

META-INTERPRETATION OF THE
SELF-PERCIEVED NEEDS OF SUICIDE SURVIVORS

By

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A thesis submitted in partial fulfillment of the requirements
for the degree of

Masters of Counselling (MC)

City University of Seattle
Victoria BC, Canada site

May 29, 2015

APPROVED BY

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Division of Arts and Sciences

SELF-PERCIEVED NEEDS OF SUICIDE SURVIVIORS

Abstract

Suicide is a major issue around the world, leaving a staggering number of individuals are left behind to suffer navigate the complicated bereavement process after a loved one dies. These individuals are at high risk of many challenges including complicated grief and suicide. The purpose of this meta-interpretation is to analyze and interpret what previous research has found the self-perceived needs of suicide survivors are. A typology of suicide survivors needs is developed to help guide organizations when they are implementing support services for those left behind after a suicide death.

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Acknowledgements

I would like to thank Dale Jarvis my mother and long suffering editor for her support. One day I'll get a hang of this grammar and spelling business and your job will be easier.

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Chapter 1: Introduction

“A person’s death is not only an ending: it is also a beginning – for the survivors. Indeed, in the case of suicide, the largest public health problem is neither the prevention of suicide ... nor the management of attempts ... but the alleviation of the effects of stress in the survivor-victims of suicidal deaths, whose lives are forever changed” (Shneiddman, 1973, p.33).

Impacts of Suicide deaths

Suicide is a major issue facing mental health care workers, first responders, health care providers, and health organizations worldwide. The World Health Organization estimates that world wide over 800,000 people die by suicide each year (World Health Organization, 2014). There are other estimates that place the number of suicides at over one million (Wilson, & Marshall, 2010, Clark, 2001; Andriessen, 2014). These estimates do not include drug overdoses, single person car accidents, and other events where it is unknown if the death was a suicide (Wilson & Marshall, 2010). In Canada there are close to 4,000 suicides per year; it is the ninth leading cause of death in Canada and the seventh leading cause of death among males (Statistics Canada, 2014). Although suicide is a solitary act, family and friends are left behind to grieve; for these individuals the suicide is simply the beginning of a new phase of their life. According to Shneiddman (1973) “In the case of suicide, the largest public health problem is neither the prevention of suicide ... nor the management of attempts ... but the alleviation of the effects of stress in the survivor-victims of suicidal deaths, whose lives are forever changed” (p.33). Chow (2006) described this phenomenon well when he stated that, “A suicide seems to end the pain of the completer, yet commences a lengthy agony of those who love him or

her.” (p. 293). It was originally estimated by Shneidman, a pioneer in the field, that there are six people left to grieve for every death by suicide (Shneidman, 1973). There are estimates that there could be as many as 425 individuals who are exposed to a single suicide, and up to fourteen individuals who are profoundly impacted (Jordan & McIntosh, 2011). Based upon the number of suicide deaths in Canada, in 2014 there were 1.7 million people exposed to a suicide death that year, with 56 thousand who were profoundly impacted. Worldwide, 465 million people are exposed to a suicide death and 14 million people are left behind to cope every year. It is well documented that the bereavement process after losing a loved one to suicide is different than other types of death (Dyregrov, 2011, Cerel et al., 2008, Provini, Everett, & Pfeffer, 2000, Moore et al., 2013; Sakinofsky, 2007), and can create additional emotional, physical, cognitive, mental, social, and spiritual challenges. Those bereaved by suicide have very different needs from others who are grieving the death of a loved one (Wilson & Marshall, 2010). Individuals who have lost someone to suicide are at higher than normal risk for complicated grief (Provini, Everett, & Pfeffer, 2000; Sakinofsky, 2007), physical illness, depression (Wilson, & Marshall, 2010), anxiety, substance use, family breakdown, and dying by suicide themselves (Clark, 2001; Crosby & Sacks, 2002; Jordan & McIntosh, 2011; Jordan, Feigelman, McMenemy & Mitchell, 2011). Research has found that individuals who know someone who has died by suicide are from 2.9 to 8.3 percent more likely to attempt suicide (Crosby & Sacks, 2002; Hedstrom, Liu & Nordvik, 2008). These increases in suicidal behaviour after exposure to a suicide death are particularly heightened in youth (Jordan & McIntosh, 2011). Wilson and Marshall (2010) highlight that the grieving process can take several years and research by McKinnon and Chonody

(2014) discovered that even five years after the death of a loved one by suicide levels of trauma and distress were three times higher than non-bereaved individuals. The long lasting negative impacts that death by suicide has on those left behind will be discussed further in the second chapter of this thesis document.

Research Area

This thesis document will focus on the bereavement of individuals who are impacted by a death by suicide. Specifically, what supports they self-report as being beneficial in the aftermath of the death, what supports were not beneficial, and what additional supports they would liked to have had available during their bereavement. I aim to discover what current research has found to be the perceived needs of survivors of suicide in the aftermath of the death by using meta-interpretation as a means of synthesizing the qualitative research done thus far in the field. The results of my synthesis will provide an evidence-based outline of the needs of individuals bereaved by suicide, thereby allowing professionals and organizations to be better educated on the types of resources needed by this vast and vulnerable population.

Significance of Studying Those Bereaved by a Suicide Death

“Young people in Australia and other Western countries now die by suicide at a greater rate than at any other time in recorded history... For more than 30 years, international research and national policy initiatives have tried to curb this phenomenon ... yet the effects of a suicide death on those left behind remains under conceptualized and poorly understood” (Maple et al., 2010, p. 241)

The sheer number of people bereaved by suicide every year, and the devastating impact it can have on their lives for years to come, establishes the need to understand which services will best serve this growing population. Maple et al. (2010) point out that individuals in Western countries are dying by suicide more than at any other time in recorded history, yet the effects of suicide on those left behind remain poorly understood. Maple et al. (2010) are joined by many of their colleagues in the scientific community who are also calling for research in this area, including: Provini, Everett, and Pfeffer (2000); Dyregrov (2002); McMenemy, Jordan and Mitchell (2008); Cerel et al. (2008); Sakinofsky (2007); Jordan, Feigelman, McMenemy and Mitchell (2011); and Clifford et al. (2013). In addition there are few studies that look specifically at which resources are reported as being beneficial during the bereavement process.

Although there is a demonstrated need for additional research, there has been some scientific attention aimed at learning more about suicide bereavement in recent years. Unfortunately, real life support services for those grieving after a suicide death are often lacking and individuals are left to navigate the complex and stressful experience with limited social support and little or no professional support. It is well documented that services following a death by suicide are not prioritized and that there is a clear lack of resources for those grieving (Aguirre & Slater, 2010; Dyregrov, 2002; McMenemy, Jordan, & Mitchell, 2008; Dyregrov, 2002; Provini, Everett, & Pfeffer, 2000). Maple et al. (2010) and Moore et al. (2013) both highlight that survivors are often excluded from research and are poorly understood, as most funding is filtered into suicide prevention research. A positive family history of suicide is a documented risk factor for suicide (MacNeil, 2008; Moore et al., 2013; Clark, 2001; McMenemy, Jordan, & Mitchell, 2008;

Dyregrov, 2002) therefore services for those bereaved by suicide can and should be considered a primary prevention strategy.

As part of the process of learning more about the self-reported needs of individuals bereaved after a suicide it is important to synthesize what has been researched up to this time. According to Weed (2005), examining and synthesizing research that is already publically available will contribute to the improvement of the body of knowledge in a particular area.

Perhaps the most compelling reason to expand scientific knowledge and real life supports is not how difficult the grieving process is for those left behind after a suicide, or how there is limited research on what resources were helpful, but that those bereaved by suicide who do access support show enhanced coping skills and reduced risk for negative impacts associated with losing a loved one to suicide (McKinnon & Chonody, 2014). This is a powerful reason to research and implement resources so that all individuals who are bereaved by suicide can access resources and better cope with the tragic death of their loved one. Although there is much still to learn about those bereaved by a suicide death, the research which is available will be reviewed in the following chapter.

Chapter 2: Literature Review

“The question of how the bereaved can be helped is an important one, not only for secondary prevention of complicated grief for an at-risk population, but also for primary prevention of suicide. However, our knowledge about effective postvention strategies is currently rudimentary at best” (Dyrgrov, 2011, p.311)

The study of suicide and its impacts on those left behind to grieve has gained momentum since Shneidman; “the legendary guru of suicidology” (Grad, 2014, p.173) began research in the 1970’s. Although there has been an increase in research considering the effects of a suicide death, there is still much that is unknown about the bereavement process and what resources are helpful to an individual during this challenging time in their lives. As briefly discussed in chapter one, a death by suicide has serious and long-term effects on those left behind to grieve. Individuals grieving a suicide death are abundant and, until recently, have been largely ignored in scientific research. There is, however, a movement among researchers in the field to expand the understanding of this vulnerable group of people. This chapter will provide a review of relevant research looking at individuals left to grieve after a suicide. It will include a review of key concepts used in the field, general information about the rate of suicide in Canada and around the world, specific information about those left to grieve after a suicide death, a look at programs aimed at those who have lost someone to suicide, and a review of what research is missing in this field.

Key Concepts

It is important to understand some key concepts used in the field of suicidology and throughout this document. This section will provide explanations and definitions for some of the essential words and concepts used in the field.

Suicide Survivor

The term suicide survivor is commonly used in North America and is synonymous with the term “suicide bereaved” that is used in other parts of the world (Dryegrov, 2011). Surprisingly, to date there is no clear consensus among researchers in the field on the conceptual specification of who can be referred to as suicide survivor (Jordan & McIntosh, 2011; Berman, 2011; Adriessen, 2014; Cerel et al., 2013). Traditionally the term suicide survivor was reserved for family members (Dryegrov, 2013). In the 1970s Shneidman defined suicide survivors as only extended family members, he determined this based on the fact that it was the deceased persons family members who would receive compensation following two specific incidents, one in which bodies were double buried in a cemetery, and the other an airline disaster (Cerel et al., 2013). In the modern use of the word, all attempts at defining the term extend beyond kinship relationships. Current attempts at defining the term mostly note that exposure to a suicide does not imply one is a suicide survivor, that only a subset of individuals who are exposed to or know about a suicide will become suicide survivors (Jordan & McIntosh, 2011).

Various writers in the field have attempted to define who is a suicide survivor. Sakinofsky (2007) provides an overly simplistic definition of a suicide survivor as a “family member or friend left behind by a suicide” (p. 130). However other individuals

have provided more complex descriptions, for example Adriessen (2009) who describes a suicide survivor as “a person who has lost a significant other (or a loved one) by suicide, and whose life is changed because of the loss.” (p. 43). Berman (2011) defined suicide survivor in his research study as “those believed to be intimately and directly affected by a suicide” (p.111). These definitions all include that there was a relationship or psychological attachment between the suicide survivor and the deceased individuals, and that this relationship was close enough for the death to cause an impact on their life. However, Jordan and McIntosh (2011) believe there does not necessarily have to be a close relationship between the suicide survivor and the deceased; they define a suicide survivor as “someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person” (p.7). There is no mention of a close relationship or kinship or otherwise in their definition. Common features among all of these definitions include vague criteria such as that the suicide survivor’s ‘life was changed’, they were ‘directly affected’, or experienced a ‘high level of distress’ after the suicide. This type of vague criteria is difficult to define and hinders its ability to be operationalized (Adriessen, 2014). It remains unclear based on these definitions if being identified as a suicide survivor can be determined by external criteria or if one must self-identify as meeting the requirements. Cerel et al. (2013), believe that “there is presently no other way to identify a survivor save self-identification” (p.413). Jordan and McIntosh (2011) believe that self-definition will always be a key element in the definition of being a suicide survivor, and that it would be unrealistic to define someone as a suicide survivor if they did not feel their life was significantly affected by the death.

Postvention

Shneidman was one of the first individuals to consider the needs of what he called survivor-victims (now referred to as suicide survivors); through his research he coined the term “postvention”, he described postvention as a combination of prevention and intervention (Dyregrov, 2011). According to Dyregrov (2011), Shneidman defined postvention as, “primarily aimed at mollifying the psychological sequel of a suicidal death, by alleviating the effects of stress in the survivor-victims” (p. 311). Andriessen (2009) provides a more current definition that is widely referenced in the field, “postvention is those activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behaviour.” (p. 43). A simplified definition provided by Aguirre and Slater (2010) is, “activities that come after suicide to alleviate its impact on survivors”. These definitions show the necessity of a facilitated bereavement process after a suicide. A more detailed discussion of current forms of postvention will follow in this chapter, and a discussion of what types of postvention both formal and informal suicide survivors self-report finding beneficial can be found in the chapter 4 of this document.

Complicated Grief

Complicated grief is relevant to this discussion as it is often referenced as a way of showing the challenges and risk level that survivors face; for example McMenemy, Jordan and Mitchell (2008) found that one quarter of their sample of survivors were experiencing complicated grief and Dyregrov (2002) found 78% of her survivor participants scored above the cut off level for complicated grief reactions. Complicated grief is a diagnosable disorder that is distinct from a major depressive disorder

(Sakinofsky, 2007). The criteria for diagnosis includes “intrusive thoughts about and yearning for the deceased, excessive loneliness, disbelief, and excessive bitterness or anger related to the death, lasting longer than 6 months” (Sakinofsky, 2007, p. 130).

The Impact of Suicide in Contemporary Society

“Globally nearly one million deaths are attributed to suicide each year with one death occurring every 40 seconds. In the last 45 years, suicide deaths have increased by 60%.” (Moore et al., 2013, p. 297)

Suicide Occurrences

Suicide rates have grown exponentially worldwide in the last fifty years and are expected to continue to rise (Aguirre & Slater, 2010). In Australia approximately seven individuals die by suicide every day (McKinnon & Chonody, 2014) or over 2,200 deaths each year (Wilson & Marshall, 2010) and suicide accounts for 20 percent of deaths for those aged 20-34 years old (Maple et al., 2010). In the United States suicide is the third leading cause of death for individuals aged 15 to 24 and the ninth leading cause of death overall, accounting for over 30, 000 deaths annually (Terhorst & Mitchell, 2012) with one suicide occurring every 14.2 minutes (Cerel et al., 2013). In Canada there are 4,000 suicides each year, it is the ninth leading cause of death overall, and the seventh leading cause of death among males (Statistics Canada, 2014). Suicide rates among Indigenous individuals in Canada are even higher than average and have reached epidemic proportions (MacNeil, 2008); rates are estimated to be from two (Clifford et all, 2013) to six (White, 2007) times higher, with rates in some communities as high as 36 times the national average (MacNeil, 2008). Sadly, Canadian Indigenous youth have a higher rate

of suicide than any other identified culture in the world (MacNeil, 2008). In addition to these staggering statistics there are many deaths around the world that are due to drug overdoses and single person motor vehicle accidents which may also be a form of self-inflicted death (Wilson & Marshal, 2010). Based upon the vast number deaths it is clear that suicide is a leading public health issue worldwide.

The study of why people die by suicide is complex. There are many theories created in response to this question; for example, Baumeister theorized that people use suicide as an escape after experiencing a variety of stressful life events. He believed one may begin to feel hopeless about the future and if positive events or social supports do not intervene an individual may suicide as an escape (Aguirre & Slater, 2010). This is one of many theories, however it is not imperative for this document to fully understand the complex reasons for suicide but simply to understand that it commonly believed to occur as a consequence of serious psychiatric disorders (Terhorst & Mitchell, 2012) and they are the outcome of a bio-psycho-social process (Andriessen, 2014).

History of Stigma Around Suicide

“Suicide remains on the fringe of social consciousness regardless of efforts to try to mainstream it as a public health issue” (Maple et al., 2010, p. 241)

Perhaps what makes suicide an even greater public health crisis is the stigma that historically, and to this day, surrounds it. This stigma causes people around the world to refrain from discussing suicide both before and after it occurs. There is a long history of stigma around suicide that continues in varying degrees around the world today; societies have in the past, or still do, have legal and religious sanctions against survivors of suicide

(Dyregrov, 2002). Maple et al. (2010) highlight that Western societies do not afford an individual the right to take their own life. There is an unwritten expectation that people will do all that they can to stay alive; that life is precious and should be maintained at all cost. Although suicide is no longer a criminal act in Western societies, it continues to have criminal undertones, including the common statement that one is said to ‘commit suicide’ and the involvement of the coronial system following a suicide (Maple et al., 2010). The stigma connected to suicide impacts public and professional knowledge as well as the economic funding provided through public and private donations (Dyregrov, 2011). Stigma and its influence on the bereavement process of suicide survivors will be discussed further in the discussion on suicide survivors.

Suicide Survivors

Extent Population is Affected

As mentioned in chapter one, there is debate on how many suicide survivors there are after a death. The original estimate by Shneidman of six suicide survivors for every death has been repeated over and over in research and is often taken for fact, when in reality it was the estimate of a pioneer in suicidology. The figure of six survivors for every suicide has become entrenched in policy and campaigns promoting suicide prevention and postvention around the world, even though it lacks empirical testing and validation (Berman, 2011). In the last decade researchers have begun to question the accuracy of this number. Maple et al. (2010) and Cerel et al. (2013) believe six is an underestimate of people grieving after each suicide. Moore et al. (2013), also believe that the number is greater, possibly as high as 28 individuals, but points out that there is no clear documentation in literature on the number of survivors per suicide death. Most

research has found that the number is much higher, however as discussed earlier, without a clear definition of what a suicide survivor is, it is hard to know exactly how many survivors there are for each suicide. Cerel et al. (2013) conducted a random-digit dial telephone survey of 302 individuals and found that over 40% of the sample stated they knew at least one person who had died by suicide and 20% of the total sample self-identified as being impacted by a suicide death and considered themselves a suicide survivor. At this rate of survivorship, and with the current population in Canada according to Statistics Canada (2015) at over 35 million, there are over 7 million individuals in Canada who can be considered suicide survivors. It is clear from the research that the number of suicide survivors for each death is much higher than Shneidman originally estimated, however the number has yet to be agreed upon in the field. The lack of a clear definition of what a survivor is and the variables of age and culture have made determining the number of survivors per suicide impossible up to this time. However, it has become clear that suicide survivors are prevalent and, as the following discussion will show, can have a very challenging and long bereavement process to navigate.

Implications for Suicide Survivor

“Suicide has far reaching consequences, and the ultimate victims of suicide are those who survive.” (Mckinnon & Chonody, 2014, p. 231)

As discussed, suicide survivors are prevalent in society. This is a large population of individuals who are experiencing a very challenging time in their lives. Although there is some disagreement in the field, which I will discuss later, it is well documented

in literature that the grief from losing a loved one to suicide creates a more problematic bereavement course than other causes of unexpected deaths (Dyregrov, 2011; Cerel et al., 2008; Provini, Everett, & Pfeffer, 2000; Moore et al., 2013; Sakinofsky, 2007; Wilson & Marshall, 2010). Suicide deaths can create additional emotional, physical, cognitive, mental, social, familial, and spiritual challenges. The reasons why losing someone to suicide can be more challenging are complex and not clearly understood; stigma around suicide is identified as one of the main sources of many of the complications associated with the bereavement of a survivor.

Some reasons that a suicide survivor faces a challenging bereavement trajectory include feelings of guilt, blame of self and/or others, rejection, shame and abandonment (Moore et al., 2013; Sakinofsky, 2007; Aguirre & Slater, 2010; Dyregrov, 2011). In addition suicide is often an unexpected and violent death and can lead to unique reactions such as pretending the death was not a suicide and obsessing over the motivations of the deceased (Sakinofsky, 2007). Trying to rebuild one's life while simultaneously trying to understand the reasons for the suicide and hiding the real cause make the bereavement process highly stressful (Moore et al., 2013). Social networks such as families, schools, workplaces, and churches have been found to be a crucial aspect of support during bereavement, however when the cause of death is suicide this essential support system can be interrupted due to the unique feelings, including stigma, associated with a suicide death. These unique feelings can lead to misunderstandings between survivors and their social networks or avoidance and withdrawal (Cerel et al., 2008; Clark, 2001; Sakinofsky, 2007).

Research has shown that suicide survivors are at risk for a variety of complications during their bereavement particularly complicated grief, depression, family breakdown and further suicide (McMenamy et al., 2008; Clark, 2001; Crosby & Sacks, 2002; Jordan & McIntosh, 2011; Jordan, Feigelman, McMenamy & Mitchell, 2011). Suicide has been found to affect individuals and families differently. Cerel et al. (2008) found that families showed decreased emotional bonds towards one another and decreased ability to adapt to new roles after a family member died by suicide when compared to families bereaved by other types of death. There is evidence adult family members place blame on one another for the suicide and avoid discussing it for this reason (Provini, Everett, & Pfeffer, 2000). Children bereaved by suicide experience higher rates of anxiety, aggressive and withdrawn behaviour, symptoms of post-traumatic stress disorder, depressive symptoms, and interpersonal problems (Cerel et al., 2008). In addition the risk of complicated grief is heightened in suicide survivors (Provini, Everett, & Pfeffer, 2000; Sakinofsky, 2007). In a sample of 128 parents who had lost their children to suicide Dyregrov (2002) found that 78% of them had symptoms of complicated grief. Perhaps the most frightening risk factor for survivors is that of dying by suicide themselves; Crosby and Sacks (2002) found in their study that individuals who were exposed to a suicide within the last year were 3.7 times more likely to have made a suicide attempt. These individuals were not necessarily survivors; they simple knew someone who had died by suicide in the previous year. Hedstrom, Liu, and Nordvik (2008), sampled men in Norway and found a death by suicide within their family made them 8.3 times more likely to die by suicide themselves; if they had a coworker who died by suicide their risk still went up by 3.5 times. Others have documented this increase in

risk of suicide, including Agerboo (2005), and Jordan and McIntosh (2011) who noted the risk was particularly prevalent in young people.

Although most individuals in the field agree that suicide survivors face a more complicated grieving trajectory and are at a higher risk for complications, there are some who take a different stance. Andriessen (2014) believes that there are more similarities than differences among groups of people bereaved through different types of deaths and that the crisis atmosphere that others in the field perpetuate may be further stigmatizing suicide survivors. Sakinofsky (2007) also draws readers' attention to some of the similarities in the grieving process between parents whose children died through violent means (suicide, homicide, and accident), including when it comes to levels of distress, depression, and suicidal ideation. As with many things in the field of suicidology there is no consensus among all researchers, however it is clear that the bereavement process of suicide survivors is challenging, and due to increasing rates of suicide there are millions of survivors around the world who require much needed support.

Postvention Services

“Suicide postvention is often seen as the poor relation to prevention” (Grad et al., 2004)

Grieving the death of a loved one is one of life's most challenging experiences, and regardless of the reason for the death, services to support individuals through their grieving process are important. When the cause of death is suicide there is a need for specialized services aimed specifically at suicide survivors, as it is well documented that the bereavement process after losing a loved one to suicide is different from other forms

of unexpected death (Dyregrov, 2011; Cerel et al., 2008; Provini, Everett, & Pfeffer, 2000; Moore et al., 2013; Sakinofsky, 2007; Wilson & Marshall, 2010). These unique challenges include feelings of guilt, blame of self and others, rejection, shame and abandonment (Moore et al., 2013; Sakinofsky, 2007; Aguirre & Slater, 2010; Dyregrov, 2011). In addition, when the death is due to suicide an individual's social support system, a vital aspect of support during bereavement, may be unable to provide the same type of support they would after a non-stigmatized death. Some examples of postvention services are individual therapy, bereavement groups specifically for suicide survivors, and outreach services to connect suicide survivors to services, as they may not have the capacity to find them on their own. Postvention services vary from other services available to support grieving individuals in that they provide a space where the specific needs of suicide survivors are met. This includes offering a space to speak with individuals who understand the unique experience of losing a loved one to suicide, and an environment free from the stigma they may experience in other non-specific groups, interactions with professionals, and in their personal relationships.

The majority of postvention services wait for survivors to seek help, however with estimates that only one in four survivors will reach out for help, this seems inadequate (Aguirre & Slater, 2010). The other form is when service providers are actively reaching out to new survivors to provide education and to direct them to resources; this form of postvention has been found to reduce the average time between the death and access of services from four and a half years to one month (Aguirre & Slater, 2010). Unfortunately, the need for postvention services is not being met and resources for survivors are lacking, leaving survivors to navigate the complex and

stressful experience with little or no professional support. Clark (2001) believes that in the United States there is “a poverty of resources for survivors and a flawed entry system for those services” (p. 333). Dyregrov (2002) finds that, “studies point to the need for more professional or community-based bereavement services because of the failure of social networks to provide adequate support during the lengthy bereavement period” (p. 648). Many in the field echo these sentiments. It was found that in Europe (one of the areas most developed in this field) only 17 countries had any type of postvention service available for survivors (Grad, 2014); this means that dozens of countries remain without services. The International Association for Suicide Prevention (IASP), one of the world’s leaders in policies on suicide does include postvention work in their mandate.

Unfortunately, despite the policies and good intentions, only 27% of the IASP member countries had postvention programs, the majority of which were run entirely by volunteers (Grad et al., 2004). In 1999 the National Strategy for Suicide Prevention (NSSP) was developed in the United States. One of its aims was to reduce the impact of suicide on family and friends, yet it lacked any specific mention of postvention services (Aguirre & Slater, 2010). In the state plans that were developed to fulfill NSSP requirements only half of the states included general statements about expansion or development of postvention services and only four states went beyond general statements about services and addressed the need more specifically (Aguirre & Slater, 2010). The majority of funding and initiatives from governments and other private and public organizations is filtered into services for suicide prevention, leaving services for survivors lacking (Moore et al., 2013). However, as demonstrated by the risk of suicide for survivors, postvention can and should be considered a necessary form of prevention.

Research Required in the Field

Although there is growing recognition of the importance of learning about how suicide impacts survivors, at this point there is a somewhat limited research base. Most individuals working in the area recognize the need for agreement on key concepts and definitions, as well as additional quality research studies, so there can be a greater understanding of what is occurring, and what individuals need during this complex and challenging time.

Of course stigma and funding play a part in what research is undertaken, however Dyregrov (2002) points out that it could be due to the difficult task of doing research with a vulnerable population. Clark (2001) believes suicide bereavement is a neglected area because of challenges in recruiting true randomized groups and standardizing for culture, age, gender, and relationship. She believes the stigmatization of suicide may add an additional challenge to gaining a representative sample (Clark, 2001).

In a search done by Andriessen (2014) of articles published in four suicidology journals from 2003 to 2013 it was found that in total there were fewer than 6 articles published per year on the topic of postvention and all of the articles were written by authors from western countries. Andriessen (2014) calls for more research on postvention and suicide survivors, particularly looking at cultures where suicide rates are higher and there is currently no focus on postvention. Specifically, Dyregrov (2002), McMenemy et al. and Dyregrov (2011), note that little research has focused on the self-reported needs for assistance following suicide, and that it is vital to gain more knowledge about what survivors' subjective needs are for help. It seems many individuals are calling for the controlled study of postvention services due to a lack of

scientific validation on the limited postvention services that are currently offered (Jordan & McMenemy, 2004; Sakinofsky, 2007). Learning about the self-reported needs for assistance, and which support services both formal and informal survivors report as beneficial, is the best place to start.

Research on Frist Nations Suicide Survivors

The culture of an individual will impact many facets of suicide bereavement, including the level of stigma around the suicide, understandings about why the individual died by suicide, what social supports may be provided, and what formal supports would be beneficial. It is therefore ignorant to assume that the resources that an individual from a Western culture finds beneficial will be the same as an individual from a different culture. Dyregrov (2011) states that the perceived needs of survivors will vary based on their culture, as grief reactions are molded by culture. Grad (2014) highlights that explanations of suicide and survivors' reactions to it vary greatly in different cultures; cultural explanations for suicides vary from being out of human reach, such as demons or evil spirits, to psychodynamic causes.

There are many ways culture impacts the bereavement process. Unfortunately, during a search of the four core suicidology journals Andriessen (2014) found no articles on postvention that were published by authors from a non-Western culture; in conclusion Andriessen (2014) calls for research to be completed in other countries. I would move this further to a call for research within Canada's Aboriginal population; although they are from the same country, their culture is undeniably unique. In an in depth systematic review of evaluations of suicide prevention interventions, only a single article was found that evaluated a prevention intervention for Canadian Aboriginal peoples (Clifford,

Doran & Tsey, 2013). This speaks to the lack of attention within suicidology given to Canadian Aboriginal peoples, a population who has the highest rate of suicide in the world (MacNeil, 2008) and clearly needs greater access to effective prevention and postvention resources. White (2007) points out that there is no singular Aboriginal culture within Canada, however there are shared common cultural, political and historical experiences across the country. Although cultures differ from one group to the next, research with one Aboriginal culture would be more culturally relevant to another than research with Western cultures. In chapter five of this thesis document I will discuss further why there is a need for research that attempts to uncover the self-perceived needs of Aboriginal suicide survivors during their bereavement.

Chapter 3: Methodology

“Most research effort is expended on new primary research and yet, on virtually any topic you can name, there is a vast body of past research that may have some continuing value but mostly remains ignored.” (Solesbury, 2002, p. 92)

Despite a growing body of literature on suicide survivors, there is limited information on the self-reported needs of survivors during bereavement. In 2011 Dyregrov (2011) completed a search of research studies looking at survivor’s self-reported needs and found only five articles meeting the inclusion criteria. Since Dyregrov’s 2011 study there has been no synthesis or review of research looking at the self-reported needs of suicide survivors. To meet this unmet need I will use a meta-interpretation approach to conduct an interpretive synthesis and analysis of qualitative research looking at the self-perceived needs of suicide survivors during their bereavement. In the current body of research I hope to find some consensus about what the self-perceived needs of suicide survivors are, and that this information will inform postvention programs and further research in the area. In this chapter I will outline my research approach, discuss in detail the process of selecting studies for meta-interpretation, and outline the challenges and limitations that were encountered.

Many researchers have identified the value of examining and synthesizing research that has already been completed and therefor maximizing previous findings (Solesbury, 2002; Weed, 2008). By fully utilizing existing data and research findings one can develop additional insight and knowledge in the field of study.

Weed (2008) developed meta-interpretation through the analysis and evaluation of nine research methods involving synthesis. Meta-interpretation allows for the synthesis of qualitative research data without reducing it to statistical data, and therefore maintain the richness of qualitative research; in addition it does not require re-analysis of the entire qualitative data set, which is often not available in full, thereby limiting researchers ability to do this type of synthesis (Weed, 2008). Meta-interpretation upholds the same interpretive epistemology as many qualitative research studies; this allows for consistency between the synthesis and the original research (Weed, 2008). Meta-interpretation looks at the synthesizer as an active interpretive agent in the process and the interpretation as ‘one interpretation’ not ‘the interpretation’. It is an ideographic not a predetermined approach, and focuses on meaning in context; it provides a clear audit trail that will show the integrity of the synthesis. In the following section I will outline the steps I took in completing my meta-interpretation.

Meta-Interpretation Research Steps

Selecting a Research Area

Meta-interpretation begins by identifying a research area. I began by identifying specifically First Nations survivors of suicide. However, after extensive literature searches I found that there was no research looking specifically at First Nations individuals, and therefore survivors of suicide in general was identified as my final research area. The next step in meta-interpretation is to undergo a search of literature and select four or five research articles for the initial thematic and context analysis (Weed, 2008).

Process of Data Collection

The data for this document was collected using an iterative approach to ensure the theoretical saturation point was reached. After deciding upon an area of research, articles were found by searching the PsycARTICLES, PsycBOOKS, PsycINFO, and Psychology and Behavioural Sciences Collection databases for the following key words: suicide and survivor, suicide and postvention, suicide and bereaved, suicide and grief, postvention and needs, suicide and survivor and needs, suicide and survivor and postvention and needs. The process was followed as outlined by Weed (2008) in his article in the Journal of Social Research Methodology on the process of meta-interpretation. In total three iterations were completed before theoretical saturation was reached. Six research articles with a focus on the self-reported needs of suicide survivors were located; the limited number of studies in this area speaks to the need for additional research. By analyzing and synthesizing the research results to date, a deeper understanding of the issue and of the specific research needs in the field will be available to potential researchers. The articles that were used in this meta-interpretation are: “A Phenomological Study of Family Needs Following the Suicide of a Teenager” by Miers, Abbot, and Springer (2012); “What do Suicide Survivors Tell us They Need? Results of a Pilot Study” by McMenamy, Jordan, and Mitchell (2008); “Assistance From Local Authorities Versus Survivors’ Needs for Support After Suicide” by Dyregrov (2002); “Adults Mourning Suicide: Self-Reported Concerns About Bereavement, Needs for Assistance, and Help-Seeking Behaviour” by Provini, Everett, and Pfeffer (2000); “The Support Needs and Experiences of Suicidally Bereaved Family and Friends” by Wilson and Marshall (2010);

and “Exploring the Formal Supports Used by People Bereaved Through Suicide: A Qualitative Study” by McKinnon and Chonody (2014).

Analysis and synthesis of the articles identified as meeting inclusion criteria was done with a focus on the meaning in context, as is inherent in the meta-interpretation process. The author of this document underwent a concurrent thematic and contextual analysis of the articles. The process began with familiarization with the articles by methodically reading and rereading the articles until commonalities and differences emerged. Throughout this process the author created logs noting the context of the research, including the academic context in which the research was conceived and conducted, such as the disciplinary department the authors belong to, the geographical location of the authors, the funding sources and other relevant information. Logs were also kept noting the methodological context of the research study, the results of the study, the recommendations of the researchers based upon their findings, and the limitations of the study. In addition, themes and discrepancies that emerged from the research studies were tracked and charts were created to organize themes.

Iterative Process

First Iterative

I began by selecting articles by Maple et al. (2010), Sakinofsky (2007), McMenamy, Jordan and Mitchell (2008), and Dreygrov (2002) for the initial analysis. As this was the first iteration there were no previous exclusion criteria. It was at this point that I decided to focus specifically on studies that inquired into the self-reported needs of suicide survivors. As a result, the articles by Maple et al. (2010) and Sakinofsky (2007) were excluded. The research study by Maple et al. (2010) used a narrative inquiry

approach to look at the experiences, meanings, and patterns among parents whose children had died by suicide, but did not specifically look at their self-reported needs and was therefore excluded from the meta-interpretation process. Sakinofsky (2007) looked at the effectiveness of existing treatment for suicide survivors and was therefore also excluded. The articles by McMenamy, Jordan and Mitchell (2008) and Dryegrov (2002) looked at the self-reported needs in a different way and with a different population of survivors, however both were included as they met the newly developed criteria of having a specific focus on the survivor's self-reported needs. After the first iterative the excluding criteria developed was that the article must focus on the self-reported needs of suicide survivors, that the quality of research is not flawed, and that it was published in a peer reviewed article or book.

Second Iterative

During the second iteration I analyzed articles by Tehorst (2012), Provini, Everett and Pfeffer (2000), Grad et al. (2004), and Wilson and Marshall (2010). The article by Grad et al (2004) was excluded, as it was a review of other research articles and provided no original research. The article by Tehorst (2012) was excluded for the same reasons as the article by Grad (2004), it was utilizing old research and did not include any new research data. The necessity of being original research was added to the exclusion criteria along with the previous criteria that continued to be relevant. The articles by Provini, Everett, and Pfeffer (2000) and Wilson and Marshall (2010) were both found to meet the updated criteria and were included in the meta-interpretation.

Third Iterative

During the third iterative, articles by Mckinnon and Chonody (2014) and Miers, Abbott and Springer (2012) were analyzed. Both articles met the previously developed inclusion criteria and could be included. At this point theoretical saturation was reached and further searches of literature could not find any additional research studies to be analyzed.

In total six articles were found to meet the developed inclusion criteria and were included in the meta-interpretation. The results of the meta-interpretation will be explained in chapter four.

Challenges and Limitations

Challenges and Limitations of this research design and approach include that only peer-reviewed articles written in English were used, a limited number of studies were available, and because existing studies were used their limitations and challenges are inherited.

As only articles in English that were published in peer-reviewed journals were analyzed, studies published in other languages, or studies that were not accepted for publication by a journal, were not included. There is a possibility that research findings were not included in this interpretive analysis due to the research being inaccessible by the author. In addition, as the focus is on peer reviewed work, other material that could contribute to a more complete understanding of the self perceived needs of suicide survivors is omitted. This information could be found in online material such as blogs, online support forums and video diaries, or though other material such as autobiographies, magazine articles, and published documents that are not peer reviewed.

Due to the fact that only peer-reviewed articles published in English were analyzed, there are only six articles used in this meta-interpretation. Although this is adequate to develop a deeper understanding of what is known in the field, it is a small sample and therefore cannot provide the same in depth knowledge that a larger sample would.

Finally, as existing studies were used, this meta-interpretation inherits all of the challenges and limitations found within those studies; any flaws in the six studies will be carried forward in the results documented in this paper.

Chapter 4: Results

“To secure knowledge that will make a difference, this must include the perceived needs for help from the target group” (Dyregrov, 2011, p. 311-312).

In this chapter the results of meta-interpretation that was completed with research studies looking at the self-reported needs of suicide survivors during their bereavement, will be outlined. It will begin with a description of how data was collected, followed by a presentation of the themes and discrepancies found during the synthesis and analysis of the articles included in the meta-interpretation.

Findings

The results of meta-interpretation are based in context and provide not ‘the truth’ but ‘a truth’; these results will provide a truth that is the synthesis of multiple truths found in each research study. I will begin with a statement of applicability, followed by a review of the contextual elements of the six articles, a review of themes, a review of discrepancies, and the theoretical insights that emerged from the process of analyzing and synthesizing the data.

Statement of Applicability

Meta-interpretation requires a written statement of applicability that identifies the boundaries of applicability and plays an important role in ensuring the meta-interpretation is of a high standard and maintains integrity (Weed, 2008). The findings presented in this document are bound by the exclusion criteria and are only relevant in situations that fit within the exclusion criteria. The interpretations and theoretical insights found by the author of this document are relevant only to the needs of suicide

survivors during their bereavement process. Theoretical insights are based on the self-reported benefits of formal and informal supports and the self-reported needs of suicide survivors; they are bound by these criteria.

Contextual Elements

The contextual elements of the research are very important in meta-interpretation. In this section I will outline contextual information about the researchers, methods and participants, as the context in which the research was completed and the context of the sample influences the results of each research study.

Academic Context

The results of each study cannot be analyzed effectively without an understanding of the context in which the research was performed and written up. The background of the authors and the setting are important pieces of knowledge to have when considering what information the research results can provide. I will provide information on the geographical location of the authors, the field that they work within, and additional information about collaborators or funding when available.

The six papers being analyzed include fourteen individuals who contributed to the research. Of those fourteen individuals, ten are from the USA, one is from Norway, and three are from Australia. All researchers are from western cultures, with all but one from English speaking countries. There is very little diversity in the geographic location and culture in which the researchers are located.

The majority of the researchers work in a University setting, with only three working in the private sector. Reserachers working in the private sector are Jordan (2008) who is with the Family Loss Project in the United States, Dyregrov (2002) who is

with the Centre for Crisis Psychology in Norway and Miers (2012) who works at the BryanLGH Medical Centre in the Mental Health Services Department in the USA. The researchers working in University settings come from a wide variety of disciplines, and they are often collaborating with peers from other disciplines to complete their studies. This shows that studies of suicide survivors' needs are relevant to, and have implications in, a variety of disciplines. There is one researcher working in each of the following fields: the department of behavioural sciences, social work, and psychiatry. Two authors work in the department of child, youth, and family studies. The most well represented fields, with three working in each, are nursing and psychology.

In addition to the geographic area and the discipline in which the researchers work, other collaborations that were undertaken to produce the final research are an important piece of contextual information. Funding through grants was acknowledged in three of the research studies: Provini, Everett, and Pfeffer (2000) received a grant from the William T. Grant Foundation in New York City; McMenemy, Jordan, and Mitchell (2008) received a pilot grant from the American Foundation for Suicide Prevention; and Dyregrov (2002) received funding from The Norwegian Foundation for Health and Rehabilitation and the Norwegian Sudden Infant Death Society. Although no other grants or funding sources were acknowledged there are were two research studies that received permission from a government organization to access information about suicide deaths in their community. Provini, Everett, and Pfeffer (2000) acknowledged the New York Chief Medical Examiner and New York City Director of Medicolegal Investigations for providing information and making the identification of their sample possible. They received a list of all suicides that occurred in New York City in 1997 and

information about their relatives so they could be contacted for the study. Dyregrov (2002) also received access to government records for her study; she received permission from the Ministry of Law and Justice in Norway to access police records for names and addresses of suicide survivors who had lost a family member to suicide from July 1997 to December 1998. Partnerships with local government can be a very effective way of identifying suicide survivors, however as mentioned by both Provini, Everett, and Pfeffer (2000) and Dyregrov (2002) it can be a long and challenging process to gain access to this information, which may explain why the four other research studies utilized different methods to recruit participants.

Methodological Context

The specifics of the sampling method and data collection method of each study provide essential contextual information. Methodological differences should be celebrated as they will each work to provide a deeper understanding of the overall picture of what suicide survivors' self-reported needs are, and lead to deeper theoretical insights being reached. In this section the way that each research study recruits its sample and the data collection methods will be reviewed.

The majority of the research studies use a mixture of convenience and purposive sampling methods. Miers, Abbott, and Springer (2012) contacted individuals who facilitated bereavement groups and requested they forward information about their study to group members who may volunteer to participate. McMenamy, Jordan, and Mitchell (2008) recruited volunteers through similar means of contacting group facilitators, as well as by advertising at a conference for suicide survivors. Wilson and Marshall (2010) also advertised with suicide survivors' bereavement groups; in addition, they used radio

interviews, newspaper articles, and the internet to advertise. McKinnon and Choenody (2014) used a variety of techniques similar to the previously mentioned researchers including speaking at suicide survivor groups, and advertising with a variety of organizations, on websites, and in flyers. Dyregrov (2002) and Provini, Everett, and Pfeffer (2000) used a census technique as they had access to the entire population they were attempting to sample. Both research studies had access to government records, which identified their entire sample. Dyregrov (2002) contacted her entire sample population by letter and received completed surveys from 50%. Provini, Everett, and Pfeffer (2000) contacted their sample by phone and were able to survey 63%. The majority of the research studies found their sample in a similar way, through purposive and convenience sampling, with just two studies using other means as they had access to contact information for the entire population they were looking to sample.

The style of data collection is another important piece of contextual information that is important to understand. The research studies being analyzed used a variety of interview, survey or questionnaire methods to collect their data depending upon the size and geographical spread of their participants. Miers, Abbott, and Springer (2012) and McKinnon and Choenody (2014) used face-to-face semi-structured interviews to collect information from their participants. Provini, Everett, and Pfeffer (2000) also used interview techniques, however they conducted their interviews over the phone and used an unstructured format; they did not ask specific questions, but let participants bring up what information they thought was important to share. McMenemy, Jordan, and Mitchell (2008) used a survey technique; participants filled in a survivor needs assessment survey that they created. Wilson and Marshall (2010) also used a survey with

closed and open questions to gather information from their participants. Dyregrov (2002), gathered information from all of her participants through a questionnaire and then selected a subset to complete in depth, semi structured interviews in order to gather richer more complete information about their experiences.

Participant Context

The final contextual element that will be provided is an overview of information about the participants in each study. Miers, Abbott, and Springer (2012) had a relatively small sample with only eight individuals, all of them Caucasian parents who has lost children to suicide and resided in Nebraska, USA. The majority of the participants identified as female (75%), and considered their religious beliefs to be very important to them. In all of the cases it had been over one year since the death of their child. The sixty-three participants in McMenemy, Jordan, and Mitchells (2008) study were also from the USA; 95% were Caucasian, and again the majority were female (71%). The participants in this study had a variety of familial relationships with the deceased, including parents, children, siblings and spouses. The mean length of time since the suicide for this group was 47.9 months. The study by Provini, Everett, and Pfeffer (2000) included 144 participants from around the USA. Their study included individuals with a variety of familial relationships to the deceased and a mean of only 5 months since the death of their family member. The studies by Wilson and Marshall (2010) and McKinnon and Choenody (2014) were conducted with primarily Caucasian female participants from Southern Australia. The study by Wilson and Marshall (2010) had 166 participants, with the majority being family members of the deceased, however this study also included some friends and work colleagues who identified themselves as suicide

survivors. The mean time since the suicide for this group was 5.8 years. McKinnon and Choenody (2014) had fourteen participants in their study; all were family members, including parents, siblings, and spouses and the mean time since death was six years. The final study by Dyregrov (2002) was conducted with 128 Norwegian participants who were all parents of the deceased with a range of six to twenty-three months since the death of their child. When looked at together, the majority of participants were female and Caucasian from three western countries. In addition it is important to note that all participants were adults at the time they participated in the study.

Understanding and highlighting the contextual information of the research studies allows for a deeper and more complete understanding when analyzing and synthesizing the results.

Themes

While analyzing and synthesizing the results from the research studies, seven clear themes emerged. Although there are many differences in the contextual information in terms of the academic background of the researchers, the geographic locations, the methodologies used, and the participants in each of the six unique studies, there were common themes found across the majority of the studies. The seven common themes that emerged from the data are: the importance of first responders, barriers to accessing support, one-on-one support from other survivors, professional support, informal support, group based support and written information.

First Responders

First responders were identified as important in both positive and negative ways in four of the studies. First responders include police, ambulance, and other personnel

that arrive on the scene in the immediate aftermath of the suicide. As this is the first social response many survivors will receive it can have a big impact on their bereavement process. Participants in Miers, Abbott, and Springer's (2012) and Wilson and Marshall's (2010) studies identified first responders as playing an important role in their experience. Unfortunately, both McMenemy, Jordan, and Mitchell (2008) and McKinnon and Choenody's (2014) found that although all of their participants said their experience with first responders was important, 51% and 65% respectively, had a negative experience. A negative experience is an interaction that provides a negative response for the survivor, does not assist the survivor in the immediate context of the suicide, and will negatively impact their bereavement trajectory. Specifically, this could be a lack of compassion and respect for the survivor, causing the survivor to feel unheard and judged by the first responder. All four articles recommend specific training for first responders regarding how to respond appropriately to suicide survivors in the immediate aftermath of a suicide.

Barriers to Accessing Support

Barriers to receiving or seeking support were a common theme explored in all of the studies. Most found that there were a variety of barriers to accessing support, including: lack of information, depression, feelings of being overwhelmed, believing that no one can help, family opposition, lack of financial resources, lack of time, and concerns around what others would think. Along with the identification of barriers, participants in Dyregrov (2002) and McKinnon and Choenody (2014) identified a clear unmet need was contact by professionals or connection to resources, as they felt unable to reach out. Other articles identified outreach as an integral part of their recommendations for

improving support for suicide survivors based upon the barriers their participants identified.

One-on-one Support from Survivors

In the study by McMenemy, Jordan, and Mitchell (2008) individual support from a person who had also experienced the loss of a loved one to suicide was found to be very effective by 100% of those that accessed this type of support. In addition, this was found to be an unmet need by those in both McKinnon and Choenody's (2014) and Miers, Abbott, and Springer's (2012) studies. The researchers also found that survivors expressed a desire to give back as a way of healing; this is a perfect opportunity for both the mentor survivor and the newly bereaved survivor to benefit from the relationship.

Professional Support

Individuals such as doctors, mental health professionals, outreach workers, counsellors and other paid professionals in the field were mentioned by every study in some way. Dyregrov (2013), Miers, Abbott, and Springer (2012) and Wilson and Marshall (2010) all found that there was a high level of need in their participants for professional support, with as many as 95% of participants in one study expressing their need for professional support and only 44% receiving it. Rates of receiving professional help vary from the previously mentioned 44% to 100% in one study (McKinnon and Choenody, 2014) and 78% in another (McMenemy, Jordan, and Mitchell, 2008). Unfortunately, the helpfulness of this support varied greatly; some participants found their experiences with professionals beneficial, however in the study by Wilson and Marshall (2010) 39% found the professional support provided little to no help.

Differences in accessing help could be impacted by the contextual information provided, such as the time elapsed since the suicide, or the type of data collection done.

Informal Support

Informal support is defined as friends, family, and other social or non-professional supports available to the suicide survivors. Informal supports were explored less than professional support, which could be attributed to the questions asked by researchers or that participants did not think of help from friends and family as a type of support when being interviewed. Participants in Miers, Abbott, and Springer's (2012) study identified needing informal supports as a resource for someone to listen and respond kindly to them. In Provini, Everett, and Pfeffer's (2000) study informal support was touched on briefly as something that 24% identified as accessing during their bereavement. The results of McMenemy, Jordan, and Mitchell's (2008) study was that informal supports were accessed more often than professional support, and that a higher percentage of those that accessed informal supports found them helpful when compared to the helpfulness of professional support.

Group Support

Formal support groups were discussed by all of the research studies. It is important to consider that four of the six studies recruited at least some of their participants from suicide survivor support groups, and therefore some of participants were actively engaged with a support group at the time of participating in the study. Those individuals who attended and quit or chose not to attend a support group were less likely to be a part of the sample due to sampling techniques used. Both McMenemy, Jordan, and Mitchell (2008) and Mckinnon and Choenody (2014) found the majority

(95% and 78%) of the participants who attended groups found them helpful, and that support groups specifically aimed at suicide survivors were more helpful than those for general bereavement. In Wilson and Marshalls (2010) study 35% of participants identified support groups as an unmet need during their bereavement.

Written Information

Written material, including books and pamphlets with information about suicide bereavement and where to find resources, was identified as an unmet need by some of the participants in three of the studies. Miers, Abbott, and Springer (2012) and Dyregrov (2002) found that many participants wished they had been given written information to support them through their bereavement. In McMenemy, Jordan, and Mitchell's (2008) study written information was found to be used by 85% of their participants and 85% of those found it beneficial; in addition, some participants who did not have access to written material expressed it was an unmet need.

Discrepancies

Within the six studies that were synthesized for this document the overwhelming majority had many themes congruent throughout, however the study by Provini, Everett, and Pfeffer (2000) had a variety of discrepancies when compared to the other studies. The most noticeable difference is the number of participants who identified a need for support during bereavement. Only 12% of the sample identified a desire for support; this is drastically different from the 88% (Dyregrov, 2002) and 95% (Wilson and Mitchell, 2010) found in other studies. There are some contextual differences that could provide an explanation for the discrepancy in these numbers. Provini, Everett, and Pfeffer (2000) had access to all family members who had lost someone to suicide, as opposed to the

volunteer based sample of other studies. However this does not explain why Dyregrov (2002) who also had access to government records would have different findings.

Another unique contextual element of the Provini, Everett, and Pfeffer (2000) study is that they completed interviews over the telephone, and the interviews were unstructured; they relied on the participants' volunteer information without specific questions being asked. In addition, the mean time elapsed since the death was considerably shorter than for other studies, which could change the participants' ability to understand and identify their needs. Perhaps a participant in Wilson and Marshalls (2010) study put it best when they said, "It's only after you come out of grief that you realize you needed help" (p. 633). If they are correct, it is possible that after a longer time had elapsed the same individuals may identify an increased level of need.

Theoretical Insights

Through the meta-interpretation process, theoretical insight emerged from the rich data provided by the six unique research studies. The combination of all of the research study data provides a newly uncovered look at the overall picture of suicide survivors' self-perceived needs. From this new picture a typology of suicide survivor needs was developed shown in Table 1. It provides a clearer understanding and classifies the diverse needs that a suicide survivor may experience. Each suicide survivor will have a unique experience, depending upon the many variables distinctive to each situation; the needs of one suicide survivor will vary greatly from those of another. With the typology of suicide survivors' needs, the needs of a suicide survivor can be classified into one of four types. The categories are short term/group, short term/individual, long term/group and long term/individual. Examples of services that can meet each type of need can be

found in Table 1, however, the list is not exhaustive and there are many postvention services that can meet each type of need, many postvention services will meet both short term and long term needs.

Table 1: Typology of Suicide Survivor Needs

	Group	Individual
Short Term	<ul style="list-style-type: none"> *Psychoeducational groups to inform suicide survivors about impacts they may notice in their life *Written information 	<ul style="list-style-type: none"> *Individual counselling *Support with decisions (financial, funeral etc.) *Written information *Outreach work connecting survivors to resources *Positive responses from first responders
Long Term	<ul style="list-style-type: none"> *Suicide survivor bereavement support groups *Educational campaign informing the general public about suicide survivors 	<ul style="list-style-type: none"> *Individual counselling *Network of friends and family to listen and respond appropriately

Short term/group needs can be met by psychoeducational groups; these groups provide suicide survivors an opportunity to learn what responses they may expect during their bereavement process. This will help to normalize the challenges they may experience and ensure that they do not feel alone; it will also provide an opportunity for survivors to learn more about what postvention services are available, how they can be beneficial, and how to access them. Written information such as pamphlets, websites or handouts can also provide the above information in the comfort of ones own home, in a low-pressure environment, to large numbers of people at low costs.

Short term/individual needs can be met through individual counselling, providing the survivor with a non-judgmental environment to express their feelings and learn what they may experience during their bereavement. They will also learn coping tools to support them with their grief. Practical support with decision-making can also be provided; survivors overwhelmed by the situation can benefit from support with decision making around finances, funeral arrangements, legal matters and any additional practical support they require during this time. Outreach is important at this time, as many survivors are overwhelmed and may be unable to reach out for the support they need. Outreach workers who can go to the survivors and provide information about postvention services can make the difference between someone being isolated and someone being connected to support. First responders are another important part of the short term needs for individual survivors; if trained properly to respond with compassion and understanding they can not only provide a positive start to the bereavement process they can also provide a link to other professionals who can support the survivors in the short and long term.

Long term/group needs can be met within ongoing suicide survivor bereavement groups where survivors can openly express their feelings and experiences with others who have experienced the same thing. Educational campaigns can provide ongoing information to vast numbers of individuals, both survivors and the general public. Survivors may learn more about services in their community and feel they are not alone. The general public may become more aware of the experiences of suicide survivors and learn how to support them more effectively.

Long term/individual needs can be met with ongoing individual counselling and a network of friends and family who are educated and able to provide ongoing positive responses to survivors.

The typology of suicide survivor needs will allow professionals working in the field to have an improved understanding of suicide survivors' needs and therefore they will be better informed when developing and facilitating postvention services. They will be informed of the variety of needs survivors have and be able to provide services that will meet the needs of each unique suicide survivor. Ensuring that a variety of supports are available for individuals, including at least one from each type of need, will allow suicide survivors to select the support(s) that will be most effective for them and their unique situation. In addition, it provides a clear picture of the types of postvention services that should be developed and evaluated for their effectiveness. This will provide outlines, manuals, and other information for diverse postvention services, enabling organizations to put effective postvention services into practice in their community. Every community should have postvention services available that will effectively support a survivor with any of the four types of needs, depending on the stage of bereavement and the unique preferences they have.

Chapter 5: Discussion

Interpretations of Results

The purpose of this study was to discover if the limited current research that looks at suicide survivors' self-reported needs during their bereavement would, when analyzed as a collective, reveal insights into the experience of being a suicide survivor. Through meta-interpretation, seven themes emerged from the data. These themes are the importance of first responders, barriers to accessing support, one-on-one support from other survivors, professional support, informal support, group based support, and written information. These themes were touched on in many of the studies and emerged from the data as important aspects in the field. The themes highlight both positive and negative experiences reported by suicide survivors, as well as the types of supports they found most beneficial, or they felt were lacking during their bereavement process. The themes show that a variety of support is reported to be beneficial and that there is no 'one size fits all' solution for how to support suicide survivors. The variety of themes shows the diverse experiences that survivors have, and the diverse types of support that each individual reported as needing. One-on-one support from a fellow survivor, professional support, informal support, group based support and written information were the main types of support identified across multiple studies, each working with a unique population of survivors. One-on-one support from a survivor helped normalize survivors' feelings; knowing that another individual had experienced the same thing and had made it through was comforting for recent survivors. Connecting with an individual who has had similar experience may also ensure responses were positive, as many survivors experienced hurtful responses from individuals, including professional support

providers, first responders, friends, and family members. Professional supports such as counsellors, doctors, and social workers were another theme; survivors who accessed professional support reported both positive and negative experiences. Overall there was a high level of self-reported need for professional supports during bereavement. Informal supports were also needed; friends and family played an important role in suicide survivors' bereavement processes, and having a loved one to listen and respond kindly was reported as beneficial during bereavement. The other types of support that emerged as themes were group based support and written information, both identified by many survivors as a support they either found beneficial or wished they had had access to. Encounters with first responders were identified as an important event that had implications for the survivors. Some survivors reported positive interactions, however numerous suicide survivors found interactions with first responders to be negative; as this is often the first social response suicide survivors experience, it may have a influence on their bereavement trajectory. Barriers to accessing support were another common theme and are important to understand. In order for services to be effective, they must overcome barriers so that suicide survivors can access and benefit from supports available in their community.

Through the meta-interpretation, and the emergence of the seven themes, the author developed a typology of suicide survivors' needs. The typology of needs (Table 1) identifies four types of needs that suicide survivors experience. The four types of needs are short term/group, short term/individual, long term/group, and long term/individual. As discussed above there are a wide variety of needs that suicide survivors experience; this typology works to categorize the needs and more clearly

outline the variety of supports that should be made available to suicide survivors. An individual suicide survivor may experience a need for support from one or all of the types depending upon the type of support they personally find beneficial. For example some suicide survivors may benefit from group-based support and not require individual support, whereas another individual may find group based support overwhelming and instead only desire individual support. Some individuals may find they are not ready to access support in the short term, but after some time has passed identify a need for ongoing or long-term support. Other individuals may access immediate short-term support and then find they do not need any long-term support. Ensuring postvention services that meet all four types of needs are available will provide a wide range of options that individuals can then decide which services they would like to access.

Limitations

This meta-interpretation is limited in that it only looks at research studies that were published; therefore, any publishing biases that occurred within the publishing process will impact results. In addition, only articles published in English were included; this could exclude research articles written in other languages that could provide more depth to the results. The results are also limited by the original data; any limitations or flaws that were present in the original data will impact and limit my data as well.

The main limitation of this meta-interpretation is the general homogenous nature of the participants of the studies and the individuals who completed the research. All of the individuals who contributed to the research studies are from only three countries, Australia, USA and Norway. Considering suicide is a global health issue, having research take place in only three countries cannot provide information that will be

relevant around the world. In addition all of the researchers are influenced by western cultural beliefs about suicide; these underlying belief systems will influence their research. The author of this document is from Canada, another western culture, so she will have similar cultural norms and beliefs about suicide. The themes and theoretical insights that emerge will be formed based on her subjective understanding of what is important.

The overwhelming majority of participants across all of the studies are identified as Caucasian females and all were adults at the time they participated in the study. This is an incredibly homogenous sample and places great limitations on the applicability of results of each individual study and the meta-interpretation. Not only was global diversity not represented, as all of the participants were from one of three western countries, the diversity within each country was not represented. Almost all of the studies looked exclusively at individuals with familial relationships to the deceased, this speaks to the challenge of identifying who is a suicide survivor as there is no agreed upon definition. This limits the applicability of the findings to suicide survivors who are also family members.

Implications for Counsellors

The findings of this meta-interpretation have important implications for how counsellors, other professional who support survivors of suicide and organizations should respond to those who have lost a loved one to suicide, and for what services should be established.

Responding to Suicide Survivors

It is clear that many suicide survivors experience negative responses from first responders, professionals in the helping field, friends and family members. Counsellors and other professionals who are supporting suicide survivors should understand that their responses, negative or positive, often have a lasting impact on survivors of suicide. Creating training materials for first responders would have a lasting positive impact on survivors. Providing first responders with the knowledge and tools to respond compassionately when they arrive at the scene of a suicide would support survivors in the beginning of their grieving process; in addition first responders could play an important role in providing information about postvention services available in their community for suicide survivors. It is critical that professionals be cautious and intentional with what words are used and what questions are asked of suicide survivors; many participants in the research studies simply wanted someone who was compassionate, showed a level of comfort discussing their deceased loved one, and remained non-judgmental of both the individual who died by suicide and the responses of the suicide survivor. Professionals should learn of resources in their community and provide the appropriate referrals to clients who may need more than individual counselling. Most importantly counsellors should know themselves and acknowledge if supporting a suicide survivor is something they are comfortable with and/or qualified to do; if not, appropriate referrals should be made. Although this research found that the responses of professionals towards suicide survivors is important, it did not go into depth about which types of responses are perceived as positive or negative by suicide survivors, therefore implications on precisely how to respond to suicide survivors cannot be made. Counsellors should be cautious and

educate themselves on the experience of suicide survivors and resources in their community so that appropriate referrals can be made.

Establishing Services

The most important implication for counsellors, other professionals and organizations that are supporting suicide survivors is the recommendations on the types of services to establish. The seven themes and the typology of suicide survivors' needs provide vital information so that individuals and organizations can establish appropriate postvention services based on the self-reported needs of suicide survivors and that the barriers to accessing those services can be overcome by survivors. Through a clear understanding of the typology of suicide survivors' needs and the barriers to accessing services which emerged during the meta-interpretation, service providers can get a clear picture of what services need to be implemented in their community to serve the unfortunately large population of suicide survivors. It is important to keep in mind the variety of barriers that suicide survivors experience: financial, lack of knowledge of services available, and past negative experiences are a few, however the most important when establishing services are that many survivors feel unable to actively seek out services and reported a need to be referred to services without having to ask for help. An important postvention service is outreach that could be done in collaboration with police departments. This will ensure that survivors of suicide are made aware of services immediately after a suicide occurs and that a professional follows up with the survivors to encourage them to access postvention services that meet their needs.

By understanding the typology of suicide survivor needs, professionals and organizations working in the field will better recognize suicide survivors needs and use

this knowledge to develop postvention services that will meet each type of need, ensuring that a variety of supports are available for individuals, including at least one from each type of need. All communities should have supports available that will effectively help a survivor with any of the four types of needs depending on the stage of bereavement they are in and the individual preferences they have.

Recommendations for Research

The research on the self-reported needs of suicide survivors is completed with participants who are from western countries and who are Caucasian. Although research should be conducted with individuals from a variety of cultures from around the world, this author believes that research should be conducted with Indigenous Canadians. Suicide amongst Indigenous adolescents in Canada is of epidemic proportions and suicide rates continue to rise in this demographic (MacNeil, 2008). Ideas about how much higher the rates of suicide are amongst Indigenous youth compared to the general population in Canada vary depending upon the source. Some sources put the rate at two times higher (Clifford et al., 2013), and others at five to six times higher (White, 2007; MacNeil, 2008), with some communities having 470 deaths per 100,000, or 36 times the national average (MacNeil, 2008). Canadian Indigenous youth have a higher rate of suicide than any other identified culture in the world (MacNeil, 2008). Although accurate data is challenging to collect due to underreporting, misclassification and wide variations in reporting suicide rates (MacNeil, 2008), it is clear that the prevalence of suicide is higher amongst the Aboriginal population than amongst the rest of Canada. Due to high suicide rates, suicide survivors are even more prevalent in Indigenous communities. Alan Berman (2011) found that the number of survivors per death by

suicide could vary greatly depending on the culture of the person who died. It is possible that the number of survivors for each individual suicide is higher in small close-knit Indigenous communities, which would lead to even higher numbers of suicide survivors and many individuals who have lost more than one loved one to suicide.

The beliefs around death and suicide vary from one culture to another; because of this, suicide survivors will have explanations that fit their belief system and find meaning in different ways depending on their culture (Grad, 2014). The cultural understanding of suicide will dictate the type of social reactions and support a suicide survivor receives. Cultural mourning practices also vary and impact how the suicide survivor grieves. Therefore, support that is beneficial to suicide survivors in Western societies may not be effective or may even be offensive to individuals from other cultures.

Not a single research study has looked specifically at what supports a Canadian Indigenous suicide survivor perceives as beneficial in the aftermath of a suicide. In fact, 'A systematic review of suicide prevention interventions targeting indigenous people in Australia, United States, Canada, and New Zealand', which searched for the period 1981 to 2012, found only a single article that pertained to Indigenous Canadians (Clifford et al. 2013). It is clear that suicide amongst Indigenous populations is high and that suicide survivors are very prevalent in these communities. Research should be completed in Indigenous communities so that effective postvention strategies can be implemented where there are high rates of suicide, and therefore high rates of suicide survivors who are at high risk for a number of complications including future suicidal behaviour.

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