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Exploring the complexities of suicide bereavement research

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Abstract

Statistics indicate a projected increase in the number of suicides by those in receipt of mental health services in England. Research has also shown that the impact of suicide on individuals who have lost someone to suicide have an increased risk of poor physical and mental health, including a higher risk of suicidality. However, research within suicide bereavement is limited due to the lack of methodologically robust studies involving those bereaved through suicide. This paper will offer an overview of current debates in the suicide bereavement literature and discuss a forthcoming qualitative study that will examine the impact of suicide by those in receipt of mental health services on their families. The current research will utilise a constructivist grounded theory approach. Analysis of the data will include a process of coding and comparison, leading to theory generation. This study aims to contribute to knowledge of the impact of suicide on family members (where the deceased was in receipt of mental health services) and how to provide effective post-intervention support for these particular families.

1. Introduction

Research examining the impact of suicide on family members and friends has been limited. The latest statistics for suicide published by the Department of Health (DH) in 2014, estimate a 13% increase from 2010 to 2011, with figures anticipated to rise from 1,175 to 1,333. These statistics are based on individuals who were in receipt of mental health services the year prior to their death. Acting on this growing issue, the most recent national suicide prevention policy by the DH, outlines current developments in public policy which advocate a need for introducing

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strategies to target the increase of suicide (DH, 2012). A recent addition to this strategy acknowledges the impact of suicide within family and communities, and the importance of including information and support not only for close friends and family members, but also those who are indirectly related, including health professionals. This policy further highlights that those affected by the suicide of a loved one, may be at a higher risk of mental health problems including suicidality. Therefore, recommending a need for effective and timely practical support to assist the grieving process and promote the recovery of individuals affected by suicide. Determining the exact number of individuals in a person's social network who are affected by a suicide is difficult to establish from current literature, with approximations varying from 6 individuals to 100 people (Cerel, Padgett, Conwell, & Reed, 2009). Despite this uncertainty, the increase in suicide numbers confirms that more individuals will be exposed to and affected by a suicide in the near future.

Internationally, suicide figures published by the World Health Organization (WHO, 2014) reported approximately 804,000 suicides in 2012. It is important to acknowledge that under-reporting of figures may occur in some countries where suicide is still classed as illegal, as well as the contentiousness of recording a death as suicide. The WHO further adds that globally, suicide is attributed to 50% of violent deaths in men and 71% in women. In terms of suicide prevention within the international context, WHO advocate that communities can prove to be a useful resource in providing social support to individuals at risk of suicide, as well as supporting bereaved individuals.

Whilst it is acknowledged that a wealth of information in this area exists, this paper will only aim to highlight current debates within grief and bereavement research literature, specifically in relation to suicide. Accepting that a comprehensive literature review is beyond the scope of this paper, the focus will be on the complexities in suicide bereavement research, and draw attention to gaps in knowledge in understanding the experiences of those who have lost someone to suicide. This paper will also introduce a forthcoming empirical study which will aim to understand the impact of suicide on family members, where the deceased was in receipt of mental health services prior to their death.

1.1. Conceptualising key terms

In order to contextualise key debates within suicide bereavement literature, it is necessary to conceptualise key terms. Reviewing empirical literature within suicide research has uncovered disagreement and difficulties amongst researchers in operationalising key terms. In particular, providing a term to describe individuals who have lost someone to suicide has brought much contention (Cutcliffe & Santos, 2012). Emerging suicide bereavement literature has proposed the term 'suicide survivor' (Jordan & McIntosh, 2011), which describes a "person who has lost a significant other (or a loved one) by suicide, and whose life is changed because of that loss" (Andriessen, 2009, p.43). Whilst most researchers agree with this definition (Farberow, 2005), Andriessen (2009) outlines limitations of the definition and also recognises that using the term suicide survivors can be confused with someone who has survived a suicide attempt. Suicide survivor was also originally used to include only family or relatives of the deceased, however, recent research now includes individuals who may not be related or closely linked with the deceased, but may have been in some way affected by the suicide such as friends for example (Cutcliffe & Santos, 2012). It is, therefore, not clear who in a person's social network would be considered to be a suicide survivor. However, for the practical purpose of this paper, suicide survivor will be used to describe someone affected by a suicide, and it is a term widely used and accepted in literature.

Zisook and Shear (2009) further discuss difficulties in conceptualising other key terms in this research area such as 'bereavement', 'mourning, and 'grief'. They argue these terms are used interchangeably and fail to recognise the subtle differences in meanings. They define 'grief' as "the emotional, cognitive, functional and behavioural responses to death", and describe 'mourning' as the "behavioural manifestations of grief, which are influenced by social and cultural rituals, such as funerals, visitations, or other customs" (Zisook & Shear, 2009, p.67). Furthermore, Bereavement is described as "the objective reality of a loss" by Klein and Alexander (2003, p.261).

Although, there is much debate surrounding terminology in this research area, 'postvention' is one definition widely agreed upon in practice and researchers in bereavement literature. Postvention refers to the support or interventions put in place to address reduce the risk of any negative consequences experienced by individuals as a result of the suicide (Parrish & Tunkle, 2005, p.89). Even though many of these terms have been critiqued in research, they are frequently used in the bereavement literature, thus are the chosen definitions drawn upon for this current study.

2. Normal and abnormal grief

There are also debates in bereavement literature about distinctions between 'normal grief' and 'pathological grief' (Stroebe, Von Son, Stroebe, Kleber, Schut, & Van den Bout, 2000). There is strong support within the bereavement research to not medicalise 'normal' grief, which is seen as an adaptive response to a potentially stressful event (Klein & Alexander, 2003). Similarly, discord amongst researchers persists in classifying symptoms associated with 'abnormal' grief as a mental disorder. Psychiatric disorders such as complicated grief have been used to diagnose individuals whose grief experience may be more intense or prolonged compared to normal grief (Stroebe, Stroebe, & Schut, 2002). Similarly, acute grief, integrated grief, prolonged grief (Young, et al., 2012) and traumatic grief (Prigerson et al., 1999) are terms frequently used to describe abnormal grief.

This lack of consensus amongst researchers has resulted in challenging discussions about the advantages and disadvantages of classifying pathological grief as a mental disorder. Incorrectly labelling individuals with a mental disorder could marginalise individuals further through the negative connotations associated with a mental illness such as stigma or shame (Shear et al., 2011). In contrast, Horowitz et al (1997) argue that unless complicated grief, for example, is classified as a mental disorder, clinicians and researchers will fail to meet the needs of those bereaved. What is clear from the literature is that challenges are being made to existing assumptions of grief and bereavement and there is now acceptance of the wide variations in bereavement experiences (Rothaupt & Becker, 2007).

3. Suicide grief experiences

Although a considerable amount of research has been carried out on general bereavement, research on suicide bereavement is limited, especially with studies exploring families of someone who committed suicide whilst in receipt of mental health services (Grad, 2005). Jordan (2001) discusses whether the experiences of this sub group of suicide survivors is distinctive from other types of bereavement. For example, the relationship between the deceased and suicide survivor may have been unstable and difficult, especially when the deceased may have attempted suicide previously. Contrary to the assumptions that all suicide survivors are bereaved, Jordan (2001) suggests that the completed suicide may bring relief to some suicide survivors, resulting in complex and conflicting emotions contributing to a different bereavement experience. It has been suggested that when the deceased had been diagnosed with a psychiatric illness, the impact of their death may make it easier for those bereaved to understand and accept the death. (Young et al, 2012).

A review of existing suicide bereavement studies has the found literature to be contradictory and inconsistent in terms of understanding the differences and similarities in the experiences of suicide survivors as compared to those bereaved through non-suicide deaths (Cvinar, 2005). A number of mitigating factors have prevented further research within this area. For example, researchers have to overcome the many challenging ethical and moral difficulties of research in suicide bereavement. Researchers may struggle in seeking ethics approval from research ethics committees who may regard suicide survivors as vulnerable (Grad, 2005). This could account for why the majority of studies in this area have been quantitative in nature. Furthermore, previous clinical studies in this area have been criticised for a lack of robust methodological designs due to small sample sizes, lack of control groups, and selection bias with suicide survivors (Andriessen & Krysinska, 2012). The majority of general bereavement studies have implemented quantitative self-reporting questionnaires to measure symptoms of depression, anxiety and other

psychiatric disorders, which although insightful, fail to extract the qualitative elements of bereavement (Jordan, 2001). Additionally, bereavement studies have been found to focus on the symptomology of grief, rather than the underlying experience of grief (Rothaupt & Becker, 2007). Some recent qualitative studies have recruited suicide survivors from bereavement support groups. As these individuals are already engaged in receiving support, participants may be more likely to share their experiences and, therefore, may not be representative of suicide survivors as a whole (Toller, 2011), It is consequently argued that suicide survivors not engaged in bereavement support groups should be involved in research (Toller, 2011).

A literature review by Cvinar (2005) investigated the differences of the grief experience between people bereaved through suicide and non-suicide deaths. Discussing the differences in grief experiences, Cvinar (2005) found that suicide survivors were at an increased risk of psychological problems and stigma which could deter them from participating in research. Similarly, some suicide survivors were more likely to disassociate themselves from their social support, relationships and networks in an attempt to distance themselves from the suicide event and ensuing stigma. Consequently, these factors can discourage suicide survivors from participating in suicide bereavement studies.

Whilst some research indicates no difference in the bereavement experiences, other studies oppose this view and suggest the grief experience of suicide survivors could be qualitatively and quantitatively different from non-suicide grief owing to different feelings of guilt, shame, blame and stigma (Gaffney & Hannigan, 2010; Cvinar 2005; Peters, Murphy & Jackson, 2013). Although not all suicide survivors may experience stigma (Gall, Henneberry, & Eyre, 2014), suicide is deep rooted in historical legal and religious contexts which still to some extent influence how society perceives the act of suicide and attitudes towards suicide survivors (Parrish & Tunkle, 2005). Additionally, suicide survivors have also identified complex feelings of rejection, isolation, abandonment and anger, which can have a negative effect on the process of healing and coping with suicide (Young et al., 2012). Missing warning signs or a sense of failure in preventing the suicide for some suicide survivors can severely impact their bereavement experience (Peters et al., 2013). Similarly, for some suicide survivors, a strong desire to find answers to why someone would die by suicide is also reported, thereby adding to the already complex process of bereavement (Hawton & Simkin, 2003).

An empirical study carried out by Bailley, Kral and Dunham (1999) sheds light on the unique experiences of suicide bereavement compared to individuals bereaved through non-suicide deaths. Using a quantitative methodological approach, a large sample of 350 participants completed a number of self-reported grief experience questionnaires. Participants were separated into groups according to whether the death was anticipated or unanticipated and categorised into those who were bereaved through suicide and non-suicide deaths. Examples of anticipated death included death as result of terminal illness and unanticipated death included sudden death, for example caused by accidents. Statistical analysis of the data found similarities and disparities in the grief experiences of suicide survivors and those bereaved through non-suicide deaths. Marked differences for suicide survivors included a strong sense of responsibility for the deceased's death as well feelings of rejection, shame and stigma (Bailley et al., 1999).

Evidence that suicide survivors may experience serious psychosocial effects is offered in a review by Andriessen and Krysinska (2012). Drawing on empirical studies relating to issues on suicide bereavement and postvention, these authors provide strong evidence that suicide bereavement could potentially have long lasting implications for their health. Many studies have reported that suicide survivors who have lost an immediate family member are at a higher risk of suicidality, complicated grief and depression (De Groot & Kollen, 2013). Jordan (2001) also suggests that the suicide of a close relative in the family unit may be result in a more detrimental impact on family functioning and relationships compared to death by non-suicide means. Similarly, a review by Young et al (2012), ascertained that suicide survivors are more likely to experience anxiety, depression, posttraumatic stress disorder and complicated grief, increasing the risk of poorer physical and mental health. Whilst accepting that the focus of

most grief work has been used to address the negative consequences of bereavement, Wortman and Boerner (2011) contend that there is an obligation for researchers to understand whether positive emotions are felt by individuals in adapting to life after suicide. These positive emotions can include individuals feeling greater self-confidence, empathy for others in a similar situation and independence (Wortman & Boerner, 2011).

4. Key factors affecting grief reaction

Although grief theories are inherently integrated into bereavement studies, it should be noted that in-depth discussions of traditional grief theories such as stage, task or linear models are not covered in this paper. Criticisms of linear and stage grief models include imposing assumptions on how individuals should grieve (Schuchter & Zisook, 1999) and influence clinicians in their bereavement work (Worden, 2003). With limited evidence to substantiate the effectiveness of traditional western based grief theories, these models have been comprehensively utilised in grief therapy without accommodating western and non-western cultural responses to bereavement (Valentine, 2006). Moreover, postvention activities formulated from a western philosophical framework can be ineffective in addressing the needs of culturally diverse groups who may require more culturally appropriate interventions reflecting their cultural background (McDaid, Trowman, Golder, Hawton, & Sowden, 2008). According to Rothaupt & Becker (2007), understanding normal and adaptive responses to grief within different cultural contexts is important in generating knowledge within this area.

Recognising the uniqueness of each suicide survivor's experience and in particular their lived experience is proving to be critical within this area (McKinnon & Chonody, 2014). From a psychological perspective, studies examining lived experiences have generally focused on the internal grief processes and their impact on the bereaved individual, but applying a sociological lens can capture how the individual's social and cultural context can have a strong influence on their grief process (Pietila, 2010). The grief process for those who are bereaved can also be affected by the depth of attachment with the deceased, the strength of the individual's social networks, the point in the bereaved person's and deceased person's life when the suicide occurred, and the bereaved person's cultural and religious affiliation (Parris, 2011). Any underlying psychological conditions that the bereaved individual may have such as depression can negatively add to the grief experience (Gerrish, Dyck, & Marsh, 2009). Conversely, the mode of death can impact the grief experience, more so if the death was sudden, unexpected or traumatic and especially where the bereaved was exposed to the deceased's body after the suicide (Klein & Alexander, 2003).

Exploring whether gender influences the grief experience is debated quite frequently in research, with studies showing women are more likely to share their grief experiences, whereas men are less likely to express their grief (Rothaupt & Becker, 2007). However, the trend in suicides indicates men are more likely to die by suicide than women, and this could explain why more women access these services (Mann 2002). Undoubtedly, limited empirical evidence demands further investigation into how gender, age, familial bond and strength of attachment with the deceased influence the suicide survivor's experience (Andriessen & Krysinska, 2012).

5. Postvention services and support

Suicide survivors have access to a variety of postvention services including General Practitioners, bereavement support groups, individual counselling, group therapy (Hawton & Simkin, 2003), and psychotherapy (Pietila, 2010). Recent developments have seen suicide survivors use the internet as a means of on-line support through virtual peer support networks (Rawlinson, Schiff, & Barlow, 2009). Whilst it is difficult to determine why some suicide survivors access particular interventions, bereavement support groups for example can provide a forum which is supportive, cathartic, compassionate and non-judgemental for those who wish to share their experiences with others going through a similar event (Pietila, 2010). Furthermore, studies have also shown that specialist and psychological treatments such as cognitive behavioural therapy (Young et al., 2012) can to some extent provide relief to those who are experiencing intense or complicated grief (Klein & Alexander, 2003). Similarly, pharmacotherapy can also

prove useful in helping suicide survivors cope with the grieving process, although criticisms towards medicating suicide survivors suggest it can hinder the grieving process for some individuals (Klein & Alexander, 2003). Considering the diversity of suicide survivors and their experiences, some professional or community based interventions can negatively impact some suicide survivors. Criticisms of formal interventions include their use of a blanket approach in providing generic support for suicide survivors, which by ignoring cultural or individual differences can potentially be more harmful in some cases (Cerel et al., 2009). In addition, it is acknowledged that some strategies created and led by health professionals or clinicians may be unable to meet the identified needs of suicide survivors. It is thought that some clinicians fail to fully understand the process of suicide bereavement (Peters et al., 2013). The fear of being judged or stigmatised by health professionals can also prevent suicide survivors in accessing postvention support (Trimble, Hannigan & Gaffney, 2012).

Lack of professional services or appropriate support from professionals and clinicians has also been suggested as obstacles for suicide survivors in accessing help (Peters et al., 2013). An insightful small qualitative study by McKinnon and Chonody (2014), explored postvention support used by people bereaved through suicide, and examined what support suicide survivors used, how useful this support was for them as well as what they felt were their unmet needs. It also highlights which professionals and services the suicide survivors came into contact with. Analysis of the data within a phenomenological framework highlighted two themes relating to immediate support and ongoing support raised as concerns by suicide survivors. Immediate support provided to suicide survivors included emergency services and personnel, as well as the Coroner's Office, funeral directors and early intervention professionals. Fundamentally, most participants reported that there were inconsistencies in support provided but especially poor support from the Coroner's Office whilst awaiting an outcome of their investigation. A lack of compassion and consideration from the Coroner's Office resulted in frustration and potentially contributed negatively to grief experiences as well as prolonging the bereavement process. Similarly, participants implied that some healthcare professionals lack the expertise or confidence in supporting bereaved individuals, due to their own inexperience and limited knowledge in recognising the diversity and uniqueness of the suicide experience (Buglass, 2010).

In relation to the theme of ongoing support, McKinnon and Chonody (2014) identified that participants described their mental and physical ailments resulting from the grief as preventing them from accessing postvention support. These included lack of energy, heightened anxiety, difficulty sleeping, intense periods of crying and depression. Additionally, factors impeding participants from utilising ongoing support included the difficulty in finding these services as well as poor availability of local services. The few participants who accessed peer support groups found the process of sharing their stories and listening to others distressing, thereby discouraging them from continuing this support. In contrast, other participants who used peer group support benefitted from the mutual understanding and support it offered (McKinnon & Chonody, 2014). Adding to this debate, research into the efficacy of bereavement support groups suggests they can be helpful in providing advice to suicide survivors in dealing with the practicalities of everyday life post suicide (Young et al., 2012). Participants suggested an early supportive response to suicide survivors would be beneficial, especially from public sector professionals who may have first contact with the bereaved person. Also, they recommended that early postvention support should be consistent, accessible and easily available to reduce any negative grief experiences (McKinnon & Chonody, 2014).

In their study, Trimble et al (2012) reported that their participants utilised community based interventions after the suicide such as support from their communities and support groups rather than from professional support. Clearly, some suicide survivors may prefer to access non-clinician or professional led sources of support, including their own social networks, self-help support groups, religion or spirituality (Klein & Alexander, 2003). Individuals most likely to access bereavement support groups are those who want to share their experiences with others who can truly empathise with their situation (Young et al, 2012). A minority of suicide survivors may also become activists in campaigning, lobbying and advocacy in suicide prevention initiatives, thereby channeling their grief into practical ways of raising awareness with others and wider society (Cerel et al., 2009).

Evidence does show that for some suicide survivors, social support networks can be effective which consist of family members and close friends (Fiegelman, Gorman, & Jordan, 2009). These networks can provide the bereaved individual with emotional and practical support after the suicide, especially soon after the suicide (Trimble et al, 2012). However, the difficulty arises when individuals do not have strong social support networks, in which case there is a demand for professional or community based bereavement services (Murphy, 2000). Moreover, the distressing nature of suicide may make it difficult for the suicide survivor to discuss the death with people from their wider social network such as neighbours and community (Begley & Quayle, 2007). In some cases, suicide survivors may feel isolated when people from their social network and community who previously provided them with support, begin avoiding them or withdrawing from them leaving them feeling isolated (Trimble et al, (2012).

Undoubtedly, there is still a need for further suicide bereavement studies in determining the effectiveness of postvention services including support groups and how they make use of their own resources such as their social networks to deal with the suicide (Andriessen & Krysinska, 2012). The importance of implementing long term studies to examine the efficacy of postvention support for suicide survivors is also essential, for example with individuals experiencing complicated grief (Wittouck, Van Autreve, Portzky, & Van Heeringen, 2014). Understandably, some suicide survivors may feel that they do not need to access interventions or share their problems with others, but they may use alternative methods of dealing with their emotions by self-medicating, overworking, alcohol or substance misuse (Grad, 2005). Evidently, recognising the individual differences in bereavement processes is important in identifying, designing and implementing effective preventative interventions for those at risk of health related issues as a result of bereavement (Breen & O'Connor, 2007). As McKinnon and Chonody (2014: p.238) state, "individuals react differently to the distinct feelings associated with a death by suicide, which in turn means that they will require different coping strategies. Hence, they will have different support need".

6. Rationale for qualitative empirical study

Accepting that the impact of suicide on families can result in a complex and a unique suicide experience, addressing some of the gaps in suicide bereavement research provides a need for further investigation. Studies involving suicide survivors who are not accessing recognised postvention support such as through on-line peer support, bereavement support groups for example is also necessary (Trimble, Hannigan, & Gaffney, 2012). Their experiences and expertise can inform more appropriate support for bereaved others, especially in early intervention support (McKinnon & Chonody, 2014). Previous studies have indicated that suicide survivors not accessing early postvention support are at a higher risk of experiencing personal distress, or developing complicated grief, anxiety and depression (McKinnon & Chonody, 2014). Without targeted postvention support or support from their communities, some suicide survivors report feeling vulnerable, leaving them isolated, withdrawn and having to deal with their own internal conflict, grief and loss (Cvinar, 2005).

Emergent research in suicide bereavement strongly supports valuing the individual's choice in how they wish to grieve, but "until the importance of bereavement care is fully recognised, provision will continue to be haphazard with adverse consequences for the bereaved" (Parris, 2011, p.151). More specifically, Young et al (2012, p.184) state, "while the field of suicide bereavement research is growing, there remains a need for more knowledge on this psychological sequelae of suicide bereavement and its treatment in general". However, suicide survivors are not a homogenous group, so researchers need to be attentive to the variability in unique grief experiences, which cannot be generalisable to all suicide survivors (Bailley et al., 1999).

Given the competing viewpoints and relative lack of empirical studies in suicide bereavement, this research aims to understand the impact of suicide on families where the deceased was in receipt of mental health services in the 12 months prior to their death. The objectives of the study include exploring the experiences of suicide survivors and identifying their individual needs in the aftermath of suicide. In addition, further objectives include exploring

suicide survivors' perceptions of the service support which they and the suicide patient received and to investigate health professional's perspectives on how suicide survivors deal with this event. A final objective is to generate and evaluate proposals for improving services for suicide survivors.

Taking into account methodological weaknesses in existing research and the lack of qualitative studies, a qualitative methodology will be used to provide a narrative of suicide survivors' experiences (Hardiman, 2004). A qualitative approach involving interviewing suicide survivors can add a deeper understanding and offer a unique perspective on subjective experiences, rather than based on assumptions about what is considered a normal grief process (Rawlinson et al., 2009). Moreover, suicide survivors can discuss their needs and what support they think would be useful for others in a similar situation (Peters et al, 2013). Carverhill (2002) report that suicide survivors who have previously participated in suicide bereavement research, have described the interviewing process as being beneficial when talking to strangers. Additionally, a qualitative approach may also highlight other areas requiring further research, which may previously have been overlooked (Carverhill, 2002). To acknowledge multiple perspectives in this research, health professionals who have been involved with the recruited families will also be individually interviewed if prior consent from the families has been given. These health professionals will be asked to discuss their professional experience and perceptions of the needs of the family, how the family has dealt with suicide and the support offered. This will provide an understanding of how they view the needs of suicide survivors, which is important in developing appropriate services and support. As Wortman and Boerner (2011, p.312) state, "it is less clear, however, whether the accumulation of research findings has filtered down to clinicians or other health care providers working with the bereaved, to potential support providers of the bereaved, or to the bereaved themselves."

The theoretical underpinning of the proposed research is social constructivism, which fundamentally explores an individual's social construct of the world in order to examine the phenomena being researched (Gergen & Gergen, 2003). Charmaz (2007) states that understanding how an individual's knowledge is constructed is important, and data elicited by investigating their interactions with others, their cultural influences, surroundings, social practices, realities and language. Charmaz (2007) further adds that by exploring an individual's actions and meanings in a particular situation can help the researcher in developing a theory based on their interpretation. Symbolic interaction is also an important dimension within social constructivism and considers the communication between individuals such as language, focusing particularly at how individuals interpret their meanings, feelings, and attitudes (Crotty, 2012). An added element in constructivist grounded theory is recognising the researcher's role in interpreting data through reflexivity, as Charmaz (2007) points out we all have assumptions and knowledge which influences our research. Constant comparative analysis will be used in this study (Strauss & Corbin, 1991), which essentially involves coding verbatim transcripts typed up from the interviews. Text will be organised through comparing data for similarities and differences and categorising them. Each category is then given a label or code. Data will be coded on concepts, theories, social and psychological processes, and meanings rather than descriptions with the goal being the generation of theory (Charmaz, 2007).

As each subsequent interview is analysed, it will be compared with the themes identified from analysis on previous interviews which will highlight similarities or differences within these themes. The process continues as new areas are identified which may need to be examined further, and these emerging hypotheses will again be checked in the research field using theoretical sampling to interview new participants. This means that changes may be made to the interview guide to research further participants where necessary in order to check or test emerging theories. practical ways of raising awareness with others and wider society (Cerel et al., 2009).

7. Conclusion

For suicide survivors, barriers in accessing postvention support may include not being aware of available support services, stigma, culturally unresponsive interventions, poor quality, inadequate and inappropriate services, as well

as unsupportive health professionals and services. However, the fact remains that the majority of suicide survivors are not engaged in any type of postvention or support, but may be receiving support which they would not necessarily classify as such. This, therefore, raises the important question of how they deal with the experience of suicide bereavement.

Whilst accepting that disparities in suicide bereavement literature exist, evidence strongly supports the fact that suicide survivors are at an increased risk of developing physical ill health, poor mental health, psychiatric disorders and suicidality. In order to provide effective interventions and support for suicide survivors, a deeper understanding of their experiences, support needs and coping strategies is required which is the principal aim of this empirical study. There is some evidence supporting the effectiveness of some postvention activities to enable suicide survivors in negotiating the complex process of suicide bereavement, the evidence is limited and the efficacy of postvention services remains disputed.

The outcomes of the empirical study will be published for health professionals and organisations, leading to an increased understanding of how family members or 'suicide survivors' deal with suicide and how best to support them. Essentially this learning must be reflected in research, policy planning, clinical practice and timely services to improve support available to suicide survivors with individualised, targeted and effective support in order to reduce possible negative health implications.

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