed lack thereof. If individuals surrounding the bereaved are cognisant of the small window of opportunity to mediate the responses of bereaved people to sudden death, their sensitive interactions can mitigate the trauma of loss and provide the base for a healthy grief process (Vanezis & McGee, 1999). The consistency of participants’ responses suggests that there are several areas within the interactive processes that need improvement.

For the public at large, this probably necessitates an extensive and comprehensive movement to increase people’s awareness and knowledge of the issues and experiences that confront survivors of suicide. In terms of service provision, the pattern of participant responses suggests a serious need to revise the in-house training and education of those who are required to have contact with recently bereaved family members. Raising staff awareness of the potential influence on bereavement of the activities of staff in the period surrounding a sudden death is imperative.

A lack of support, particularly in the time following the funeral, was also an aspect highlighted by participants. It appeared that the first few days after the death were intensely demanding, with many decisions to be made and procedural requirements to be satisfied. Inadvertently, the heightened activity during this time may delay or obstruct the commencement of the grieving process. However, participants reported that activity abated after the funeral, a time when the full reality of what had happened dawned on them. Ironically, this was also the time when many survivors reported that most of their support was withdrawn, dissipated or needed to be actively pursued on their own accord.

A number of participants were either children of parents who had suicided, or parents, who had children at the time of death, but whose spouse had suicided. This provided an ideal opportunity to report on unique insights and experiences from
differing perspectives. Parents commented on the dearth of tailored and appropriate advice and guidance on how best to deal with children during this time. Children also consistently stated that being excluded from proceedings, being “lied” to by others regarding the circumstances surrounding the death, and not having access to information, either at that time or in the future, all had deleterious ramifications for their respective grieving processes. Whilst I acknowledge that personal and circumstantial variables would have mediated the unfolding of post-suicide events, the consistency with which these themes were mentioned suggests that this is an area deserving of closer attention.

In conclusion, the days following a suicide are a time when the suicidally bereaved may feel particularly vulnerable and sensitive. What may be construed as a relatively neutral comment or statement by the non-bereaved individual, or a relatively simple and outcome driven legal or administrative procedure, may have a significant effect on the survivor. Both this data and popular literature concur that the grieving process is a painful and challenging one, which can be complicated by numerous factors. By increasing people’s awareness of the significance and impact of interactions and activities during this time, future survivors may be more appropriately engaged, additional trauma caused by insensitive interactions and inappropriate procedures may be limited, and the potential for the bereaved to experience unhealthy or complicated grief reactions can be addressed.

Limitations

Limitations of the present study need to be acknowledged. The first limitation of this study relates to sample size. A prevailing undercurrent in many research circles is that, the larger the sample, the better. This does not necessarily hold true for qualitative research studies, which tend to be intensive research efforts among small samples (Thorson, 1996). In terms of this study, whilst the distressing nature of the topic may
have deterred possible participants, it served to attract those individuals who had a
desire to express and relate their experience of, and exposure to, a family member's
suicide. Thus, although some may construe the total number of persons interviewed (44)
as a rather small sample, theoretical saturation of primary themes occurred quickly. This
strengthened my belief that the sample size was adequate.

The ability to generalise from any study employing anything short of a totally
random and representative sample is questionable. The second limitation thus relates to
the generalisability of conclusions drawn from the research findings. Guba and Lincoln
(1989) refer to this. Their third criterion for maintaining trustworthiness in research is
the transferability or fittingness of findings. It is virtually impossible to determine who
did not participate in the study and consequently any conclusions drawn cannot validly
be reflective of all survivors' experiences. In addition, the impact of bereavement on the
grief experiences of members from different racial or ethnic groups is a neglected area
of study (Reed, 1998). Most samples are ethnically homogenous, a pattern which was
inadvertently replicated in this study. The involvement of authorities, together with
services and procedures implemented after a suicide, may not always be culturally
sensitive, particularly when they are guided by legislation. Themes and dimensions
drawn from the data are thus not reflective of the experiences among members of
diverse racial and cultural groups and may not necessarily be generalisable for culturally
diverse families. Additional research, aimed at increasing our understanding of how
social institutions and culture shape mourning customs and grieving patterns, as well as
exploring ethnically diverse families' experiences after a suicide, is sorely needed.

Similarly, the validity and reliability of a subjective method such as that
employed in the current study is always open to criticism. To mitigate this third
limitation, I put in place the following validation processes. I attempted to document the
data collection and analysis procedures in considerable detail. During the interviews, I
repeatedly checked with participants as to their meanings behind statements and
reflections. The data coding and classification procedure, implemented during data
analysis, was also continually reviewed and refined. The research was exploratory in its
aims however, and the aim was for the generation and saturation of concepts, ideas and
themes. All information gained from participants was based on their subjective
experiences, and recommendations made are based on accurately reporting these.

Fourthly, the title of this study may suggest that the impact of events is
somehow being measured, thus enabling accurate and definitive comment on varying
levels of impact. In fact, I sought to understand and report on each person's individual
and subjective beliefs about the impact of certain events. For the purposes of this study,
it was felt that the benefit of obtaining rich and detailed qualitative data outweighed the
benefits of quantifying or measuring a particular variable. It is hoped that the definitions
provided by this study can help define variables for future broader studies.

Finally, it needs to be acknowledged that personality factors play a critical role
in the way different people come to terms with a loss. The reality of a loved one’s
suicide is difficult to accept. Consequently, there is a heightened chance that survivors
experience any subsequent and related procedures, or unsolicited involvement of service
providers, as distressing and negative. However, the aim of this study was to look
beyond any idiosyncratic variables, and instead focus on the discovery of any themes
that were consistently experienced in the same manner by various participants.

As previously mentioned, this was an exploratory study, undertaken in a
relatively under-researched area. Consequently, these shortcomings in methodology
may be balanced by the usefulness of the data to inform bereavement and suicide
literature about the impact of a leading cause of death in WA. Furthermore, despite
these limitations, the richness of the data generated provided ample opportunities for the
development of several viable recommendations with positive and potentially far-
reaching ramifications. The participants' suggestions for improvements are included, as are recommendations aimed at addressing individual service providers' specific deficiencies and several more generic areas or procedures, in Appendix H.

**Future Directions for Research**

As much as this data provided a basis for the development of several key recommendations, it also highlighted the need and scope for additional research in the field of survivors' immediate post-suicide experiences. Firstly, a number of individuals who had seen the research advertisements, but did not fulfil the participant criteria, i.e., were not immediate family members of the deceased, contacted me. These included grandparents, an aunt, and a number of close friends of the deceased. Although I was not able to accommodate their offer of participation, the response from individuals other than immediate family members suggests that these individuals also have their unique stories and experiences to share and do not presently have a forum within which to do it. As one of the callers commented, "It's almost like people forget that we are grieving too" (anonymous telephone caller). Doka refers to a loss that does not attract support or is largely unrecognised as disenfranchised grief (1989). People whose losses are not afforded the necessary attention they deserve or require are of particular importance to healthcare professionals because their overall health may be at risk, and yet they seldom come to the notice of the necessary health organizations (Parkes, 1998b). Thus it is not surprising that this need for research into the needs and issues which confront extended family members has previously been highlighted in the literature (eg., Knieper, 1999).

Another issue of interest that warrants scrutiny relates to several similar experiences which one particular family had. According to this participant, the deceased was a renowned drug user who had spent time in prison and was well-known to local police. He resided in a suburb which according to his family is "...poor and full of druggies and ex-cons" (8). As is evidenced in examples throughout this paper, this
particular participant had numerous unsatisfactory and traumatic experiences with most service providers. Interestingly, she also experienced a suicide in her extended family subsequent to the suicide of her brother. This family member resided in a suburb which she referred to as being “...very upmarket and upperclass” (8). She spoke of the significant and marked differences between the manner in which service providers dealt with her, and the way in which they dealt with her extended family. She was clearly of the opinion that her brother’s financial status, criminal history and residential area were the reasons that she perceived the service from the relevant workers to have been prejudiced. As she said,

> We were treated like absolute shit, like they just wanted to brush the case under the carpet and get it over with. It was like (Name of deceased) was just a piece of flotsam. ...very different for my family though. I saw the way the police dealt with them, and there were two people to collect the body and it was carried out with a special covering over it, and on a trolley. It was chalk and cheese really. (8)

The fact that she had unsatisfactory interactions with all service providers may suggest that her ideas about the reasons for her treatment are not unfounded. It may therefore be of benefit to undertake a study that seeks to explore the differences between survivors’ experiences according to specific demographic and social criteria.

In addition, and as highlighted in the study limitations, research participants were largely an ethnically or culturally homogenous group. Consequently, no information was gained from individuals representing different cultural or ethnic backgrounds. A study focusing on these individual’s experiences would generate rich and unique data that would serve a crucial and invaluable role in improving service providers' in-house training and the general public's level of awareness of issues pertaining to such groups.
A noticeable dearth in studies documenting the emotional and behavioural sequelae of parental suicide in community samples of children is also apparent throughout the literature. In addition, the wealth of rich and valuable information generated from child survivors in this study, together with the link between parental suicide and an increased risk for bereaved children to develop psychiatric symptoms, would suggest that this is an area which deserves immediate and intense scrutiny.

Finally, it may be worthwhile to explore the service providers' experiences of survivors and their relevant procedures and interactions following the suicide. Information generated from such interviews could only serve to inform any recommendations regarding training, practice and policy modifications in a constructive manner.

Concluding Comments

The dearth in the relevant literature regarding survivors' experiences in the immediate aftermath of their loved one's suicide was evident from the outset of this study. However, the implications and effects of such a paucity of information for survivors, as well as for those individuals involved with survivors during this time, really became apparent as the study progressed. It is therefore hoped that the findings of the current study add to the knowledge base in this area, and contribute to a greater understanding of the significance of events in the time following a suicide.

In addition, I believe that the applied social nature of the research and the relevant findings have the potential to contribute immensely to policy development, appropriate training of service providers, and the implementation of more sensitive legal, administrative and procedural processes. This in turn may benefit those who are bereaved by suicide, as well as those who are required to interact with or administer services to them.


Impact of Events in the Aftermath of Suicide


Turner, R. (1983). Direct, indirect, and moderating effects of social support on psychological distress and associated conditions. In H. Kaplan (Ed.),...


APPENDIXES

Appendix A

*Letter Detailing Study*

To Whom It May Concern

My name is Kelly-Joy Botha and I am a Doctor of Psychology candidate at Edith Cowan University, Joondalup Campus. As part of my thesis preparation for the Doctoral Program, I am undertaking a study with survivors of suicide.

This study focuses specifically on bereaved family members’ experiences during the aftermath of a loved one’s suicide. The specific aim of the study is to ascertain the existence of any specific helpful or unhelpful events or factors, as identified by bereaved family members (survivors of suicide), in the immediate aftermath of the suicide. Family members include partners, spouses, children, parents and siblings. Due to the traumatic nature of the death, as well as the challenges faced by survivors subsequent to a family death by suicide, I aim to use the survivors’ experiences in the aftermath to identify opportunities to modify the way in which services are implemented, as well as increase the knowledge base in this area.

In order to undertake a valid study that is reflective of an extensive range of survivors’ experiences, as many survivors as possible need to be interviewed. Due to the nature of work undertaken by your organization, I am requesting your assistance in recruiting participants for this study. While the traumatic nature of this event cannot be overestimated, it is hoped that survivors will support the need for improvement in service provision and involvement in the aftermath of a loved one’s suicide. Their participation in this study will contribute towards this. It is requested that you introduce this study, together with its aims to members of your organization and provide them with my contact details. Greater detail regarding their involvement will be provided to potential participants, however broadly speaking, their involvement in the study will include completing a questionnaire regarding demographic information, and participating in an interview. It is estimated that the entire interview should take approximately 1-2 hours.

While participants will be encouraged to offer as much information as possible, they are free to refrain from discussing any issues that they choose not to. Their participation in the study is totally voluntary and they are free to withdraw and to remove any data that they may have contributed, at any time.

The rationale and design of this study has satisfied the strict guidelines laid down by the Ethics Committee of Edith Cowan University. Subject to any legal obligations, all data will remain confidential and publication of the results will not disclose participants’, or their family member’s, identities. At no time will names be reported along with the results of the study. If participants are interested in the outcome of this research project, I will be pleased to share it with them upon its completion which is scheduled for 2005.

If at any time participants become distressed with any aspect of this study, referrals for appropriate assistance will be made.
If you have any questions regarding any aspect of this research please feel free to contact me, or my supervisor, Dr Lisbeth Pike.

If you have any concerns about the study or would like to talk to an independent person, you may contact the Head of the School of Psychology, Dr Craig Speelman, on 6304-5551.

Thank you in advance for your assistance in this project.

Yours Sincerely

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Appendix B

Participant Introductory Letter

Thank you for your interest in this study. My name is Kelly-Joy Botha and I am a Doctor of Psychology candidate at Edith Cowan University, Joondalup Campus.

This study forms the practical component of my thesis preparation for the Doctoral Program. It focuses on bereaved family members' experiences during the aftermath of a loved one's suicide. The specific aim of the study is to ascertain the existence of any specific helpful or unhelpful events or factors, as identified by bereaved family members (survivors of suicide), in the immediate aftermath of the suicide. Due to the traumatic nature of the death, as well as the challenges faced by survivors subsequent to a family death by suicide, I aim to use your experiences during the aftermath to identify opportunities to modify the way in which services are implemented.

Your involvement in this study will include completing a questionnaire regarding demographic information. Following that, an interview will be undertaken, which should extend for between 1-2 hours. During this interview you will be guided through the sequence of events in the aftermath of your loved one's suicide. By working through your experiences in a time sequence, we attempt to ensure we gain as much information as possible. You will be asked to offer a free narrative of each stage with particular emphasis on any aspects which were perceived to have a helpful or unhelpful impact on your bereavement. Interviews will be tape recorded in order to assist the researcher to identify key issues. Interviews will not be transcribed per se.

You will be encouraged to give as much information in response to questions as you feel comfortable doing. There are no right or wrong answers and your honest reflection of experiences will be most appreciated. If there are any issues which you do not want to discuss, please feel free to indicate this.

Should you consent to participate in this study it is requested that you complete the attached consent document and return it to me before your involvement commences. Please understand that your participation in this study is totally voluntary and you are free to withdraw and to remove any data that you may have contributed, at any time.

The rationale and design of this study has satisfied the strict guidelines laid down by the Ethics Committee of Edith Cowan University. Subject to any legal obligations, all data remain confidential and publication of the results will not disclose your, or your family member's, identity. At no time will your name be reported along with the results of the study.

If you are interested in the outcome of this research project, I will be pleased to share it with you upon its completion which is scheduled for 2005. My contact details are listed below. If at any time you become distressed with any aspect of this study, referrals for assistance will be made.

If you have any questions regarding any aspect of this research please feel free to contact me, my supervisor, Dr Lisbeth Pike.
If you have any concerns about the study or would like to talk to an independent person, you may contact the Head of the School of Psychology, Dr Craig Speelman, on 6304-5551.

Thank you again for your interest in this research project. You may keep this document for your records.

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Appendix C

*Participant Consent Form*

Proband Number: ______

**Consent to Participate**

I, have read the Information Sheet and any questions I have asked have been answered to my satisfaction. I thus agree to participate in this study. I understand that my interview will be tape-recorded and that the research data gathered for the study may be published, provided I am not identifiable. I understand that my participation is voluntary and I am free to withdraw at any time and remove any data that I may have contributed. I also acknowledge that should I become distressed with any aspect of this study, assistance is available via the means detailed in the Information Sheet.

Signed: ____________________________

Date: ____________________________

_______________________________

Participant

Witness: ____________________________

Date: ____________________________

_______________________________

Researcher

*Thank You*
Proband Number: 

**Consent to Participate (Child)**

I, _______________________________ have read the attached Information Sheet and give permission for my child, _______________________________ to participate in this study. I understand that the interview will be tape-recorded and that the research data gathered for the study may be published, provided my child is not identifiable. I understand that my child’s participation is voluntary and that he/she is free to withdraw at any time and remove any data that he/she may have contributed. I also acknowledge that should my child become distressed with any aspect of this study, assistance is available via the means detailed in the Information Sheet.

Signed: 

______________________________ 

Parent / Guardian 

Date: 

______________________________ 

Participant 

Date: 

Thank You
Proband Number: ______
Date: __________________________

Participant Demographic Information

Personal details

Gender (please circle one): M / F / Other

Participant’s Age at Time of Deceased’s Suicide: ______________

Decedent’s Age at Time of Suicide: ______________

Participant’s Relation to Deceased: ______________

Duration of this relationship prior to death: ______________

Ethnic Group: ______________

Religion: ______________

Details of the event

Date of event: ______________

Time since event: ______________

Method used: ______________

Did you have any idea that your family member may suicide? If so, can you briefly expand on this (i.e., previous history of attempts etc)?

________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

Thank You
Appendix E

Abridged Circumstances of Exposure to Death Interview Protocol

**INTERVIEW SCHEDULE – CED**

Name of deceased: ______________________

I now have some set questions regarding your experience in the aftermath of the suicide. These are grouped in accordance with the sequence of events following (Name of deceased)'s death, starting with the Circumstances surrounding the death, followed by your Direct Exposure (what was witnessed), Indirect Exposure (visiting scene of death, viewing body), Events after the death (wake, funeral) and ending with experiences of later events (police interview, Coroner's Court). Thus we will attempt to work our way through your experiences in a time sequence in order to ensure we gain as much information as possible.

While I do have set questions, these merely serve as a guide to ensure we cover all of the necessary areas. Feel free to give as much information in response to questions as you feel comfortable. There are no right or wrong answers and your honest reflection of experiences will be most appreciated.

- **Circumstances surrounding the death.**

*Talk through the circumstances surrounding the death.*

Particular emphasis on anything which stands out, or anything during this experience which you believe was particularly helpful or unhelpful?

- **Direct Exposure:**

*Talk through your direct exposure to the suicide.*

Particular emphasis on anything which stands out, or anything during this experience which you believe was particularly helpful or unhelpful?

Did you go to the scene of injury/death before he/she was removed?

Was he/she dead?

Were you the first person to discover him/her?

Did you see him/her taken to the hospital?

**Prompts**

- **Indirect Exposure:**

*The Scene:*

*Did you go to the scene of the suicide afterwards? What can you tell me about your experiences?*

Were you offered the opportunity to visit the scene at this stage, or do you wish you had gone to the scene?

Were you advised either way?

What and by whom?

In retrospect how do you feel about that?
Prompts

Death notification:
*Talk through the experience of finding out, being notified and/or notifying authorities.*

Particular emphasis on anything which stands out, or anything during this experience which you believe was particularly helpful or unhelpful?
When and how did you first learn of the suicide?
Were you alone, or were other family members present?
Did you have to notify the authorities?
How did they respond?
If you were informed by authorities what were you told?
By who?
Were you offered the opportunity to be taken to the scene, or to the body at this time?
Were you kept informed of developments and events at this time?
Did _leave a letter?
What happened to this letter?

Prompts

Identifying the body:
*Talk through the experience of identifying the body. What can you tell me about your experiences?*

Particular emphasis on anything which stands out, or anything during this experience which you believe was particularly helpful or unhelpful?
What happened to _’s body subsequent to the discovery?
Were you kept informed of developments and procedures underway at this stage?
Who identified the body?

Prompts

The Autopsy:
*What can you tell me about your experiences of this procedure?*

Talk about your understanding of the autopsy in terms of the reasons for it, as well as any relevant information, guidance or advice you were given? Particular emphasis on anything which stands out, or anything during this experience which you believe was particularly helpful or unhelpful?

Prompts

Personal effects of the deceased:
*Talk through the processes involved with returning or removing any personal effects.*

Particular emphasis on anything which stands out, or anything during this experience which you believe was particularly helpful or unhelpful?
Were you involved with removing _’s personal effects from the home?

Prompts

Viewing the body:
*Talk through the experience of viewing the body. What can you tell me about your experiences?*
Particular emphasis on anything which stands out, or anything during this experience which you believe was particularly helpful or unhelpful?
Over and above identifying the body, did you view the body at a later stage?
If so, where and when?
Were you encouraged either way?
If so, by who and how?
In retrospect how do you feel about your decision and any advice given?

Prompts

- Events after death:

The Funeral or Wake:
*Talk us through the events, routines or mourning rituals which were undertaken after the death. What can you tell me about this time and your experiences?*

Particular emphasis on anything which stands out, or anything during this experience which you believe was particularly helpful or unhelpful?
Did you hold a funeral, and if so did you attend?
Did you have a casket?
Was it open or closed?
Did you have an active part in the funeral?
If so, what? (e.g., pall bearer, reader, other)
If you didn’t attend the funeral, why not?
In retrospect, how do feel about this?
Did you hold any type of remembrance or commemorative service for ________?
If so, can you tell us about it?

Prompts

- General:

Did you expect ________ to suicide?
Did you have any idea that they might?
Did you feel in control of proceedings and developments throughout the immediate aftermath?
Were there any stages where you felt less in control than others, and if so when were they? What more can you tell me about your experiences?

Finally, is there anything else you would like to share with me, or feel we have not covered, or any suggestions stemming from your experience of this event, that you feel will benefit others who are forced to embark on this traumatic journey?
Appendix F

Preset Mediating Prompts

**MEDIATING PROMPTS**

Were there any specific experiences or events, or lack thereof, that occurred during this stage that you feel had a particularly helpful or unhelpful impact on your bereavement?

Which service providers or authorities were involved in this stage and what was their role?

What was your experience of service providers or authorities involvement at this time?

How do you think your experiences during this stage impacted on your bereavement?

In retrospect is there anything that happened during this time that you wish had happened differently?
Advertisement for Research Participants

Been affected by **SUICIDE**?

My name is Kelly Botha and I am conducting Doctoral research in Clinical Psychology at Edith Cowan University. I am interested in speaking with parents (biological, step or de facto), children, siblings and partners (married and de facto) who have been bereaved due to the suicide of a family member. The event may have occurred recently or many years ago.

My focus is on your experiences in the time directly after the suicide - specifically events that you found helpful or unhelpful to your grieving process.

By sharing the results and information from this study with relevant service providers (eg. police, funeral directors, clergy) we will hopefully contribute to more appropriate support of others who are bereaved by suicide. Participation entails an informal interview lasting approximately one hour. All identifying information will be kept confidential. If you would like to participate in this study, or would like more information, please contact me. You can leave an anonymous message if you wish.
Appendix H

Recommendations

These recommendations are based on the data generated in this study. Whilst their development or exploration was not part of the initial aims of the study, they have emerged as a valuable product of the research.

1. Certain service providers inevitably encounter suddenly bereaved family members during the course of their professional work. Therefore, the need for these workers to receive appropriate education, information and training, regarding the importance and influence of their interactions with recently bereaved family members, is essential. All who interact with survivors need to be made aware that the time immediately surrounding the death of a close family member is considered to be crucial in determining a family's ability to accept the death and deal with the crisis, and that these individuals can play an integral role in facilitating the bereavement process. It is important that these individuals are able to visit the family in their home in the process of carrying out any official tasks, and are able to keep them informed of all relevant procedures and developments. It would also be helpful if family members were only required to deal with one person from each service organization.

2. Secondly, in conjunction with a suggestion put forward by the participants in this study, the potential benefits of having a single liaison officer or resource person, who has in-depth knowledge about all legal and administrative procedures and requirements following a suicide, as well as information and details relevant to the families' specific case, cannot be overlooked. This resource person should not only initially attend the family together with the police who are performing the death notification, but also needs to have ongoing contact with service providers and should be able to address any queries on the families' behalf, as well as assist
survivors with decision making and practical matters. Having access to such a person provides the family with the ongoing opportunity to ask any questions which they may not have been able to express at the time of the death. It is also crucial for this person to be able to make referrals and link survivors in with relevant support networks. These workers need to be aware of the unique aspects that characterise suicide bereavement, and thus be adequately trained and prepared to anticipate and meet the needs of this particular group. They should also be aware of issues that confront suicidally bereaved children, and be in a position to guide parents on how best to deal with children during this time. Such a person may also facilitate the grief process by assisting the survivors to engage with and accept the reality of the event. At this stage, it seems from the survivors’ feedback that a fellow survivor would be best suited for the nature of this work. Support for the benefit of assistance from a fellow survivor is offered by Klass and Shinners (1982-1983) who suggested that survivors may find it far more significant and beneficial to hear what it is like to be a survivor from a lay person who has a similar experience, rather than be guided by an unaffected professional. I do however feel that this may not be without its limitations either, and an alternative option may be for survivors to be actively involved in the training of such individuals.

3. The data also highlighted several general and service-provider specific procedures that participants deemed to have been unsatisfactory and to have had a clear detrimental impact on their respective bereavement experiences. The following recommendations thus address these individual procedural aspects with reference to each relevant service provider, as well as the more generic procedures that are not necessarily service provider specific. The format follows that of the Discussion section of this paper.
a) Ambulance. The ambulance attendance at the scene of the suicide is an understandable practise, as is their policy of not transporting deceased individuals. Findings from the data do however suggest that these emergency responders should be made aware of the impact of hearing that the organization is not licensed to transport dead bodies, as well as the benefits of imparting this knowledge in a sensitive and tactful manner. In addition, the practise of billing family members when no direct service has been administered to the deceased, apart from attending the scene, does appear insensitive and inappropriate. It is understandable that participants in this study experienced this procedure as painful and additionally traumatic. It is proposed that in a case of suicide, or any unnatural death in fact, where no services are rendered, compassion and understanding on behalf of the service provider should be exercised and the expense for the ambulance attendance voided.

b) Police. From the data there appear to be numerous areas or opportunities for service improvements within the police service. These included the police officer's manner when conducting any of the compulsory interviews, the nature of the investigative questions, as well as procedure of death notification. Although it is understandable that there is much to be covered during cadet training, I believe that the processes and procedures surrounding death notification and dealing with bereaved families were afforded insufficient attention. In addition, the manner in which the Trainer of Recruits dealt with content of the lessons as well as the cadets' queries was deemed less than satisfactory. By creating a greater awareness of the issues that confront survivors in the time following a suicide, as well as the impact which the police interactions have on the grief process, police officers may apply
themselves in the course of their duties in a more appropriate and sensitive manner. This in turn may limit additional trauma for the survivors as well as inadvertently limit the distress that is inherent in performing these tasks. It is also recommended that the nature of the questions asked by the investigating officer from the Coronal Inquiries Section is addressed. Concerted efforts to phrase the necessary questions in a manner that is more respectful of the deceased, the survivor, and the survivor's emotional state at the time of interview, and not so clearly aimed at the benefit of Coroner, need to be incorporated. Finally, bearing in mind that officers in this department of the police force are required to have regular interactions with survivors, the fact that have no additional training in this field is unacceptable.

c) Government contractor. Based on the data generated, it appears that the contractor needs to be made accountable to the department by whom they are employed. It may also be beneficial to hire more than one such individual in the event that the primary contractor becomes too busy to deliver an acceptable service. Finally, there needs to be liaison between any service providers who have seen the body and are aware of the circumstances, and the contractor. In this way, the contractor can be notified of any information that may influence or affect the contractor's routine, or manner in which the service is undertaken.

d) Office of the State Coroner. The need for participants to own a copy of the Coroner's final report was strongly evidenced throughout the data. Not only did participants believe they had a right to such a report, it also appeared that the lack of access to this report had a significant and negative impact on their grieving process. Understandably, caution needs to be exercised regarding the availability of sensitive material, however the support that this issue was
given throughout the study suggests that the principles and procedures which govern the accessibility of this report warrant further exploration and possible amendments.

e) Clergy. The clergy may benefit from additional education educated regarding the significant and influential role it plays in educating both members of their congregation, as well as the community at large, about the issues that confront suicide survivors. Furthermore, the clergy also plays a vital role in continuing to dispel suicide-related myths that they may previously have initiated, ascribed to and enforced.

f) Mental health professionals. Bearing in mind the distress that unsatisfactory interactions with mental health professionals, namely psychiatrists, caused participants in this study, it is recommended that such professionals are encouraged to contact the family following a suicide, not only to provide them with information that they may require (within relevant ethical constraints), but also as an expression of compassion, and as a reflection of their respect for the patient and their relations. In addition and where appropriate, the treating professional should be encouraged to attend the funeral. Such practises may also assist the treating professional in their own related grieving process.

g) Airlines. The importance of familial support in the time following a suicide, as well as the role which attending the deceased’s funeral may play in facilitating the survivor’s bereavement, was highlighted in this study. However, the supposed compassionate airfares charged by airlines not only prevented certain survivors travelling to their family at this time, but also prohibited certainly family member’s attendance at the funeral. The fact that the compassionate fare was more expensive than other flights was deemed by
participants to be incongruent, insensitive, and to have had undesirable ramifications for the affected participants and their families. It is therefore proposed that airlines are made aware of the far-reaching impact of this practise, as well as the role that they can play in limiting additional trauma for families who need to travel at this time.

h) Death notification. In terms of the official death notification delivered by members of the WA police, the importance of improved education and training has already been highlighted. With a greater understanding of the dynamics and issues that confront survivors during this time, as well as more applied training in this area, police officers are likely to undertake this task in a more appropriate manner, and thus hopefully ameliorate some of the trauma that is inherent in delivery such news, both for the police and the family members.

i) Viewing the deceased's body. All evidence suggests that viewing the body of the dead person is an important part of the adjustment process. This knowledge, in conjunction with the participants' reflections, highlighted the importance of offering survivors the opportunity to see, spend time with and touch the body. Informing family members that spending time with the deceased helps some people accept the loss and facilitate the grieving process is also important. Ultimately, it is crucial that family members are made aware of what to expect and then chose for themselves whether or not to they want to view the body.

j) Mementoes. The importance of being offered the deceased's personal belongings, irrespective of their state, cannot be ignored and needs to be shared with those who may be involved with this process. In the case of
broken or soiled items, the family should be advised accordingly, but still be
given the opportunity to acquire these items.

k) Finalising the deceased's estate. The importance of service providers
attending to the survivors in their own home has already been mentioned. The
notion of having a specially trained individual within each organization or
institution (i.e., banks, insurance companies) who attends the survivors in
their home, and who is responsible for assisting family members with
finalising the deceased's estate, warrants further attention. As far as such
organizations and institutions are concerned, there also appears to be scope for
improvement in certain administrative procedures to insure that families do
not continue to receive communications addressed to the deceased,
subsequent to being notified of the death. In addition, the feasibility of the
state government providing a free or inexpensive legal support service to
specifically assist bereaved families with the procedures incumbent in
finalising a deceased's estate, needs to be explored. Such assistance may
ensure a smooth and efficient estate closure, which may in turn facilitate the
survivor's grief process.

l) Child survivors. Due to the unique issues that this data suggested confronts
suicidally bereaved children, it appears that the practise of providing bereaved
children with their own specially trained support person may have far-
reaching and positive ramifications. In addition, guidelines for parents
regarding manners and methods of best practise when dealing with their
bereaved children should be developed and offered to these parents, in
conjunction with the bereavement support pack sent by the Office of the State
Coroner.
4. Finally, it appears that suicide survivors in WA lack the opportunity to voice what was important to them during the critical emotional period following a family member’s suicide. Consequently, their specific suggestions and complaints often go unrecognised. This lack of feedback perpetuates the recurrence of fundamental errors, as well as prohibits extrapolation from positive experiences. It would thus appear that both service providers and past and future suicide survivors might benefit from such a provision. Many participants commented on the cathartic experience of being able to participate in this study, and expressed appreciation for the opportunity to provide information and tell their story. Ensuring future survivors have an opportunity to provide feedback about their experiences to both service providers and the community at large may be of therapeutic benefit as well.