

Marquette University

e-Publications@Marquette

---

Dissertations (1934 -)

Dissertations, Theses, and Professional  
Projects

---

## More Than “Just a Friend”: Exploring the Therapeutic Needs of Adult Survivors of a Suicide Loss of a Friend

Kat R. McConnell  
*Marquette University*

Follow this and additional works at: [https://epublications.marquette.edu/dissertations\\_mu](https://epublications.marquette.edu/dissertations_mu)



Part of the [Counseling Psychology Commons](#)

---

### Recommended Citation

McConnell, Kat R., "More Than “Just a Friend”: Exploring the Therapeutic Needs of Adult Survivors of a Suicide Loss of a Friend" (2023). *Dissertations (1934 -)*. 3158.  
[https://epublications.marquette.edu/dissertations\\_mu/3158](https://epublications.marquette.edu/dissertations_mu/3158)

MORE THAN “JUST A FRIEND”: EXPLORING THE THERAPEUTIC NEEDS OF  
ADULT SURVIVORS OF A SUICIDE LOSS OF A FRIEND

by

Kat R. McConnell, MA

A Dissertation submitted to the Faculty of the Graduate School,  
Marquette University, in Partial Fulfillment of the  
Requirements for the Degree of Doctor of Philosophy

Milwaukee, Wisconsin

September 2023

ABSTRACT  
MORE THAN “JUST A FRIEND”: EXPLORING THE THERAPEUTIC NEEDS OF  
ADULT SURVIVORS OF A SUICIDE LOSS OF A FRIEND

Kat R. McConnell, MA

Marquette University, 2023

Individuals who are bereaved by the suicide loss of a loved one (also known as “suicide survivors”) face high rates of complicated grief, mental illness, social isolation, experiences of stigma, and suicide attempts. While suicide loss therapy (or “postvention”) attracts many individuals grieving familial suicides, those impacted by the suicide loss of a close friend are underrepresented in both individual and group therapies, despite indications that friend suicide survivors are impacted at an equivalent level and frequency to family members. Using a constructivist grounded theory method, this study aimed to investigate the lived experiences and therapeutic needs of 8 adults who identified as suicide survivors and attended psychotherapy to address grief after the suicide loss of a friend.

Findings suggest that friend suicide survivors benefit from both individual therapy and suicide loss support groups; specifically, friend suicide survivors view therapy as a space to process complex emotions, challenge self-blame, obtain education about grief, and connect with group members. However, friend suicide survivors also desire to receive more specialized care from individual therapists with experience and training in suicide bereavement. While friend suicide survivors may experience challenges to help-seeking, including stigma and a perceived lack of social permission to grieve friends, they may feel motivated by the “wake-up call” of friends’ suicides and existing relationships with therapists. Outside of therapy, friend suicide survivors appear to benefit from social support from other suicide survivors and engaging in meaning-making activities. Results of this study have implications for training of mental health professionals and best practices for working with suicide survivors.

## ACKNOWLEDGEMENTS

Kat R. McConnell, M.A.

This project would not have been possible without the support and guidance of my advisor and dissertation chair, Dr. Lisa Edwards, whom I admire deeply. I am also indebted to my other dissertation committee members, Dr. Alan Burkard and Dr. Lynne Knobloch-Fedders, for their encouragement and advice throughout the research process. I have immense gratitude for my coding team, Asianna Harris and Julia Pawlowski, who committed their time, assistance, and feedback throughout the data analyses stage of research. Additionally, I would like to extend thanks to the numerous faculty members, clinical supervisors, classmates, and colleagues who supported and inspired me throughout my doctoral journey. Lastly, I would like to acknowledge my support system of family and friends who offered encouragement, companionship, and community during my years of education – I love you all.

## TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	i
LIST OF TABLES.....	vii
LIST OF FIGURES.....	viii
 CHAPTER	
I. INTRODUCTION.....	1
Rationale for the Present Study.....	4
Purpose of the Present Study.....	5
Definition of Terms.....	6
Suicide Survivor.....	6
Died by Suicide or Completed Suicide.....	7
Suicide Contagion.....	7
Psychotherapy.....	8
Postvention.....	8
Research Questions.....	9
Overview of Study Methods.....	9
II. LITERATURE REVIEW.....	11
Suicide Bereavement Rates.....	11
Characteristics of Suicide Bereavement.....	13
Complicated Grief.....	13
Mental Illness.....	15
Suicidality.....	16

Stigma.....	17
Self-Blame.....	18
Interpersonal Effects.....	19
Types of Suicide Survivor.....	20
Familial Survivors.....	21
Parents.....	21
Children.....	22
Siblings.....	23
Partners.....	23
Nonfamilial Survivors.....	24
Coworkers and Classmates.....	25
Mental Health/Health Professionals.....	26
Friends.....	27
Young Adult and Adolescent Friends.....	29
Postvention.....	31
Types of Postvention.....	31
Group Postvention.....	31
Individual Postvention.....	33
School-Based and Work-Based Postvention.....	36
Online Postvention.....	38
Outreach Postvention.....	39
Active Postvention.....	40
Interdisciplinary Postvention.....	42

Postvention Outcomes.....	44
Ethical Considerations.....	48
Research Gaps.....	50
III. METHODS.....	52
Constructivist Grounded Theory.....	52
Ethical Considerations.....	55
Research Team.....	58
Coding Team Positionality.....	58
Measures.....	60
Participants.....	60
Data Collection Procedures.....	63
Data Analysis Procedures.....	64
Initial Coding.....	64
Focused Coding.....	64
Theoretical Coding.....	65
Conceptual Mapping.....	65
IV. PRESENTATION OF RESULTS.....	68
A Constructivist Grounded Theory.....	68
Motivation for Seeking Support.....	69
Suicide Loss as a “Wake-Up Call”.....	70
Utilizing Existing Therapy.....	72
Challenges to Seeking Support.....	75

Experience of Stigma.....	75
Lack of Social Permission to Grieve Friends.....	78
Impact of Mental Health Support Services.....	83
Allowing Space to Process Complex Emotions.....	83
Providing Education.....	89
Challenging Self-Blame.....	92
Connecting Through Shared Experiences.....	93
Desire for More Specialized Care.....	97
External Coping Resources.....	99
Connecting with Other Suicide Survivors.....	100
Channeling Grief Into Action.....	103
V. DISCUSSION.....	106
Connections to Current Literature.....	107
Motivation for Seeking Support.....	108
Challenges in Seeking Support.....	109
Impact of Mental Health Support Services.....	113
External Coping Resources.....	115
Limitations.....	117
Research Implications.....	119
Clinical and Training Implications.....	122
Conclusion.....	124
BIBLIOGRAPHY.....	126



## APPENDICES

A. Recruitment Letter.....	138
B. Demographic Form.....	140
C. Screening Form.....	141
D. Informed Consent.....	142
E. Interview Protocol.....	146
F. Resource List.....	148

## LIST OF TABLES

Table 1. Participant Demographics.....	62
Table 2. Coding Sample.....	67

LIST OF FIGURES

Figure 1. Therapy experiences of adult survivors of suicide loss of a friend.....70

More Than “Just a Friend”: Exploring the Therapeutic Needs of  
Adult Survivors of a Suicide Loss of a Friend

**Chapter 1: Introduction**

“The loss of a friend is like that of a limb; time may heal the anguish of the wound, but the loss cannot be repaired.”

—Robert Southey (1799)

The experience of losing a loved one is a significant life event for most who encounter it, bringing periods of grief, yearning, and adjustment to life without the decedent. However, a death by suicide offers a unique course of grief for those left behind. In addition to the typical experiences and emotions of mourning, *suicide survivors* (the preferred term for a person impacted by suicide loss) may face additional challenges in comparison to the typical mourner (Andriessen, Krysinska, et al., 2017). For those closest to the death, suicide bereavement is associated with impairments in emotional, occupational, and social functioning (Chapple et al., 2015; Hunt & Hertlein, 2015; Mitchell et al., 2009; Pitman et al., 2018).

While it is difficult to accurately estimate how many individuals are significantly impacted by suicide bereavement, Feigelman et al. (2017) found that 51% of surveyed Americans reported exposure to at least one suicide, and 35% of those exposed felt emotionally distressed by the death. Even by conservative estimates, suicide survivors could number over 45 million in the United States alone (Feigelman et al., 2017). With the noted recent rises in suicide rates in the United States following the global COVID-19

pandemic, it is inevitable that the number of individuals affected by suicide bereavement will also rise (Curtin et al., 2022). Considering the negative effects and risks associated with suicide loss, rising numbers of suicide survivors is cause for concern in the mental health field.

The act of suicide has faced public condemnation and criminalization throughout history, and as a result, family members and others connected to those who took their own lives often faced stigma and isolation (Andriessen & Krysinska, 2015; Cvinar, 2005). Although suicide has gradually been decriminalized and recognized as a legitimate mental health concern in most of the world, suicide survivors still face more stigma and social consequences than those mourning a natural or accidental death, often leading to social isolation and shame (Bottomley et al., 2018; Clark, 2001; Cvinar, 2005; de Groot et al., 2006; Feigelman et al., 2009; Jordan, 2008; Range & Calhoun, 1990; Seguin et al., 1995; Sveen & Walby, 2008). In addition to social effects, suicide survivors struggle with higher rates of mental illness diagnoses, trauma, complicated grief, and suicide risk (sometimes referred to as *suicide contagion*) than other mourners (de Groot et al., 2006; Erlangsen & Pitman, 2017; Feigelman, et al., 2017; Pitman et al., 2017).

In order to cope with the negative effects of suicide bereavement, many suicide survivors turn to *postvention* services for assistance. Prevalent suicide bereavement researcher Karl Andriessen (2009) defines postvention as “those activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behavior” (p. 43). Postvention services are offered in a wide range of modalities, including individual counseling, support groups, family counseling, telehealth, school-based/workplace-based services, outreach efforts, and

interdisciplinary services (Bottomley et al., 2018; Castelli Dransart, 2017; Genest et al., 2017; Krysinska & Andriessen, 2015; McIntosh, 2017; Rothes et al., 2017; Scocco et al., 2017; Spencer-Thomas & Stohlmann-Rainey, 2017). Although many postvention services are organized by fellow survivors, research has found that services involving mental health professionals may be the most effective (Andriessen et al., 2019; Jordan & McMenemy, 2004).

While the serious impact of suicide bereavement on survivors has been well-documented, previous research and postvention efforts have primarily focused on the experiences and needs of familial survivors, including the parents, siblings, children, and spouses of individuals who die by suicide (Adams et al., 2019; Mitchell et al., 2009; Sklarew et al., 2012; Sugrue et al., 2014). However, there are indications that nonfamilial survivors, such as friends or colleagues, are also strongly impacted by suicide loss and may even outnumber familial survivors (Andriessen, Rahman, et al., 2017; Bartic et al., 2013a, 2013b; Causer et al., 2022).

Close friends are a “hidden population” of mourners, according to sociologists Sklar and Hartley (1990); although their pain may be just as deep as that of family, there are fewer formal or informal supports in place for non-familial mourners and thus friends must carry the “double burden” of grieving while keeping up the appearance of life as usual. Indeed, there are indications that friend survivors experience a delayed grief reaction and that their symptoms of grief may last even longer than those of some family members, despite initially showing fewer acute symptoms than family in the immediate aftermath of the suicide (Brent et al., 1996). This may be due to friends believing that they have less of a right to grieve than family members and stifling outward expressions

of mourning or help-seeking as a result (Bartik et al., 2013a; Causer et al., 2022; Dyregrov et al., 2011). In addition to emotional consequences of grief, friend survivors may also see an impact on their social lives; some may become overprotective or anxious around their surviving friends, while others might isolate out of a fear of losing more friends to suicide (Azorina et al., 2019; Pitman et al., 2017).

While many suicide survivors experience difficulty reaching out for professional support related to suicide loss, friend survivors may be even less likely to seek counseling or postvention services (Bartik et al., 2013a; Feigelman et al., 2017). Despite findings that a high number of friends are affected by suicide loss, such survivors are underrepresented within postvention programs and support groups, which are largely attended by familial survivors (Feigelman et al., 2017). As a result, the therapeutic needs of individuals mourning the suicide of a close friend are not only unmet but also largely not understood.

### **Rationale for the Present Study**

Counseling psychologists are tasked with approaching mental health in a holistic and contextual manner, “as situated in multiple relational, sociocultural, and structural contexts interacting with intrapersonal experiences” (Scheel et al., 2018, p. 18). Suicide bereavement is one such area in which counselors and counseling psychologists can assist clients with relational, sociocultural, and structural issues of grief, isolation, and stigma through the use of postvention services. In the past, when suicide bereavement has been addressed, intervention and research efforts often focused on immediate family members, such as parents, children, and spouses, potentially neglecting the needs of nonfamilial suicide survivors. However, counseling professionals have the opportunity to expand

their competencies to make psychotherapy services accessible to all suicide survivors, including friends bereaved of suicide.

Additionally, counseling psychologists are encouraged to pursue “methods that limit the length and severity of distress and enhance human functioning” (Scheel et al., 2018, p. 29). By better understanding and addressing the impact of suicide loss early on, counseling professionals can ideally minimize or prevent many of the negative long-term impacts which follow those bereaved by suicide, including further suicide attempts and losses. Considering that individuals who lost a friend to suicide are at a high risk of adverse consequences, including suicide risk, this is one population which could benefit from additional attention from the counseling psychology profession.

### **Purpose of the Present Study**

Although it is evident that suicide survivors mourning a friend are likely at high risk for mental illness, complicated grief, and suicide attempts, the paucity of research on this sub-population makes it difficult to identify specific therapeutic strategies and outcomes for such survivors. The purpose of this dissertation study, therefore, is to pursue a more robust understanding of the psychotherapy experiences and needs of nonfamilial suicide survivors, specifically, adults who lost meaningful friends to suicide.

While a picture of friend suicide loss may be captured in part by quantitative methods of study, the unique and varied experiences of suicide survivors justifies the use of qualitative methods, in order to capture rich, in-depth perspectives and lived experiences of suicide loss. Specifically, participants were interviewed individually about their experiences seeking and receiving postvention psychotherapy services related to the suicide of a friend. By collecting and analyzing such data, results may inform future



counselor/psychologist training and intervention best practices for mental health practitioners who work with suicide survivors.

### **Definition of Terms**

The field of suicidology utilizes specific terminology to describe various experiences and phenomena associated with suicide. Additionally, those affected by suicide bereavement have gradually developed their own unique culture of grief and healing and thus have adopted their own unique colloquial terms. As this dissertation will utilize both formal suicidology and informal suicide bereavement terminology, key terms and phrases are defined below.

#### **Suicide Survivor**

At first glance, the term “suicide survivor” could be assumed to refer to individuals who lived through a suicide attempt. Rather, in the suicide bereavement community, “suicide survivor” is the most commonly preferred term for individuals who have *survived* suicide bereavement or otherwise been deeply affected by a suicide loss; those who survive an attempted suicide are instead referred to as “suicide attempt survivors” (Andriessen, Krysinska, et al., 2017).

Perhaps first used in A.C. Cain’s 1972 book “Survivors of Suicide” (as cited in Andriessen, 2005), the term “suicide survivor” has grown in use over the decades and is now the term most widely adopted by the suicide bereaved and by suicide bereavement groups. Although alternate titles are sometimes used, including “survivors *after* suicide” or “suicide bereaved,” suicidology as a whole has continued to favor the title of “survivor.” As prolific suicidology researcher Andriessen (2005) explained, this bereaved

group finds meaning in the word “survivor,” as loss by suicide is often marked by “a struggle (to stay alive) and a long journey to find new meaning in life” (p. 38).

### **Died By Suicide or Completed Suicide**

Suicide survivors have been some of the strongest advocates for the change in language from “committed suicide” to “died by suicide,” “completed suicide,” or “took their own life” (Silverman, 2006). Suicide survivors and other advocates have brought to light the stigmatizing nature of the word “commit” in relation to suicide, due to the historical context of suicide being regarded as a criminal act (Jamison, 1999; Silverman, 2006). Due to the proliferation of this terminology in the suicidology field, and with consideration to the importance the terms hold amongst survivors themselves, the terms “died by suicide” or “completed suicide” are used in place of “committed suicide” within this dissertation.

### **Suicide Contagion**

Also referred to as a “suicide cluster,” suicide contagion refers to the phenomenon of suicide incidents triggering further suicide attempts and deaths. Multiple suicides occurring in close proximity and in a short time period can occur in communities, schools, workplaces, and cultural groups, especially when the inciting suicide is highly publicized, glorified, or romanticized (Jamison, 1999; Ma-Kellams et al., 2018). For example, widely covered celebrity suicides often result in an increase in suicides and suicide attempts, especially amongst individuals who share demographic characteristics with the deceased (Ma-Kellams et al, 2018). For those already at risk, seeing a suicide death highly publicized may normalize the act, as well as demonstrating the perceived benefits of notoriety and public mourning (Jamison, 1999). Types of suicide contagion

can include *geographical proximity*, which includes those who witness the suicide or have contact with the scene of the suicide, and *psychological proximity*, often experienced by family, friends, and those with close emotional connections with the deceased; no matter the form of suicide contagion, those affected are at a higher risk of suicide ideation, attempt, and/or completion (Arensman & McCathy, 2017).

### **Psychotherapy**

Psychotherapy refers to the “informed & intentional application of clinical methods & interpersonal stances, derived from established psychological principles, for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics” (Prochaska & Norcross, 2018, p. 2). In other words, psychotherapy involves: a) applied clinical techniques; b) a psychological basis; and c) the goal of helping individuals change ways of thinking, feeling, or behaving.

Psychotherapy most often involves a therapeutic relationship between a licensed mental health practitioner (e.g. counselor, psychologist, social worker) and one or more clients (Prochaska & Norcross, 2018). While much of psychotherapy involves traditional one-on-one “talk therapy,” psychotherapy can also involve groups, families, or couples and can integrate creative methods beyond discussion alone.

### **Postvention**

The term “postvention” is thought to have been coined by psychologist Edwin Shneidman in 1968 at the first American Association of Suicidology conference, in reference to activities and techniques designed to lessen the impact of a suicide on survivors, which may include individual psychotherapy, support groups, and school/workplace programming (Andriessen, 2009; McIntosh et al., 2017). With the

invention of this term came the acknowledgement that even when prevention and intervention have failed to prevent a suicide death, there is still work to be done after (or “post”) the loss. Suicide bereavement researcher Karl Andriessen (2009) defines postvention as “those activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behavior” (p. 43).

### **Research Questions**

This study seeks to better understand the lived experiences and therapeutic needs of adults who sought psychotherapy services following the suicide of a close friend. Specifically, the following research questions will be addressed in this study:

- 1) What are the therapeutic needs of adults grieving the loss of a friend to suicide?
- 2) What were the psychotherapy experiences of adults who sought therapy after the loss of a friend to suicide?

### **Overview of Study Methods**

For this study, the choice was made to use the qualitative research method of constructivist grounded theory (CGT), which aims to utilize qualitative data to build theory in relation to the co-occurring lived experiences of participants, while taking into consideration the influences of various external systems, including the influence of the researchers themselves upon the research process and results (Charmaz, 2014, 2017).

Utilizing suicide loss organizations and online databases of suicide survivor support groups, recruitment targeted adult suicide survivors who have been impacted by the suicide of a friend with whom they had a meaningful relationship and have received

some form of psychotherapy from a mental health practitioner to address their loss. After screening and collecting demographic information from these participants, the primary researcher conducted 60-120 minute semi-structured interviews with participants addressing: 1) their experience of suicide loss, 2) their process of seeking psychotherapy, and 3) their experience of participating in psychotherapy. For their time, participants were sent a \$15 gift card or given the opportunity to have a \$15 donation made on their behalf.

All interviews were recorded and transcribed. The primary researcher assembled a research team consisting of two other doctoral students who were trained and then assisted with coding the transcribed interviews. The dissertation chair provided auditing of the coding process. Coding was completed according to CGT procedures, including initial line-by-line analysis of transcripts, focused coding to identify emergent patterns, theoretical coding to synthesize coding themes, and conceptual mapping. The methods of data collection and analysis will be explored in more detail in Chapter 3.

## **Chapter 2: Literature Review**

Suicide is one of the most prominent mental health issues of the modern era, with 47,646 deaths by suicide occurring in 2021 in the U.S. alone (Curtin et al., 2022). Suicide rates reached a modern peak in 2018 at over 48,000, a 35% increase from 1999 (National Institute of Mental Health, 2021). While the loss of life to suicide is devastating within itself, the fallout of suicide loss can gravely impact family, friends, and others exposed to the event, resulting in mental health disorders, social isolation, complicated grief, and even further suicide attempts and deaths. With the growing number of suicides, there is also a growing need for support for those left behind – namely, suicide survivors.

The following chapter will review the existing literature on suicide bereavement in a few key areas: 1) Suicide Bereavement Rates, 2) Characteristics of Suicide Bereavement, 4) Types of Suicide Survivor, 5) Postvention, 6) Ethical Considerations, and 7) Research Gaps.

### **Suicide Bereavement Rates**

In order to address the needs of a population, it is imperative to know the inclusion criteria and the size of that population. Unfortunately, suicide survivors are not a straightforward or easy population to define and count. Much of the issue with determining rates of suicide survivors lies with defining survivorship itself (Berman, 2011). The key question is “Who do we count as a suicide survivor?” Suicide bereavement research is often aimed at immediate family, such as parents, children, siblings, or spouses of the deceased. However, immediate family members are not the only individuals who may be significantly impacted by a suicide. Nonfamilial survivors – including friends, coworkers, classmates, or acquaintances – can be strongly affected by

suicide loss as well (Andriessen, Rahman, et al., 2017; Berman, 2011; Causer et al., 2022).

The General Social Survey (GSS) from 2016 does offer a picture of self-identified survivors in the United States. After adding questions about suicide for the first time in 2016, the GSS showed that rates of suicide bereavement were higher than most researchers had predicted; 51% of participants reported exposure to suicide at some point in their lives, and 27% had experienced two or more suicides (Feigelman et al., 2017). Even at the most conservative estimate from this data (i.e. looking only at survivors who reported being greatly distressed by the suicide), 18% of the adult US population could be considered suicide survivors, adding up to an astonishing 45 million people (Feigelman et al., 2017).

Due to the ambiguity surrounding who can be considered a survivor, suicide survivors are assumed to be a self-identified category made up of individuals who feel that they have been significantly affected by a suicide (Andriessen, Rahman, et al., 2017). Under this assumption, Andriessen, Rahman, and colleagues (2017) conducted a meta-analysis of prior research in which suicide survivors self-identified through survey or interview. Through this meta-analysis, it was determined that lifetime prevalence of exposure to suicide was 21.83%. When looking only at those who had lost a family member to suicide, the lifetime prevalence rate was 3.90%, while the lifetime prevalence of losing a friend/peer to suicide was 14.53%. That the familial rate of suicide bereavement is significantly lower ( $p < 0.001$ ) than the friend/peer rate lends credence to the idea that survivor rates should not be counted only in number of immediate family members (Andriessen, Rahman, et al., 2017).

## **Characteristics of Suicide Bereavement**

Grieving a suicide loss shares many commonalities with grieving a death by natural or accidental means. Most experiences of bereavement include elements of denial, sadness, anger, longing, a period of adjustment to life without a loved one, and a journey to find acceptance or meaning in the loss (Kübler-Ross & Kessler, 2005; Morales, 2019). However, suicide bereavement is differentiated from other losses in a few significant ways, which will be discussed below.

### **Complicated Grief**

The typical course of grief is usually considered to involve a period of acute grief, in which grief-related emotions (e.g. sadness, anger, anxiety) are strongest, followed by an adjustment and restoration period, sometimes known as integrated grief, in which the bereaved begins to return to an emotional baseline and learns to create a life without their lost loved one (Jordan & Litz, 2014; Young et al., 2012). However, not every bereaved person follows this course. A small but significant percentage (10 - 20%) of bereaved persons experience what is known as complicated grief (Young et al., 2012).

Also known as prolonged grief disorder (PGD) or traumatic grief, complicated grief involves a continuation, or even increase, of acute grief symptoms and yearning for the lost loved one (Andriessen, Krysinska, et al., 2017; Young et al., 2012). Rather than learning how to move on with their lives, those with complicated grief find themselves continually stuck in a cycle of grief and rumination which affects their ability to function in daily life and which keeps the loss feeling fresh and sharp (Jordan & Litz, 2014; Young et al., 2012). While those with a natural course of grief find themselves eventually able to focus on happy memories of the deceased, create meaning from the loss, and find



pleasure in their lives again, individuals experiencing complicated grief continue to struggle to imagine a future without their lost loved one, avoid reminders of the deceased, and experience intrusive and traumatic memories of the death. Thus, it is unsurprising that complicated grief carries a high comorbidity with depression, PTSD, and substance abuse. The intense pain and yearning of complicated grief often leads to suicidal ideation and suicide attempts, and it tends to be resistant to antidepressant medication (Latham & Prigerson, 2004; Young et al., 2012).

For a bereaved population with inherent trauma, it is unsurprising that complicated grief would be an issue in the suicide survivor community. Indeed, survivors are much more likely to experience complicated grief in comparison to those bereaved by illness-related death (de Groot et al., 2006). In a study comparing 153 suicide survivors to 70 bereaved relatives of natural death, it was found that suicide survivors were more likely than the naturally bereaved to experience complicated grief and require professional help to cope with the loss (de Groot et al., 2006). A study of survivors in the month after their suicide loss saw a high rate of risk factors for later development of complicated grief (Mitchell et al., 2009). In a study of Italian suicide survivors, up to 64% showed symptoms of complicated grief, even 3+ years after the loss (Bellini et al., 2018). Survivors experiencing complicated grief are also at a higher risk of suicide ideation, even after controlling for depression and PTSD (Jordan, 2008; Young et al., 2012). A longitudinal study of adolescents exposed to the suicide of a friend or peer found that while depression, PTSD, and complicated grief were distinct from one another, early symptoms of complicated grief predicted later onset of depression and PTSD (Melhem et al., 2004).

## **Mental Illness**

The trauma and complicated grief which often accompany suicide bereavement may lead to symptoms or diagnoses of mental illness in survivors, such as clinical depression, anxiety, PTSD, and substance abuse disorders (Erlangsen & Pitman, 2017). Monitoring mental illness in suicide survivors is important not only in terms of general well-being, but also because mental illness and depressed mood are significant risk factors for suicide attempts by survivors (Jamison, 1999; Ma-Kellams et al., 2018).

A longitudinal study of the effects of an adolescent's suicide on 20 families revealed that mothers experienced recurrent depression (Brent et al., 1996). In China, survivors were shown to be at higher risk of depression than a control group; amongst the survivor group, those related to the deceased, living in rural environments, and who had lived with the deceased at the time of the suicide were at the highest risk for depression, (Zhang et al., 2005). Among adolescents who lost a friend to suicide, depressive symptoms and risk for a depression diagnosis in the first year after the suicide were especially elevated (Bridge et al., 2003; Feigelman & Gorman, 2008). This risk was especially strong for adolescents with a family history of major depressive disorder and those who felt personal responsibility for their friend's suicide (Bridge et al., 2003).

Indeed, survivors with a history of anxiety, depression, or suicidal ideation are at higher risk of depressive symptoms after suicide loss (de Groot & Kollen, 2013). A qualitative study of the impact of suicide bereavement on survivors' work and school functioning found that many survivors reported anxiety related to the suicide, as well as a resurgence of pre-bereavement mental illnesses, including depression and eating disorders (Pitman et al., 2018).

One reason why mental illness symptomatology could affect suicide survivors at a higher rate than other mourners is the high level of emotional turmoil and distress which results from suicide loss. When comparing two forms of traumatic loss – suicide and car accident – a study of 60 bereaved parents found that suicide survivors were felt more depressed, ashamed, and guilty in the months following the loss, in comparison to those bereaved by car accident (Seguin et al., 1995). Trolley (1993) makes the point that, in comparison to a natural death, grief by suicide or other sudden death often involves elements of unfinished business, challenges to belief systems, and feelings of abandonment. Unlike those bereaved by other sudden death, one in ten suicide survivors feels a sense of relief after the suicide, especially in cases where the deceased had a long history of mental illness and low quality of life. However, this relief is often combined with a sense of shame and guilt for feeling relief at all (Jamison, 1999).

### **Suicidality**

Unlike most other bereavement situations, suicide survivors are at a heightened risk of attempting or completing suicide themselves (Clark, 2001; Erlangsen & Pitman, 2017). The reasons behind the increased suicidality of survivors include shared genetic risk, depressive symptoms associated with the loss, normalization of suicide as a solution to distress, and a desire to be reunited with the deceased (Hunt & Hertlein, 2015; Jamison, 1999; Pitman et al., 2017; Sugrue et al., 2014). A qualitative study of suicide bereavement in the UK found that 26% of survivors thought of suicide as a more tangible option after experiencing the suicide death of a loved one. For some, the feeling of increased suicide risk was frightening; one survivor described feeling that she had been “contaminated by violence” and that suicide may “draw me in and take control of me”

(Pitman et al., 2017, p. 6). For others, the option of suicide was comforting or even compelling. They spoke of suicide being normalized as a potential escape, or of being curious what it felt like to take one's own life (Pitman et al., 2017).

### **Stigma**

Perhaps the factor which most strongly differentiates suicide bereavement from other loss is that of stigma. While the process of grief may be very similar no matter how the loss occurred, stigma surrounding the manner of death may act as a barrier to social support, which is a necessary coping mechanism after loss (Cvinar, 2005). A study by Range and Calhoun (1990) found that while suicide survivors and those bereaved by accident grieved in similar manners, accident survivors found more positive social support after the death, while suicide survivors reported being treated differently in a negative fashion, such as being blamed for the death or being pressured to share details about the death. The stigma surrounding suicide may lead to discriminatory interactions with survivors or avoidance of social contact (Range & Calhoun, 1990).

Stigma itself carries heavy consequences for its targets. The experience of stigma, including stigma around suicide bereavement, has been linked to lowered self-esteem, increased isolation, and an increased risk for suicide (Carpiniello & Pinna, 2017). Kawashima and Kawano (2017) refer to insensitive comments and stigmatizing behaviors towards survivors as “secondary wounds” for already hurting survivors. Receiving stigmatized responses to their grief sends survivors the implicit message that their grief is a private matter to be resolved behind closed doors; in a time when many survivors desire social support, this can feel “incredibly, incredibly lonely” (Chapple et al., 2015, p. 616).

## **Self-Blame**

Negative judgments received from a survivor's social sphere are not the only, or even the most detrimental, source of stigma. Many survivors also struggle with an inner sense of self-blame or self-stigma. In comparison to natural or accidental deaths, suicide survivors feel more intense guilt and responsibility for the death of their loved one (Carpiniello & Pinna, 2017; Sugrue et al., 2014). The suicide may even call into doubt the survivor's self-identity or relationship with the deceased (Jordan, 2008).

Survivors are often plagued by "what ifs" (e.g., *What if I had reached out more?*) and guilt over not anticipating and stopping their loved one's suicide (Adams et al., 2019; Sugrue et al., 2014). Due to misunderstandings around the nature of suicide, survivors have been found to overestimate the role they played in their loved one's choice to take their life, which exacerbates their sense of guilt and responsibility (Jamison, 1999; Jordan, 2008). Negative social stigma may help further solidify the self-identification of guilt and blame in survivors (Sheehan et al., 2018).

Aside from inner turmoil, self-blame also acts as a barrier to help-seeking for many survivors. Whether they believe they do not deserve support, or fear the stigma they may receive from others, survivors tend to reach out for help from friends, family, and professionals less often than those bereaved by other means (Barlow & Coleman, 2003; Cerel & Campbell, 2008; Hunt et al., 2019). Interestingly, a study of college students in New Zealand found that students who had personal experience with others' mental illness and suicidality held less stigma about others seeking mental health help, but were significantly less likely to seek mental health help for themselves, viewing it as a sign of weakness or an opening for stigma (Curtis, 2010).

For many survivors, there may be pressure – whether internal or external – to conceal the suicide and keep the manner of death a secret (Sheehan et al., 2018). Concealment of suicide is often done out of shame, embarrassment, or fear of stigma; survivors who keep the loved one’s manner of death a secret also tend to isolate themselves and receive less support (Hanschmidt et al., 2016; Hunt et al., 2019).

### **Interpersonal Effects**

For many experiencing significant grief, social support is an important element in healing (Dyregrov, 2011; Grad et al., 2004). According to Maple et al. (2010), being able to tell an oral narrative of a death event and the life of a lost loved one to others is an important step in meaning-making and establishing a new world view after experiencing loss. Support can even be an effective protective factor against depression in survivors (de Groot & Kollen, 2013).

However, many suicide survivors have been found to experience interpersonal difficulties following their loss (Azorina et al., 2019; Barlow & Coleman, 2003; McMenemy et al., 2008). Survivors may find themselves uncomfortable, ashamed, or unable to discuss the suicide loss with others (McMenemy et al., 2008). Range and Calhoun (1990) found that, in comparison to those bereaved by natural death, individuals bereaved by suicide and accidental death were more often asked intrusive questions about the circumstances of the death, and that the questions and attitudes expressed by others felt especially negative and unsupportive to survivors.

Even when they do have supportive persons in their life, survivors may find themselves frozen or exhausted by grief, and unable to reach out for support and ask for help (Dyregrov, 2002, 2004). In turn, friends and other social contacts of survivors may

withdraw from survivors, sometimes out of negative judgment, but more often out of an awkwardness and ambiguity in dealing with an unfamiliar form of grief (Chapple et al., 2015; Jordan, 2008).

To investigate the reasons behind survivor isolation, Azorina and colleagues (2019) conducted text analysis on answers from 499 young adult survivors (ages 18-40) in the United Kingdom. They found that the primary reasons why survivors intentionally or unintentionally withdrew from social connections included social discomfort around the suicide, perceived lack of support and/or stigma, perceived burden of grief on others, and fear of losing other close relationships. While some survivors reported remaining or growing close to other survivors, others reported that witnessing the grief of others was painful and uncomfortable for them, causing them to withdraw from these relationships. Survivors who did maintain close relationships often lived with the fear of losing others to suicide and felt a burden of overprotectiveness towards loved ones exhibiting symptoms of mental illness (Azorina et al., 2019; Pitman et al., 2017). The fear of losing others to suicide is especially potent for survivors whose original exposure to suicide came with no perceivable warning signs or triggers, thus making suicide seem like a random and unpredictable act which could happen to anyone at any time (Pitman et al., 2017).

### **Types of Suicide Survivor**

As discussed previously, suicide survivorship is not restricted only to immediate family. Rather, survivors have a variety of different relationships with the deceased, from family to friend to coworker. But do all types of survivors experience survivorship in the

same way? The following section will explore the unique experiences of survivors with different relationships to the deceased.

### **Familial Survivors**

For years, immediate family members have been the focus of suicide bereavement research, and thus, there is an abundance of research which demonstrates the effects of suicide loss on parents, children, siblings, and partners. These types of suicide loss relationships will be explored in the following subsections.

#### ***Parents***

The impact of suicide on the parents of the deceased, especially in cases of younger children, have been widely documented. In a study of the impact of adolescent suicide on families, the loss was found to deeply affect the whole family, but especially mothers, who were more likely to experience recurrent depression than fathers or siblings (Brent et al., 1996). Mothers in particular may feel additional responsibility to care for other distraught family members in addition to themselves, neglecting their own grief or feeling silenced in the process (Sklarew et al., 2012; Sugrue et al., 2014). A qualitative study focusing on mothers bereaved of suicide found that some mothers desired suicide themselves, specifically to seek out their child in the afterlife and assure their well-being (Sugrue et al., 2014).

In addition to the emotional impact of losing a child, parents have also been found to be at higher risk of overt and implicit stigma and blame from others (Cerel & Jordan, 2008). Ellis and Lane (1995) found that men in particular were more likely to blame parents bereaved by suicide for the death of their children, and that parents of younger children who died by suicide (age 10) were more harshly blamed than parents of older



children (ages 13-17). Seguin and colleagues (1995) found that parents bereaved by suicide experienced more shame, guilt, and isolation than parents bereaved by car accident death. Perhaps in contrast to other types of survivors, parent survivors are expected to not only process and make sense of the suicide for themselves, but also explain and justify it to others (Maple et al., 2010).

### *Children*

On the other end of the survivor spectrum is children who lose a parent to suicide. An estimated 7,000-12,000 children become survivors of a parent's suicide per year in the United States (Cerel & Jordan, 2008). Survivorship may hit children particularly hard, with children recently bereaved by suicide being shown to have higher anxiety levels than any other type of survivor, matched only by spouse survivors (Mitchell et al., 2009). Children and adolescent survivors are more likely than their peers to self-report substance use, suicidal ideation, and emotional distress (Cerel & Jordan, 2008). Compared to children who lose a parent to other forms of death, child survivors of suicide show higher depressive, anxious, and behavioral symptoms in the months following the suicide (Cerel & Jordan, 2008).

However, this difference is found to dissipate after several months (Cerel & Jordan, 2008). In fact, Hung and Rabin (2009) concluded that for young children in particular, suicide bereavement does not resolve itself much differently than other forms of bereavement, depending on how the rest of the family deals with the loss. For children who do suffer adverse consequences of their parent's suicide, it may be due more to the dysfunction in the rest of the surviving family rather than the death itself. In a longitudinal comparison to other first-degree relatives and spouse survivors, children of

the deceased were found to show fewer symptoms of depression and complicated grief after suicide loss (de Groot & Kollen, 2013).

### ***Siblings***

Parents and children are not the only family members potentially impacted by a suicide loss. Sibling survivors not only lose a childhood companion, but also a future confidant, aunt/uncle to their children, and more (Adams et al., 2019). One study by Brent and colleagues (1996) found that those bereaved by the suicide of an adolescent sibling experienced more intense grief following the loss than did friends or acquaintances of the deceased. This effect was especially strong in younger siblings, possibly due to an increased family burden on young children who cannot remove themselves from the home environment as easily as adolescent or adult siblings. However, at three years after the loss, all siblings in the study were found to have recovered in terms of mental illness symptomology, indicating that there may not be significant long-term effects on sibling mental health (Brent et al., 1996).

### ***Partners***

Losing a spouse or romantic partner to suicide comes with its own unique challenges. Many of these survivors lose not only a loved one but also a co-parent and/or a source of household income. Partners are often the survivors who must deal with logistics such as funeral arrangements, body identification, insurance negotiation, and other practical consequences of bereavement (Jamison, 1999; Sklarew et al., 2012). Additionally, in cases in which the cause of death is questionable, the partner of the deceased is the individual most likely to fall under police scrutiny (Jamison, 1999).

Outside of these practical stressors, researchers have noted that survivors who lost a spouse or romantic partner to suicide can feel a particular sense of loss and betrayal after the death. The implicit (or sometimes explicit) message of suicide may be interpreted as “I would rather die than be with you” (Hunt & Hertlein, 2015, p.22). In comparison to other first-degree relative survivors, spouses of the deceased are the most likely to experience recurrent depression, higher levels of depressive symptoms, and higher levels of anxiety (de Groot & Kollen, 2013; Mitchell et al., 2009). In comparison to the general public, suicide survivor spouses are at increased risk for mental illness (especially “mood disorders, PTSD, anxiety disorders, alcohol use disorders, drug use disorders, receiving prescriptions for antidepressants, and self-harm”) and physical complications (including cancer, cirrhosis, herniated discs, and sleep disorders) in the years following the loss (Erlangsen et al., 2017, p. 458). The physical complications in this population could be explained by a neglect of one’s health while grieving, unhealthy coping mechanisms (e.g. smoking, substance use, etc.), fluctuations in weight/nutrition, and stress. Additionally, surviving spouses were found to be more likely to have a child removed from the home by authorities, take extended sick leave from work, become unemployed, or be admitted to a psychiatric hospital (Erlangsen et al., 2017).

### **Nonfamilial Survivors**

A more often forgotten category of survivor is that of nonfamilial survivors. Even when not related by blood or marriage to a suicide decedent, individuals can still be strongly impacted by suicide loss and experience much of the same symptoms and consequences as familial survivors. Some categories of non-familial suicide survivors will be explored below.

### *Coworkers and Classmates*

Co-workers of the deceased are an often overlooked survivor group. Too often, employees affected by a suicide death at their workplace are given a brief debriefing and offer of support, and then encouraged to get back to their regular work schedule (Causer et al., 2022; Spencer-Thomas & Stohlmann-Rainey, 2017). However, like any other group of survivors, colleagues and workplace friends of the deceased are at high risk of experiencing trauma and suicidality after the loss, particularly in tight-knit work communities, such as EMTs and nursing staff (Causer et al., 2022). If the suicide is thought to be linked in some way to the workplace, such as the suicide of an overwhelmed or recently terminated employee, the risk for employee distress and anger is even higher (Kinder & Cooper, 2009). When co-worker suicide survivors feel “silenced,” dismissed, not given sufficient space to grieve, or that their relationship to the deceased was unacknowledged by their management, it can lead to feelings of abandonment and disenfranchised grief (Causer et al., 2022).

In an extensive qualitative study in the UK, Pitman and colleagues (2018) described a negative picture of how suicide bereavement affects experiences in school and at work. Overall, 50% of participants reported a negative impact on their education, and 36% reported a negative impact on their work. Survivors spoke of crying at work, trouble concentrating on work tasks or assignments, confusion, low motivation, and anger. These experiences were often embarrassing, anxiety-provoking, and frustrating for survivors, and sometimes undermined their confidence in their work (Pitman et al., 2018).

Schools are another environment which can be greatly impacted by a suicide loss. When a student dies by suicide, the potential for trauma to other students is high (Callahan, 1996; Rothes et al., 2017). Not only do students experience the typical course of grief for their classmate, but the phenomenon of suicide contagion is also most often observed in adolescents and young adults, especially within school populations (Cox et al., 2012). As students deal with their grief, they may also see suicide as a more viable option, after having observed it in their classmate (Cox et al., 2012). When schools are underprepared for handling student suicides, they may inadvertently make suicide contagion worse by incentivizing grief and romanticizing the suicide of the deceased student (Callahan, 1996).

### ***Mental Health/Health Professionals***

For mental health practitioners and other health professionals (e.g. physicians and nurses), the suicide of a client or patient may be experienced as professional failure (Castelli Dransart et al., 2017; Valente & Saunders, 2002). Although a large number of health professionals will encounter a client suicide over the course of their career – ranging from 33% of social workers to 82% of psychiatrists – only a third report receiving training on how to handle a client suicide (Castelli Dransart et al., 2017).

While health professionals may experience a very similar trajectory of grief to that of family and friends, their experience is often considered a form of disenfranchised grief. Unlike family or friends, health professionals' grief over the loss of a client is not always deemed socially acceptable, and they may be expected to continue their professional role with little or no respite for processing the loss. Not receiving support after a client suicide loss is associated with having strong emotional or stress reactions

after the loss, along with being a new clinician, being a woman, encountering a high number of suicides, and feeling emotionally close to the client (Castelli Dransart et al., 2017).

Losing a client to suicide can impact work performance and professional practice, as well as personal grief. Some professionals may take what they have learned from the experience of client suicide to increase their risk assessment competencies and sensitivity to warning signs (Knox et al., 2006; Rothes et al., 2017). However, other professionals may begin to doubt their professional capabilities, experience anxiety at work, worry about legal repercussions, become overcautious or refuse to treat suicidal clients, experience burnout, or even leave the profession altogether (Castelli Dransart et al., 2017; Rothes et al., 2017; Valente & Saunders, 2002).

### *Friends*

A widely unrecognized and under-researched survivor relationship is that of the friend survivor. Not living with or being related to an individual who dies by suicide does not mean a lack of emotional impact. Sklar and Hartley (1990) identified close friends as an invisible population of mourners regardless of cause of death, noting that friends deal with a “double burden” of grief: “they may experience the social and emotional transformations of bereavement, while they are forced to suffer the lack of institutional outlets that act as support for these transformations” (p. 105). Indeed, friends, neighbors, and co-workers are often overlooked when it comes to receiving professional support in the wake of a suicide, potentially ignoring a population of survivors suffering real post-suicide grief and trauma (Harwood et al., 2002). Some studies have even demonstrated that while immediate family show the strongest symptoms at the outset, the effects of

suicide bereavement on friends may emerge later and last longer (Brent et al., 1996; Feigelman & Gorman, 2008).

In a quantitative study examining the effect of suicide exposure on men and women, being related to the deceased was a strong predictor for depression in female survivors *until* closeness of relationship was factored into the model; once level of closeness was considered, the effect of kinship lost statistical significance (van de Venne, et al., 2019). In other words, although blood relationships are positively associated with a higher level of suicide bereavement overall, a strong friendship lost to suicide can overshadow family ties in terms of mental health impact.

The loss of a friend to suicide can also impact the survivor's relationship with other friends. After losing one friend to suicide, survivors often live with the fear of losing others to the same fate and feel a burden of overprotectiveness towards loved ones exhibiting symptoms of mental illness (Azorina et al., 2019; Pitman et al., 2017). In a study by Bartik and colleagues (2013a), young adult survivors who lost a friend to suicide expressed difficulty relating to and trusting other friends, especially those who were not understanding of their grief.

Friends may face additional barriers to seeking psychotherapy services after their loss, perhaps due to the focus on family support after suicide (Bartik et al., 2013a; Feigelman et al., 2017). Friend survivors are vastly underrepresented in suicide survivor support groups; although some groups are specifically aimed at family, even groups open to all survivors have a minority of friend survivors in attendance (Higgins et al., 2022). Feigelman and colleagues (2017) found that "friends do not affiliate in any significant

numbers with peer support groups, which are predominately populated with the deceased's first degree relatives” (p. 5).

**Young Adult and Adolescent Friends.** Of the research which does exist on friend survivors, the majority of studies focus on adolescent or college-aged survivors. In a comparison of surviving friends and siblings of an adolescent suicide, it was found that friend survivors showed less acute grief symptoms than sibling survivors immediately following the death, but friends were more likely to show long term effects and mental illness symptomology (Brent et al., 1996). Indeed, other studies have shown that adolescents grieving a friend’s suicide are likely to experience symptoms of depression, PTSD, complicated grief, suicidal ideation, and suicide attempts (Bridge et al., 2003; Feigelman & Gorman, 2008; Melhem et al., 2004). One proposed reason for this more intense reaction in adolescent friends as compared to siblings is the possibility that family members are “allowed or encouraged more direct expression, thereby leading to more complete resolution of grief than unrelated peers of the victim” (Brent et al., 1996, p. 258).

Among adolescents who lost a friend to suicide, depressive symptoms and risk for a depression diagnosis in the first year after the suicide were especially elevated (Bridge et al., 2003; Feigelman & Gorman, 2008). This risk was especially strong for adolescents with a family history of major depressive disorder and those who felt personal responsibility for their friend’s suicide (Bridge et al., 2003). In a study of both adolescents and young adults who lost a friend to suicide, Bartik and colleagues (2013b) found that such survivors showed similar levels of depression, prolonged grief, and self-harm/suicide risk as familial survivors, as well as showing poor and avoidant coping with



their grief. The young adult/adolescent survivors also expressed feelings of guilt over not being able to prevent their friend's suicide. As one survivor expressed, "I feel really guilty all the time in case I wasn't the kind of friend I should have been, like I'm not quite sure what else I could have changed exactly, but I feel like I should have been there more" (Bartik et al., 2013a, p. 213).

Additionally, young adult/adolescent survivors may feel insecure and guilty about their entitlement to their own grief, in comparison to familial survivors (Bartik et al., 2013a). This confusion over the boundaries of grieving for a non-family member can make young friend survivors more reticent to openly mourn or to seek psychotherapy services. "When you are friends with someone who commits suicide, sometimes you think that you don't deserve that kind of care or that kind of service offered to you," one survivor said. "Like I thought that if his family aren't having counseling why should I?" (Bartik et al., 2013a, p. 214).

However, Labestre and Gayoles (2021) found that young adult friend survivors may also be uniquely situated for post-traumatic growth through utilization of existing social supports. In a qualitative study of ten 20-year-old college students in the Philippines who were grieving the suicide loss of a friend/classmate, it was found that after the initial shock and grief of losing a peer to suicide, the young survivors found "strength in unity" by turning to each other for support, normalizing one another's feelings, and creating meaning around not taking any of their friends for granted (Labestre & Gayoles, 2021). The researchers noted that in the wake of suicide bereavement, friend survivors more closely bonded with their social communities,

“became more caring towards others, and developed a different worldview and life perspective” (Labestre & Gayoles, 2021, p. 309).

### **Postvention**

The term “postvention” is thought to have been coined by psychologist Edwin Shneidman in 1968 at the first American Association of Suicidology conference, in reference to the activities designed to lessen the impact of a suicide on survivors (Andriessen, 2009; McIntosh et al., 2017). With the invention of this term came the acknowledgement that even when prevention and intervention had failed to prevent a suicide death, there was still work to be done after (or “post”) the loss.

### **Types of Postvention**

Just as with other forms of psychotherapy, a variety of models and formats exist for postvention services, in order to meet the varied needs of different survivors. The following section will explore a few of these postvention services and the populations they best serve.

### ***Group Postvention***

Probably the most widely utilized and popular form of postvention is in the form of group therapy. Support groups for suicide survivors began as early as the 1960s with the opening of one of the foremost suicide prevention centers, the Los Angeles Suicide Prevention Center. By the late 1970s, suicide support groups were becoming more commonplace and well-utilized (McIntosh, 2017). For a population that often feels stigmatized and isolated from their pre-loss social circle, survivor support groups offer a refuge of community support, mutual understanding, camaraderie, and advice from

seasoned survivors, as well as the chance to learn coping skills (Bottomley et al., 2018; Griffin et al., 2022; Higgins et al., 2022; McIntosh, 2017).

From the beginning, suicide survivor groups were most often founded by other survivors who were acutely aware of the need for community support (McIntosh et al., 2017). To this day, a large percentage of suicide support groups are peer-led, or have a peer survivor co-facilitating the group with a mental health professional (McIntosh, 2017). A scoping review of peer-led support group studies found that suicide survivor participants benefitted from a sense of shared understanding and empathy amongst group members, which often resulted in a reduction in isolation, self-blame, and stigma and an increase in hope and general well-being (Higgins et al., 2022). Peer facilitators of groups also benefitted from a sense of altruism or giving back to the suicide survivor community (Higgins et al., 2022). One subgroup of survivors who may not benefit from group therapy are individuals with more severe mental illness symptomology, who may find exposure to others' grief narratives uncomfortable or re-traumatizing (Higgins et al., 2022).

While some peer-led groups include training and/or professional consultation for group facilitators, there are no requirements or regulations for the credentials of a peer support group leader (Higgins et al., 2022). However, research demonstrates the importance of peer group leaders being well-trained for facilitating survivor support groups, as leaders who are poorly prepared, do not provide enough structure, or who are still overly-fixated on their own grief may end up as an ineffective or even harmful group leader, causing some participants to leave groups early (Dyregrov et al., 2013; Higgins et al., 2022).

Due in part to concerns around the efficacy and consistency of peer-led groups, some suicide survivor groups are led by trained mental health professionals. While some of these professionally-led groups look similar to the group support format of peer-led groups, other groups are more structured and empirically-based. Constantino and colleagues (2001) lay out two such empirically-based group structures designed for widowed suicide survivors: Bereavement Group Postvention (BGP) and Social Group Postvention (SGP). The BGP structure emphasizes Yalom's 12 curative factors of group therapy and relies on group dynamics to achieve therapeutic outcomes for survivor participants. Conversely, the SGP structure focuses on the need for survivors to achieve healthy social support for healing, and involves group members planning outings and activities together, without focusing on grief-based conversations or interventions. Both of these group interventions were found to reduce depressive symptoms, distress, and grief, and increase social adjustment (Constantino et al., 2001).

Sands and Tennant (2010) reported on a transformative learning suicide bereavement workshop, in which a therapist led survivors through activities focused on meaning reconstruction, including group discussion, art therapy, journaling, and grief rituals. There has been movement towards non-traditional group structures, as initial research indicates that incorporating music therapy, art therapy, or other forms of creative expression into postvention groups may be beneficial to survivors (Edmonds, 2016; Ratkowska & De Leo, 2017).

### ***Individual Postvention***

In comparison to group work, individual therapy for suicide bereavement appears to be underutilized and understudied. There is no agreed-upon or empirically validated

method for addressing the needs of suicide survivors specifically, and few therapists receive specific training on suicide bereavement. Despite the lack of agreement amongst providers of individual postvention therapy, there a variety of ideas and theories on how mental health professionals can best support survivors. Castelli Dransart (2017) emphasizes the role of empathic, compassionate support and allowing space for survivors to express their complicated feelings and thoughts in the therapeutic environment. For clients experiencing traumatic or complicated grief, recursive narration is a helpful tool by which individuals tell and then retell their story “to sustain survivors’ realignment of their world view” (Castelli Dransart, 2017, p. 67). Therapists may also be called upon to help survivors deal with the social issues commonly associated with suicide bereavement; professionals can help survivors develop the public narrative of the suicide or practice communication skills for dealing with stigmatizing or difficult social interactions (Castelli Dransart, 2017).

An integral part of healing after suicide loss is the process of meaning making or meaning reconstruction (Bottomley et al., 2018; Hunt et al., 2019). Neimeyer and Sands (2017) describe meaning reconstruction in suicide bereavement as involving two key pieces: 1) processing the event of the death and its impact on the survivor, and 2) processing the backstory of the deceased’s life and relationship with the survivor. Through telling these two stories, the survivor is able to tackle both the traumatic distress surrounding the suicide, as well as the separation distress from losing the relationship with their loved one (Neimeyer & Sands, 2017). Bottomley and colleagues (2018) emphasize the importance of survivors finding a personal understanding of *why* the loss

occurred, whether the reason be practical or philosophical, and coming to terms with the ongoing impact of that loss on the survivors' lives.

Spirituality is also important to a large portion of survivors; Jahn and Spencer (2014) found that in a sample of suicide survivors, 63% reported a continued spiritual bond with the deceased following the suicide, such as communication with the deceased in dreams, sensing the presence of the deceased, noticing symbols/coincidences related to the deceased, or even hearing or seeing the deceased. Survivors largely report these experiences as positive and 75% reported the experiences being helpful to their healing; the authors recommend that grief therapists be welcoming and accepting of survivors discussing such experiences in therapy (Jahn & Spencer, 2014).

In addition to suicide-specific processing and treatment, many practitioners working with suicide survivors may utilize methods used in other forms of bereavement including journaling, loss rituals, restorative retelling, attachment-based interventions, telling the story of the loss through music, analogical listening (i.e. focusing on the physical symptoms of grief), writing letters to the deceased, chair work (i.e. having a conversation with the deceased in the form of an empty chair), using photography to document the loss, and more (Bottomley et al., 2018; Neimeyer & Sands, 2017).

It is highly recommended that therapists working with suicide survivors be trained and knowledgeable about the nature of suicide and the complex dynamics of suicide bereavement, in order to avoid unintentional harm to survivors (Castelli Dransart, 2017; Dyregrov, 2009). A mixed methods study investigating postvention experiences of adolescent survivors found that while 69% of the participants felt a strong need for professional help following the suicide event, young survivors perceived a lack of

empathy, an avoidance of the topic of suicide, or a sense of not being taken seriously by their therapists (Dyregrov, 2009). Dyregrov (2009) notes that while stigma and avoidance were likely not the intention of the therapists in question, a lack of training and a discomfort with suicide bereavement may lead to a perception of therapist callousness or incompetence in the eyes of the survivor-client. Despite many practitioners' discomfort with or avoidance of the details of the death, being able to have frank conversations about morbid details of the suicide in therapy can be beneficial to survivors and help them feel less isolated (Daoust, 2017).

### ***School-Based and Work-Based Postvention***

When a suicide occurs within the context of a certain environment – such as a school or a workplace – the effect of the loss can reverberate through the other members of the community, affecting daily functioning, mental health, and even risk for suicide contagion. Thus, schools and workplaces often institute short-term postvention programming for those affected by the event.

One example of a school postvention program is +Contigo (“More With You”) in Portugal. The +Contigo program provides both suicide prevention and postvention to adolescents in schools through special training for schools and parents, socioeducational sessions for students, and crisis intervention when a suicide has occurred (Rothes et al., 2017). Pre- and post-data conducted by +Contigo found that their postvention services increased self-concept and coping strategies in students, and decreased symptoms of depression and suicidal behaviors (Rothes et al., 2017).

However, issues arise when school-based postvention is poorly executed. Andriessen (2018) found that adolescent suicide survivors did not trust school personnel

to assist them in their grief, raising concerns of unqualified school counselors and a lack of confidentiality. Improper school postvention may even have the potential to lead to an increased risk of trauma and suicide attempts within the student body, rather than a decreased risk (Callahan, 1996).

In an attempt to assist schools with safe and effective postvention efforts, some postvention resources and plans have been designed specifically for the school setting. The school-based postvention toolkit designed by the American Foundation for Suicide Prevention (ASFP) and the National Suicide Prevention Resource Center (SPRC) is one such resource that offers free online content and information for schools, including information on how to properly memorialize students who die by suicide, how to avoid contagion, and how to bring in outside support (Gebbia & Moutier, 2017).

Due to the high risk of negative effect from suicide loss on workplace survivors, suicide bereavement experts recommend an involved approach to postvention in this setting. According to Spencer-Thomas and Stohlmann-Rainey (2017), in the event of workplace suicide, employers should immediately: 1) *coordinate* a response; 2) *notify* employees of the death in a timely and straightforward manner; 3) *communicate* in a safe manner to avoid exacerbating risk; and 4) *support* the deceased employee's family in a practical manner. Beyond the acute phase of handling suicide loss, it is recommended that employers identify affected employees and connect them to mental health services, create a supportive workplace environment, restore equilibrium by gradually returning to regular tasks, and honor the lost employee in a workplace-appropriate way (Spencer-Thomas & Stohlmann-Rainey, 2017).



### *Online Postvention*

In a digital age where limitless resources exist online for a vast variety of problems, it is unsurprising that online suicide bereavement resources have become available to survivors. Online resources are especially beneficial for adolescent survivors, survivors living in areas without nearby postvention options, survivors with disabilities, and survivors who feel stigmatized, isolated, or otherwise uncomfortable seeking help from their social world during the bereavement process (Krysinska & Andriessen, 2017; McMenemy & Jordan, 2008; Scocco et al., 2017). The anonymity of posting online, combined with 24/7 access to support from other survivors, makes online postvention an attractive and oftentimes therapeutic outlet for survivors (Krysinska & Andriessen, 2017).

Survivors looking for help online can find a plethora of support options, including teletherapy, informational websites about suicide loss, “online cemeteries” where survivors can build memorials to their loved ones, and online support groups and message boards (Krysinska & Andriessen, 2015; McIntosh et al., 2017; Ratkowska & De Leo, 2017; Scocco et al., 2017). By analyzing online memorial sites, Krysinska and Andriessen (2015) found that digital memorials were primarily created by immediate family members within 5 years of the death, and survivors used the sites to share obituaries (71% of memorial posts), write letters to the deceased (20%), and create tributes (9%; Krysinska & Andriessen, 2015). The authors theorized that online memorials both allowed survivors to continue their bonds with the deceased and “introduce him or her to the visitors at an online cemetery” (Krysinska & Andriessen, 2015, p. 36).

However, not many of the readily and easily accessible websites are created and monitored by mental health professionals or suicide experts, and such sites are often found to lack information or encouragement on seeking help from professional bereavement counselors (Krysinska & Andriessen, 2017). The lack of professionally-run suicide bereavement sites may be cause for some concern; although most sites are positive in intent and content, there is the chance of survivors encountering misinformation, online “trolls,” or even distressing pro-suicide websites (Krysinska & Andriessen, 2017).

Additionally, not enough research has been conducted on whether participation in online memorials or survivor message boards is helpful or harmful for the healing of survivors; there are concerns that spending an excessive amount of time on online cemeteries or other suicide bereavement websites may lead to unhealthy rumination for survivors (Krysinska & Andriessen, 2015; Krysinska & Andriessen, 2017). Experts suggest that survivors supplement online postvention content with face-to-face postvention services, when possible, and that creators of suicide bereavement websites follow recommendations from professionals in order to ensure that the websites are accessible, safe, and effective (Krysinska & Andriessen, 2017).

### ***Outreach Postvention***

The shame, guilt, and perceived stigma experienced by suicide survivors unfortunately makes them less likely to seek out mental health services, compared to other bereaved individuals. Even for survivors who may recognize their need for services, the acute grief in the days, weeks, and months following the suicide may emotionally incapacitate a survivor and make it difficult for them to gather the energy to seek out

services (Trolley, 1993). Survivors may be unaware of the resources available to them, or may overlook resources labeled as “suicide survivor support,” due to misunderstandings of what “suicide survivor” denotes (Cerel & Campbell, 2008). Due to these considerations, practitioners have made more efforts to be the ones to reach out to survivors and offer services, rather than waiting for survivors to reach out themselves (Castelli Dransart, 2017).

The first widely-known suicide survivor outreach program began in 1972 in Contra Costa County in California. The county’s crisis center made an arrangement with the coroner’s office, by which they were able to contact survivors directly to ask if they needed support services and provide home visits from a grief counselor (McIntosh et al., 2017). Other outreach programs have incorporated methods such as providing aid at the scene of the death, sending volunteers or health professionals to perform in-home check-ins or crisis intervention, provision of mental health referrals for survivors, and automatically contacting survivors after the provision of a suicide-related death certificate (McIntosh et al., 2017). Outreach can also take the form of public education, such as Italy’s SOPROxi Project’s efforts to spread information about their postvention services at public events like concerts (Scocco et al., 2017).

### ***Active Postvention***

As discussed, suicide survivor outreach programs have been developed as a solution to the issue of reduced help-seeking behavior in survivors. Active postvention has emerged as one such innovative solution. Rather than reaching out to survivors in the days or weeks following the suicide, or waiting for survivors to make the first move,

active postvention attempts to provide face-to-face crisis intervention and support as soon as possible.

In active postvention models, a trained individual or team is contacted when a suicide death occurs, and they respond to the scene of the death alongside first responders to provide crisis intervention, support, psychoeducation, and referrals for further mental health services (Campbell et al., 2004; Cerel & Campbell, 2008). First responders, who are often undertrained on how to interact with survivors, have reported gratitude for the presence of qualified support professionals (Nilsson et al., 2017). Active postvention teams may be composed of mental health workers, trained volunteers, or other survivors. Teams are highly trained on crisis intervention and grief counseling, as well as crime scene preservation and safety (Campbell et al., 2004).

This service provides not only an additional layer of support to traumatized survivors immediately following the suicide loss, but also has been shown to improve the chances of survivors reaching out for help, and decrease the time between the suicide event and seeking of resources (Campbell et al., 2004; Cerel & Campbell, 2008; Law et al., 2017; McIntosh et al., 2017). Archival data analysis by Cerel and Campbell (2008) showed that survivors who had received active postvention sought out treatment significantly sooner (an average of 48 days after the death) than survivors who had not received active postvention (an average of 97 days after the death). A case study on the LOSS Active Postvention team of Baton Rouge revealed that the presence of LOSS teams at the scene of suicides or at the notification of next-of-kin helped de-escalate scenarios such as “hysterical” reactions from family members and helped dismantle a pattern of insensitive behavior towards survivors by local law enforcement (Campbell et

al., 2004). A pilot project in Hong Kong showed that survivors who were actively engaged by mental health workers during the body identification were more likely to accept follow-up services or otherwise seek help, as compared to those who were simply given referrals or service pamphlets (Law et al., 2017).

### ***Interdisciplinary Postvention***

Efforts have been made in recent years to incorporate psychology and mental health work with other relevant professional spheres, including healthcare, education, and public safety. Suicide bereavement is one such area that benefits from an interdisciplinary perspective and cooperation amongst professions (McIntosh et al., 2017). Although mental health practitioners are often thought to do the “work” in bereavement care, suicide survivors can also benefit from interacting with professionals from other fields who are competent in the basics of suicide bereavement (Norton, 2017).

Suicide Action Montreal, a suicide prevention and postvention initiative, reported that a vast number of survivor referrals they receive come from funeral homes, first responders, government agencies, and nonprofit organizations (Daoust, 2017). Northeast England established a suicide alert system in which coroners alert local public health agencies of any suicide deaths and connect survivors with local survivor services (Lascelles et al., 2017). Norton (2017) recognized that when various professional groups, including first responders, faith leaders, and mental health workers, understand their role in postvention and are trained in providing an integrated response, the risk to suicide survivors is reduced. The wider the net cast for suicide survivor support, the more survivors will be reached.

Funeral directors, morticians, and medical examiners are one important group of professionals with close access to suicide survivors in the days and weeks following the loss. Unlike most first responders, funeral directors and coroners have a more extended relationship and time spent with survivors as they assist them with funeral arrangements and communicate autopsy results. This extra time, combined with a more professional familiarity with death and grief, gives funeral professionals an open opportunity to provide some level of postvention or other comfort to survivors (Norton, 2017). It should be noted that, just as with EMTs and police officers, a negative interaction with an employee of a coroner's office may have a negative impact on survivors' grief processes and help-seeking behavior (Berry et al., 2013; Norton, 2017).

Although local forensic/coroner-based support programs vary in structure and services, they all have in common the acknowledgement of the need for immediate postvention services after a suicide. Like most other violent deaths, suicide cases often go through an investigation process which may feel intrusive and traumatic to survivors. Forensic counselors can help ease the process simply by accompanying survivors through steps such as identifying the body, receiving the autopsy report, and arranging for funeral services (Mowll et al., 2017; Sklarew et al., 2012).

A form of interdisciplinary postvention advocated for by the CDC itself is the forming of community response plans to handle the after-effects of suicides which may impact the community and potentially result in suicide contagion (Cox et al., 2012). The response team may be made up of mental health professionals, educators, parents, trauma specialists, public safety officials, and representatives of local government or local media. Utilizing their combined resources and skills, the response team completes tasks such as

monitoring for suicide clusters in the community, screening at-risk individuals, and providing postvention resources to those who need them (Cox et al., 2012). Portugal has implemented such an interdisciplinary response team specifically for schools, composed of psychiatrists, psychologists, pediatricians, physicians, sociologists, social workers, and teachers; together, the Nucleo de Estudos do Suicido (“Suicide Studies Group”) researches, advocates for, and promotes postvention services for adolescents and schools (Rothes et al., 2017).

Finally, faith leaders and clergy members are another group which has frequent contact with suicide survivors. For survivors actively involved in a church or religious community, a faith leader may be called immediately and be involved as early as at the scene of the suicide. In other cases, faith leaders may become involved later on, in the funeral arrangements or general faith practice of survivors (Krysinska et al., 2017). When the deceased was a part of a church or faith organization, faith leaders may have the additional responsibility of assisting the faith community in processing the loss (Krysinska et al., 2017). Emphasizing the opportunity to create mass healing and education around suicide, Norton (2017) suggests that faith leaders address the suicide death in a compassionate and open way to the church community.

### **Postvention Outcomes**

It is clear that support options exist for suicide survivors, but do they work? The lack of expert consensus, specialized training in postvention work, and empirical data supporting methods of treatment are major detriments to the current suicide survivor population and research on postvention (Jordan & McMenemy, 2004). However, there is

some limited research which may give mental health practitioners an idea of best practices for postvention.

An extensive review of postvention studies by Jordan and McMenemy (2004) found that most outcome research on postvention is anecdotal, based on self-report, or otherwise not methodologically sound. Self-report data from postvention participants is widely positive, which is beneficial information, although it does not tell researchers if the benefits gained from postvention services are long-lasting or significantly different from the course of symptoms seen in survivors who do not utilize postvention. For example, a pilot study tracking the results of a group postvention program by Walijarvi and colleagues (2012) showed progressive improvement in self-reported survivor “grief journey” progress, increasing from a mean of 31.24 (on a scale of 0 – 100) before the first group session to 63.52 after the final group session. However, the lack of control groups and the self-report nature of the survey leaves doubt as to whether these results are inherently different from the natural progression of grief for all survivors, including those not in groups.

Of the empirical and controlled research on postvention which does exist, findings suggest that postvention is most efficacious when delivered by trained professionals in an individual setting on a longer term basis, as opposed to brief interventions and interventions led by peers or untrained volunteers (Andriessen et al., 2019; Jordan & McMenemy, 2004). The most efficacious interventions involved components of support, therapy, and psychoeducation (Andriessen et al., 2019). Additionally, postvention services seem to most benefit higher-risk survivors who are experiencing traumatic or complicated grief, as opposed to the typical course of survivor grief, which may not



change much in therapy simply because of the traumatic nature of the experience (Jordan and McMenemy, 2004).

While support groups are one of the most widely implemented methods of postvention, and participants report largely positive benefits from participation, research has shown mixed results on their efficacy in lessening negative symptoms (McIntosh, 2017). For example, a longitudinal study tracking symptoms of participants in a peer-led suicide survivor support group found that while participants reported increased well-being and decreased traumatic grief over time, no significant impact was seen on depressive symptoms, somatic symptoms, social adjustment, or experiences of stigma (Griffin et al., 2022).

Group postvention is hard to measure, in part, because there is no standard for what suicide survivor support groups should look like, who should lead them, what topics should be discussed, or what coping skills (if any) should be taught (Higgins et al., 2022). The result is a wide amalgamation of support groups which may be conducted in very different ways and produce very different outcomes. Adding to the problem is a lack of standardization in tracking and evaluating outcomes of such groups; many groups are not evaluated at all, and those that do track outcomes may use vastly different measures or methods (McIntosh, 2017).

Groups which do track outcomes often use simple pre- and post-measures, without utilizing control groups. For example, Scocco and colleagues (2017) reported a high rate of reduction in depressive symptoms for participants in their postvention groups, as measured by the Beck Depression Inventory; however, since control groups were not utilized, it is difficult to know if this effect is due to the groups alone. Due to the

deficiency in postvention group research, researchers are left with the general conclusion that group postvention work is helpful and efficacious in some cases, but the empirically-supported processes of an effective survivor group have yet to be established. In addition to utilizing control groups, researchers have suggested the use of live observation and longitudinal studies to increase understanding of the processes of suicide survivor support groups (Griffin et al., 2022; Higgins et al., 2022).

In an attempt to shed some light on postvention group efficacy, Dyregrov and colleagues (2013) conducted qualitative analysis of interviews with postvention support group participants. They found that many participants benefitted from a judgment-free environment with like-minded survivors, the ability to exchange advice and information, the normalization of suicide bereavement, and the provision of hope. However, participants had negative experiences when groups failed to meet expectations of support, added stress through exposure to others' trauma, were poorly organized, or had ineffective or inappropriate leaders. The researchers concluded that while support groups may be beneficial for certain survivors seeking community and normalization, survivors with more complicated grief or lasting trauma may not have their needs met by informal support groups, or may even experience further trauma through exposure to other survivors' loss narratives (Dyregrov et al., 2013; Higgins et al., 2022).

In their comparison of two different empirical group postvention structures for widowed survivors, Constantino and colleagues (2001) found that both a group which focused on grief-based conversations and interventions and a group which focused on the members planning social outings together produced nearly identical decreases in depression, distress, and grief symptoms, and increases in social adjustment. The authors

concluded that simply the process of allowing survivors to interact with one another in a therapeutic environment, no matter the topic they are focused upon, may be beneficial for often-isolated survivors (Constantino et al., 2001).

### **Ethical Considerations**

Suicide survivors are inherently a high-risk, vulnerable population due to their exposure to traumatic experiences and their increased risk of mental illness, social isolation, and suicide attempts. Thus, when working with and conducting research about suicide survivors, researchers and clinicians must be cautious and considerate of the unique needs of this population.

Although the majority of survivors have reported that participating in suicide bereavement research, particularly qualitative interviews, has been beneficial or therapeutic, there is always the risk of re-traumatizing survivors by having them recount details of a suicide (Andriessen et al., 2018; Dyregrov et al., 2011). Those most likely to experience research participation as negative or painful include female survivors, those bereaved of a more “severe” (i.e. violent) suicide, and spouses or close friends of the deceased (Dyregrov et al., 2011). In order to combat or prevent negative effects on survivors, Andriessen and colleagues (2018) recommend that interviewers be properly trained on supporting distressed participants, participants be appropriately informed of risks of participating and their rights to withdraw at any time, interviews be conducted with empathy and trust, and additional resources be available to participants who may require them. When interviews with survivors do go well, survivors experience relief, new insights on the loss, and a sense of altruism (Dyregrov et al., 2011).

Including survivors may be especially imperative in research with survivors from different cultures than the researchers. As with nearly any other human phenomenon, the experiences of grief and suicide loss are influenced by a variety of individual and cultural factors. Different groups view suicide differently, grieve differently, benefit from different bereavement services, and are held to different standards and expectations around the grieving process. Unfortunately, diversity and cultural context around suicide bereavement is an understudied area, with many high-risk groups (e.g. Native Americans, men, veterans) lacking research and therapeutic attention (Reed et al., 2017). Without a solid understanding of how grief and healing look in different cultural contexts, survivors may be overlooked or misdiagnosed. Healthy grieving in some cultures may even look like disordered grieving or lack of grief in another culture (Andriessen et al., 2017).

Dyregrov (2011) emphasizes the problem of researchers attempting to replicate previous suicide bereavement and postvention research with culturally diverse populations without consideration of the unique culture, taboos, and grief practices of the survivors involved. Rather than assuming that the same postvention strategies and quantitative measures used with White Americans will translate over to survivors in different countries or cultures, researchers should make true attempts to get to know the culture and people they are studying, as well as incorporating more exploratory methods of research, such as qualitative interviews, storytelling, and ethnography (Dyregrov, 2011; Tiatia-Seath, 2017). Including cultural representatives as co-researchers can assist researchers in understanding the culture they are studying, as well as creating buy-in with potential research participants (Dyregrov, 2011).

Cultural considerations and collaboration are also imperative when developing and implementing postvention services. Schlebusch (2017) and Tiatia-Seath (2017) point out that common Westernized postvention practices are not as effective in the unique cultural settings of South African and Pacific communities. Rather than trying to copy-and-paste American postvention practices into South Africa, researchers advocate for community-based interventions and support focused on empowering survivors in a society in which survivors are routinely stigmatized and ostracized (Schlebusch, 2017; Tiatia-Seath, 2017). Additionally, mental health workers and first-responders should be trained on how to respond to specific cultures and honor cultural practices of survivors (Tiatia-Seath, 2017).

### **Research Gaps**

It is evident that although there is an abundance of literature describing the phenomenon of suicide bereavement, there are still many research gaps and underdeveloped areas within suicide survivor research. The research clearly establishes that suicide bereavement is deeply felt by survivors and, if not addressed properly, can have strikingly negative effects on survivors' mental health, social interactions, and quality of life. However, the literature does little to address how the experience of suicide bereavement is felt by different types of survivors, including friends of the deceased.

Despite evidence that there are a great number of adults who are affected by the suicide of a friend, and that friend survivors may even outnumber family survivors, there is very little research directly investigating the suicide bereavement experiences of adult friends (Andriessen, Rahman, et al., 2017; Feigelman et al., 2017). There is even less research addressing the psychotherapy experiences and needs of adult friend survivors.

As Feigelman et al. (2017) noted, “We know very little about the friends of the suicide deceased, whether they seek help from bereavement counselors, psychotherapists or are inclined to avert caregivers altogether” (p. 5).

While there exists some research on the experiences of adolescents who lose a friend to suicide, and presumably some of the findings from those studies could be generalized to adults, it is difficult to truly determine the effects of suicide loss on adult friends without additional study. Further, there is a lack of research on psychotherapy efficacy for either adolescent or adult friend survivors. Without knowing the bereavement or psychotherapy experiences of such survivors, it is difficult to train mental health practitioners on best practices for treating suicide bereavement in therapy. Thus, the current state of field justifies further exploration of this population.

### **Chapter 3: Methods**

In order to explore the lived experiences of adult friend suicide survivors, the author chose to conduct a qualitative study utilizing the specific method of Constructivist Grounded Theory (CGT). The choice to use qualitative methods of inquiry over quantitative methods was prompted by: 1) the acknowledgement that very little focused research has been done with this population, and thus a more exploratory interview-based method of research would allow a broader scope of data collection, and 2) the recognition that suicide bereavement is unique and varied, and thus individual interviews would allow opportunities for richer data and the ability to capture unique lived experiences of each participant in their own words (Nagel et al., 2015). Through this method of research, the intention was to find emergent themes and patterns which allow for a theory that may assist future counselors and counseling psychologists to address the mental health needs of the adult friend suicide survivor population.

This chapter will discuss CGT as a form of qualitative analysis, consider ethical concerns, and expound upon the details of this study's participants, measures, data collection procedures, and data analysis procedures.

#### **Constructivist Grounded Theory**

Constructivist Grounded Theory, or CGT, is a qualitative model of study which builds upon the well-established qualitative method of Grounded Theory, or GT (Charmaz, 2014; Charmaz & Thornberg, 2021; Mohajan & Mohajan, 2022). The original purpose of the GT research approach was to establish theory around social phenomena using systematic qualitative data collection and analysis methods, including: 1) simultaneous collection and analysis of data; 2) comparative analysis; 3) both open and

focused coding; and 4) identification of categories which may be transformed into theory (Glaser & Strauss, 1967). However, some critics have taken issue with certain aspects of GT, including the authoritative role of the researcher, the positivistic underpinnings of theory, and the assumption of an objective universal truth to be found in the data (Charmaz, 2014; Charmaz & Thornberg, 2021; Mohajan & Mohajan, 2022; Nagel et al., 2015).

Thus, researcher Kathy Charmaz's intention in creating Constructivist Grounded Theory was to take a pragmatic approach to GT, in which a theory is developed through much of the same qualitative methods as in the original GT, but with a difference in philosophical approach (Mohajan & Mohajan, 2022; Nagel et al., 2015). Specifically, CGT branches off from GT through the acknowledgement of the influence of external systems, researcher bias, and multiple co-occurring lived experiences on the research (Charmaz, 2014; Charmaz, 2016; Charmaz & Thornberg, 2021). Rather than assuming the researcher is a neutral observer, CGT takes a constructivist perspective which acknowledges the innate biases and values held by researchers (Charmaz, 2014). Under a CGT model, researchers are challenged to take note of both the influence of their own experiences and biases on the research, as well as the influence of other external forces and systems (Charmaz, 2014).

While GT puts the researcher in an authoritative role, CGT strives to co-construct theory alongside participants and encourages an openness to new ideas and perspectives in researchers (Charmaz & Thornberg, 2021; Nagel et al., 2015). Outside of theory construction itself, Charmaz (2021) has highlighted the usefulness of CGT for psychological research goals, including elevating voices of individuals who may not



otherwise have a public platform and creating suggestions for clinical practice. Indeed, although GT has been a standard of qualitative research for decades, Nagel and colleagues (2015) note that CGT has become an appealing, value-aligned avenue of research for recent doctoral students in the social science and health domains:

First, we all believe that perception of reality varies between individuals, and there are pluralities of reality experienced by different people exposed to the same phenomenon. Further, we believe a singular truth can neither be objectively appreciated nor directly measured given differing perceptions of people and the complex nature of interpreting meanings of phenomenon (p. 367).

In order to acknowledge different realities and experiences within qualitative research, CGT focuses heavily on the concept of *researcher reflexivity*, which refers to the researcher's ability to analyze and scrutinize the research process. This process includes consideration of how the researchers' own positionality may influence the data collection and analysis processes (Charmaz, 2020).

One such way researchers practice reflexivity in CGT is through the process of memo-writing, or keeping detailed notes and observations about the research process as it is happening, for purposes of identifying gaps, biases, and other important aspects of the research process (Charmaz, 2014). Memo-writing can take many forms, including journaling, post-interview reflection, free-writing, and even transcribing coding team meetings (Charmaz, 2014). By writing memos throughout the process, researchers may stay engaged in critical thought about their role in the research process, as well as creating helpful documentation of ideas which may be referred back to later in the research process (Charmaz, 2014).

When considering the social context in which suicide bereavement occurs, including the historical context of criminalization and the current culture of stigma and shame around suicide, CGT fits as a research methodology in which to elevate the voices of a population which has often been silenced or stigmatized (Charmaz & Thornberg, 2021). Additionally, the openness and curiosity inherent in CGT is ideal for exploring the experiences of a group which has garnered very little research attention, namely, adult friend suicide survivors. By engaging in CGT, the coding team in this study was able to check their own biases about suicide, suicide survivorship, and adult friendship dynamics throughout the research process. Additionally, CGT's emphasis on allowing for multiple co-occurring realities was beneficial in being able to capture and acknowledge the many diverse methods of grief and experiences with psychotherapy brought forth by participants.

### **Ethical Considerations**

Suicide survivors are an inherently at-risk population, between increased risk of mental health symptoms, potential trauma, and even risk for suicide attempt themselves. Thus, when working with such a population, it is imperative to take proper precautions and measures to ensure the safety and well-being of participants. Fortunately, previous research has found that participating in qualitative research is largely experienced as positive and beneficial by the majority of suicide survivors (62%), due to the opportunity to process their loss with another person, the ability to gain insight from telling their story, and positive feelings gained from helping others or giving back by participating in research (Dyregrov et al., 2011). However, some survivors (28%) who reported positive experiences participating in research also reported painful aspects of being interviewed;

namely, these participants dreaded the interview beforehand, felt insecure during the interview, or experienced painful emotions while talking about the suicide (Dyregrov et al., 2011). The researchers found that male survivors and nonfamilial survivors experienced more pain during the interview process, which was attributed to the fact that friends and colleagues of the deceased had had fewer opportunities to openly discuss their loss prior to the interview, and male survivors were less likely to openly discuss their feelings around grief in general (Dyregrov et al., 2011).

Considering the painful nature of discussing suicide loss in interviews, Dyregrov and colleagues' (2011) recommendations for researchers conducting qualitative research with suicide survivors include: 1) interviewing survivors only once they are out of the acute stage of grief (i.e. at least 6-18 months after the suicide); 2) taking note of populations who may find the interview process more painful (i.e. friends and male survivors) and taking extra care to ensure their comfort in the interview process; 3) conducting the interview in a structured manner to increase feelings of security; and 4) treating the survivors with empathy and warmth.

Outside of Dyregrov et al.'s (2011) suggestions, one way to ensure the safety and comfort of participants is by creating a thorough informed consent process. Before joining this study, participants were fully informed of 1) the purpose of the study; 2) the potential risks involved (e.g. being reminded of painful memories associated with the suicide); 3) their ability to withdraw from the study at any time; 4) the questions they would be asked during the interview; and 5) and the process of the interview itself (including being recorded). This informed consent process was communicated through a written informed consent statement, as well as a discussion at the beginning of the

interview. Another measure taken in order to protect the safety of participants was the offering of a list of resources to all participants after the conclusion of the interview. This list included crisis hotline numbers and information about seeking further postvention services.

Lastly, one must consider the ethical implications of CGT research itself. The integrity of CGT research hinges on the ability and willingness of the researcher to examine their own biases, assumptions, and beliefs which may color the research process and results (Charmaz, 2014). Thus, it is the researchers' responsibility to ensure that they monitor themselves throughout the research process, including by memo-writing about reactions to data throughout the process, checking in with coding teams, and ensuring that the researcher is not shaping theory to fit their pre-existing assumptions or beliefs.

In addition to the above considerations, the following ethics procedures were followed over the course of this study.

1. Ethical oversight and approval of this study was obtained through Marquette University's Institutional Review Board.
2. Written consent was obtained from each participant ahead of their interview.
3. Informed consent documents with identifying information and audio recordings of interviews were stored on a password protected computer under the care of the author.
4. Participants were assigned unique numeric identifiers which were used during the coding process, and pseudonyms which are used in the results section of this dissertation. Any other identifying information was omitted from final results.

## **Research Team**

The research team involved with this study included the author (primary researcher), two doctoral students (coding team), and Dr. Lisa Edwards, the author's dissertation chair (auditor). All researchers involved had prior experience with qualitative research, ranging from participation in other dissertation coding teams to authorship of peer-reviewed qualitative research articles. Utilizing a team for qualitative coding helps clarify findings by offering multiple perspectives on the data collected, rather than relying on one researcher's interpretation (Hemmler et al., 2020). Through team-based coding and reaching of consensus on codes, the researchers are able to build rigor and trustworthiness into the research study (Hemmler et al., 2020).

After recruiting the coding team based on research interest and experience with qualitative coding, two initial meetings were held to discuss coding procedures, orient the team to the basics of CGT and the purpose of the study, and to discuss initial assumptions and potential biases. After being oriented to the study, the coding team met to perform initial coding on the first transcript as a group, which took place over several weekly meetings. This was done to ensure that all team members felt comfortable and in agreement with coding procedures as it was essential for all team members to fully understand the coding process in order to ensure inter-rater reliability and to confirm that all team members are coding in the same manner (Hemmler et al., 2020).

### **Coding Team Positionality**

As previously discussed, researcher reflexivity is an integral element of CGT, in that researchers should take deliberate and conscious steps to acknowledge the effect of their own biases, assumptions, and worldview upon the research procedures and

formation of theory (Charmaz, 2014, 2020). In order to engage in research reflexivity in this study, the coding team participated in group discussions of assumptions and predictions about the data, as well as engaging in the practice of memo-writing.

In disclosing the identities, assumptions, and positionality of the coding team, the following observations are made. The coding team consisted of the primary researcher/author and two first-year counseling psychology doctoral students. All three team members identified as cisgender women, with two holding White racial identities and one holding a Multiracial identity. No team members identified as suicide survivors, although the primary researcher has experienced suicide attempts of multiple close friends. All three team members reported some clinical experience providing psychotherapy to suicide survivors, who ranged in age from adolescent to adult.

In discussing assumptions about the present study, two team members stated assumptions that participants would have experienced suicide stigma which affected their help-seeking behaviors, two team members predicted that participants would feel that their grief as a friend was less valid/invalidated in comparison to the grief of family members, one team member assumed that participants would have found individual therapy to be the most helpful resource, and one team member predicted that participants would have found support groups to be the most helpful resource.

Throughout the coding process, all three coding team members participated in memo-writing by adding comments to the interview transcripts and focused coding spreadsheet; these memos included personal impressions, assumptions, or questions. Additionally, the primary researcher kept a private memo journal where she documented personal reactions to interview data, early assumptions about themes, and summaries of

discussions had with the rest of the coding team. These various types of memo-writing allowed for further discussion amongst the coding team, discussion with the auditor, and a resource to refer back to during the theoretical coding and conceptual mapping stages of analysis.

### **Measures**

Measures for this study included: 1) a screening form; 2) a demographic form; 3) an informed consent form; and 4) an interview protocol (see Appendices B, C, D, E). The screening, demographic, and informed consent forms were sent to the participants to be signed, completed, and returned prior to the interview, in order to streamline the process and to ensure eligibility to participate in the study. The interview protocol was additionally sent to participants prior to the interview, so that they were aware of the interview content ahead of time, including potentially sensitive subject areas.

### **Participants**

Participants for this study were adults who self-identified as being a suicide survivor who sought psychotherapy services to cope with the suicide of a friend.

Inclusion criteria included the following:

- 1) Participants must be bereaved of a friend's suicide which occurred between one and ten years ago.
- 2) Participants must have been at least 18 years old when the suicide loss occurred.
- 3) Participants must have engaged in some form of psychotherapy (including individual therapy or support groups) in which suicide loss was a focus.

- 4) At least one of the psychotherapy services utilized by the participants must have been led by a mental health professional (including psychologists, counselors, or social workers).
- 5) Participants must be currently living in the United States.

Interviews lasted between 45-120 minutes and were semi-structured in nature, allowing for both focused questions and organic exploration of participants' unique experiences. Interviews were recorded and transcribed for coding purposes. After the interviews, participants were sent a follow-up email with a list of resources, including suicide bereavement services and the suicide crisis line telephone number (see Appendix F).

Constructivist grounded theory calls for data collection to continue until data saturation occurs, regardless of the number of subjects. Saturation refers to the point in a research study in which researchers “seek more data while theoretical sampling, but find no new properties or characteristics of their categories” (Charmaz & Thornberg, 2021, p. 309). At the point of saturation, a researcher is able to cease data collection with the understanding that further data collected would be unlikely to contribute original findings. In the case of this study, saturation was determined at 8 interviews after the coding team agreed that no new themes were emerging from interview data.

Demographic information for study participants can be found in Table 1.



**Table 1**  
*Participant Demographics*

---

Gender	Male: 25% (n = 2) Female: 75% (n = 6)
Race	White: 87.5% (n = 7) Asian American: 12.5% (n = 1)
Age	Range: 27-65 Mean: 42.5
Years Since Loss	Range: 2-6 years Mode: 5 Mean: 4.88
Type of Services	Individual Therapy: 100% (n = 8) Peer Support Group: 87.5% (n = 7) Psychiatry: 37.5% (n = 3)
Length of Services	Range: 3 months-6 years
Type of Individual Therapy Clinician	Psychologist: 25% (n = 2) Social Worker: 50% (n = 4) Counselor: 12.5% (n = 1) Unsure: 12.5% (n = 1)

---

Of the eight participants, six identified as female and two as male. Seven of the participants identified their race as White, with one participant identifying as Asian-American. Ages of participants at the time of interview ranged from 27 to 65, with a mean age of 42.5. Time since the death of participants' friends ranged from 2 to 6 years, with a mode of 5 years.

All eight participants attended individual counseling with a licensed mental health practitioner, ranging from social workers to professional counselors to psychologists; six

of the participants utilized the services of a therapist already known to them, while two found new therapists. Seven of the participants attended peer support groups for suicide loss, in which all group facilitators underwent training for group leadership but were not licensed mental health professionals. Three participants additionally saw a psychiatrist for medication management. Length of services ranged from three months to over six years.

### **Data Collection Procedures**

After the study was approved by the Marquette University Institutional Review Board (IRB), the data collection process was initiated. Participants were recruited primarily through emails and phone calls to suicide survivor organizations and suicide survivor support groups, as well as snowball sampling, in which participants distributed information about the study to other known qualified parties. Recruitment sources were asked to distribute a recruitment letter to anyone interested (see Appendix A). For their time, participants were offered the choice of a \$15 gift card or a donation of \$15 to a suicide-related organization of their choosing.

When interested survivors reached out to inquire about the study, they were sent a screening form, a demographic form, and an informed consent document to complete and/or sign (see Appendices B, C, & D). Once these forms were returned and it was determined that individuals met the inclusion criteria for participation, they were contacted to schedule an interview and provided with the interview protocol to review prior to their interview date (see Appendix E).

Interviews were conducted over video conferencing or audio call, per the preference of each participant. The interviews lasted between 45 and 120 minutes and

were audio-recorded for transcription purposes. After each interview, the primary researcher transcribed the recording of the interview verbatim.

### **Data Analysis Procedures**

As interviews were recorded and transcribed, the data analysis process began. The following section will relate each stage of the data analysis process within this study.

#### **Initial Coding**

Initial coding involves analyzing each line of an interview transcript and assigning a short code, describing the components of the data (Charmaz, 2014). CGT often utilizes action-oriented codes and gerunds (i.e. verbs which function as nouns and often end in -ing, such as “*asking* of questions”) in order to make the data more interactive (Charmaz, 2014). Initial coding is provisional, as researchers are permitted to go back and change wording later, if needed.

Once all team members felt confident in their ability to perform initial coding on their own, each team member completed a short portion of the transcript code on their own and then shared it with the group for revisions and suggestions. After completing the first transcript in this manner, subsequent transcripts were coded by the primary researcher and reviewed by the other team members. The team met as a group after each transcript had been coded to discuss questions, concerns, and changes in initial codes and to reach consensus on uncertain codes (Hemmler et al., 2020).

#### **Focused Coding**

Once the team had determined that data saturation was reached, team efforts were shifted to focused coding in order to identify emergent themes in the data (Charmaz, 2014). Focused coding refers to the process of identifying themes or patterns within the

initial codes, especially those with high significance to the study (Charmaz, 2014). Researchers are then able to synthesize and combine previous codes into larger emergent categories. In addition to identifying emergent patterns, focused coding also allows researcher to note any negative cases, or data which stand out or contradict other data (Charmaz, 2014). Using a spreadsheet containing all the initial codes, team members assisted in color-coding initial codes within overarching categories and continued to meet weekly to discuss impressions and collaborate on establishing focus code categories. At this stage in the data analysis process, the auditor assisted with auditing focused codes and offering additional impressions and suggestions.

### **Theoretical Coding**

When focused coding was complete, the primary researcher reviewed focused codes to assemble final theoretical codes, which address the initial research questions (Charmaz, 2014). In this stage of coding, all previous codes are integrated into one overarching theory, usually consisting of several overarching codes. This is done by analyzing the focused code categories which emerged from initial codes and using them to tell one integrated “story” from the data (Charmaz, 2014). Theoretical coding should emerge naturally from the data, rather than being forced to fit the researcher’s preconceived idea of what theory should emerge from the study (Charmaz, 2014). The primary researcher met with the coding team and the auditor several times to workshop the final theoretical codes.

### **Conceptual Mapping**

Using the theoretical codes, the primary researcher designed a conceptual mapping graphic to visually show the theoretical themes discovered in the data

(Charmaz, 2014). In addition to creating a visual diagram for research consumers, the process of conceptual mapping may help researchers identify any previously-overlooked weaknesses in the data, as well as illustrating the strengths and positive discoveries within the data (Charmaz, 2014). The final conceptual map was shared with the coding team and auditor to give opportunities for suggestions and edits.

The process of turning interview data into qualitative codes and eventual theory can be seen in Table 2. The results of this analysis will be discussed in the following chapter.

**Table 2**  
*Coding Sample*

Participant Quote	Initial Code	Focused Code	Theoretical Code
<p>“But at the same time I made new connections with people who've experienced the same thing, so I didn't have to explain why, you know, months and years later, I'm still upset. They get it.” – Participant 3/ “Robin”</p>	<p>Making new connections with friends who experienced similar loss</p>	<p>Connecting with Other Suicide Survivors</p>	<p>External Coping Resources</p>
<p>“And I think that by them coaching me, it took a lot of guilt off of me, and I think that we did focus on the guilt. With the counselor and with the group therapy, and I think if you could focus more on that because the first thing you're gonna feel is guilt. It's very overpowering. Very overpowering. And I think that if you can focus on that to tell the person, “There's nothing you could've done.” It helps a lot.” – Participant 5/“Lucy”</p>	<p>"Coaching" from group/therapist helping with guilt</p> <p>Recommending therapists help by telling suicide survivor: "there's nothing you could've done"</p>	<p>Challenging Self-Blame</p>	<p>Impact of Mental Health Support Services</p>
<p>“I think it's hard for people to talk about a someone's death when it's by suicide because it just seems like kind of, like it's like, so tragic and so depressing that it's like hard to just, like, talk about it with anyone because it's kind of depressing and like a downer, you know what I mean?” – Participant 4/ “Mary”</p>	<p>Speaking to difficulty of talking about suicide loss with others due to fear of being a "downer" or too depressing</p>	<p>Experience of Suicide; Isolative Grief (double-code)</p>	<p>Challenges in Seeking Support</p>

## Chapter 4: Presentation of Results

The purpose of this study was to investigate the lived experiences of adults who pursued psychotherapy related to the suicide loss of a friend, a population which has received little research attention in the past. Under a CGT research model, research results are presented as a synthesized theory which has been constructed to explain the lived experiences of the population of study (Charmaz, 2014). Accordingly, the following chapter will present the constructivist grounded theory developed from the CGT coding process and the individual theoretical themes which emerged from the data.

### A Constructivist Grounded Theory

From the synthetization of data gleaned from this research study, a constructivist grounded theory may be proposed to explain the therapy experiences of adult friend suicide survivors and to answer the research questions, *What are the therapeutic needs of adults grieving the loss of a friend to suicide?* and *What were the psychotherapy experiences of adults who sought therapy after the loss of a friend to suicide?* Through analysis of the data, four overarching themes emerged: 1) Motivation for Seeking Support, 2) Challenges in Seeking Support, 3) Impact of Mental Health Support Services, and 4) External Resources for Coping. The constructivist grounded theory from this data can be summarized as such:

The core therapeutic needs of adult suicide survivor friends are centered in impacts offered by mental health support services, which include both individual psychotherapy and support groups. Mental health support services provide space to process complex emotions, provision of education about suicide and grief, and challenging of self-blame beliefs. Support groups offer the additional benefit of

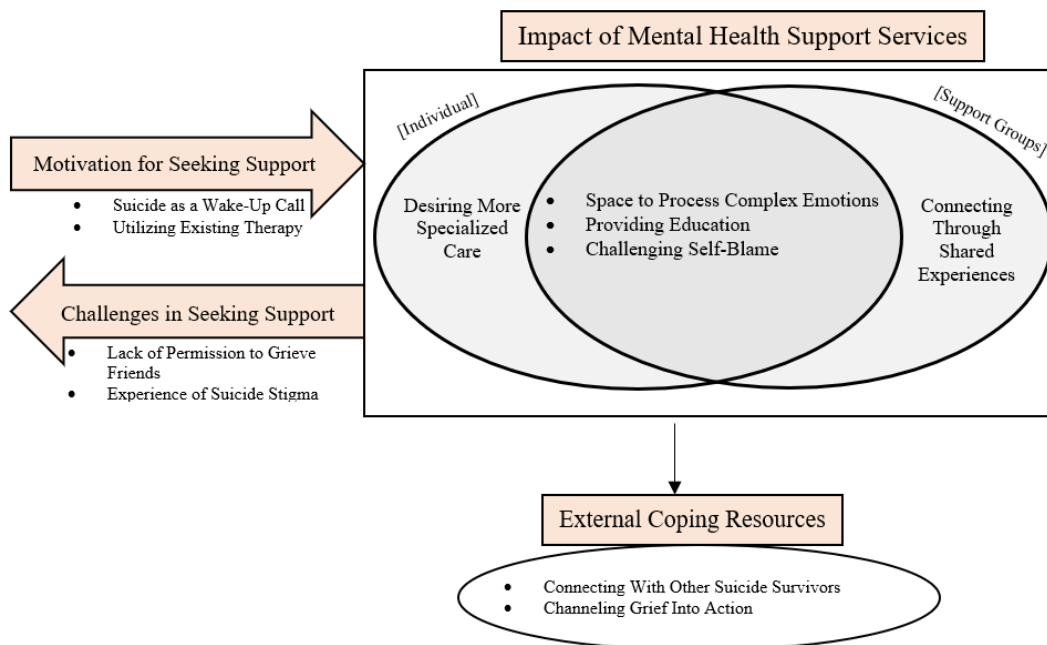
connecting with other survivors through shared experiences. While mental health support services are perceived as widely positive, survivors do desire more specialized care from individual therapists. Friend suicide survivors find auxiliary support through seeking informal connection with other suicide survivors and creating meaning-making action out of grief. Friend suicide survivors are motivated to seek support by post-loss revelations about taking care of one's mental health and access to pre-existing therapy services. Elements which detract from seeking support include experiences of stigma and a perception of lacking social permission to grieve friends.

This theory is visually presented through a conceptual map, as found in Figure 1. The four theoretical themes integral to this theory, and related sub-themes, will be explored at length in the following sub-sections. All of participants' names have been replaced with pseudonyms, and any identifying information has been removed.

### **Motivation for Seeking Support**

The theme of Motivation for Seeking Support was constructed from participants' reflections on the driving forces and motivating factors which contributed to seeking additional support, whether in the form of individual therapy, peer support groups, or other resources. The factors discussed in this section made seeking support services more appealing and/or more accessible for suicide survivors coping with the loss of a friend. Two sub-themes include: 1) Suicide Loss as a "Wake-Up Call" and 2) Utilizing Existing Therapy.





*Figure 1.* Therapy experiences of adult survivors of suicide loss of a friend

### **Suicide Loss as a “Wake-Up Call”**

The suicide loss of a close friend was an impactful and life-shattering event for all of the participants interviewed for this study. Several participants identified their loss as a type of “wake-up call” for personal change and taking charge of their own mental wellness. Even before the loss of her friend, Robin was already acutely aware of the impact of suicide contagion. Shortly before her friend’s suicide, she witnessed him grieving the suicide loss of a friend of his own. She shared her fear of following in her friend’s footsteps if she did not address her own mental health concerns:

I decided that it was probably a smart idea to do the things he hadn't done to try and fix what was going on in my head [...] I either need to figure out how to deal with this, or I'm going to be the third domino.

Some participants experienced concern in their recognition of similarities between their friends' mental health symptomology and their own, with Elizabeth noting that experiencing a parallel "mental health journey" was a consistent element in her long-standing friendship. Similarly, Mary recognized how easily she could fall into the same pattern as her best friend:

I think my friend and I, we were pretty tight and I think we could relate to each other because she struggled with depression and I did too a little bit, but mine was not as severe as hers. But I think it like really woke me up like oh, I really need to like do everything I can to take care of my mental health and appreciate my life because I want to live.

This recognition of similar symptoms and emotional challenges to those of their lost friends led participants to the recognition of a need for personal change. Taylor reflected on feeling blindsided after the suicide event: "I had even mentioned to him sometimes that I was dealing with depression and stuff. And so I kind of hoped that he would have opened up as well. But, you know, he didn't talk about this to anyone." Taylor concluded this friend must have been bottling up emotions and hiding symptoms of mental illness in an attempt to avoid burdening his loved ones, a tendency which Taylor found felt familiar: "Just having that loss kind of forced me to, yeah, come to terms with more stuff about myself." Taylor shared the revelation that "[I can't] make the same mistake that [Friend] did. You can't bottle it up and you can't deal with it on your own."

For many participants, the answer to the revelation of suicide loss was to pursue therapeutic support, whether in the form of individual therapy, a peer support group, or both. In some cases, participants realized their need for support in the weeks after their

loss. For others, the “wake-up call” came years after their friend’s death, when they realized that despite the passage of time, they were not healing. For Mary, her wake-up call became apparent when she realized that years after her loss, she was still breaking down in tears on a regular basis: “This is really hard for me still and it’s been years, you know? It was like two years. [...] I felt like, ‘Hmm I think I might need a support group.’” Although she had already been seeing an individual therapist, Mary realized that she needed an additional layer of support, and she began searching for a peer support group.

Another participant, Elizabeth, took six years to realize her need for additional support. She noted that despite her best efforts to avoid thinking about the loss of her best friend by staying busy and working long hours, her grief re-emerged whenever she was physically ill or on vacation, times in which “you have a little too much time to think, can't keep yourself busy for 24 hours a day.” When the COVID-19 pandemic lockdown brought forced isolation and free time, she reached her breaking point and finally reached out to a former therapist about re-starting psychotherapy.

### **Utilizing Existing Therapy**

For all but two of the participants, a significant motivating factor in seeking mental health support services was having access to a current or former therapist. At the time of their friends’ suicides, many participants were already receiving individual therapy for a variety of presenting problems, ranging from depression to OCD. These participants described an almost instantaneous transition to processing suicide loss in therapy. Christina remembered calling her therapist for an emergency phone session on the day of the loss itself. Jeremy recalled entering his weekly appointment and telling his

therapist “something huge has happened.” Similarly, Tessa requested to move her next therapy appointment up sooner and upon entering her therapist’s office, immediately stated, “I lost my best friend and like, we gotta talk about this.”

During a time of crisis, participants noted the benefit of having access to an already known, trusted therapist, rather than having to put in the mental labor to search for a new provider. Even for Elizabeth, who spent years away from therapy, being able to call upon her former therapist in her time of need made it much easier to access services: “I had already known her and trusted her. So I just reached out to her again. I was like, ‘Hey, I’m really not doing well. Can you fit me in?’”

Many participants noted the benefit of their existing therapist having knowledge of the history and symptoms which played into processing the new loss. As Taylor noted: “Having that ongoing relationship was also a big support.” Since she had had joint sessions with her friend in therapy prior to his death, Christina spoke to the advantage of not having to explain the context of her loss to her therapist: “She knew him and she knew me, and she knew all the things that have led up to that and what had happened afterwards.”

Some suicide survivors with previous mental health history noted the benefit of being able to address mental illness, grief, and the interaction of the two in therapy, as well as being able to call on previously learned skills and strategies which were applicable to coping with grief. Both Elizabeth and Taylor discussed how previous experiences with depression, combined with their grief, provided a unique clinical picture which their therapists were able to address, due to prior familiarity with their cases. As Taylor noted:

I was already kind of trying to come up with strategies to manage that, you know, chronic depression of every once in a while, I would just fall into a hole where I couldn't do much for a few weeks. And so this became kind of one of those times.

Originally attending counseling to address another death, Tessa spoke about how her therapist was able to address her multiple losses simultaneously “because those two deaths for me are a bit intertwined.” Elizabeth reflected on questioning whether to pursue a new therapist to deal specifically with her grief, before realizing that her former therapist would be able to address the complex dynamics tied up between her grief and other diagnoses:

I had actually wondered when I started seeing [former therapist] again, if I should go to a grief specific counselor. But I think for maybe somebody like me that there's probably other things tied up in it. And so sticking to the general, like versus somebody who generally had not had mental health issues before, where I think a grief counselor might have been more helpful.

Recognizing the ease of access which came with having an existing therapist, some participants expressed doubt that they would have been able or willing to access services if they were not already connected. They noted that knowing where to look for a therapist, finding a good fit, coping with long waitlists, and navigating insurance were all barriers which they had faced in the past when searching for mental health services and could anticipate facing if they had had to find a new therapist, especially in the midst of coping with a crisis of suicide grief.

## **Challenges to Seeking Support**

Despite the ease of access many participants found by utilizing previous and current therapists, most participants also experienced challenges to seeking support and to their overall healing process as they dealt with the suicide loss of their friend.

Specifically, participants found that two areas were challenging: 1) Experience of Stigma and 2) Lack of Social Permission to Grieve Friends.

### **Experience of Stigma**

The experience of suicide stigma is a well-documented challenge that nearly all suicide survivors face, and friends are no exception. All participants encountered incidents of stigma, ranging from well-intended misunderstandings to explicit judgment and condemnation. These incidents exacerbated participants' difficult emotions around grief and contributed to patterns of isolation and avoidance around sharing their experiences with others or seeking support.

The most blatant instances of stigma experienced by participants involved hearing upsetting assumptions about the friends lost to suicide, including conclusions that people who die by suicide are "crazy," "weak," "selfish," or have poor moral character. Some judgments took the form of religious condemnation. Mary said, "People still will, like, blame the person or like, think it's like bad or, you know, if you're religious, you might think you're gonna go to hell or something." Recalling her own experiences, Robin shared, "I heard some ridiculous things. If you read the Bible more, if you prayed more. If he was more religious." Questions about their friends often took on an intrusive or voyeuristic tone; Lucy recalled warding off "too personal" questions about whether her friend had relapsed into substance use at the time of her death and whether she had left a

suicide note. As she noted, “when there's a tragedy, everybody wants to know all the details.”

Others experienced the lack of acknowledgement or discussion of suicide as a form of stigma, noticing that other people got “awkward” when the topic of suicide came up or avoided talking about it at all. Some participants found they could only talk about their grief if they did not mention the cause of death. Christina spoke to “not really having people respect the depths of [suicide] loss, where if you said ‘my best friend just died of breast cancer,’ everyone all of a sudden is like, ‘Oh my gosh, that sounds tragic.’” Although her employer knew she had lost a friend, Lucy avoided telling him that her friend had died by suicide, fearing a lack of understanding, if not full-on condemnation. Robin noted: “Grief is only allowed in society under certain conditions.” Echoing this sentiment, Elizabeth expressed the message she received from society as: “Keep on and carry on ... ok, it's done. Now it's time to get back to your life.” At her friend’s funeral, Mary realized the word “suicide” did not come up at all:

Her family wanted a small funeral [...] which I think was like a euphemism for they don't want everyone finding out that she died by suicide. So it just seemed very like kind of a hush hush sort of like, let's not talk about how she died kind of thing.

Elizabeth also shared an incident of trying to open up to her co-workers about her loss and feeling shut down:

And then I had a picture of [Friend] for a while and myself on my phone, like my screensaver, and [we were] out at a bar drinking and somebody asked about her, and [...] I just mentioned her suicide. And the reaction was so curious of, like,

somebody who talked to me a lot about what they had been through personally, they're like, "Oh, that's too dark to talk about now."

In a similar fashion, many participants felt pressure to avoid speaking about their friend in front of others, for fear of being a "downer" or making others uncomfortable. Some found that even when they did speak about their loss, they often received unsolicited advice or unhelpful comparisons to other losses. Even when others wanted to be supportive, it was not always perceived as helpful to grieving participants. Jeremy described months of avoiding anyone who did not personally know his deceased friend out of a feeling of mental exhaustion around answering questions about the death. Lucy shared that she hated when others assumed they understood her experience and told her they knew what she was feeling, wishing she could reply, "You have no idea what I'm going through."

While participants did not report any experiences of stigma from individual therapists or peer support group leaders, one participant did experience an unfortunate incident of suicide stigma from his psychiatrist. When asked about recent changes in his life by his long-standing psychiatrist, Jeremy reported the recent suicide of his best friend. In response, the psychiatrist made a comment about individuals who complete suicide which Jeremy perceived as ignorant and dismissive: "They never need to do that, and I don't understand why someone would." As a result of this interaction, Jeremy shared that he ended his appointment early and neglected to share anything too personal with the psychiatrist in the future.

The result of experiencing suicide stigma led to a conclusion for many participants: to avoid stigma, one must keep their grief to themselves. Participants learned



the lesson to be careful to whom they disclosed their loss, if they disclosed it at all, because, in Robin's words, "people would intentionally say things intentionally designed to hurt you." These suicide survivors learned not to be a "downer" and expose others to discomfort by keeping their grief internalized and compartmentalized. For participants who already struggled with help-seeking due to existing experiences of depression or social anxiety, experiences or fear of stigma only exacerbated isolative tendencies.

Elizabeth reflected on how the experience of stigma might act as a barrier to those suicide survivors seeking individual therapy or support group services: "I think that societal stigma of it just makes it more difficult to open up about, so maybe it's like, just like having an awareness of that." On top of general suicide stigma, for many participants, the status of being a friend of suicide loss made grief even more uniquely isolating.

### **Lack of Social Permission to Grieve Friends**

A common thread in the discussion of grief amongst participants was a perceived lack of social permission to grieve friends. Without exception, all participants described incredibly close, decades-long relationships with the friends they lost to suicide, often using terms such as "best friend," "my person," or "like a sister/brother" to describe the depth of the friendship. Many participants met their friends in childhood and described a close intertwining of their families, with their friend playing the role of a sibling to the participants themselves and sometimes as a surrogate child/aunt/uncle/parent to participants' own family members. They not only held long histories with their friends but also envisioned futures together; Taylor recalled, "no matter what, I always figured

eventually, you know, when we're 30 or whatever, we'd be able to look back on life together.”

For some participants with distant or dysfunctional relationships with their biological family members, the friendship played an even bigger role. “There are a lot of us out there,” Robin noted, “where friends are our family.” While maintaining relationships with family held a sense of obligation for some participants, Jeremy explained that “friends hold a special kind of relationship [...] that you don't have with your family. Friends are the people you choose.” Although she had lost family members before, Christina felt much more affected by the loss of her best friend:

For me, it felt almost like you sort of lose a part of yourself because it's a person you're closer to in many ways for a lot of people than you are to your own family. So you share things with them you might not tell your parents, you share things with them and you've been through things together [...] like you feel like you've lost a limb or you feel like a piece of yourself is gone. I think people underestimate how deep that loss is.

Despite this level of intimacy and closeness with their friends, many participants found their role diminished to “just a friend” after the suicide loss. For some participants, this included feeling excluded from grief rituals and collective mourning by their friends’ family. Often, participants acknowledged, such exclusion is unconscious on the part of the family, who are too consumed in their own grief to think of including friends. As Robin stated: “They don't necessarily consider that friendships can be just as profound as blood relation.”

Christina, however, experienced more direct exclusion from the family of her lifelong best friend. She described flying across the country to participate in grief rituals for her friend, only to leave early due to discomfort with how her friend's family was treating her. She told of later receiving blame for the suicide from family members. She noted that feeling blamed and excluded resulted in a "second kind of grieving" and was a primary focus of her therapy for quite a while.

Without family to grieve alongside, many participants were left feeling isolated. Christina reflected on both her own experiences and those of other suicide survivor friends she had met through her support group, "I think a lot more people who lose friends to suicide feel alone in their grief." While some participants had close friend groups with which to participate in shared mourning, suicide survivor friends who did not share many mutual connections with the friend they lost, or who lived far away from that community, found themselves alone in their period of mourning. As Jeremy pointed out, when one loses a family member, they are almost guaranteed a shared grieving circle within their family unit; "the family gathers around each other." Friends, on the other hand, are often left to grieve in isolation. "The family tends to kind of close ranks and you're just left," said Robin.

Even for participants who maintained close and positive relationships with their friends' family and loved ones, they still received discouraging messages about their right to grieve from outside sources. Some noted that unlike with familial loss, friends are not often granted bereavement leave from work and instead must "power through" their grief. Others noted that family, friends, and coworkers seemed to gloss over their loss. Elizabeth recalled entertaining guests a week after her best friend's funeral:

And it was just a bit surreal [...] They were like, “I'm sorry about your friend,” but that was kind of like it. That was, like, the end of conversation. And I was like, this feels a little... I don't know. There should be more to this, but [...] I just felt like a lot of pressure to be like, “OK, it happened. Move on.” Where I don't think that that's really how it works.

Whether intentional or not, participants found themselves interpreting others' perceived dismissal as a lack of permission to grieve as long and as publicly as family members might. Mary summed up her assumption of what others were thinking: “It's been a year or two, aren't you over it? Can't you move on?”

This lack of permission to grieve extended, for some participants, to their willingness to seek help. Although she did not experience judgment from her own therapist, Robin considered the possibility of a therapist de-legitimizing friend loss as a barrier to help-seeking:

You can't guarantee that you're going to find a therapist who's not going to give you that attitude, that, “Oh, well, it was just your friend. So let's explore why you're so upset when it was only a friend.” And I don't know, if somebody said “only a friend” to me, I think that would probably be my last session with that therapist.

Suicide loss support groups, in particular, felt off-limits to several participants who assumed that such groups must be meant for family members. Mary shared her assumption that groups are “only for people who lose relatives or like, you know, a kid or a child or like a partner or something [...] not for people who just lose their friends.”

Once they did join support groups, participants found that, indeed, the majority of other group members were family members and spouses of suicide loss; and although no participants experienced devaluing of their loss from other group members, the knowledge of the group demographics sometimes made participants self-conscious of their loss. Christina felt like the “odd one out” in her group and found herself believing that her grief “shouldn’t be the same size or bigger” than other group members who lost family members:

Okay, so I'm this crazy person who's still is suffering the loss of my friendship while there is no other person here suffering the loss of their friends. So am I someone who's over-seeking support? Or is it other people under-seeking it or, like, am I making too big a thing of this loss?

Over time, some participants took the role of advocating for the legitimacy of friend bereavement to familial suicide survivors, such as recommending change of language in advertisements for the group or sharing stories of how exclusion by family was painful. Robin recalls advocating for her experiences in her support group:

It was enlightening for family members who had been there because they had never thought about what happens to the friends that are left behind until, you know, I showed up in the group and start talking about what happens to friends that are left behind it and it just made them realize that there is a lot of emotional trauma there too. [...] So maybe we need to remove the quotes in the “just” [in “just a friend”] and call it what it was. It's a deep relationship and it was an emotional connection. And it doesn't need a label beyond that.

## **Impact of Mental Health Support Services**

The two formal supports utilized by participants in this study included both individual therapy with a licensed mental health professional (including social workers, counselors, and psychologists) and suicide loss support groups led by a trained peer facilitator. The majority of participants (88%,  $n = 7$ ) took advantage of both of these supports simultaneously and found parallel benefits in both modalities. In Taylor's words, "It was very helpful for me to have both an individual therapist and have the support group to go to."

This section will address a variety of impacts found in both of these mental health support services, as well as impacts unique to each modality. Sub-themes for this category include: 1) Allowing Space to Process Complex Emotions, 2) Providing Education, 3) Challenging Self-Blame, 4) Connecting Through Shared Experiences, and 5) Desiring More Specialized Care.

### **Allowing Space to Process Complex Emotions**

Within the grieving process, suicide survivors experience an array of complex and often contradictory emotions, including anger, despair, abandonment, guilt, and denial. Participants described the full spectrum of emotions they experienced in the wake of their close friends' suicides. For those who were already receiving mental health treatment for existing diagnoses, such as depression or anxiety, the new wave of grief elevated or complicated existing symptoms. Christina described the "black hole" and "horrible open space" of her grief, while Lucy told of disbelief followed by anger at her friend: "How can you put me through this? How can you do this to me?" Taylor summed up conflicting emotions towards the friend lost: "It wasn't just that I have lost my best friend. But

[Friend] is the one who killed him too.” Speaking of her own feelings of anger and abandonment, Christina said, “Here I am now dealing with this and I do not have my best friend. I don't have the person who knows me the best to deal with their loss.”

This intense and sometimes confusing array of emotions was often difficult to talk about with family, friends, or coworkers, as many participants found. When they were not met with stigmatizing reactions from others, the mere act of opening up the floodgate of emotions still made talking about their loss difficult. Even in interviews for this study, some participants grew tearful and expressed the difficulty of speaking about their grief experience. As Taylor noted; “Sure enough, it's still hard to talk about. I hadn't thought of this yet.” Engaging with mental health services offered a space where participants felt safe to air and process their complex emotions around suicide loss.

A theme through most participants' accounts was a sense of guilt for not preventing their friends' deaths. Mary recounted her thought process: “Whoa, I was her best friend. Like, was I not there for her? What did I not do? You know, how could I have been a better friend?” Similarly, Lucy found herself excessively ruminating on memories, looking for evidence for and against her friend's suicidality, and asking herself, “How could such a good friend, me, not see it?” Elizabeth, who spent years talking her friend through difficult mental health crises prior to her death, noted certain expectations and responsibilities around female friendship, stating that she felt that she had “dropped the ball” after her friend died by suicide, stating “I should have asked her more questions.” Guilt also took the form of obsessive replaying and ruminating over the circumstances around friends' deaths. Lucy shared, “I just kept on wanting to turn back time. I was doing that for a very long time. Just let me go back one day, just one day, how I would

have changed things.” Even though participants knew there was nothing they could have done, they still had questions on how things could have been different. Taylor reflected, “I wish he had come to me with anything, like it doesn't matter. I wouldn't have seen it as a burden, you know? I wish I could have helped.”

Another common emotion to be addressed in therapy was disbelief. In Lucy's words, “I wake up in the middle night grasping like, you know, reaching out [...] I'm like, ‘this can't be, this can't be, this can't be.’” After facing the suicide of an intimately known friend, many participants struggled with the question of “why?” and struggled to find the same closure which they imagined would come with another manner of death. Lucy shared, “I just wish she would have died in a car accident. I just wish she would have had cancer. Suicide is very hard for me to accept.” Robin elaborated on this sentiment, “I mean, it's not like cancer. They didn't have a choice about getting cancer, but suicide every time, that's a choice.” She went on to describe how her individual therapist helped her address her “flurry of questions” and complicated emotions:

There's always the “wait... wait, wait, wait. We've been here before. And you got over it. So why now did you not get over it? What's the difference that made you decide that, OK, I'm not fixing it. I'm just done.” So we talked a little bit about, about that, things like that and how to get past the “why, why, why, why, why” and just get to figuring out how to let go.

The most frequently cited benefit of therapy services, individual and group alike, was the allowance of an open, non-judgmental space to speak about and process these conflicting emotions. Even in cases where participants did not feel that their individual therapist had particular knowledge or expertise working with suicide survivors, there was still benefit



in having a designated person with whom to talk, especially for those who worried about burdening friends and family with their grief. In Mary's words:

I suppose if you talk to your friends or family members, they might tell you what to do. Or like give you unsolicited advice. But at least like a trained therapist and maybe even a trained support group leader will just, you know, just listen and give you [...] compassion and empathy.

Also struggling with worries about "annoying people" by talking about her grief, Robin saw the benefit of her therapist as someone "who it's their job to sit there for an hour and listen to you talk about this." Speaking to both her support group and individual therapy, Tessa expressed her belief that "I don't know if I would have been OK if I hadn't had the opportunity to speak candidly about what I was feeling."

Jeremy noted that "there wasn't anything very groundbreaking or [...] any epiphanies made" in his therapy sessions, and yet, the "supporting, validating, giving some feedback" elements of the therapy space still had a positive impact. Similarly, Robin emphasized the impact of simply being able to admit to a therapist, "I'm not okay" and having that feeling validated. For Taylor, who was completing graduate school at the time of loss, attending a support group allowed a designated "sad hour" in the week where emotions that had to be compartmentalized for graduate school could be aired out, and Jeremy echoed this, stating that the structure of "knowing that you have an upcoming outlet that you don't have to just talk about it when it hits you" was beneficial. Finally, Mary named the most beneficial lesson learned from her individual therapist as "[I can] let myself feel some of the feelings and maybe not like not like judge some of the feelings that I'm having for myself." She added, "Maybe I could have learned that on my

own without going to therapy. But [...] I definitely learned it faster than if I just tried to do it on my own, you know.”

Another important element of processing difficult emotions was normalizing the experience of grief. Participants spoke of feeling crazy and broken by the severity and length of their grief. “I guess I was like kind of like being hard on myself. Like, what's wrong with me? How come I can't shake this, you know?” Mary said. However, individual therapists and support groups offered reassurance that participants' grief reactions were neither disproportional nor unusual for their experience. Lucy said, “I felt comfortable in the group, I felt comfortable with the counselor because they didn't discount what I was feeling.”

Individual therapists provided normalizing of grief primarily through simply providing a free space for suicide survivors to air out the feelings and lived experiences of coping with suicide loss. Often, simple affirmation and validation of emotions went a long way. Jeremy named the significance of having his experiences normalized:

Just confirming or affirming rather just, you know, saying a lot of the feelings I was feeling are valid and that's, you know, how the grief process goes and everybody grieves differently, like a lot of what you would think were very entry level, easy kind of common things, but, honestly, affirmation helps a ton, it really does, because you feel like everything is chaos and there's no like order or structure or even like a fairness. And when somebody just validates you and says like no, what you're feeling is completely reasonable and fair and justified. That stuff all helped a lot.

When they were struggling with emotions which felt overwhelming, conflicting, or “wrong,” friend suicide survivor particularly benefitted from being reassured that such emotions are to be expected. Christina spoke to the reassurance her therapist gave her regarding her conflicting emotions:

I felt a lot of guilt about being angry at him and she helped me to, you know, understand that it was OK to feel angry at him. It was OK to feel sad, angry. You know, all of those different layers of grief that take place [...] it helped me to understand that the grieving of each individual person is unique.

While individual therapists were able to provide some forms of normalizing in one-on-one session with participants, participants felt their grief most normalized by others in support groups. Elizabeth summed up the message she received through the normalizing of her grief by her support group: “It wasn't like weird, or wasn't overreacting, or it wasn't, you know, being too much.” Of her own group experience, Mary said, “It was just very helpful for me to listen to other people's stories, to feel like, OK. Well, I don't feel so alone in this.” Elizabeth recalled that listening to others' experiences in group was even more beneficial than speaking herself: “I think more than even me speaking it was listening to other people's experiences and seeing what they're going through and [...] like seeing how, you know, like how common what I was experiencing [was].”

The group milieu also triggered important realizations in some suicide survivors, like Tessa who recalled, “People would talk about things that like I hadn't even thought of as related, and I was like, 'Oh my gosh. Like, that's happening to me.’” Lucy spoke of the ways in which her group normalized her conflicting feelings:

All my feelings I was feeling, they told me it would be, it was very normal. I said, “How can I be mad at someone that committed suicide, that was so lost?” I felt very guilty over that. And they said that's a normal reaction to feel like that [...]. Sometimes you think you're crazy, you know, thinking oh my God, and I said, “I'm never ever gonna get out of this process.” And they [said], “You are. You will.”

Taylor also spoke of realizations about the normalcy of grief reactions found in group:

I think the support group [...] really showed me that it's OK to have those feelings. It's OK to not be able to cope on your own. It very much normalized it of like, you know that other people [...] lose people all the time. You know that everybody's dealing with grief or loss or something at some point in their life. But it's not very openly talked about. The support group definitely helped in, like I said, kind of showing me that other people are going through this and it's OK for me to be going through this and some people might be struggling more and some people might be struggling less, but it's OK to feel however you feel.

### **Providing Education**

In the wake of their loss, many participants shared the experience of craving knowledge about the grief process and answers to their questions about suicide. Lucy described becoming “obsessive” in her search for knowledge, sometimes spending hours a day on Google, typing her questions about suicide into the search bar and reading the same articles over and over again. During her interview, Robin quoted statistics about suicide loss that she had researched for her own understanding of the grief process. Other

participants read books about coping with grief or reached out to friends and family who had experienced suicide loss to ask about their experiences.

It is then unsurprising to find that when participants sought out mental health services, education about suicide loss was one element for which they were searching. When asked to provide advice to mental health practitioners working with suicide survivors, Lucy emphasized the role of a therapist in educating around what to expect when grieving: “be the guide – don’t let [suicide survivors] be in the dark.”

Indeed, one of the often-cited assistances offered by participants’ therapists was education around what to expect in their grief journey and skills for coping with this grief journey, such as journaling and visualization. Stages of grief, the non-linear timeline of healing, interaction of grief with existing mental illness diagnoses, and re-triggering effects of other life stressors on unresolved grief were all discussed in the therapy room. Elizabeth noticed that when she was feeling physically ill or had too much free time, her grief would come back in full force; her therapist helped her understand why: “She would say, like when somebody feels really bad, like maybe grief or things that haven't been processed in the past just tend to come up.” Taylor shared how therapy offered:

understanding of, if not the stages of grief, because it's not always clean like that, but kind of understanding that this is not, you know, there's kind of the goal of, OK, I'm going to process this death and then move on and [...] kind of understanding that that's not really how it works, and there would be times it's better and times that it's worse and it's kind of learning that it's something else that you have to manage and kind of learn to live with rather than try to escape.

Taylor's therapist shared additional education around utilizing journaling as a coping mechanism and taught Taylor cognitive skills such as "reframing that narrative, and OK, this isn't the end of the world. And you'll get, you know, get through this like everything else."

Support groups served as an opportunity to share knowledge and resources, with group members exchanging books about loss and lessons learned through their own experiences with suicide bereavement. Although she attended a group that emphasized support over advice, Christina craved for and appreciated the wisdom shared by group members who "understood how to navigate this sort of like 'don't give advice' advice." Mary recalled sharing of resources and advice amongst group members: "A lot of people in the group were reading the books on grief or books on like losing people to suicide. So people actually had very helpful comments to give each other. So I found that kind of refreshing and helpful."

Several participants cited long-term group members as some of the best sources of education and wisdom about coping with suicide loss. Christina told stories of a married couple who had been attending her suicide loss group for years and were able to offer guidance to newer members:

I think that piece that was very helpful was what I actually got from the people who had been grieving a suicide loss for a long time, that was very beneficial [...] Just knowing that some days it feels like it happened yesterday and some days they feel the space of the four or eight years that have passed. And that certain things will bring it up again, as if it were just moments ago that you heard about it. And

the strangest things can happen. You can smell a smell and all of a sudden you feel this devastation.

Lucy, too, felt comforted by the guidance and “coaching” offered by senior members of her peer support group. She recalled long-time group members telling her about aspects of grieving she should expect to experience: “Everything that they told me, how it's gonna feel like, “there's no way,” I'm thinking like, ‘oh, they're so full of it. There's no way I'm gonna feel like this.’ And sure enough, they were right.”

### **Challenging Self-Blame**

As discussed prior, feelings of guilt, responsibility, and self-blame were common amongst participants grappling with the suicide deaths of some of their closest friends. One important task in individual psychotherapy and peer support groups was challenging self-blame beliefs and forgiving oneself for not predicting or preventing the suicide. Mary described her therapist’s cognitive-based approach to challenging unhelpful assumptions about her role in her best friend’s death:

But my therapist kind of helped me like, you know, just think of it a little bit more like logically, like oh, you know, she had serious clinical depression and she got so depressed that she was like a little [...] delusional at the end and like, paranoid. [...] So I think the therapist sort of helped me come to terms with like, you know, some of the thoughts, some of the feelings that I was having afterwards of like just feeling bad, you know, just like feeling guilty or bad or just like sad.

Another approach to challenging self-blame was the “bold” and “adamant” tone taken by Lucy’s crisis counselor, who specialized in suicide loss. Lucy expressed exceeding

gratitude for her therapist who “pulled no punches” and was not afraid to argue with the participant about her role in her friend’s death:

And she said “I’m going to tell you one thing right now. Even if she told you she wanted to kill herself and you brought her in [to the hospital], there's no guarantee they would have kept her.” And she said, “there was no stopping her.” And the guilt, I still have guilt today because I'm human. But she really is gonna be very frank with you. “You can feel guilty the rest of your life [...] but this was her plan, and she was gonna do it no matter what.” And at first like I was arguing with the counselor, I'm saying “No, no, you don't understand. If I knew,” and I said, “No, no, no. If I knew about this, she'd still be here.” She says, “No, she wouldn't. She was determined.”

Lucy’s peer support group also joined in on challenging her self-blame. When she shared with them that she had been scouring the internet for answers on why her friend ended her life, “they said, ‘You're not gonna know why.’ [...] And they also said like, ‘You know, it's not gonna bring her back.’” For participants consumed with guilt and what-if questions, therapists and groups played a key role in helping directly confront and challenge assumptions of responsibility and helping to, in Taylor’s words, “challenging me gently” to “push me out of that hole” and re-join life.

### **Connecting Through Shared Experiences**

While both groups and individual therapists offered the normalization of grief, the group dynamic held a unique element that individual therapists did not: a community of individuals with the same shared experience. Although Mary was in individual psychotherapy at the time of her loss and found benefit from processing her grief with her



therapist, she realized an element was missing: “Oh, I think I have to go to [a support group] cause I need to just be around, you know, be with people who understand the specific issue.” After months of individual therapy, Christina similarly had the thought of wanting something more: “I just figured there had to be other people somehow. I didn't know there was even such a thing as a suicide survivor, but I figured there had to be like, other people who were also mourning the loss of a friend.”

Elizabeth noted that even excellent individual therapy did not meet every need that support groups could: “Yeah, it's great to have individual therapy, but you still have that isolated feeling because you're only talking directly to one person.” For Taylor, individual therapy may have offered individualized attention for a variety of concerns, but the support group allowed space to really focus on suicide loss: “I think that the combination of the two was helpful as well because like having the support group was a space where I could go to, you know, deal with [grief] specifically.”

While individual therapists were supportive and helpful, they did not have the specific understanding and connection of someone with a shared experience of suicide loss. “These people, they get it,” as Lucy told herself the first time she attended her support group. She went on, “I couldn't call my mother and my sister when I was feeling, because they didn't, wouldn't understand it. You have to call someone that understands it.” Echoing this sentiment, Taylor shared that group offered a different outlet than a usual social circle:

It is a heavy topic that you can't just constantly bring up around friends like, even though you know it's kind of constantly in my mind [...] and it did make a difference to kind of have other people who were feeling the same things around.

Nobody wants to be there, but they're all there giving support to each other because it's like, wow, that horrible thing happened that brought everybody together. It does matter to have other people there, kind of yeah, just supporting you through it.

For Elizabeth, who had participated in individual therapy for years before her friend's death, attending a virtual support group offered a new type of support that she found even more effective than her individual counseling: "To talk about something so private with strangers was an eye opening experience for me [...] It was surprising to me to feel so supported by like complete strangers I've never met in person."

In peer-led support groups, participants found themselves surrounded by others who had very similar experiences of and reactions to grief, despite their different backgrounds and social groups. Elizabeth said of her group,

It was nice because it was very diverse group of people I would have never spoken to otherwise, like I just would never have met them in my day-to-day life [...] it's just nice to have like this group coming together where, I guess that's the point of support groups, where you don't have to be a certain... That you all have the same shared event.

The sentiment of being paired together by unfortunate tragedy was a common one in groups. As Mary recounted, "We used to always say, [...] it's like a group that you don't really wanna be a member of, but it's like you're just all here to help each other, [...] unfortunately, we're all here right together." Wishing that her group had more frequent meetings, Lucy would even reach out to various group members and facilitators during

weeks the group did not meet. The space of shared experience also allowed for more openness and vulnerability. Per Christina,

I think each person sharing how they navigated grief, even if it was something that other people might find disturbing, it opened the door to other people feeling like they could share the very, you know, the oddities of their grief [...] that feeling in that group that other people had felt the way I felt was a huge relief and very comforting.

Lucy recalled not only having unique aspects of grief, such as difficult anniversaries and non-linear healing, normalized but also having hope instilled that things would eventually feel easier: “You’re going to be able to breathe again. Live again. The further out you are.” And with so much firsthand knowledge at hand, how could she not trust that promise? “They were just in sync. So I wasn’t confused, you know, there was no confusion. They made it clear,” said Lucy of her group members. “They lost children. And I’m thinking, and I would say to myself, ‘Man, if they got through it, I’m going to get through it.’”

Many participants cited support groups as a solution to a lack of social support around grief and as an auxiliary support to individual therapy. They spoke of suicide loss being isolating and “a wildly unique thing.” It’s for this reason that Jeremy suggested that friend suicide survivors seek out support groups: “I think hearing other people's stories and knowing other people have experienced the similar thing and how they are coping with it and what they think of it is enlightening and super supportive.” Elizabeth suggested that there could be benefits even for suicide survivors who did feel supported in their day-to-day life:

Even if it feels like you're handling it well, and like you don't like, you're talking about with friends or family members. I think you might, that person might be surprised at how much more there is to talk about with a group of people who have actually been through it versus thinking like you're doing fine, like on your own or with your own social circle.

### **Desire for More Specialized Care**

Unique to the individual psychotherapy experience was a desire amongst participants to receive more specialized care from therapists, specifically wishing that their therapists had more training and expertise regarding suicide loss. Participants recognized that suicide loss is a unique experience. Many spoke to the alienation of going through a form of grief that few others experience or can even comprehend. Due to these unique factors, some participants wondered why there were not more therapists available who held specialized knowledge or skills specific to their situation. All but one participant stated their belief that their therapists did not have experience or training in providing counseling to suicide survivors. Although no participants interviewed in this study characterized their individual therapy experiences as negative, some did wish for a therapist with more education or training in this area.

When she realized she was still struggling with her grief after 2 years in individual therapy, Mary wondered whether she should switch to a therapist with more experience treating her specific concerns: “Maybe I should just go talk to someone who has a little bit more experience with suicide because, you know, because obviously that was not her like specialty or anything.” When asked about advice for suicide survivors seeking resources, Robin advised that they “find a therapist that isn't just grief, but is

suicide grief, because there is a huge difference.” The one participant to see a counselor specializing in suicide loss was Lucy. She was adamant that her therapist’s specialized knowledge is what made all the difference: “I think if I went to another counselor that just dealt in- [...] it had to be someone in suicide. It’s a whole different ball game, it’s a whole different blowback.”

When participants envisioned seeing a therapist with specific education in suicide loss, they imagined being able to extend therapy beyond traditional talk therapy.

Elizabeth said, “Maybe there are certain exercises or grief-specific things I could have done versus just purely it being pure psychotherapy.” Although Jeremy appreciated his therapist’s supportive approach to his grief, he echoed this wish: “I’m sure there are methods specifically to grief and even suicide loss out there. So it would have been nice to have kind of a specialty or specialist or some kind of specific practice.”

Others wished that even if therapists did not have specific techniques for dealing with suicide loss, it would be beneficial for them to provide more resources, such as referrals to groups, medication prescribers, book recommendations, or even another therapist with more suicide loss specialty experience. Robin suggested that therapists could tell suicide survivors, “Okay, I will counsel you in just generic grief as long as you want me to, but these other things I’m not really a specialist in, and it might help if you saw someone else.” Christina described her desire for suicide loss resources from therapists, after realizing that the only resources being shared in her suicide survivor community were between peers.

I found it surprising that people's therapists had not recommended a lot of those helpful tools. And I wish that there was sort of a toolkit, you know, for people

who have suffered suicide loss [...] it doesn't mean you need all of those things, but maybe take some and leave some. But here's at least an idea. Here's support systems, here's groups that you could go to, here's books that can help you [...] so that you're not just grasping at straws all the time.

While finding individual therapy to be supportive, Taylor was grateful to have a support group to make up for gaps in their therapist's knowledge base: "I think the combination of the two (individual therapy and peer support group) in that regard was pretty helpful because [my therapist] is not specialized in grief. I mean what she did help certainly with it, but yeah, it didn't feel like those sessions were specifically targeted at grief."

Aside from grief-specific therapeutic techniques, participants saw the benefit in therapists simply having more knowledge about what to look for in suicide loss survivors. Elizabeth thought that more training could provide therapists with knowledge of how to work with suicide survivors of different cultural backgrounds and coping styles. Robin felt that her symptoms of PTSD were overlooked by her therapist, due to lack of knowledge. She said she wanted to "make sure that therapists are aware, even if suicide grief isn't their specialty [...] Take out an afternoon class at the Hilton or something and at least get, you know, the basics."

### **External Coping Resources**

While the benefits of directly addressing grief in psychotherapy were undeniable for participants, there were additional resources and elements which assisted participants in their journey of healing and processing their suicide loss. These two additional resources included 1) Connecting with Other Suicide Survivors and 2) Channeling Grief into Action.

### **Connecting with Other Suicide Survivors**

Between the debilitating effects of traumatic grief, experiences of suicide stigma, and a lack of social permission to publicly mourn friends, many participants in this study spoke of becoming isolated in the wake of their loss. “I think for three weeks maybe I didn’t leave the house,” said Taylor. “I couldn’t do anything.” Christina described her life in the months following her loss:

I mostly came home and got on my air mattress and did a lot of crocheting for like hours and hours and hours and hours and made massive king size blankets and watched a lot of Food Network and then went to support group and work and that was really all I did. I didn’t really visit with anyone except my one friend who had helped me when [my best friend] had died.

For as isolating an experience as suicide loss, finding a sense of community amongst those with relatable experiences was a life-changing resource for many participants. In many cases, peer suicide survivor support groups were where these connections were most readily found.

However, peer support groups were not the only places where participants found these connections. Some found support within their own community, forming informal support systems amongst other friends and loved ones mourning the same loss. Jeremy and Tessa experienced the loss of the same friend and described their own perspectives of turning to their mutual friend group in the wake of their mourning. Tessa said of her friend group, “It wasn’t like necessarily a psychotherapy, but it was a support system on its own. A lot of us just, like, came together and really like, you know, like emotionally held one another during that time.” Jeremy recalled organizing a meeting of their friend

group at a local bar in the days after the suicide, where the group was able to mourn and support one another as a community. In the months following his loss, Jeremy continued to find himself choosing to spend time with mutual mourners of his friend, as opposed to those who did not understand his grief: “Part of me just wanted to be with this community that we were all in.”

After months of isolation and devastating grief, Christina finally found solace through contacting mutual friends to share memories together: “And I think what felt legitimate to reach out to different people and sort of share our grief together because we had lost our friend together.” Lucy recounted how, even years after her friend’s death, mutual friends would still gather to tell stories about their lost friend and offer reassurances for one another’s grief and guilt. After losing several friends due to a lack of understanding around her grief, Robin formed new friendships with other suicide survivors: “I made new connections with people who've experienced the same thing, so I didn't have to explain why, you know, months and years later, I'm still upset. They get it.”

After the loss of her best friend, Mary grew close to her friend’s husband, and she spoke to the importance of having communication with someone who could understand what she was going through:

I never felt too alone because I always texted my best friend's husband, and so he and I became very close, just like we're very good friends now through this because, you know, we've been leaning on each other for support, and I think that's like been the important part is just like you have to find support somewhere, right? Whether it's just like another person who also is grieving just as much as



you are because of the same loss or if not the same loss, then like a similar type of loss and you can kind of understand each other.

Online support communities were another viable option for some participants. Although she found witnessing others' grief in formal support groups to be an exacerbating factor in her own trauma, Robin discovered that joining suicide loss support groups on Facebook offered a low-pressure outlet for venting and asking questions. She suggested that for suicide survivors who are unable to attend a formal group, the social media equivalent may be a good alternative for connection. "You can vent and you can say what you're feeling and you can ask questions and everybody on that group knows exactly what you're talking about. You don't even have to explain it."

Sometimes connection with other suicide survivors was found in unexpected places. Taylor, who lived in a different state than the community mourning their friend's death, turned to the only other local person who would understand: an ex-girlfriend had also previously experienced suicide loss and happened to be living nearby. Despite never intending to reconnect with this figure from the past, it was this connection that offered the most comfort, as well as a referral to a support group, in the weeks following the loss. Taylor said, "It was nice to have somebody to talk to who also knew him, because all my other friends there were, you know, newer friends that didn't know him." Years after the loss of her best friend, Lucy received an invitation to connect with an unexpected person: her friend's divorced ex-husband. She recalled, "He wanted to meet me and I said OK, let's go, and all he did was reminisce. That's it. We just reminisced."

One of Tessa's strongest suggestions for therapists was that they recommend seeking out social support to suicide survivors: "I think the social support is something

that I would say that like the therapist should be very keen on recommending.” For her, the benefits were clear: “It's like having a therapist is one thing. Like, I can chat all day to a therapist, but it's like still it's not... it's not the same.” While formal mental health supports were helpful, the added support of a community of relatable others was a resource that bolstered the effects of more structured support systems.

### **Channeling Grief into Action**

Another resource which enhanced the effects of therapy was the opportunity to translate grief into action for the greater good. Whether it was attending charity walks, helping co-lead support groups, giving talks about suicide prevention at local schools, offering support to other suicide survivors, creating artwork to memorialize their friend, or even just making an effort to improve relationships with living friends, taking action helped participants feel like their friends' deaths meant something. Taylor stated, “I want his life to mean something.” Robin echoed, “That's been my whole thing since the day after he died. Something good needs to come out of this.”

Taking action was sometimes simply a way to carry on the legacy of their friends, who they regarded highly for their positive impact. “If he had survived his friend's suicide,” said Robin of her work in suicide prevention awareness, “he'd be doing the same thing. This would be his new talking point.” Christina described her friend as “the compassionate kind; he was endlessly helping people.” For her, taking positive action “helps me to feel like I'm spreading the support that he was offering to so many in his time when he was alive.”

Sometimes, the positive action participants channeled their grief into took place within their own circle of loved ones. Taylor spoke of the motivation to “to show love to

the people all around me while I can, to let them know.” Not only did losing a friend to suicide influence motivation to engage in self-care and therapy, but:

it also made me think about how I wanted to manage my own friendships and like how you know, I wanted to act towards my friends and things like that [...] I never want to feel like I could have done more for my friends.

Mary said, “I want to like live a good life, you know, for my friend who did not live like a long life, you know? [...] Because I think she was just in such a deep, deep depression that she couldn't see a lot of that.”

For some participants, it was their own devastating experiences with suicide loss that motivated their actions. If they could take even a small action to make the process of healing from suicide loss feel just a little easier for someone else, it would be worth it. Mary spoke to her desire to raise awareness around suicide loss, after experiences of isolation and silence:

Actually this whole experience has definitely inspired me to like, I did raise money for the organization AFSP (American Foundation for Suicide Prevention) [...] I'm just like, giving more to this cause. And I do actually feel a little bit more like you know, like this is something I feel pretty passionately about. So like, I do feel like I'm like trying to be more activist about, like, about talking about this with more people because it's, I don't think there's, like, any shame to any of this. And it's like, I think people just need to talk about it more in general, like in public and with people just need to, there needs to be more awareness.

It was this desire to take positive action that motivated many of the participants to agree to being interviewed for this study in the first place. The idea of helping further research

for future suicide survivors was a driving force. "It's not costing me anything," said Tessa, "to make [...] the worst time of someone's life maybe, like an ounce better." Lucy said, "if I can help one person get through the trauma I went through? That's why I did it. It's a tough road." Elizabeth also credited her desire to make the path towards healing from suicide bereavement easier for future suicide survivors: "I think once you go through something like this, you have the feeling of like whatever I can do to help somebody in the future, no matter how small, like sure I'll do that."

## Chapter 5: Discussion

The aim of this study was to pursue a better understanding of the psychotherapy experiences and needs of adults who lost meaningful friends to suicide. This research is unique in that it explores the lived experience of a population which has received little research or clinical attention: adult friend suicide survivors. Prior research has shown that adult friends of suicide loss participate in mental health services less often than do familial survivors, despite a high number of friends being significantly affected by suicide loss (Andriessen, Rahman, et al., 2017; Berman, 2011; Causer et al., 2022; Feigelman et al., 2017). Non-familial suicide survivors are also less likely to participate in suicide bereavement research, which may help explain why there is minimal existing research exploring the potential reasons why friend survivors are underrepresented in postvention service participation (Dyregrov et al., 2011). One hope of this study was to help bridge this research gap through the collection and exploration of lived experiences of friend survivors.

Research was conducted utilizing a constructivist grounded theory (CGT) approach, which seeks to create a theory around qualitative research data, but with the recognition of the influence that researcher bias has on the construction of results and the utilization of researcher reflexivity techniques such as memo-writing to account for and recognize the influence of the researcher on the data (Charmaz, 2014; Charmaz, 2017; Charmaz & Thornberg, 2021). A total of eight participants who met the criteria of being an adult suicide survivor and engaging in therapy services after the loss of a friend in the last ten years were recruited for semi-structured individual interviews.

In revisiting the first research question (*What are the therapeutic needs of adults grieving the loss of a friend to suicide?*), one could conclude that the primary therapeutic needs of friend suicide survivors include: 1) ease of access to services, 2) feeling welcomed as a friend survivor to postvention settings, 3) psychotherapy which focuses on normalizing of complex emotions, psychoeducation, and challenging self-blame, 4) connections with other suicide survivors, and 5) trust in the expertise of therapy providers. Addressing the second research question (*What were the psychotherapy experiences of adults who sought therapy after the loss of a friend to suicide?*), the conclusion may be drawn that despite challenges of stigma, friend suicide survivors feel motivated by their loss to pursue psychotherapy services, find both individual and group mental health services largely beneficial, and benefit from additional external coping resources, such as interpersonal support and meaning-making activities.

This chapter will integrate the findings of this study with the existing literature, utilize the qualitative findings to answer this study's two research questions, and address research limitations and implications.

### **Connections to Current Literature**

Qualitative analysis of the data in this study revealed four theoretical categories, including 1) Motivation for Seeking Support, 2) Challenges in Seeking Support, 3) Impact of Mental Health Support Services, and 4) External Coping Resources. The following section will integrate these findings with the existing literature to answer the two research questions: 1) *What are the therapeutic needs of adults grieving the loss of a friend to suicide?* and 2) *What were the psychotherapy experiences of adults who sought therapy after the loss of a friend to suicide?*

### **Motivation for Seeking Support**

Participants spoke of two primary motivations for seeking support: the experience of a “wake-up call” as a result of their friend’s suicide and, in many cases, the availability of existing relationships with psychotherapy providers. Many of the friend suicide survivors in this study felt a bond with their friends due to similar experiences with depression, anxiety, and other challenging mental health symptoms. Losing their friend to suicide opened several participants’ eyes to the possibility that they could follow the same path without intervention. For others, their “wake-up call” came in the form of the desire to live their best life on behalf of their lost friend. In either case, many participants turned to current or prior therapists for assistance.

The abundance of research on the phenomenon of suicide contagion affirms that participants’ “wake-up calls” were not unfounded; those close to suicide loss do indeed find themselves at higher risk of attempting or completing suicide (Clark, 2001; Erlangsen & Pitman, 2017; Jamison, 1999). Similar to the participants in this study, Pitman and colleagues (2017) interviewed suicide survivors who were aware of and frightened by the idea of falling victim to suicide contagion. Theories on why suicide contagion occurs include the increased risk of depressive symptoms after suicide exposure, the act of suicide becoming normalized, and a desire to reunite with the loved one lost to suicide (Hunt & Hertlein, 2015; Jamison, 1999; Pitman et al., 2017; Sugrue et al., 2014).

Although this author has not encountered any previous research on suicide survivors utilizing existing therapy services after a suicide loss, there are studies documenting the barriers survivors face when trying to seek formal supports, including

lessened help-seeking due to self-blame and fear of stigma (Barlow & Coleman, 2003; Cerel & Campbell, 2008; Curtis, 2010). Some studies found that friend survivors face even more barriers to seeking postvention services, perhaps due to postvention's typical focus on supporting familial survivors (Bartik et al., 2013a; Feigelman et al., 2017).

All but two participants in this study (75%) accessed individual therapy by contacting an existing or prior therapist. Having almost immediate access to a known and trusted mental health practitioner made help-seeking a smoother and more accessible process for suicide survivors, especially while in a state of crisis. Some participants expressed the belief that they may not have sought individual therapy if they were not already connected, as the prospect of searching for a provider, navigating insurance, and building rapport with a new practitioner, all while in the crisis of grief, sounded daunting. Participant Robin, who sought a new individual therapist, faced barriers of long wait lists and unavailability of psychiatric prescribers. Another participant, Jeremy, wished to find a new psychiatrist after a stigmatizing interaction, but decided the work of finding one was not worth it, instead staying with a provider with whom he no longer felt comfortable. It would be reasonable to conclude that friend survivors are underrepresented in postvention services due to lack of easy access, rather than a lack of interest or need.

### **Challenges in Seeking Support**

As hinted at in the discussion of what made support services easier to pursue, friend survivors in this study also spoke to what made seeking support more challenging. Namely, participants found the experience of suicide stigma and a perceived lack of social permission to grieve friends as challenges in their healing and help-seeking



journeys. While these factors did not act explicitly as *barriers* to receiving mental health services, as every participant in this study did get connected with some form of postvention, these factors did serve as a form of perceived or internalized stigma, which has been noted to decrease help-seeking in suicide survivors (Azorina et al., 2019; Hanschmidt et al., 2016).

Experiences of suicide stigma are nearly universal amongst suicide survivors, regardless of relationship to the deceased. Countless studies have documented both the existence of suicide stigma and the impact of this stigma upon suicide survivors, which includes increased social isolation, lowered self-esteem, lowered help-seeking behavior, and increased risk for suicide (Carpiniello & Pinna, 2017; Chapple et al., 2015; Cvinar, 2005; Kawashima & Kawano, 2017; Range & Calhoun, 1990). Participants in this study recalled stigma events ranging from explicit statements of moral judgment or religious condemnation to well-intentioned but intrusive questions and advice. One participant, Jeremy, even experienced a stigmatizing conversation with his psychiatrist, which hurt his trust and confidence in that provider.

Even when not experiencing explicit instances of stigma, the awareness of societal attitudes towards suicide can increase survivors' sense of self-stigma and self-blame (Azorina et al., 2019; Hanschmidt et al., 2016; Sheehan et al., 2018). When suicide survivors blame themselves for their loved one's suicide, they are more likely to assume that others also blame them and conceal the cause of death and/or isolate as a result (Hanschmidt et al., 2016). Considering their close relationship and frequent contact with friends who died by suicide, many participants in this study took on a sense of guilt and self-stigma in the midst of their grief. Some questioned how a close friend like

themselves could not have seen the signs, while others re-traced how they could have acted differently to prevent their friends' deaths. Due to the deeply ingrained societal taboo surrounding suicide and the perception of suicide as a preventable death, feelings of guilt and self-blame are common amongst suicide survivors (Cerel & Jordan, 2008; Chapple et al., 2015; Hunt et al., 2019).

In addition to stigma around suicide loss, many participants felt like they had experienced an additional level of social judgment surrounding their status as a friend. This particular type of stigma was a unique finding of this study, as little prior research has focused on the challenges specific to non-familial suicide survivors. While they observed family members and romantic partners being given space and time to grieve, participants in this study felt that others expected them to move on more quickly from losing "just a friend." Between suicide stigma generally and prescribed ideas of how to mourn friends, many participants self-isolated and kept their grief protected and private.

Although not extensively studied, there is evidence in existing literature of the disenfranchised grief involved with being a non-familial suicide survivor. Bartik and colleagues (2013a) discovered that young adult and adolescent friend survivors felt confused as to their role in the grieving process and/or less entitled to grief than family of the deceased. In a review of studies involving the suicide loss of co-workers, Causer and colleagues (2022) found that individuals who lost a co-worker to suicide were often greatly impacted, with some even comparing the loss to that of a family member, and yet they felt that their grief was dismissed or silenced due to their status as a colleague. Rather than being allowed space to grieve, co-workers and work friends were encouraged to return to work as normal, despite facing feelings of intense grief, anger, and even

suicidality (Causer et al., 2022). This mirrors the experiences of many participants in this study, who felt an unspoken expectation to return to life as normal due to their status as “just a friend,” despite the loss of close and intimate friendships often spanning decades.

Sociologists Sklar and Hartley (1990) described friends as “invisible” mourners due to a lack of recognition in society, observing that while official titles exist for bereaved who lose family members (“widow,” “orphan”), there exists no term to describe a close friend left behind after a death. Some participants made similar observations, noting that society does not designate space for friends in grief rituals and that friendships in general are regarded as less significant and impactful relationships than that of family. It was observed by the coding team that even in interview, participants seemed to justify their friendships by describing them in familial terminology: “she was like a sister to me;” “I was part of the family.”

While the experience of having the status of a friend questioned was largely not reflected in the mental health services sought, participants in this study still held a fear that they might face such an attitude from therapists or group members. Participants expressed fears around individual therapists passing judgment on the length and depth of their grief, and they shared their self-consciousness around joining peer support groups filled with family member survivors, due to their perceptions that friend grief is less acceptable than familial grief. Conversely, finding that therapists, group facilitators, and group members alike validated the legitimacy of their grief went a long way in setting the foundation for healing and openness in therapy.

When considering both the themes of Motivations for Seeking Help and Challenges to Seeking Help in unison, one may conclude that the key to effective help-

seeking in friend suicide survivors is ease of access to postvention services and feeling welcomed/accepted as a friend in those postvention services.

### **Impact of Mental Health Support Services**

The most prominent theme which emerged from interview data in this study was the impact which mental health support services (both individual psychotherapy and peer-led support groups) had upon participants. Again, this was the first study to explore the impact of these supports on adult friend survivors specifically. In fact, previous research has indicated that non-familial survivors are less likely to participate in research, possibly due to less familiarity/more pain around talking about suicide loss as opposed to familial suicide loss survivors (Dyregrov et al., 2011).

Impacts were largely positive, with participants sharing how support services assisted with processing complex emotions, challenging self-blame, providing psychoeducation about suicide and grief, and in the case of support groups, allowing for connection through shared bereavement experiences. One area for growth, according to many participants, was a desire for individual therapists to have more specific training and experience working with suicide survivors.

The experience of complex emotions around suicide loss is well-established in prior research. Previous studies describe the shock, denial, anger, guilt, and abandonment associated with suicide loss (Erlangsen & Pitman, 2017; Jamison, 1999; Labestre & Gayoles, 2021; Seguin et al., 1995). Although strong emotion is to be expected in the aftermath of any form of grief, emotions may be even more tumultuous and conflicted after suicide loss and may lead to complicated grief, depression, and suicide risk (Andriessen, Kryszynska, et al., 2017; Feigelman & Gorman, 2008; Seguin et al., 1995).

Participants in this study described experiencing emotions such as depression, denial, anger, abandonment, and guilt, often in short succession or even simultaneously. For some, these intense emotions lasted for an extended period of months to years and led to feelings of being “crazy.”

It is thus unsurprising that processing these emotions was a primary task in individual therapy and support groups. Participants described the helpfulness of having space to air such emotions and having their emotional experience normalized by therapists and support group members. Indeed, research on postvention support groups and therapy models note that empathy and emotional processing are key benefits to both services (Castelli Dransart; Higgins et al., 2022).

Support groups offer the additional benefit of allowing survivors to meet other survivors further along their healing journey and gain hope for their own futures (Bottomley et al., 2018; Griffin et al., 2022; Higgins et al., 2022; McIntosh, 2017). Although there have been efforts to introduce more evidence-based forms of group therapy, Constantino and colleagues (2001) found that both structured, psychoeducation-based groups and informal peer-focused groups offered decreases in depressive symptoms and increases in healthy social adjustment in suicide survivors. This echoes the experience of many survivors in this study who found simply the experience of being around other suicide survivors just as helpful, if not more so, as individual psychotherapy.

However, another therapeutic need became evident in the form of something that was missing from many participants’ experiences: namely, having an individual therapist with specialized skills and/or training in suicide loss. Although participants benefitted

from the general support structure of talk therapy, many surmised that their therapist had not encountered suicide loss survivors before or did not have specialized knowledge/skills to provide in the therapy room. Sometimes, this resulted in a feeling of wanting for more, or even wondering if important symptoms were being missed by practitioners.

The participants in this study are not alone in their desire for more education and training for therapists working in the field of postvention. Previous researchers have also expressed concern that a lack of education and experience could lead to unintentional harm to suicide survivors, such as by therapists unknowingly making stigmatizing statements or even being uncomfortable directly addressing the loss (Castelli Dransart, 2017; Daoust, 2017; Dyregrov, 2009). Although no participants in this study experienced explicit negative consequences of a lack of training, many expressed a general wish for “something more,” such as more specialized advice, techniques, or resources. The one participant who did work with a specialist in suicide loss found the experience incredibly helpful, especially when it came to her therapist’s ability to provide detailed information about suicide loss and directly challenge her self-blame beliefs.

### **External Coping Resources**

Many participants in this study found solace not only from formal individual therapy and support groups, but also from external coping techniques, such as seeking informal support amongst other suicide survivors and channeling their grief into some form of action or meaning-making activity. These outside resources included connecting with other suicide survivors, such as other loved ones of the friend lost to suicide, and channeling grief into action, through advocacy work, volunteering efforts, artistic

pursuits, or care for others. Although these additional resources were external to mental health services, participants made it clear that relatable social support and meaning-making action added an additional layer of support to that which they were receiving in individual therapy and peer support groups.

A study of peer suicide loss by Labestre and Gayoles (2021) similarly found that one of the first resources survivors of friend suicide turned to was what the authors' termed "strength in unity," specifically, turning to other friends experiencing the same loss for "comfort and assurance that I'm not alone" (p. 307). Such statements mirror quotes from the participants in this study, such as Christina's statement that "I think what felt legitimate was to reach out to different people and sort of share our grief together because we had lost our friend together." Just as in other forms of grief, suicide survivors can find great comfort and healing in being able to share stories of their lost loved one with others, whether with an already-known entity or complete stranger (Krysinska & Andriessen, 2015; Neimeyer & Sands, 2017). Connecting with other survivors contributes the additional benefit of increasing healthy socialization after loss, a task with which many survivors struggle, due to concerns about stigma (Barlow & Coleman, 2003; Cerel & Campbell, 2008; Curtis, 2010). Socializing with survivors who have experienced the same or a similar loss can help eliminate worries about being judged or misunderstood by others.

Meaning-making is another important task in the grieving process which may be difficult for suicide survivors due to the unexpected and often violent nature of suicide deaths (Bottomley et al., 2018; Hunt et al., 2019; Labestre & Gayoles, 2021). Although meaning reconstruction can take place within the therapy context, survivors are also

capable of finding and completing meaning-making tasks outside of therapy (Higgins et al., 2022; Sands and Tennant, 2010). For survivors in this study, finding ways to give back through volunteer work or creating personal meaning through artistic endeavors helped them feel that something good was being done on their friend's behalf. Even participating in the study itself gave participants a feeling of giving back or carrying on the legacy of the friends they lost. Indeed, meaning-making tasks have been found to be beneficial in that they allow suicide survivors motivation to participate in positive activities and give survivors a sense of continuing their bond with their deceased loved one (Hunt et al., 2019).

### **Limitations**

One primary limitation of this study is that conclusions can only be drawn about the experiences of adults who lost friends to suicide and chose to pursue mental health services. Although interpretations may be made based on participants' reflections about challenges to seeking support and barriers they imagined other survivors experiencing in the pursuit of therapy services, no definitive conclusions can be made without further research into non-help-seeking friend survivors. It is difficult to determine why a survivor of friend suicide loss may not seek or access mental health services, or the differences between those who choose or do not choose this path, without access to their own accounts and lived experiences.

Unlike most quantitative research, qualitative processes collect data from a relatively small number of participants, and thus, it is imperative that researchers closely monitor for data saturation to ensure that a full theoretical picture emerges from the data, despite fewer data points. One noted issue with suicide survivor research in particular is



that there are certain demographics or personalities of survivors that are more likely to participate in research studies than others. Male suicide survivors have been noted to participate less often in suicide loss research, as is reflected in the low number of male participants (25%) in this study. Lower male participation may be due to societal stigmas or gendered socialization around men sharing difficult emotional experiences (Dyregrov et al., 2011).

Researchers have suggested that much of the existing suicide bereavement research may be focused on socially-active, emotionally-open survivors who are eager to “give back,” as evidenced by their willingness to participate in a study (Andriessen & Kryszka, 2011). The concern is that a large population of survivors – particularly those who are less emotionally open about their loss or who hold more shame and self-stigma – may be overlooked by qualitative research. Although this study used multiple recruitment avenues with the intention of accessing a sample of suicide survivor participants with diverse experiences, the majority of participants were recruited from suicide support groups and organizations, which may have also contributed a higher number of highly-involved suicide survivors. It is likely that participants who were willing to participate held a similar set of personality characteristics which motivated them to volunteer for a qualitative research study.

A limitation inherent in studying the psychotherapy experiences of suicide survivors specifically is that it is difficult to collect detailed data on the therapeutic content, techniques, and education/training of their providers, based on participant perspective alone. Although participants were asked in the interview to recall the approach and technique of their provider(s), many acknowledged that they did not have

the psychotherapy literacy to be able to give name to their therapist's theoretical orientation or specific techniques. At least one participant could not even recall what type of license her therapist held. While the lay-person perspective of the participants is valuable, the researchers cannot say with certainty that participants' impressions of their therapists' education and training are accurate.

As is acknowledged by constructivist grounded theory, it is virtually impossible to conduct research without the presence of researcher bias (Charmaz, 2014). It is inevitable that qualitative researchers bring their own assumptions and biases to every stage of the research process, including questions asked during interviews, interpretations of data in the coding process, and even choice of topic itself. Although the researchers involved in the coding and theory-building of this data made conscious efforts to recognize, discuss, and write memos in relation to personal bias and assumptions around this research topic and data, it is impossible to assess the research as fully objective and free of researcher impact. Rather, the theory and themes gleaned from this project should be considered to be co-constructed between researcher and participant.

### **Research Implications**

This study aimed to contribute additional context and understanding of the lived experiences of adult friend suicide survivors. However, the results of this study only reveal one small piece of a complex and broad area of inquiry which warrants further research attention. Based on the analysis and interpretation of the data in this study, the following research recommendations are made:

This study looked specifically at the experiences of adult survivors of the suicide loss of a friend who did seek out and participate in mental health services. While many

participants in this study benefitted from prior knowledge of and access to mental health services, one could conclude that many friend survivors who do not have the same experience and connections may experience more difficulty in accessing services. Future research would benefit from investigating the experiences of adult survivors of the suicide loss of a friend who *did not* seek out or adequately access mental health services, including what barriers might preclude such survivors from accessing services and/or the traits which make formal support services unnecessary for these survivors. Recruiting participants who have not previously been active in suicide loss organizations or groups may be more difficult, but ultimately contribute a different perspective than the typical highly-motivated, altruistic profile of a suicide survivor research participant (Andriessen & Krysinska, 2011).

Much of the existing research on friend suicide survivors lies within the realm of adolescent and college-aged survivors, due to social expectations around the importance of friendship at younger stages of life (Bartik et al., 2018a; Bridge et al., 2003; Feigelman & Gorman, 2008; Melhem et al., 2004). Sociologists Sklar and Hartley (1990) suggest that, in addition to young adulthood, older age is a stage of life in which friendship may play a more important role, and thus, lead to a more impactful grief. Further research could compare the grief and psychotherapy experiences of friend suicide survivors in different age groups or stages of life.

Based on interview data from this study, many friend suicide survivors experienced a sense of not having social permission to grieve due to their status as a friend. While some friend survivors found solace in grieving with other survivors of the same suicide loss, others expressed that they felt isolated in their grief due to not having a

built-in community within which to mourn. Future research could compare the grief and psychotherapy experiences of friend survivors who do and do not have access to interpersonal support and/or community after suicide loss.

All group therapy participation in this study took place in peer-led support groups, which were widely regarded as positive and helpful. However, previous research has indicated that groups led or co-led by mental health providers may offer more benefit, evidence-based methods, and consistency than peer-led groups (Constantino et al., 2001; Dyregrov et al., 2013; Higgins et al., 2022). Future research would benefit from comparing participation in peer-led and provider-led or co-led groups, as well as exploring which elements of peer-led support groups are particularly beneficial to suicide survivors.

Many participants in this study regarded individual therapy as generally helpful but believed that their therapist did not have enough experience or training in working with suicide survivors. These participants expressed a desire to receive more specialized suicide bereavement care, in the form of more specific suicide loss psychoeducation, therapeutic techniques, or provision of resources. However, it was difficult to determine the actual training and experience of participants' providers when only collecting data from participants themselves. Future research could investigate the differences in technique and outcome amongst providers who have specialized education or training in suicide bereavement and those who do not. It may also be beneficial to examine the types and level of clinical training received by providers who work with suicide survivors overall.

## **Clinical and Training Implications**

It is the intention of this research to contribute to better understanding of the needs and experiences of suicide loss friend survivors who seek therapy services, as well as to offer suggestions for improved care and access for these stakeholders. Based on the results of this study, the following clinical implications are suggested.

It is evident that individuals who lose close loved ones to suicide have the potential to experience significant impact, whether they are a family member or a close friend. The mental health field would benefit from recognizing all forms of suicide loss, regardless of relationship, and utilizing broader language when advertising postvention or suicide loss support services, such as by using phrases like “those who have lost ones to suicide” as opposed to “those who have lost family members.”

Most participants in this study spoke to the perceived benefit of attending therapy with a mental health practitioner with prior experience, knowledge, or training in working with suicide loss. Those participants who believed that their therapist had little to no training with their presenting problem wondered whether having a therapist with more experience or foreknowledge might be able to offer more psychoeducation, specific skills or coping strategies, and/or resources. Showing transparency around competency and experience in working with suicide loss could benefit suicide loss survivors who have questions or concerns about their therapists’ training.

Some participants in this study suggested that even if a therapist does not have specialized knowledge on suicide loss, they should be willing to refer out to a practitioner who does. It is evident from these participant reflections that the mental health field could benefit from increased opportunities for education around suicide loss, whether in

masters or doctoral-level training programs, continuing education trainings, or beyond. Trainings could focus on key elements such as typical symptoms and risks associated with suicide bereavement, navigating suicide loss stigma, and best practices for conducting grief therapy with suicide loss survivors.

Despite their expressed desires for a therapist with more training and experience working with suicide survivors, all participants reported some level of benefit from their individual therapists, with the most prominent helpful component being a designated, non-judgmental space to process complex emotions with a therapist. Whether or not a mental health practitioner has specific training in suicide bereavement, they are able to provide a safe holding space for suicide survivors to air their emotions and have their grief experiences normalized. For friend survivors who may not have a community with whom to grieve, or who may feel that their grief is stigmatized, empathic care from a mental health provider may be a vital outlet. For mental health practitioners working with suicide survivors without specific training in postvention, a therapeutic focus should be put on creating a holding space for the processing and normalizing of complex emotions.

Outside of individual therapy, participants spoke highly of their experiences in suicide loss support groups. While participants in this study benefited from groups which were peer-led and did not explicitly involve licensed mental health practitioners, previous research has indicated that introducing a trained mental health provider as a leader or co-facilitator can increase efficacy of groups and provide more evidence-based practice into the group format (Constantino et al., 2001; Dyregrov et al., 2013; Higgins et al., 2022). Knowing how highly suicide survivors value such groups, it would be appropriate for

more mental health practitioners to become involved with suicide bereavement groups, whether by creating their own or joining existing groups as a co-facilitator.

Beyond mental health service participation, the suicide survivors in this study spoke to the benefits of external resources, including social connection with other suicide survivors and finding meaning-making activities, such as volunteering or creating art around their loss. Mental health practitioners who work with suicide survivors could recommend such resources as an auxiliary resource to therapy services or assist survivors in creating their own meaningful external outlets.

### **Conclusion**

With increases in suicide deaths occurring throughout the United States and beyond, it is inevitable that counseling psychologists and other mental health practitioners will encounter individuals who have been impacted by suicide loss. While the grief of family members and romantic partners coping with suicide loss may be more widely acknowledged by postvention efforts, adult friends of suicide loss may be an underserved population within the sphere of suicide bereavement services. Despite a paucity of postvention and research attention, adults who lose close friends to suicide loss may face impacts which are severe and life-altering, especially when they do not have ready access to education around suicide loss or a support system who relates to their unique grief experiences.

This study was unique in its focus on adult friend suicide survivors and their experiences participating in mental health support services. Based on the experiences of the suicide survivor friends in this study, it was found that mental health services (including both individual psychotherapy and peer support groups) do have the power to

make a positive impact on suicide survivor friends, including helping to navigate difficult emotions, provide skills and psychoeducation, and challenge self-blame. However, adult suicide survivor friends in particular may face challenges of access, stigma, and negative social assumptions around friendship loss which may hinder their ability to connect with and benefit from services. By increasing access to services and increasing training around suicide loss, the counseling psychology field has the potential to provide vital supportive resources to a population whose pain is often overlooked.



## BIBLIOGRAPHY

- Adams, E., Hawgood, J., Bundock, A., & Kølves, K. (2019). A phenomenological study of siblings bereaved by suicide: A shared experience. *Death Studies*, 43(5), 324–332. <https://doi.org/10.1080/07481187.2018.1469055>
- Andriessen, K. (2005). A reflection on “suicide survivor.” *Crisis*, 26, 38-39. <https://psycnet.apa.org/doi/10.1027/0227-5910.26.1.38>
- Andriessen, K. (2009). Can postvention be prevention? *Crisis*, 30(1), 43-47. <https://doi.org/10.1080/07481187.2018.1469055>
- Andriessen, K. (2018). Understanding and measuring the grief experiences of adolescents - with a focus on bereavement by suicide. PhD Thesis. <https://doi.org/10.26190/unsworks/20912>
- Andriessen, K. & Kryszyska, K. (2011). Essential questions on suicide bereavement and postvention. *International Journal of Environmental Research and Public Health*, 9(1):24-32. <https://doi.org/10.3390/ijerph9010024>
- Andriessen, K. & Kryszyska, K. (2015). Public disgrace and financial gain: Punishment of suicide in Mechelen (Belgium) 1366-1795. *Suicidology Online*, 6(2), 56-60.
- Andriessen, K., Kryszyska, K., & Grad, O.T. (2017). Current understandings of suicide bereavement. In K. Andriessen, K. Kryszyska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 3-16). Boston: Hogrefe.
- Andriessen, K., Kryszyska, K., Hill, N.T.M., Reifels, L., Robinson, J., Reavley, N., & Pirkis, J. (2019). Effectiveness of interventions for people bereaved through suicide: A systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. *BMC Psychiatry*, 19(1). [doi: 10.1186/s12888-019-2020-z](https://doi.org/10.1186/s12888-019-2020-z)
- Andriessen, K., Rahman, M.B., Draper, B., Dudley, M., & Mitchell, P.B. (2017). Prevalence of exposure to suicide: A meta-analysis of population-based studies. *Journal of Psychiatric Research*, 88, 113-120. <https://doi.org/10.1016/j.jpsychires.2017.01.017>

- Arensman, E. & McCarthy, S. (2017). Emerging survivor populations: Support after suicide clusters and murder-suicide events. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 225-236). Boston: Hogrefe.
- Azorina, V., Morant, N., Nesse, H., Stevenson, F., Osborn, D., King, M., & Pitman, A. (2019). The perceived impact of suicide bereavement on specific interpersonal relationships: A qualitative study of survey data. *International Journal of Environmental Research and Public Health*, *16*(10), 1801.  
<https://doi.org/10.3390/ijerph16101801>
- Barlow, C. A., & Coleman, H. (2003). Suicide and families: Considerations for therapy. *Guidance & Counseling*, *18*(2), 67. <https://doi.org/10.1037/a0038994>
- Bartik, W., Maple, M., Edwards, H., & Kiernan, M. (2013). Adolescent survivors after suicide: Australian young people's bereavement narratives. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *34*(3), 211–217.  
<https://doi.org/10.1027/0227-5910/a000185>
- Bartik, W., Maple, M., Edwards, H., & Kiernan, M. (2013). The psychological impact of losing a friend to suicide. *Australasian Psychiatry*, *21*(6), 545–549.  
<https://doi.org/10.1177/1039856213497986>
- Bellini, S., et al. (2018). Depression, hopelessness, and complicated grief in survivors of suicide. *Frontiers in Psychology*, *9*(198).  
<https://doi.org/10.3389/fpsyg.2018.00198>
- Berman, AL. (2011). Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide and Life-Threatening Behavior*, *41*(1), 110-116.  
<https://doi.org/10.1111/j.1943-278X.2010.00009.x>
- Berry, R.S., Aurelius, M.B., Barickman, N., & Lathrop, S.L. (2013). Utility of a grief services program for medical examiners' offices. *Journal of Forensic Sciences*, *58*(2), 380-384. <https://doi.org/10.1111/1556-4029.12043>
- Bottomley, J.S., Smigelsky, M.A., Bellet, B.W., Flynn, L., Price, J., & Neimeyer, R.A. (2018). Distinguishing the meaning making processes of survivors of suicide loss: A expansion of the meaning of loss codebook. *Death Studies*, *43*(2), 92-102.  
<https://doi.org/10.1080/07481187.2018.1456011>
- Brent, D., Moritz, G, Bridge, J., Perper, J., & Canobbio, R. (1996). The impact of adolescent suicide on siblings and parents: A longitudinal follow-up. *Suicide and Life-Threatening Behavior*, *26*, 253-259.

- Bridge, J., Day, N., Day, R., Richardson, G., Birhamer, B., & Brent, D. (2003). Major depressive disorder in adolescents exposed to a friend's suicide. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 1294–1300. <https://doi.org/10.1097/01.chi.0000084830.67701.9>
- Callahan, J. (1996). Negative effects of a school suicide postvention program--a case example. *Crisis*, 17(3), 108–115. <https://doi.org/10.1027/0227-5910.17.3.108>
- Carpiniello, B., & Pinna, F. (2017). The reciprocal relationship between suicidality and stigma. *Frontiers in Psychiatry*, 8(35). <https://doi.org/10.3389/fpsyt.2017.00035>
- Castelli Dransart, D.A. (2017). Feeling responsible: Pathways from guilt toward inner peace. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 60-70). Boston: Hogrefe.
- Castelli Dransart, D.A., Treven, M., Grad, O.T., & Andriessen, K. (2017). Impact of client suicide on health and mental health professionals. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 245-254). Boston: Hogrefe.
- Causar, H., Spiers, J., Efstathiou, N., Aston, S., Chew-Graham, C.A., Gopfert, A., Grayling, K., Maben, J., van Hove, M., & Riley, R. (2022). The impact of colleague suicide and the current state of postvention guidance for affected co-workers: A critical integrative review. *International Journal of Environmental Research and Public Health*, 19(18), 11565. <https://doi.org/10.3390/ijerph191811565>
- Cerel, J., & Jordan, J.J. (2008). The impact of suicide on the family. *Crisis*, 29(1), 38-44. <https://doi.org/10.1027/0227-5910.29.1.38>
- Chapple, A., Ziebland, S., & Hawton, K. (2015). Taboo and the different death? Perceptions of those bereaved by suicide or other traumatic death. *Sociology of Health & Illness*, 37(4), 610–625. <https://doi.org/10.1111/1467-9566.12224>
- Charmaz, K. (2014). *Constructing grounded theory* (2nd Ed.). Thousand Oaks, CA: Sage.
- Charmaz, K. (2017). The power of constructivist grounded theory for critical inquiry. *Qualitative Inquiry*, 23(1), 34–45. <https://doi.org/10.1177/1077800416657105>
- Charmaz, K. (2020). “With constructivist grounded theory you can’t hide”: Social justice research and critical inquiry in the public sphere. *Qualitative Inquiry*, 26(2), 165–176. <https://doi.org/10.1177/1077800419879081>

- Charmaz, K. & Thornberg, R. (2021). The pursuit of quality in grounded theory. *Qualitative Research in Psychology*, 18(3), 305-327. <https://doi.org/10.1080/14780887.2020.1780357>
- Clark, S. (2001). Bereavement after suicide. How far have we come and where do we go from here? *Crisis*, 22, 102–108. <https://doi.org/10.1027//0227-5910.22.3.102>
- Constantino, R., Sekula, L., & Rubinstein, E. (2001). Group intervention for widowed survivors of suicide. *Suicide and Life-Threatening Behavior*, 31, 428–441. <https://doi.org/10.1521/suli.31.4.428.22044>
- Cox, G. R., Robinson, J., Williamson, M., Lockley, A., Cheung, Y. T. D., & Pirkis, J. (2012). Suicide clusters in young people: Evidence for the effectiveness of postvention strategies. *Crisis*, 33(4), 208–214. <https://doi.org/10.1027/0227-5910/a000144>
- Curtin, S.C., Garnett, M.F., & Ahmad, F.B. (2022). Provisional numbers and rates of suicide by month and demographic characteristics: United States, 2021. *Vital Statistics Rapid Release*, 24, 1-7. <https://dx.doi.org/10.15620/cdc:120830>
- Curtis, C. (2010). Youth perceptions of suicide and help-seeking: “They’d think I was weak or ‘mental.’” *Journal of Youth Studies*, 13(6), 699–715. <https://doi.org/10.1080/13676261003801747>
- Cvinar, J. G. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care*, 41(1), 14–21. <https://doi.org/10.1111/j.0031-5990.2005.00004.x>
- Daoust, J.-C. (2017). Canada – Hope after loss: Suicide bereavement and postvention services of Suicide Action Montreal. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 277-280). Boston: Hogrefe.
- de Groot, M. H., de Keijser, J., & Neeleman, J. (2006). Grief shortly after suicide and natural death: A comparative study among spouses and first-degree relatives. *Suicide & Life-Threatening Behavior*, 36(4), 418–431. <https://doi.org/10.1521/suli.2006.36.4.418>
- de Groot, M., & Kollen, B.J. (2013). Course of bereavement over 8–10 years in first degree relatives and spouses of people who committed suicide: Longitudinal community based cohort study. *BMJ*, 347. <https://doi.org/10.1136/bmj.f5519>

- Dyregrov, K. (2004). Micro-sociological analysis of social support following traumatic bereavement: Unhelpful and avoidant responses from the community. *Omega*, 48(1), 23–44. <https://doi.org/10.2190%2FT3NM-VFBK-68R0-UJ60>
- Dyregrov, K. (2009). How do the young suicide survivors wish to be met by psychologists? A user study. *Omega: Journal of Death & Dying*, 59(3), 221–238. <https://doi.org/10.2190/OM.59.3.c>
- Dyregrov, K. (2011). What do we know about needs for help after suicide in different parts of the world? A phenomenological perspective. *Crisis*, 32(6), 310–318. <https://doi.org/10.1027/0227-5910/a000098>
- Dyregrov, K., Dyregrov, A., & Johnsen, I. (2013). Positive and negative experiences from grief group participation: A qualitative study. *Omega*, 68(1), 45–62. <https://doi.org/10.2190%2FOM.68.1.c>
- Edmonds, A. (2016). Music therapy as postvention for survivors of suicide: A group case study. Masters Thesis. Arizona State University ProQuest Dissertations Publishing, 10109738.
- Ellis, J. B., & Lane, D. (1995). How young men and women assess parents of a child suicide victim. *Social Behavior & Personality: An International Journal*, 23(1), 29. <https://doi.org/10.2224/sbp.1995.23.1.29>
- Erlangsen, A. & Pitman, A. (2017). Effects of suicide bereavement on mental and physical health. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 17-26). Boston: Hogrefe.
- Feigelman, W., Cerel, J., McIntosh, J.L., Brent, D., & Gutin, N. (2017). Suicide exposures and bereavement among American adults: Evidence from the 2016 General Social Survey. *Journal of Affective Disorders*, 227, 1-6. <https://doi.org/10.1016/j.jad.2017.09.056>
- Feigelman, W., & Gorman, B.S. (2008). Assessing the effects of peer suicide on youth suicide. *Suicide and Life Threatening Behavior*, 38(2), 181-194. <https://doi.org/10.1521/suli.2008.38.2.181>
- Feigelman, W., Gorman, B. S., & Jordan, J. R. (2009). Stigmatization and suicide bereavement. *Death Studies*, 33(7), 591–608. <https://doi.org/10.1080/07481180902979973>

- Gebbia, R. & Moutier, C. (2017). USA – The American Foundation for Suicide Prevention’s support of people bereaved by suicide. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 296-300). Boston: Hogrefe.
- Genest, C., Moore, M., & Nowicke, C.M. (2017). Posttraumatic growth after suicide. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 50-59). Boston: Hogrefe.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.
- Grad, O., Clark, S., Dyregrov, K., & Andriessen, K. (2004). What helps and what hinders the process of surviving the suicide of somebody close? *Crisis*, 25, 134–139. <https://doi.org/10.1027/0227-5910.25.3.134>
- Grad, O.T., Treven, M., & Krysinska, K. (2017). Suicide bereavement and gender. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 39-49). Boston: Hogrefe.
- Griffin, E., O’Connell, S., Ruane-McAteer, E., Corcoran, P., & Arensman, E. (2022). Psychosocial outcomes of individuals attending a suicide bereavement peer support group: A follow-up study. *International Journal of Environmental Research and Public Health*, 19(7). <https://doi.org/10.3390/ijerph19074076>
- Hanschmidt, F., Lehnig, F., Riedel-Heller, S. G., & Kersting, A. (2016). The stigma of suicide survivorship and related consequences—A systematic review. *PLoS ONE*, 11(9). <https://doi.org/10.1371/journal.pone.0162688>
- Harwood, D., Hawton, K., Hope, T., & Jacoby, R. (2002). The grief experiences and needs of bereaved relatives and friends of older people dying through suicide: A descriptive and case-control study. *Journal of Affective Disorders*, 72(2), 185–194. [https://doi.org/10.1016/S0165-0327\(01\)00462-1](https://doi.org/10.1016/S0165-0327(01)00462-1)
- Hemmler, V. L., Kenney, A. W., Langley, S. D., Callahan, C. M., Gubbins, E. J., & Holder, S. (2020). Beyond a coefficient: an interactive process for achieving inter-rater consistency in qualitative coding. *Qualitative Research*, 1. <https://doi.org/10.1177/1468794120976072>

- Higgins, A., Hybholt, L., Meuser, O., Cooker, J., Downes, C., & Morrissey, J. (2022). Scoping review of peer-led support for people bereaved by suicide. *International Journal of Environmental Research and Public Health*, *19*(6), 3485. <https://doi.org/10.3390/ijerph19063485>
- Hung, N. C., & Rabin, L. A. (2009). Comprehending childhood bereavement by parental suicide: A critical review of research on outcomes, grief processes, and interventions. *Death Studies*, *33*(9), 781–814. <https://doi.org/10.1080/07481180903142357>
- Hunt, Q. A., & Hertlein, K. M. (2015). Conceptualizing suicide bereavement from an attachment lens. *American Journal of Family Therapy*, *43*(1), 16–27. <https://doi.org/10.1080/01926187.2014.975651>
- Hunt, Q. A., Young, T.A., & Hertlein, K.M. (2019). The process of long-term suicide bereavement: Responsibility, familial support, and meaning making. *Contemporary Family Therapy*, *41*, 335–346. <https://doi.org/10.1007/s10591-019-09499-5>
- Jahn, D.R. & Spencer-Thomas, S. (2014). Continuing bonds through after-death spiritual experiences in individuals bereaved by suicide. *Journal of Spirituality in Mental Health*, *16*, 311-324. <https://doi.org/10.1080/19349637.2015.957612>
- Jamison, K.R. (1999). *Night falls fast: Understanding suicide*. New York: Vintage Books.
- Jordan, J.R. (2008). Bereavement after suicide. *Psychiatric Annals*, *38*(10), 1-6. <https://doi.org/10.3928/00485713-20081001-05>
- Jordan, A.H. & Litz, B.T. (2014). Prolonged Grief Disorder: Diagnostic, assessment, and treatment considerations. *Professional Psychology*, *45*(3), 180-187. <https://psycnet.apa.org/doi/10.1037/a0036836>
- Jordan, J.R. & McMenamy, J. (2004). Interventions for suicide survivors: A review of the literature. *Suicide and Life-Threatening Behavior*, *34*(4), 337-349. <https://doi.org/10.1521/suli.34.4.337.53742>
- Kawashima, D. & Kawano, K. (2017). Japan – Research-informed support for suicide survivors. In K. Andriessen, K. Krysinaka, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 396-401). Boston: Hogrefe.

- Kinder, A., & Cooper, C. L. (2009). The costs of suicide and sudden death within an organization. *Death Studies, 33*, 411–419.  
<https://doi.org/10.1080/07481180902805624>
- Knox, S., Burkard, A., Jackson, J.A., Schaak, A.M., & Hess, S.A. (2006). Therapists-in-training who experience a client suicide: Implications for supervision. *Professional Psychology: Research and Practice, 37*(5), 547-555.  
<https://doi.apa.org/doi/10.1037/0735-7028.37.5.547>
- Krysinska, K. & Andriessen, K. (2015). Online memorialization and grief after suicide: An analysis of suicide memorials on the internet. *Omega, 71*(1), 19-47.  
<https://doi.org/10.1177%2F0030222814568276>
- Krysinska, K. & Andriessen, K. (2017). Online suicide bereavement and support. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 197-211). Boston: Hogrefe.
- Kübler-Ross, E. & Kessler, D. (2005). *On grief and grieving: Finding the meaning of grief through the five stages of loss*. Simon & Schuster.
- Labestre, G. & Gayoles, L. (2021). Peer survivors of suicide loss: A phenomenological study. *Techinum Social Sciences Journal, 17*, 299-316.  
<https://doi.org/10.47577/tssj.v17i1.2702>
- Lascelles, K., Pitman, A., McDonnell, S., Elvidge, H., Garnham, H., & Hawton, K. (2017). England – Help for people bereaved by suicide. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 325-330). Boston: Hogrefe.
- Latham, A. E., & Prigerson, H. G. (2004). Suicidality and bereavement: Complicated grief as psychiatric disorder presenting greatest risk for suicidality. *Suicide and Life-Threatening Behavior, 34*(4), 350–362.  
<https://doi.org/10.1177%2F0030222814568276>
- Law, Y.W., Yip, P.S.F., Wong, P.W.C., & Chow, A.Y.M. (2017). Hong-Kong – Support for people bereaved by suicide. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 391-395). Boston: Hogrefe.
- Ma-Kellams, C., Baek, J. H., & Or, F. (2018). Suicide contagion in response to widely publicized celebrity deaths: The roles of depressed affect, death-thought accessibility, and attitudes. *Psychology of Popular Media Culture, 7*(2), 164–170.  
<https://doi.org/10.1037/ppm0000115>



- Maple M., Edwards H., Plummer D., & Minichiello V. (2010). Silenced voices: Hearing the stories of parents bereaved through the suicide death of a young adult child. *Health & Social Care in the Community*, 18(3), 241–248. <https://doi.org/10.1111/j.1365-2524.2009.00886.x>
- McIntosh, J.L., Bolton, I., Andriessen, K., & Campbell, F. (2017). History of survivor support. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 101-116). Boston: Hogrefe.
- McMenamy, J. M., Jordan, J. R., & Mitchell, A. M. (2008). What do suicide survivors tell us they need? Results of a pilot study. *Suicide and Life-Threatening Behavior*, 38(4), 375–389. <https://doi.org/10.1521/suli.2008.38.4.375>
- Melhem, N. M., Day, N., Shear, M. K., Day, R., Reynolds, C. F., III, & Brent, D. (2004). Traumatic grief among adolescents exposed to a peer's suicide. *The American Journal of Psychiatry*, 161(8), 1411–1416. <https://doi.org/10.1176/appi.ajp.161.8.1411>
- Mitchell, A. M., Sakraida, T. J., Kim, Y., Bullian, L., & Chiappetta, L. (2009). Depression, anxiety and quality of life in suicide survivors: A comparison of close and distant relationships. *Archives of Psychiatric Nursing*, 23(1), 2-10. <https://doi.org/10.1016/j.apnu.2008.02.007>
- Mohajan, D. & Mohajan H. (2022). Constructivist grounded theory: A new research approach in social science. *Research and Advances in Education*, 1(4), 8-16. <https://doi.org/10.56397/RAE.2022.10.02>
- Morales, L.B. (2019). *The labyrinth of loss: A practical framework for processing and recovering from grief*. Highlands Ranch: Author's Place.
- Mowll, J., Smith, H. & Fitzpatrick, C. (2017). Supporting families through the forensic and coronial process after a death from suicide. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 162-173). Boston: Hogrefe.
- Nagel, D. A., Burns, V. F., Tilley, C., & Aubin, D. (2015). When novice researchers adopt constructivist grounded theory: Navigating less travelled paradigmatic and methodological paths in PhD dissertation work. *International Journal of Doctoral Studies*, 10, 365-383. <https://doi.org/10.28945/2300>
- National Institute of Mental Health. (2021, January). *Suicide*. <https://www.nimh.nih.gov/health/statistics/suicide.shtml>

- Neimeyer, R.A., & Sands, D.C. (2017). Suicide loss and the quest for meaning. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 71-84). Boston: Hogrefe.
- Nilsson, C., Bremer, A., Blomberg, K. and Svantesson, M. (2017). Responsibility and compassion in prehospital support to survivors of suicide victim - Professionals' experiences. *International Emergency Nursing* 35, 37-42.  
<https://doi.org/10.1016/j.ienj.2017.06.004>
- Norton, K. (2017). Responding to a suicide death: The role of first responders. *Death Studies*, 41(10), 639-647. <https://doi.org/10.1080/07481187.2017.1335550>
- Pitman, A., Nesse, H., Morant, N., Azorina, V., Stevenson, F., King, M., & Osborn, D. (2017). Attitudes to suicide following the suicide of a friend or relative: A qualitative study of the views of 429 young bereaved adults in the UK. *BMC Psychiatry*, 17(400). <https://doi.org/10.1186/s12888-017-1560-3>
- Pitman, A., Putri, A.K., De Souza, T., Stevenson, F., King, M., Osborn, D., & Morant, N. (2018). The impact of suicide bereavement on educational and occupational functioning: A qualitative study of 460 bereaved adults. *International Journal of Environmental Research & Public Health*, 15.  
<https://doi.org/10.3390/ijerph15040643>
- Prochaska, J. O., & Norcross, J. C. (2018). *Systems of psychotherapy: A Transtheoretical analysis* (9th ed.). Stamford, CT: Oxford University Press.
- Range, L.M., & Calhoun, L.G. (1990). Responses following suicide and other types of death – The perspective of the bereaved. *Omega*, 21, 311–320.  
<https://doi.org/10.2190/LLE5-7QNT-7M59-GURY>
- Ratkowska, K.A. & De Leo, D. (2017). Italy – Support after a traumatic death. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 341-346). Boston: Hogrefe.
- Rothes, I.A., Santos, J.C., & Santos, S. (2017). Portugal – First steps of postvention practice and research. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 356-261). Boston: Hogrefe.
- Sands, D., & Tennant, M. (2010). Transformative learning in the context of suicide bereavement. *Adult Education Quarterly*, 60(2), 99–121.  
<https://doi.org/10.1177%2F0741713609349932>

- Scheel, M.J., Stabb, S.D., Cohn, T.J., Duan, C., & Sauer, E.M. (2018). Counseling psychology model training program. *The Counseling Psychologist*, 46(1), 6-49. <https://doi.org/10.1177%2F0011000018755512>
- Schlebusch, L. (2017). South Africa – Experiences of suicide survivor support. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 378-382). Boston: Hogrefe.
- Scocco, P., Toffol, E., Totaro, S., Castriotta, C., & Ferrari, A. (2017). Italy – Postvention initiatives. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 335-340). Boston: Hogrefe.
- Seguin, M., Lesage, A., & Kiely, M. (1995). Parental bereavement after suicide and accident: A comparative study. *Suicide and Life-Threatening Behavior*, 25, 489-498. <https://doi.org/10.1111/j.1943-278X.1995.tb00241.x>
- Sheehan, L., Corrigan, P. W., Al-Khouja, M. A., Lewy, S. A., Major, D. R., Mead, J., Redmon, M., Rubey, C.T., & Weber, S. (2018). Behind closed doors: The stigma of suicide loss survivors. *Omega*, 77(4), 330–349. <https://doi.org/10.1177%2F0030222816674215>
- Silverman, M. M. (2006). The language of suicidology. *Suicide and Life-Threatening Behavior*, 36(5), 519-532. <https://doi.org/10.1521/suli.2006.36.5.519>
- Sklar, F., & Hartley, S. F. (1990). Close friends as survivors: Bereavement patterns in a “hidden” population. *OMEGA - Journal of Death and Dying*, 21(2), 103–112. <https://doi.org/10.2190/3Y94-G16J-D8MY-5P9M>
- Sklarew, B.H., Handel, S., & Ley, S. (2012). The analyst at the morgue: Helping families deal with traumatic bereavement. *Psychoanalytic Inquiry*, 32, 147-157. <https://doi.org/10.1080/07351690.2011.592741>
- Spencer-Thomas, S. & Stohlmann-Rainey, J. (2017). Workplaces and the aftermath of suicide. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 174-185). Boston: Hogrefe.
- Southey, R. (1799). *Poems: The second volume*. Printed for T. Longman and O. Rees, London.

- Sugrue, J.L., McGilloway, S., & Keegan, O. (2014). The experiences of mothers bereaved by suicide: An exploratory study. *Death Studies*, 38, 118-124. <https://doi.org/10.1080/07481187.2012.738765>
- Sveen, C.-A., & Walby, F. A. (2008). Suicide survivors' mental health and grief reactions: A systematic review of controlled studies. *Suicide and Life-Threatening Behavior*, 38(1), 13–29. <https://doi.org/10.1080/07481187.2012.738765>
- Tiatia-Seath, J. (2017). New Zealand- Development of postvention guidelines for Pacific communities. In K. Andriessen, K. Krysinska, & O.T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 402-406). Boston: Hogrefe.
- Trolley, B. (1993). Kaleidoscope of aid for parents whose child died by suicidal and sudden, non-suicidal means. *Omega*, 27, 239-250. <https://doi.org/10.2190/HUMQ-KVBQ-A02B-YDYB>
- Valente, S.M. & Saunders, J.M. (2002). Nurses' grief reactions to a patient's suicide. *Perspectives in Psychiatric Care*, 38(1), 5-14. <https://doi.org/10.1111/j.1744-6163.2002.tb00650.x>
- van de Venne, J., Cerel, J., Moore, M., & Maple, M. (2019). Sex differences in mental health outcomes of suicide exposure. *Archives of Suicide Research*, 0, 1-28. <https://doi.org/10.1080/13811118.2019.1612800>
- Waljarvi, C. M., Weiss, A. H., & Weinman, M. L. (2012). A traumatic death support group program: Applying an integrated conceptual framework. *Death Studies*, 36(2), 152–181. <https://doi.org/10.1080/07481187.2011.553344>
- Young, I.T., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M., & Zisook, S. (2012). Suicide bereavement and complicated grief. *Dialogues in Clinical Neuroscience*, 14(2), 177-186. doi:[10.31887/DCNS.2012.14.2/iyoung](https://doi.org/10.31887/DCNS.2012.14.2/iyoung)
- Zhang, J., Tong, H.Q., & Zhou, L. (2005). The effect of bereavement due to suicide on survivors' depression: A study of Chinese samples. *Omega*, 51(3), 217-227. <https://doi.org/10.2190%2F496B-Q1WQ-K9TJ-518E>

## Appendix A: Recruitment Letter

Dear [Name],

My name is Kat McConnell, and I am a fourth year doctoral student studying Counseling Psychology at Marquette University. I am seeking volunteers to participate in interviews for my dissertation research which will explore the psychotherapy experiences of adults grieving the suicide of a friend. I am specifically looking to interview adults who 1) lost a meaningful friend to suicide between 1 and 10 years ago; 2) attended psychotherapy (individual counseling, group counseling, crisis counseling, etc.) led by a mental health professional, in which suicide loss was a primary focus; 3) were at least 18 years old when the suicide occurred; and 4) currently live in the United States. This research data is intended to help mental health practitioners in their work with adults dealing with suicide loss.

Volunteers will participate in an interview with the researcher via video conference, which will be audio-recorded for transcription purposes. All identifying participant data will be kept confidential and will be disposed of after research has concluded. Interviews will last approximately 1-2 hours, and participants will receive the list of interview questions ahead of time.

For their time, participants will have the option of receiving a \$15 gift certificate or having a \$15 donation made on their behalf to a suicide organization of their choosing.

If you are interested in learning more about or participating in this study, please contact Kat McConnell by email at [kat.mcconnell@marquette.edu](mailto:kat.mcconnell@marquette.edu) or by phone at 314-

607-4835. If you know other individuals who may be interested in participating in this study, please pass along this information to them.

Thank you,

Kat McConnell, M.A.

## Appendix B: Demographic Form

Age: \_\_\_\_\_

Gender: \_\_\_\_\_ Pronouns:

\_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_

Years Since Loss: \_\_\_\_\_

Types of Psychotherapy Used (circle all that apply): Individual Counseling

Teletherapy/Virtual

Counseling

Group Counseling/Support

Group

Crisis Counseling

Other

\_\_\_\_\_

How long did you attend suicide loss-focused therapy (as opposed to therapy

focused on other concerns)? \_\_\_\_\_

Type of Mental Health Practitioner (circle all that apply)

Counselor

Marriage & Family

Counselor

Clinical Social Worker

Psychiatrist

Unsure

Other \_\_\_\_\_

### Appendix C: Screening Form

Instructions: Thank you for your interest in participating in this study on psychotherapy experiences of individuals who have lost friends to suicide. In order to determine if you are eligible to participate, please fill out the following form. Please let the researcher (Kat McConnell) know if you have any questions about this form.

<b>Please check one:</b>	<b>Yes</b>	<b>No</b>
1. A friend who I had a meaningful relationship with died by suicide.		
2. My friend died by suicide over 1 year ago, but not more than 10 years ago.		
3. I was at least 18 years old when my friend died by suicide.		
4. I have used psychotherapy services (ex: individual counseling, crisis counseling, teletherapy, group therapy, support groups) since my friend's suicide.		
5. My friend's suicide was a primary focus of therapy (i.e. something I talked about frequently with my therapist).		
6. The psychotherapy services I used were led by a mental health professional (ex. counselor, psychologist, clinical social worker).		
7. I am currently living in the United States.		



## **Appendix D: Informed Consent**

MARQUETTE UNIVERSITY

AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS

### **Exploring the Psychotherapy Experiences and Therapeutic Needs of Adults Grieving the Suicide of a Friend**

**Kat R. McConnell, M.A.**

**Department of Counselor Education and Counseling Psychology**

You have been invited to participate in this research study. It is important that you read and understand the following information. Participation is entirely voluntary, and you may withdraw at any point. If you have any questions before agreeing to participate, please contact the researcher.

#### **Purpose:**

- The purpose of this research study is to explore the psychotherapy experiences and therapeutic needs of adults who have experienced the suicide of a friend with whom they had a meaningful relationship.
- By investigating this issue, other mental health providers may be better informed on how to provide effective care to individuals experiencing suicide bereavement.
- You will be one of approximately 10-15 participants in this research study.

#### **Procedures:**

- You will be invited to participate in an interview via phone or video conference, during which you will be asked a series of questions about your experiences with suicide bereavement and psychotherapy.
- You may be contacted for a brief follow-up interview to clarify or confirm your answers from the first interview.

- You will be audio recorded during the initial interview for the purposes of transcribing your answers. Five (5) years after the study is complete, the recording and transcript will be disposed of. For the purposes of confidentiality, your name will not be included on the recording and any other identifying information will be redacted from the transcript.

**Duration:**

- The interview portion of the study will last approximately 60-120 minutes. The follow-up interview will last no longer than 30 minutes.

**Risks:**

- The risks associated with participation include discomfort when discussing difficult topics, including grief and suicide. You are not required to answer any questions or discuss any topics which make you feel uncomfortable or unsafe.
- The researcher will have a list of mental health resources available to any participants who are interested.
- Although your privacy is very important, if you talk about actual or suspected abuse, neglect, or exploitation of a child or elder, or if you talk about hurting yourself or others, the researcher or other study team member must and will report this to the Bureau of Milwaukee Child Welfare, the Wisconsin Department of Children and Families Services, or law enforcement agency.

**Benefits:**

- There are no direct benefits to you for participating in this study.
- This research may benefit the mental health field by contributing research on providing psychotherapy services to those experiencing suicide bereavement.

**Confidentiality:**

- Data (including interviews and surveys) collected in this study will be kept anonymous.

- All data will be assigned a code number rather than the participant's name or other information that could identify the participant. A key containing the names and ID numbers of participants will be kept in a secure and locked location.
- The data collected in this study will not be used or distributed for future research.
- Audio recordings will be secured and stored on the password protected flash drive in the locked office of the principal investigator.
- When the results are published, participants will not be identified by name. Direct quotes collected during interviews may be used.
- The data will be destroyed by shredding paper documents and deleting electronic files within 5 years of the completion of the research study.
- Your research records may be inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies.

**Compensation:**

- You will have the choice of receiving a \$15 gift-card or having a \$15 donation made on your behalf to a suicide-related organization of your choice.

**Voluntary Nature of Participation:**

- Participating in this study is completely voluntary and you may withdraw from the study and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled.
- If you chose to withdrawal from the study, your data will be destroyed and discarded.
- You may skip any questions you do not wish to answer.
- Your decision to participant or not will not impact your relationship with the investigators or Marquette University.

**Alternatives to Participation:**

- There are no known alternatives other than to not participate in this study.

**Contact Information:**

- If you have any questions about this research project, you can contact the principal investigator, Kat McConnell via email: [kat.mcconnell@marquette.edu](mailto:kat.mcconnell@marquette.edu) or by phone: (314) 607-4835, or her dissertation chair and faculty advisor, Dr. Lisa Edwards via email: [Lisa.edwards@marquette.edu](mailto:Lisa.edwards@marquette.edu) or by phone: (414) 288-1433.
- If you have questions or concerns about your rights as a research participant, you can contact Marquette University's Office of Research Compliance at (414) 288-7570.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.

Participant Name (Printed) \_\_\_\_\_

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Principal Investigator Name (Printed) \_\_\_\_\_

Principal Investigator Signature \_\_\_\_\_ Date \_\_\_\_\_

## Appendix E: Interview Protocol

Thank you for agreeing to participate in this interview about your experiences seeking psychotherapy services related to suicide loss of a friend. I am very grateful for your time and your willingness to contribute to this research study. During this interview, I will ask you a series of questions about your experience with grief, your experience with psychotherapy, and your recommendations on how to improve therapy for other survivors.

There are no right or wrong answers to the questions I will ask you. I am interested in your honest opinions and experiences, good or bad. Some questions may be difficult to answer or bring up hard feelings or memories. If you are ever uncomfortable answering a question, you are free to skip it. You may also stop this interview at any point with no penalty.

For the purpose of this study, *psychotherapy* will refer to support services led by a mental health professional and *suicide survivors* will refer to individuals who are grieving the loss of someone to suicide.

1. Please describe your relationship with the friend you lost to suicide.
2. In what ways did your friend's suicide impact you (i.e. emotionally, mentally, socially)?
3. What prompted you to seek therapy?
  - a. How soon after the suicide did you seek therapy?
  - b. How did you get connected with the services you used?

- c. Did you have presenting concerns other than suicide loss when you began therapy?
4. Please describe the type of therapy you received (i.e. group, individual, etc.).
  - a. How long did you attend therapy focused on suicide loss?
5. How was your suicide loss addressed in therapy?
  - a. What techniques or strategies were used?
  - b. Was suicide loss the primary focus, or did you spend time on other concerns?
6. Please describe the way(s) in which therapy has changed your grief experience, if any.
7. If you could do it over again, what would you have wanted to be different about your therapy experience?
  - a. What was most helpful about your therapy experience?
    - i. How was your therapist most helpful (ex. therapeutic style, techniques used in therapy)?
    - b. What was the least helpful about your therapy experience?
      - i. Was there anything your therapist could have done differently to improve your therapy experience?
  - c. What advice would you give for mental health therapists working with suicide survivors like you?
8. Do you have any advice for other survivors seeking therapy?
9. Why did you decide to participate in this study?

## Appendix F: Resource List

*If you feel at risk of harming yourself, please call 911 or contact the National Suicide*

*Prevention Hotline: 800-273-8255*

### Information about Suicide Loss:

- American Foundation for Suicide Prevention: “I’ve Lost Someone” - <https://afsp.org/ive-lost-someone>
  - AFSP’s “I’ve Lost Someone” webpage provides information and resources for suicide loss survivors.

### Psychotherapy Services:

- Suicide Awareness Voices of Education: “Find a Support Group” - <https://save.org/what-we-do/grief-support/find-a-support-group/>
  - SAVE.org provides an interactive map of suicide loss support groups across the country.
- Alliance for Hope: Counseling Consultations - <https://allianceofhope.org/find-support/counseling/>
  - Alliance of Hope provides FREE virtual consultations to help suicide loss survivors access psychotherapy services in their area.

### Online Support:

- Alliance of Hope: Community Forum - <https://allianceofhope.org/find-support/community-forum/>

Alliance of Hope offers an online community forum for suicide loss survivors to discuss their experiences and support one another. The forum is moderated by a mental health professional.