Suicide bereavement and coping: a descriptive and interpretative analysis of the coping process

Megan Gaffneya *, Barbara Hanniganb

*aSchool of Psychology, University of Dublin, Trinity College, Dublin, Ireland

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Abstract

A qualitative approach to research was used to explore coping in the aftermath of bereavement by suicide. Ten participants completed a semi-structured qualitative questionnaire, reporting on individual coping and perceptions of effective coping during the bereavement. Responses were analysed using descriptive and interpretative thematic analysis (Elliott & Timulak, 2005). Key themes found include: initial experience of ‘shocked detachment’, helpfulness of receiving support, aiming to maintain a normal, familiar routine, balancing emotional expression and regulation, and coming to terms with the reality of the loss. All participants reported changes in general coping abilities following the loss.

Keywords: Suicide, suicide bereavement, postvention, survivors, coping.

1. Introduction

1.1 International context of suicide

Each year, nearly one million people die by suicide globally, according to the World Health Organisation (2010), the equivalent of one death every 40 seconds. Over the last 45 years, suicide rates have increased by 60% worldwide (WHO, 2010). Suicide is considered one of the most important causes of death in Europe by the WHO (2002), particularly in young and middle aged people and young men.

For every death by suicide, there are at least 6 bereaved people left behind (American Association for Suicidology, 2004), deeply impacted by the loss. The friends and family commonly referred to as ‘survivors,’ remain faced with the challenge of coping with this tragedy.

1.2 Suicide bereavement and postvention research

Suicide research has typically fallen into one of three areas: prevention, intervention, or postvention. Postvention activities are deemed appropriate, helpful, and supportive to the bereaved in the aftermath of a suicide (Schneidman,
In a research context, postvention has often been termed the poor relation of prevention because postvention generates considerably less research. Evidence based practice in this area is lacking (Clark, 2001; Grad et al., 2004). Little is known about the intricacies of how common postvention activities, such as bereavement support groups, assist individuals to cope. Research on postvention is essential both for the care of the bereaved and to prevent complications which can occur in the aftermath of a suicide, particularly further suicide (Leenars & Wenckstern, 1998; Clark, 2001; Campbell et al., 2004). It has often been stated that postvention acts as prevention for the future.

The need for more emphasis on postvention has been recognized internationally. In 1999, the International Association for Suicide Prevention (IASP) formed Task Force Postvention, with the aim of organizing knowledge and promoting research in this area. Across 42 countries in Europe, there are large variations in the type and level of supports available for suicide survivors (Andriessen, 2004). International studies have indicated a climate of “social helplessness” around this issue and a greater need for knowledge, compassion, and skills in caregivers (Grad et al., 2004).

Studies conducted on the aftermath of suicide have typically focused on whether suicide bereavement differs from bereavement by other causes and on pathology arising during the bereavement process. Somewhat conflicting findings exist in the literature as to how much the type of death effects the experience of grief and the subsequent resolution. Studies have indicated that suicide survivor reactions do not differ significantly from other types of bereavements (Barett & Scott, 1990; Van der Wahl, 1989; Muller & Thompson, 2003). However, other studies suggest that suicide bereavement involves qualitative differences as compared to other bereavements, (Van der Wahl, 1989), that the bereavement process involves different aspects, (Bailley et al., 1999), contains unique themes (Jordan, 2001), is often more complex (Knieper, 1999), and takes longer to “move on” (Fielden, 2003). These studies suggest that elements such as shame, blame, guilt, and stigma are often more present in the process of suicide bereavement than bereavement from other causes. Additionally, survivors may exhibit higher levels of problematic grief and heightened risk for physical and/or mental health complications, including suicidal ideation (Mitchell et al., 2004).

Despite the lack of clarity in the literature as to how much traditional bereavement experience extends to the experience of bereavement by suicide, it is certainly relevant to consider traditional bereavement models when examining suicide bereavement. Historically, stage models have often been used to conceptualise the process of bereavement (Kubler-Ross, 1969; Bowlby, 1980), suggesting that coping with bereavement involves moving through specific tasks. Other bereavement models, such as the Dual Process Model (DPM) (Stroebe & Schut, 1999, 2001) contend that coping with bereavement involves managing numerous and complex stressors and thus is not linear.

While several studies have tried to capture the grief experience of those bereaved by suicide (Van der Wahl, 1989; Fielden, 2003; Begley & Quayle, 2007) the development of suicide-specific models is still in its infancy. Additionally, very little is known about how suicide survivors actually cope with the loss.

Historically, coping research has focused on the concepts of defense and cognition. Lazarus (1966) defined coping as cognitive and behavioural efforts used by an individual to manage demands that exceed perceived resources. Coping strategies are often grouped into problem-focused and emotion-focused strategies (Lazarus & Folkman, 1984; Folkman & Moskowitz, 2004). More recently, coping literature has explored the emotional processes which occur during chronic stress (Lazarus, 1991) and the use of meaning-making strategies (Folkman & Moskowitz, 2000). This trend coincides with a shift in psychological literature in general from pathology towards adaptation (Seligman & Csikzentmihalyi, 2000). During bereavement, adaptive strategies can be described as those that contribute towards a decrease in negative psychological and/or physical consequences or decreased levels of grief (Stroebe & Schut, 2001). Which mechanisms for coping are likely to be adaptive during a traumatic bereavement? This question remains unanswered, particularly for those bereaved by suicide. The authors contend that while the experience of coping with bereavement by suicide is subjective and unique for each individual, it is likely that there are common themes in the experience of coping during the aftermath of this type of loss. Theory generated in this area can inform both mental health practitioners and postvention services in how to better support the bereaved.
1.3 Research Aim

Researchers have called for the generation of hypotheses in the area of suicide postvention (Leenaars et al., 1997; Leenaars & Werckstern, 1998), for more personal accounts of the survivor experience (Mcintosh, 1996) and for the use of qualitative measures to elicit further detail on the bereavement experience (Begley & Quayle, 2007). To date, most of the studies on suicide bereavement have focused on processes and pathologies as opposed to the aspect of survival and coping. This study aims to explore the processes which enable suicide survivors to manage and cope during their tragic loss.

2. Main Body

2.1 Method

Ten participants, 5 male and 5 female, who were bereaved by the suicide of a partner or family member, completed a semi-structured qualitative questionnaire. Questions guided participants to report on individual coping immediately after and during the first year post suicide (see Table 1). Questions also guided participants to describe their perceptions of effective coping and changes in stress management and coping mechanisms following the death. Participants were given the option of an interview or writing down their responses.

Participants were recruited through two local services in Dublin, Ireland for suicide bereavement support. One service operated an open support group and the other ran a closed support group and offered individual counselling. These services are roughly representative of the type of suicide bereavement support services offered across Europe as indicated by the IASP (Andreissen, 2004). Ethical approval was obtained from the University of Dublin, Trinity College Ethics Committee. To minimize potential risk, all participants were given the option of debriefing and ongoing support with a professional within the bereavement support service following participation in the research as needed.

Table 1. Researcher-constructed questions

<table>
<thead>
<tr>
<th>Demographics recorded and broad interview schedule followed</th>
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<tr>
<td>Participant age range, nationality, gender and urban/rural living.</td>
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<tr>
<th>Relationship with the deceased</th>
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<tr>
<td>What was your relationship to the person who died?</td>
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<tr>
<td>How close were you to the person who died?</td>
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<tr>
<td>How long has it been since the loss?</td>
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<tr>
<th>Coping in the first 2 weeks after the suicide</th>
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<tr>
<td>How well do you feel you coped with the loss during the first two weeks?</td>
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<tr>
<td>What, in your opinion, is coping well during the first two weeks of bereavement?</td>
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<tr>
<td>How, specifically, did you cope during the first two weeks?</td>
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<tr>
<td>What helped you most to get through the loss during the first two weeks?</td>
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<tr>
<th>Coping in the first year</th>
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<tr>
<td>How well do you feel you coped with the loss during the first year?</td>
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<tr>
<td>What, in your opinion, is coping well during the first year of bereavement?</td>
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<tr>
<td>How, specifically, did you cope during the first year?</td>
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<tr>
<td>What helped you most to get through the loss during the first year?</td>
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<tr>
<th>Coping in the aftermath of the bereavement by suicide</th>
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<tr>
<td>Are there any changes in how you cope with stressful events since the bereavement?</td>
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2.2 Analysis and Results

Responses were analysed using descriptive and interpretative thematic analysis (Elliott and Timulak, 2005). The descriptive-interpretative approach in its analysis phase observes the following steps (cf. Elliott & Timulak, 2005):

a) data collected are assigned into domains (the domains represent a conceptual framework that the researcher brings to or unearths in the data); b) meaning units are delineated (the meaning units represent the smallest essences of what is being said, distilled to form a concept that conveys meaning independently); c) categories are generated through the comparison of meaning units that link and are interrelated on the basis of conveying similar meaning; the categories are defined on the basis of meaning units they contain and can be further categorized; d) the main findings are abstracted in the form of narratives. The analysis also uses several safeguards (credibility checks) that ensure its validity (e.g. triangulation and independent auditing). All data from this study were independently analysed and compared for consensual agreement and any discrepancies that arose were discussed often at length until mutual satisfactory agreement was attained, true to the original narratives provided.

Length of time since the bereavement ranged for participants from one year to 24 years. Participants ranged in age from 18-24 to 60+ with the mean age of 38. Between the ten survivors, the participants had accessed a broad variety of professional services, including support groups, counselling, psychotherapy, group therapy, general practitioners, psychiatrists, family support services, and pharmacological treatment. Services were accessed by participants on a range from; a few days to 15 years following the bereavement.

Themes generated during the analysis have been broken down into 3 distinct periods: coping during the initial aftermath, or 2 weeks post bereavement (Table 2), coping in the medium term, or one year post bereavement (Table 3), and coping in the long term (Table 4).

### Table 2. Initial 2 weeks post-bereavement

<table>
<thead>
<tr>
<th>Perceptions of ‘coping well’ during the initial 2 weeks:</th>
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<tbody>
<tr>
<td><strong>Expressing &amp; managing loss</strong> - acknowledging reality of loss and its impact, speaking about deceased, aiming for normalcy, acceptance, fluctuating between problem solving and feeling, making funeral arrangements and recognition that deceased is no longer tormented.</td>
</tr>
<tr>
<td><strong>Meaning making</strong> - recognising the deceased is no longer tormented, appraising the loss</td>
</tr>
<tr>
<td><strong>Support seeking/giving</strong> - personal and professional support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accounts of actual experience during the initial 2 weeks:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shocked detachment</strong> – depersonalisation, detachment, blur, isolation/solitude, being robotic, survival/cope mode, attaining geographical distance, distancing/avoidance of experience and purposefully delaying the grief process</td>
</tr>
<tr>
<td><strong>Disintegration</strong> – shattered and having suicidal ideation</td>
</tr>
<tr>
<td><strong>Task oriented typical/impaired functioning</strong> – normalcy in functioning, feelings of functioning well and attending to others/impaired functioning (loss of appetite &amp; sleep)</td>
</tr>
<tr>
<td><strong>Emotional expression/regulation</strong> - expression of grief, crying, anger, numbness, flattened feeling, elation and feeling love for deceased</td>
</tr>
<tr>
<td><strong>Accepting/Giving Support</strong> - personal, professional, and pastoral, providing support for other family members</td>
</tr>
<tr>
<td><strong>Controlling impact</strong> - seeking information, knowledge and investigating the suicide, accepting the death as a choice for deceased person.</td>
</tr>
<tr>
<td><strong>Restoration tasks</strong> - involvement with funeral and morgue, pragmatically managing the ritual of burial etc.</td>
</tr>
</tbody>
</table>

### Table 3. First year post-bereavement

<table>
<thead>
<tr>
<th>Perceptions of ‘coping well’ during the first year:</th>
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<tbody>
<tr>
<td><strong>Accepting finality of loss</strong> – reality that the deceased is gone</td>
</tr>
<tr>
<td><strong>Maintaining Functionality</strong> - normalcy, coping with increased task demand</td>
</tr>
<tr>
<td><strong>Expression of loss</strong> - talking about deceased</td>
</tr>
<tr>
<td><strong>No longer asking why</strong></td>
</tr>
<tr>
<td><strong>Support seeking</strong> – personal and professional</td>
</tr>
<tr>
<td><strong>Basic coping</strong> - being in survival mode, consumed with grief, minimising the trauma</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Accounts of actual experience during the first year:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accepting &amp; giving support</strong> - personal, professional and pharmacological</td>
</tr>
<tr>
<td><strong>Maintaining familiar routine</strong> - functionality and aiming for normalcy</td>
</tr>
<tr>
<td><strong>Emotional expression/regulation</strong> - creative writing, learned expression of emotion, distraction specific techniques purposefully employed and experiencing denial and acceptance</td>
</tr>
<tr>
<td><strong>Solitude/Isolation</strong> - privately grieving in solitude, feeling stigmatised, and feeling isolated</td>
</tr>
</tbody>
</table>
Restoration tasks: reframed interpretation of death (new beginning/moving on)

Fluctuations between coping and not – disintegration, ensuing chaos, compound losses, poor coping, self soothing, escaping, mania and substance misuse

Cultural perspectives - issues of coping with stigmatisation of suicide as a crime - circa time

Death-related rituals: funeral, burial, wake and condolences

Table 4. Long term effects on coping

<table>
<thead>
<tr>
<th>Inability to cope</th>
<th>Inertia, ‘bad’ reactions, confusion, anger, depression and panic symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posttraumatic growth</td>
<td>less stress, personality change, gained increased clarity, improved attitude to stress, feeling more supported (through professionals), new outlook and more coping skills</td>
</tr>
<tr>
<td>Ongoing consequences</td>
<td>lingering feelings of guilt and increased real life responsibilities due to circumstance</td>
</tr>
</tbody>
</table>

All participants have been assigned pseudonyms to protect anonymity.

2.2.1 Initial coping

During the initial aftermath, participants described ‘coping well’ as being able to acknowledge, accept, and manage the loss, including expressing the related emotions.

“Being able to give vent to the emotions that bereavement invokes. Attempting to accept what has happened or at least that things will not be the same and trying not to let the situation shut you down so that you cannot function.” (Sarah)

The experience actually described during this time for many participants was one of shocked detachment. Participants acknowledged initial feelings of depersonalisation, detachment, blur, isolation/solitude, feeling robotic, and using strategies which created distance with the reality of the loss.

“I felt exhausted and found it hard to talk to people about what had happened. I tried to stay away or get out of the house.” (Sally)

“I think I detached myself from reality and felt like it was happening to somebody else.” (Kate)

The range of experience varies, as the theme of emotional expression and regulation, captures a continuum including crying, identifying and expressing feelings to numbing and elation:

“My mother’s philosophy was that we had to keep some sense of normalcy and try to get back into the routine of everyday life. Just to keep doing these simple things like getting dressed and washed, etc though we could deal with the emotional side however we felt like. This I found particularly important where I had three very young siblings who didn’t really understand what was going on”. (Jane)

Brian described a feeling of complete shattering and disintegration when alone, and feelings of ending his own life.

“I did go to pieces when alone at night. I felt a need to ring a gay helpline and the Samaritans (phone helpline for people experiencing distress) to deal with feelings of taking my own life.” (Brian)

Some participants described coping as being able to continue with their normal level of task functioning, while others experienced marked impairment in this area. Problem-solving the additional demands of tasks related to the bereavement were often a welcome distraction; some experienced difficulties with basic functioning such as eating, sleeping, and feeling able to get through the days. Participants reported fact-searching and investigating for information on suicide in an attempt to understand what had happened or control against the impact

“I did my own investigation into the drugs (antidepressants) my partner was taking on the internet.”

(Brian)

2.2.2 Medium-term coping

During the first year post-bereavement, participants expressed that ‘coping’ well was characterised by being able to accept the finality of the loss, and to maintain functioning as they had before:

“Accepting what happened and not letting it affect your normal life. Life must go on as they say.
Being able to cope with all the extra activities which result from such a loss is coping well in my opinion.” (Luke)

and to be able to open up about and express the loss and feelings related to the death. The term ‘committed’ is still present in the narratives of some Irish people when describing completed suicide, despite the fact that suicide has been legally decriminalised:

“To be able to express your feelings of loss and to be more open to talking about the person who committed suicide.” (Kate)

When reporting on the experience of coping during the first year, accepting support played a vital role for all participants. When asked what helped the most, participants mentioned understanding, kindness, and sympathy from those around them. Both practical and emotional support were appreciated greatly:

“. . .The support we had from other family members, other relatives, and a wide circle of friends. The local clergy also helped and the order of nuns in which the deceased’s aunt was a member. Neighbours also helped with sympathy and understanding.” (Luke)

Participants also found professional supports useful, for expressing stories and feelings and hearing the experiences of others:

“I also found doing the 8 week therapy group on suicide most helpful in hearing other people’s journey.” (Daragh)

Parents mentioned having to give support to their children and feeling that they had to stay ‘strong,’ particularly where young children were bereaved illustrating further complexity in managing their grief while considering the impact of their coping responses upon others.“. . .had to keep strong for my kids as they had lost someone so special to them through suicide.” (David)

During the first year, participants found it helpful to maintain a familiar routine and do things they had done before, such as work, school, and hobbies. Many of these activities had a ‘grounding’ quality for participants as they provided a sense of familiarity in a changed reality.

“Retaining that sense of structure where our lives had effectively been shattered was a huge factor in helping us to get on with our lives, to go back to school and do things that we were intending to do when my dad was alive.” (Sarah)

In addition to retention of structure that had been in place before, participants also found solace in pursuing projects that they had planned to pursue before the death and in creating a new reality or routine way of being for moving forward in a restorative way.

“I try to put a ‘norm’ back into life. I called (husband’s name) death another chapter in my life. So everything I did was new to me.” (Anne)

Emotional expression and emotional regulation were active processes during the first year. Participants described fluctuations between talking about the person, expressing feelings, using creative mediums such as writing and music to process feelings, alongside a desire not to talk all the time and to feel that it was acceptable not to talk. Hearing the experiences of others seemed to help survivors to contextualise and identify their own feelings about the loss.

“. . . I learned to cry. I found that I didn’t want to discuss it with my school friends although they knew what had happened. I preferred to deal with it myself. I did get involved with a support group and found that listening to other people’s experiences helped me to put my own feelings in context. I also started writing lyrics again and wrote two or three songs about my experience and my dad. It was one of the best emotional releases I had since my dad’s death.” (Sarah)

Distancing strategies were also employed by survivors at this time, such as distraction, denial, and withdrawal:

“On reflection, I was very involved in other relationships . . .I was very busy. I had a job, an intense relationship, and a band.” (Mark)

The first year was a time of fluctuations for some and more marked upheaval for others, with participants noting coping at times and not at others.

“I think I coped well at some times and really bad at other times.” (Sally)

Upheaval was experienced by some. Not coping involved losing basic security and questioning survival. “I looked for help through the health services because I thought I was going mad and I simply couldn’t cope with doing small tasks let alone try to survive. I ended up sleeping on sofas and
floors . . . I became homeless with no money or support.” (Brian)

2.2.3 Long-term coping

All participants stated they experienced changes in the way they cope with stress since the loss. David and Brian reported a complete inability to cope with stress.

“Bad reactions, not understanding situations, being confused, angry, depression, no self worth, blame, crying, panic attacks.” (Brian)

“I feel I can’t cope with stressful situations anymore and have changed jobs as a result.” (David)

Others reported posttraumatic growth, and described feeling more able to cope, being clearer, like a different person with a different attitude to stress. Participants reported developing greater access to supports and more coping skills over time.

“Throughout exams and other stressful events, I soon realised that there are more important things in life and that worrying about so many little things is just a waste of time. I refuse to get worked up too easily.” (Sarah)

Jane describes the ongoing consequences the suicide has left her to work through emotionally:

“Need to get rid of huge amount of guilt suicide leaves behind.” (Jane)

3. Discussion and Conclusion

3.1 Discussion of Analysis

While participants’ experiences in the immediate aftermath generally fit with existing literature on the experience of suicide bereavement, they did not fit with the individuals’ perceptions of what effective coping was. Thus, there may be a perceived gap as to what a ‘normal’ reaction to a traumatic loss such as bereavement by suicide may actually involve.

While participants felt that acceptance and normal functioning were signs of effective coping initially, what they actually experienced was a state of ‘Shocked detachment.’ Participants’ experiences of blurred reality and detachment are consistent with Bowlby’s (1980) first stage of grief as shock and Fielden (2003) who noted that individuals bereaved by suicide experienced feelings of shock, numbness, and disengagement, contributing towards an initial state of ‘Thrownness.’

A dissonance seems to exist between participants’ expectations of effective coping and the actual experience, which for many includes detaching emotionally during the initial stages of bereavement by suicide. This could be a defensive strategy, a conscious or unconscious attempt to minimise the trauma. Begley & Quayle (2007) suggest the primary task initially for survivors is attempting to ‘control the impact’ of the death. The initial aftermath is characterised by this avoidant emotion-focused coping. The reality of the loss may be so overwhelming initially that survivors needed to detach to survive and maintain the everyday functioning they also deemed important. Avoidant coping is generally considered less adaptive and is the opposite of what participants described as effective coping. However, avoidant coping can be effective in the short term as long as it is not employed for a length of time, leading to greater distress (Updegraff & Taylor, 2000).

Already in the first two weeks, the variation in survivors’ reactions is evident, showing the subjective nature of the bereavement and coping process. Other research (Bailley et al., 1999) has noted great variability in the experience of suicide survivors and extreme range in factors of grief. In the initial stages, the experiences felt by many participants meet definitions of post-traumatic stress. Themes generated suggest that coping was less conscious and active initially, as some reported being thrown between detachment and strong feelings, presenting similarities to the intrusion and avoidance cycle documented in trauma literature (Horowitz, 1976).

During the first year, coping was characterized by fluctuations between expression of emotions and the loss with regulatory strategies such as distancing, avoidance, and focus on daily tasks. Models such as the Dual Process Model (DPM) (Stroebe & Schut, 1999) have identified oscillations between loss and restoration coping as characteristic during the bereavement process. Some participants in this study were able to navigate the fluctuations more smoothly than others. Research has indicated that (Stroebe and Schut, 2001) with traumatic bereavements, the movement between emotional experience and restoration tasks is not as controllable as it might be with other
bereavements. Many participants in this study reported it was grounding and helpful to complete their familiar, normal routine and that this assisted them in performing other restorative tasks.

Accessing and giving support proved valuable for participants. Van der Wahl (1989) suggested that maintaining relationships and supports was an essential task in bereavement by suicide. Within the domain of accepting emotional support, there is considerable debate in the literature on the role and level of emotional expression that is helpful to the bereavement process. While bereavement models have traditionally promoted the expression of affect, the benefits of this process have been challenged (Pennebaker, 2001), may be based on cultural assumptions of how we think we should grieve (Pietila, 2002), and do not hold up in clinical trials (Wortman & Silver, 2001). However, survivors often indicate talking in support groups is helpful, to be heard and to learn to accept social support (Muller & Thompson, 2003) and to normalise the mourning process (Pietila, 2002). Participants in this study reported that voicing their own experiences and feelings along with hearing experiences of others assisted in the bereavement process. However, this is balanced with finding it helpful sometimes not to have to speak about the deceased and finding solitary grieving as helpful at times. Thus, the unique nature of this type of bereavement is held alongside the idea that common themes mark the bereavement process for many.

In the long term, ten out of ten participants indicated changes in how they cope with stressful events since the bereavement. Two distinct themes emerged; one group reported growth following the bereavement and the other felt unable to cope with stress anymore. Those who experienced growth described a cognitive restructuring of the way they see the world. These individuals no longer appraise stimuli as stressful that they may have seen as stressful prior to the bereavement. Reinterpretation and acceptance appear to be linked with growth following a stressful event (Updegraff & Taylor, 2000). These participants described posttraumatic growth, which is defined as a cognitive process that is initiated to cope with traumatic events which are cognitively and emotionally distressing (Tedeschi et al., 1998). Participants who described a perceived inability to cope describe symptoms of distress lasting long term, such as depression, panic, and the inability to manage challenges which would have been manageable prior to the death. In addition to this, emotional legacies of guilt and stigma remain. It appears that the personal, social and environmental contexts of those bereaved played a very significant role in longer term coping, ranging from the experiences of one participant; a mother of eight children whose husband died, who reported keeping the routine and daily tasks going as a protective factor for longer term coping while another male gay participant whose partner died found himself completely disenfranchised by his partners family, lost their family home and suffered long periods of isolation and felt a complete inability to cope.

3.2 Implications for therapy

These are specific areas that could be potentially addressed therapeutically and the importance of checking for such consideration in both the event of post-traumatic growth and perceived inability to cope needs to be considered. Post traumatic growth as a cognitive restructuring coping mechanism may at some level be indicative of a potential loss of attunement to more mundane stressors, this could negatively impact on a persons sense of empathy for self, others and capacity for connection in relationships. Equally, inability to cope as a defining outcome from such a loss may also need to be sensitively challenged therapeutically to unearth the unacknowledged efficacy in the survivors coping process, while simultaneously not minimising the perception of the experience. It is also important to evaluate and monitor risk in survivors of suicide in the long term aftermath. It seems vitally important to emotionally process the tragic loss while simultaneously assisting clients to derive a sense of meaning from their experience in helping them to come to terms with the loss and its consequences. Therapeutic work with clients suffering with emotional disregulation and severe or chronic stress symptoms such as anxiety and depression can be very challenging and it is important to monitor ongoing practice with effective, supportive supervision.

3.3 Reflective Practice

Conducting research in suicide postvention is a difficult task, as this population is difficult to access, perhaps due to the stigma and isolating aspects that still exist during the aftermath of this unique tragedy. The challenges in accessing these groups raise questions for reflection regarding the factors contributing to these ethical sensitivities from a phenomenological perspective. Better understanding of such phenomena is required through further research to add to the relatively sparse knowledge base and to improve therapeutic practice. The cultural considerations
present in addition to the time the suicide occurred may impact how a person responds and copes in the aftermath as stigma and cultural beliefs about suicide and grieving appear to have a role to play.

3.4 Conclusion

Coping with suicide bereavement is a complex phenomenon as richly described by the participants in this relatively small scale study. Without such openness and generosity in sharing their stories we wouldn’t have learned about the diversity in the trajectory of potential coping outcomes. It was very touching, saddening and inspiring for the research team to engage with these people in this study.

Acknowledgement

The findings presented are based on data collected for Megan Gaffney’s master’s thesis submitted in partial fulfilment for the degree of MSc in Counselling Psychology from Trinity College Dublin, supervised by Barbara Hannigan. These findings were part of a larger study, which also included quantitative data. This study was made possible by the openness and bravery of the participants and the flexibility and dedication of the suicide bereavement support services involved. Thank you also to Dr. Ladislav Timulak for kindly reviewing and editing the final draft.

References


