

The Lived Experience of Adults Bereaved by Suicide

A Phenomenological Study

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Abstract. In recent years, a plethora of research studies have attempted to delineate the grief experiences associated with suicide from those of other sudden traumatic deaths. The emerging consensus suggests that bereavement through suicide is more similar than different to other bereavements, but is characterized by the reactions of shame, stigma, and self-blame. The causal nature of these reactions has yet to be fully understood. This study reports on the lived experiences of eight adults bereaved by suicides, which were obtained through in-depth interviews. Data were analyzed using interpretative phenomenological analysis. Four main themes dominated the relatives' grief experiences. First, the early months were checkered by attempts to "control the impact of the death." The second theme was the overwhelming need to "make sense of the death" and this was coupled with a third theme, a marked "social uneasiness." Finally, participants had an eventual realization of a sense of "purposefulness" in their lives following the suicide death. Overall, the findings suggest that suicide bereavement is molded and shaped by the bereaved individual's life experiences with the deceased and their perceptions following social interactions after the event. The findings from this study suggest that "meaning making" may be an important variable in furthering our understanding of the nuances in suicide bereavement.

Keywords: suicide bereavement, grief, social interactions, meaning making, and support networks

Introduction

Suicide is a serious problem in Ireland having grown from a relatively low rate in the 1960s to a convergence with European rates in the mid 1990s with the male suicide rate having doubled in the past 20 years (National Suicide Review Group, 2002). For example, in 1980 the rate of suicide was 6.4 per 100,000 compared to 11.5 in 2002, which is now reflected in approximately 400 individuals, predominately young males dying by suicide each year in Ireland (Central Statistics Office, 2003; National Suicide Review Group 2003). It has been suggested that for every suicide death a minimum of six individuals are deeply affected by this traumatic event (Shneidman, 1969). This means that, in Ireland, at least 2,400 parents and siblings face the task of making sense of a sudden and premature loss of life each year. Our understanding of the grief process associated with suicide has yet to be fully articulated and consensus in the international research literature has yet to be reached as to whether such bereavement is quantitatively different from bereavement following other forms of traumatic

death (Jordan, 2001). Recent thinking suggests that suicide bereavement is possibly more "similar than different" to traumatic deaths such as those from sudden infant death syndrome (SIDS), auto immune deficiency syndrome (AIDS), or accidental deaths (Bailey, Kral, & Dunham, 1999; Dyregrov, Nordanger, & Dyregrov, 2003; Jordan, 2001). There is however, agreement that psychological processes such as an ongoing search for meaning, blame, guilt, rejection, and a perceived lack of social support are distinguishing factors in suicide bereavement (Clarke & Wrigley, 2004; Ellenbogen & Gratton, 2001; Knieper, 1999). International studies have indicated that individuals bereaved by suicide continuously search for meaning in the death (Allen, Calhoon, Cann, & Tedeschi, 1993) and feel embarrassed about it (Sequin, Lesage, & Kiely, 1995). It has also been reported that for the suicide-bereaved experience there is considerable within-group variation in grief experiences and subtle components such as shame need further investigation (Bailey et al., 1999; Sequin, Lesage, & Kiely, 1995). However, few studies have reported on how the bereaved have described their experiences in the aftermath of a family suicide.

Table 1. Biographical details of participants

Participant	Gender	Age	Occupation	Relationship to deceased	Gender of deceased	Age of deceased at death	Method of suicide
1	M	66	Manual worker	Father	Male	21	Hanging
2	F	27	Teacher	Sister	Male	21	Hanging
3	F	29	Psychologist	Sister	Male	21	Hanging
4	M	52	Clerical worker	Father	Male	18	Hanging
5	F	50	Nurse	Mother	Male	18	Hanging
6	F	72	Care asst./Ret	Mother	Male	23	Shooting
7	F	47	Care asst.	Sister	Female	47	Hanging
8	M	37	Businessman	Brother	Male	26	Shooting

Grief is a painful experience and making sense of a suicide death is known to be a very difficult process for the bereaved (Wertheimer, 1991). The trajectory and intensity of grief will depend on a number of variables: whether the predeath relationship with the deceased was conflictual (Samy, 1995), if the act was anticipated (Bailey et al., 1999), and whether the survivors perceived a sense of social support (Callahan, 2000). It is thought to be difficult because the bereaved have to negotiate their own inner world after the death and also because they have to negotiate sociocultural norms (Dunne, 2000; Minois, 1999). Findings from quantitative research suggest that many factors may impact on the suicide-bereavement experience. The collective influences of prior medical, relational, biological, and social factors on suicide all underscore the individualized story in suicide bereavement (Beautrais, Joyce, & Mulder, 1997; Cullen & Connolly, 1997; Makinen, 2002; Platt & Hawton, 2000; Williams & Pollock, 2002). Yet, few qualitative studies have reported on the lived experience of the bereaved, possibly reflecting the fact that it is difficult to access this population (Dyregrov et al., 2003). Given that those bereaved by suicide are a high risk population for completed suicide, the need to provide appropriate and effective support networks has been acknowledged (Clarke, 2001; Turecki, 2001). This concern is aptly echoed in the often quoted dictum "postvention is prevention for future generations" (Shneidman, 1969).

In Ireland, a network of voluntary support groups called *Living Links* has recently been established in order to provide practical assistance and social support to adults bereaved by suicide (Begley, 2003). The premise for such networks is that adults bereaved by suicide require assertive outreach support and access to other survivors in order to cope with the deliberate self-inflicted death of a relative. The aim of this study was to describe the bereavement experiences of adults whose relative had died by suicide and to explore challenges faced in coping after the death. These stories of grief provide insight into the type of issues that voluntary and statutory organizations may consider when offering support to persons bereaved by suicide.

Method

Participants

Recruitment to the study was through the *Living Links* voluntary support network that makes available practical homecare support for up to 8 weeks to individuals or families bereaved by suicide. In addition, the *Living Links* network provides an 8-week structured group program to suicide-bereaved adults to facilitate healing through the sharing of stories in small groups.

Individuals who had contacted or who were supported by the *Living Links* voluntary support networks were provided with written details of the research initiative by the organization's coordinators. The network coordinator advised those that accessed their networks that family members or other suicide-bereaved persons known to them, who may not have accessed *Living Links*, were also invited to participate. The coordinator obtained the name, telephone, and details of persons willing to participate or who were interested in further information. These were forwarded to the researcher. Eight adult participants, three males and five females, were recruited (see Table 1).

Of these, six had received support from the *Living Links* support programs. Five had attended the healing program and one had received six individual support sessions at their home. Two adults had not accessed the support services and had been advised by family members and by a neighbour about the study. All but one resided in the rural environs and all participants were bereaved between 3 and 5 years. In-depth face-to-face interviews of 2 to 3 h duration were held in the bereaved persons' homes and included three males and five females with an age range of between 27–72 years.

Interviews

To elicit the personal story of death a discussion guide was developed following a review of the international research literature on suicide bereavement and the findings of a regional survey undertaken as part of this study. Aspects of

Table 2. Discussion guide for participant interviews

Demographics

Participant's age, marital status; level of education; occupation; who living with?

The Deceased's Story

1. Can you tell me about your loved one, what were they like?
2. What was their mental and physical health like?
3. Tell me about when the suicide happened?
4. Was there any event or something significant that you feel may have happened to them before they took their life?
5. Who or what did you feel was responsible for the death?

Relationship with the Deceased

6. Can you tell me about your relationship with _____
7. Was there anything in _____ past that would have made you understand the death?

The Impact of the Death

8. Grief affects individuals in different ways. How would you describe its impact on you personally?
9. How did it impact on your family?
10. How did people react to you after the suicide?
11. When you think about the death what is most in your mind about yourself?
12. Have these views changed over time?
13. What way do you see your future now?

grief experienced by the various individuals and the quality of support received were explored. Questions also investigated the meaning individuals had made of the death and of their life after the death (see Table 2). The researcher conducted six interviews: four individual, one joint interview with parents, and a final interview was with a father and his two daughters.

The interview schedule consisted of open-ended questions but encouraged a degree of flexibility according to the different stories of loss. Permission was sought to record the interviews using 90 min cassettes so as to allow for minimal disruption. All tapes were coded with a number and no personal details (surname or address) were recorded. Each interview focused on the "story of the death" and elicited information concerning the personality and life of the deceased. It also probed relationships with family members, the wider community, and why participants felt the death had occurred. The second aspect of the interview encouraged the interviewee to elaborate on how the death impacted on their lives and what helped them to cope. Questions also investigated how they responded to the suicide and what meaning the person took from the untimely death. The final aspect of the interview probed the person's view of life, of society, and what perspectives they had about their own life since the death. The same process was used for all six interviews. Ethical approval was obtained from the Regions Ethics Committee to carry out the study within a catchment area in Ireland comprised of a population of approximately 350,000.

Data Analysis

Interpretative phenomenological analysis was utilized to explore the "lived experience" as taped during the interviews (Smith, Jarman, & Osborn, 1999). As a study of peoples' experiences, phenomenology assumes that there is an underlying structure and core meaning to shared experiences and that these can be unearthed (Patton, 1990). Based on the guidelines given by Smith et al. (1999) a thematic analysis was undertaken by listening to audiotapes and repeatedly reading individual transcripts noting the significant issues communicated, the similarities, and differences. Each taped transcript was typed verbatim and a pseudonym assigned to each participant interviewed. In each typed transcript every sentence was then given a number (using the word processor) with individual lines within the sentence given an alphabetical code (by hand). Thus, for each interview the excerpt could be identified by the pseudonym (e.g., Esther), the number of the sentence for example (24) and the line (c). In order to ensure an audit trail, the key points and themes noted were then given a title that best represented its communication and these were noted in the margins. When each series of interview files were completed all the themes that emerged from the eight interviews were listed on a blank page and these were then listed under three headings:

- "deceased's life before the suicide"
- "the early months after," and
- "adjusting to life without the deceased."

The initial themes were then clustered together into five subthemes that best described the lived experience of the participants (Table 3). Validity checks were then undertaken where each subtheme was repeatedly examined against the consistency of its appearance within the data set (Nadeau, 2001).

Table 3. Clustering of initial subthemes

Physical sequel – confusion, loss of sleep, numbness, panicky, nightmares, attempt suicide.

Cognitive sequel – feelings of unreality, loss of control, fear, black hole, blame, shattered, anger, reaching a crisis point, guilt, blame, changed as a person, worrying about God.

Trying to understand – reviewing deceased's childhood, checking lifestyle & habits, influence of friends, reviewing suicide event, reviewing personality of deceased, checking for stressors, trying to understand motive for suicide, questioning if depressed, ruminated about personality flaw, denying the deliberateness of the suicide

Social interactions – protecting information, feeling different, loss of social activity, let down, talking more, social groups, stigma, support groups, bonding, feeling marked, avoiding people, changes in communication in family, sharing part of views

Attachment to deceased – talking to the deceased, sensing the deceased, describing the deceased, motive for death, looking for signs of depression, suicide not deliberate, not done to hurt survivor.

Living in the present – new interests, altruism, world different, spiritual reason for suicide, new roles, attending other suicide funerals, support groups, safe, understood, changed lives

Table 4. Master themes and their source

Master themes	Arising from
<i>Controlling the impact of the suicide</i>	Numbness, avoidance of sharing feelings, protective, watching other family members, fearful of further suicides, responding to suicide attempts, changes in communication patterns, being careful of what is said and avoiding former social activities.
<i>Making sense of the suicide</i>	Searching for reasons why the suicide happened, questioning the prior relationship with deceased, feelings of guilt and blame. Reviewing the deceased character, looking for external stressors, the motive for suicide, re-viewing the suicide act.
<i>Social uneasiness</i>	Needing support but felt let down by friends and community. Feeling marked by suicide, upset by people's responses, self imposed social isolation. Protective about details of suicide when asked, feeling understood and safer with others that are bereaved by suicide
<i>Purposefulness</i>	The death had changed how life is viewed, a feeling that their lives are totally changed and that the deceased is now helping them. Engaging in new activities, role in helping others.

Results

The researcher then reviewed these six subthemes against each of the eight main transcripts in order to reflect on what the participants were saying and how they reflected their experiences as told in their story. The subthemes were, thus, regrouped into four master themes that the researcher felt best reflected the structure of the data set (see Table 4).

The first master theme "controlling the impact of the suicide" describes the immediate reaction of participants when they discovered that their relative had killed themselves. The early months were a time of intense pain, distress, fear, and turmoil, for both the individual and the family as a whole. The impact of the suicide on the family system was controlled in two ways. Participants assumed the role of "protector," watching for fear of more suicides occurring in the family, while siblings became "peacekeepers." Parents said that they needed to engage in "safety behaviors" because they were so very frightened and worried about further suicide occurring among surviving children.

"We walked on egg shells . . . it's the fear that's the worst . . ."
(Donal: 81a, b).

They managed this fear by adopting a watchfulness strategy with their children. Donal kept up a nightly vigil

"for three months every night, at 1:00, 2:00, and 3:00 in the morning and looking in to see was he (other son) alright"
(Donal: 81c, d).

On the other hand, siblings avoided expressing their feelings to parents, as they did not want to upset them. The reluctance to share feelings freely within the family related to the fact that participants grappled with a sense of personal blame for not having prevented the death and they had felt guilty.

"Why he did it, is there something I should have noticed, something I should have done? I have talked about this to () and she talks to her brothers and sisters but I can't do that yet"
(Grainne: 82, c).

Closing ranks to "outsiders" for support and not freely communicating within the family meant that individuals

felt stressed and found it difficult to cope with everyday living. Siblings felt compelled to bring their "inner world" of despair into the family system and this helped them. Aine mentioned how her younger son expressed the impact of his brother's suicide on him:

"He arrived up . . . with these tackie laces around his neck and he was absolutely hysterical" [long pause]. "I went over and I caught that cord around his neck and stayed up all night . . . but he began to get better after that." (Aine: 163e, f, g, & h).

In the early months, participants also went through different bereavement experiences at different times, and this had been very difficult for them. The researcher interpreted that the difficulty arose because these feelings were observed rather than shared:

"I found it very hard myself, I would listen to the girls being very bitter at times, their father saying nothing, and I felt like screaming . . ." (Esther: 177, h).

Thus, the emotional reality that a loved one had deliberately left the family was not openly acknowledged at this point. The eventual outcome was that younger participants were unable to cope with their own turmoil. They subsequently had broken rank, engaged in self-harm behaviors, or had sought professional support. Once the impact of the suicide was eventually acknowledged participants seemed to have moved from having to control overwhelming anxiety toward a more active searching mode.

The second master theme "making sense of the suicide" described how participants tried to make sense of the suicide. They achieved this by ruminating about the predeath demeanor of the deceased and about the events that led up to the actual act of suicide. The compelling factor that was noted in the transcripts was that participants needed to match the deliberateness of the suicide to what they believed about the world, about themselves, and their loved one. This task was very difficult for them. The deliberateness of the suicidal act was discrepant with their beliefs about a predictable world. They tried to integrate the experience of suicide into their schemas about life by considering how the death fitted into what they already knew about the cause of suicide:

"But I can accept there was something in [] for whatever reason, depression or something out there that led him to do that. Maybe something we didn't know about, something in his personality type, there was something in []'s personality that he went and did it" (Cathy: 94, b, c).

Participants had also tried to match their preestablished beliefs about their relationship with their deceased relative by reasoning that their relative would not intentionally hurt them. They had met with as many people as possible who may have known about the last moments of their relative's life in order to make some sense of the suicide. For example, Martin had reflected on what he knew about his son's personality, what he believed about his son's intention, and what may have caused the death in order to accommodate the experience of the suicide:

"you are thinking that [] did this because there was something in there that caused him to do it. He could not have been in his right mind, as we know him so I don't think he betrayed our trust by doing that, he was going through whatever pain and wouldn't set out to hurt us deliberately" (Martin: 46 e, f, g).

Irrespective of the how the suicide occurred, and how it fitted into some participants' frame of reference, the deliberateness of the act meant that some participants blamed themselves for failing to prevent the death. This was because they believed they failed to notice signs of suicide risk:

"I think the worst thing was not having prevented it, why didn't I see something, why didn't I spot it." (Grainne: 194, a).

It was not surprising that this self-blame was qualified. The participant intimated that in reality it is very difficult to see signs of risk:

"I didn't understand at the time, I should have done something" (Rita: 67a).

Another strategy employed in making sense of the death was the mental undoing of the events leading up to the death. In this way, participants began a journey that pointed to an incremental process of integrating the reality of the suicide and the possible motivation for the act. Esther had assimilated the reality of the death over time by thinking of past situations and gradually taking in new information:

"you stop and you think of new things all the time" (Esther: 86a).

The majority of participants had formed the view that the suicide was an impulsive act, where a single event became overwhelming, putting the deceased in a "no choice" situation. They had searched for a trigger, an event that had caused a relative to take their life even if a loved one had a mental illness. Aine and Cathy had mulled over the motivation for their relatives' deaths. These women had concluded that it was not depression or a mental illness that precipitated the death. They believed that some specific situation occurred that was just too much for them to bear at the time:

"I don't know why, we'll never know why but with [], I'd say somebody hurt his feelings that night and he wasn't guilty of anything and he just couldn't take it cos that's the type of person he was, he wasn't depressed or anything like that, no definitely not" (Aine: 136.b, c).

The sequel to participants engaging in this sense-making activity was that they eventually, albeit at different times and in different ways, began to personalize the situation. Esther personalized her son's self-killing and had felt that the suicide was a breach of trust. She had felt both abandoned and guilty for failing in her role as a mother:

"All I wonder about is why didn't my son trust me enough to say, mam, look what I got that I will always say, why didn't he tell me, the whys, did he not trust me his mother enough . . . that is my only regret" (Esther: 106, f).

Without doubt, making sense of the suicide was a complex process and not necessarily undertaken in a linear fashion. The picture that emerged from participants was that meaning-making occurred in the context of seeking out the story of death, then matching prior beliefs about the person to a possible cause of death while protecting their sense of self in the process. It was done slowly. Meaning-making occurred in the context of putting the suicide aside and living through daily routines of work. When unplanned events such as funerals occurred, they were reminded about the suicide. This meant that they found themselves having to respond in some small way to questions about the suicide and they had, for a period, returned their thoughts to the death.

The third master theme represents participants' experiences in meeting people after the suicide. It emerged that participants felt very uneasy in social interactions. Social interactions resulted in much inner unease because the participant's had constantly ruminated over their own and others' reactions. Participants had responded differently when they had met people. Grainne had controlled her conversations when she interacted with others outside the family. This was because she felt it was the only way she could manage overwhelming feelings. To her the suicide was a private family matter:

"I am not at the end of my grieving process probably so I don't really want to start talking about it. I will, if brothers and sisters ask" (Grainne: 182a, b).

Cathy also believed that access to her experience of the suicide was privileged information. She felt that not everybody had the right to know. She had not shared her story as she felt she would be judged so she regulated other people's participation in her grief:

"I won't tell others that he died by suicide. Its privileged information if you say he committed suicide. I suppose its fear of people's presumptions or what they would automatically assume or judge, so I wont give that information for people to do that" (Cathy: 83a,b).

Immediately following the suicide most participants had

felt supported by their communities. However, once the suicide mass was over they found that friends abandoned them and acted uneasy around them. Esther's experience was that she had been treated with "kid gloves" (Esther: 67, a).

The suicide made participants so uneasy in social situations that they also avoided usual social activities. Peter was so disabled by his brother's suicide that he never actually returned to going to the pub or to the GAA matches, usual activities before the suicide:

"My life is changed in the line of going out here and there, I am not interested in any type of (social) things or matches or anything like that" (Peter: 54a,b).

The impact of this loss of social support was somewhat reduced when the bereaved were made aware in advance that people could avoid them. Because of prior warning, Martin was able to cope with the rejection he experienced socially even when he detected that people were uneasy when they met him:

"But I thought it was very important to be made aware of it. There is this priest I know for years and a very holy, good priest if he ever comes near me he goes away from us. But because [a neighbour who was bereaved by suicide] had told us this would happen, I understood . . ." (Martin: 86, a, b, c).

The consequences of the social uneasiness was that Peter joined the Living Links suicide healing support group and this resulted in him feeling less vulnerable as he could identify with people: "everybody understood the next because it was all suicide people" (Peter: 102,a). Martin found he was at ease in the support group. He was able to disclose his private self because he felt safe and understood. This was in contrast to the uneasiness he had felt in social interactions with the wider community:

"I would not be able to talk to them people the same as I would with someone who has been bereaved by suicide. So I think suicide (suicide bereavement support) should be kept separate" (Martin: 132d, e).

The fourth master theme reflects the participant's personal experiences about how the suicide had changed their lives. This change was mostly positive and had resulted in a sense of "purposefulness." Seven of the participants, two males and five females, all spoke about how much they had changed. They shared how they eventually found meaning in life after the death. For Martin this change was a permanent one:

"it changed our whole family, our life, nothing ever will be the same again" (Martin: 75a).

Many participants described a change in terms of life's priorities. After the suicide they developed a tendency toward helping others who were vulnerable. The purpose and meaning in life came from taking action as opposed to philosophical questioning. Participants had resorted to doing new things, which they believed only occurred because

they had experienced a suicide death of a relative. Rita said she was a different person:

"I have done things that I never would have done." (Rita, 48a)

Siblings in particular, noted positive changes among each other over time. Before the death, Cathy would rarely have "frank discussions" with her older brother but since the suicide she describes him as:

"[] has changed so much since the suicide, he is much more open now." (Cathy: 151, a).

Of note, purposefulness was most often associated with a continual "magical attachment" to the deceased. Events such as house sales, acquiring new ideas, making important decisions and getting general assistance with day-to-day social tasks were attributed to the deceased person's continual supportive involvement in their lives. The attachment meant that participants had adapted to a life without the physical presence of the deceased and it was achieved by maintaining a "mental" bond with the deceased. Martin made a distinct decision not to sever his relationship with his son but decided to cherish it:

"But if you mean moving on, that I move on that some day I won't be relying on [] in my life, no or I never want to. I don't think I ever will and I have no goals set to do that and I wouldn't like to. I am happy, it's a wonderful feeling for me, and I am closer to []" (Martin: 123 d, e, f, g, h, I, j, and k).

Discussion and Conclusion

During the review of the transcripts it was seen that participants did not necessarily move from one stage to another through the four themes. The initial chaos, trying to control the impact of the suicide, and fear of more suicide deaths was the most clearly demarcated period. This period had mainly occurred in the first 12 months of bereavement. All the participants' narratives attest to the experiences of numbness, disbelief, physical sickness, fear, and panic, outcomes that bear a striking resemblance to posttraumatic stress responses. Of note, is that the physical and cognitive reactions that occurred mirror other empirical evidence on coping with traumatic experiences (Chung, Farmer, Werrrett, Easthope, & Chung, 2001; Foa & Herst-Ikeda, 1996; Janoff-Bulman, 1992). Some researchers have suggested that the presence of intense symptoms shortly after a loss does not necessarily indicate disturbance or emotional problems (Boelen, van de Bout, & van den Hout, 2003). These findings imply that information about what emotions the bereaved can expect, and provision of training in stress management techniques and adaptive coping strategies may be of real value to the bereaved in the immediate aftermath of the suicide.

Once participants began to search for meaning, they experienced much difficulty both socially and interpersonal-

ly. Participants had expectations of others that they perceived were not met. They sensed that friends, neighbors and the wider community were uncomfortable around them and failed to understand that they also had real difficulties in communicating to others about the suicide death. A number of studies have reported this phenomena indicating that the unease is associated with feelings of shame and guilt, unique features in suicide grief compared with bereavements by other traumatic deaths (Harwood, Hawton, Hope, & Jacoby, 2002; McIntosh, 1993; Reed, 1993; Van Dongen, 1993). However, participants in this study had, themselves, avoided social interactions as they needed to control their own overwhelming emotions, which in turn reinforced their belief that other people had changed in their behavior toward them. Although there were different degrees of social unease reported among the participants it was the extent of the inner turmoil that modulated the level of social interactions with the wider community. From this perspective it seems likely that Sequin et al.'s, (1995) contention was correct when they posited "that there may be a feedback loop between social and psychological dimensions that is extremely important in suicide bereavement" (p. 496).

Although participants reported that they were able to find a purpose in the suicide death, they did not communicate that they had moved on from the suicide. Instead, the majority of the participants were deliberately living in the shadow of the suicide 5 years after its occurrence. However, unlike stage theories of grief, making sense of the suicide and sensing some purpose in the death did not occur in a linear fashion. Participants had engaged in what other researchers have noted is a reappraisal back and forth between stories of the deceased and the suicide event in order to make sense of and cope with the suicide (Davis, Noelen-Hoeksema, & Larson, 1998; Stroebe & Schut, 1999). Many of the participants explained how their lives had changed, which resulted in them engaging in new behaviors. What was striking was that the participants had chosen not to relinquish their attachments to the deceased but believed that their loved one continued to have a role in their families' lives. It could be interpreted that the bereaved had not accepted the deliberateness of the death and were coping by retaining their relatives in an altered life-purpose within the family. Whether this behavior is indicative of a complicated grief, as recently highlighted in the research literature, needs further illumination (Prigerson et al., 1999; Mitchell, Kim, Prigerson, & Stephens, 2004).

The majority of participants in this study had attended general bereavement support networks. However, they believed that they only understood their reactions to the suicide death when they met with others who were also bereaved by suicide. They believed that suicide support should be exclusive to those who had the lived experience of suicide, as those who did not have a personal experience of suicide could not fully appreciate its overwhelming impact on a relative's life. They also felt that the sharing of stories in the suicide bereavement group helped them make

sense of their loved one's death and they felt understood. Neimeyer (2000) has argued that meaning-making occurs in the context of "sense-making" and later "benefit-finding." It would be interesting to investigate the social construction of grief and how meaning-making evolves in the context of support groups. This is an area that is under-investigated in the suicide bereavement literature.

Finally, what relevance have these findings in terms of understanding bereavement following suicide deaths? Unequivocally, suicide bereavement occurs within the context of a combined interpersonal and social landscape that oscillates between appraisal of the suicide act and engaging in the task of day-to-day living. The bereaved are challenged by their inner interpretation of the loss in the context of their prior relationship with the deceased. In this study, the willingness and ability to accept support or engage in social interactions was modulated by the individual's perception about the death and cultural notions regarding suicide deaths. The suicide death was a powerful social force on participants, regulating their engagements in social pathways and attachment to suicide bereavement groups. The findings from this study indicate that a greater understanding of the meaning-making process in suicide bereavement is warranted, while the use of qualitative research designs may be essential if researchers are to elicit the important details in suicide bereavement.

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