

MIDLANDS STATE UNIVERSITY



FACULTY OF SOCIAL SCIENCES  
DEPARTMENT OF PSYCHOLOGY

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**APPROVAL FORM**

The undersigned certify that they have read and recommended to Midlands State University for acceptance of a dissertation entitled:

**Experiences of bereavement and coping strategies among people who have lost their significant others to suicide.**

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**FACULTY OF SOCIAL SCIENCES**

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**RELEASE FORM**

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TITLE OF DISSERTATION: EXPERIENCES OF BEREAVEMENT AND COPING STRATEGIES AMONG PEOPLE WHO HAVE LOST THEIR SIGNIFICANT OTHERS TO SUICIDE.

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## **DEDICATION**

This synopsis is for my family especially my late parents. Through your pressure and motivation I made it. I also dedicate this dissertation to all my young cousins. I would not have made it without my family and my friends' support. Thank you so much. Lots of love.

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## **ABSTRACT**

Suicide is one of the leading cause of death around the world. All age groups are targets of suicide. Major causes of suicide are depression, mental illness and even different life constraints. Pesticides, guns, poison and hanging are some of the other risk factors to suicide. The study reviewed that even though research has been done on suicide a blind eye has been paid to the experiences of people bereaved by suicide hence the purpose of this study. The qualitative approach was used in this study and the Interpretive Phenomenological Analysis was used to analyse data. Snowballing and Purposive sampling were used as sampling techniques to obtain data. Interviews were used as a method of data collection. Data was collected from ten participants who were bereaved by suicide directly and indirectly. A few expenses were made while conducting the study as participants were within the author's reach. However, it was difficult to get many participants for the study. The study outlined that people bereaved by suicide suffer emotionally (guilt, blame, fear, etc.), behaviourally (lack of concentration, physical reactions, crying etc.) and socially (stigma, family disintegration, etc.) in their lives. However, they try by all means to survive through coping strategies like counselling, spirituality and having available social systems in the form of family or friends to enhance the bereaved's psychological wellbeing. The study also identified recommendations that can be done to help people bereaved by suicide and how the bereaved can also cope with their lives fully.

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## **List of Acronyms**

AAS – American Association of Suicidology

ABS – American Bureau Statistics

AFSP – American Foundation for Suicide Prevention

APA - American Psychiatric Association

IPA – Interpretative Phenomenological Analysis

NAASP – National Action Alliance for Suicide Prevention

NSPA – National Suicide Prevention Alliance

OECD – Organisation for Economic Co-operation and Development

PTSD – Post-traumatic Stress Disorder

SOSAD – Save Our Sons And Daughters

SPA – Suicide Prevention Australia

SPINZ - Suicide Prevention Information New Zealand

WHO – World Health organisation

## **CHAPTER 1: INTRODUCTION**

### **1.1 Introduction**

This chapter reviews the recent literature describing and assessing the experiences and coping strategies of people bereaved by suicide to be explored in the research. The presentation is achieved through giving the background of the study, statement of the problem, purpose of the study, research questions, significance of the study, assumptions, delimitations of the study, limitations of the study and definition of terms. This will help to bring to light what suicide is, who 'suicide survivors' are, the statistics and risk factors of suicide and lastly the bereavement experiences.

### **1.2 Background of the study**

Schneidman (2005) defined suicide as an intentional death, a self-inflicted death which one makes an intentional direct and conscious effort to end one's life. According to World Health Organisation (2004), suicide is the act of deliberately killing oneself. Among the Shona, suicide is felt to be a most unnatural death (Laubscher in Mangena, 2012a). The Shona explain its rare occurrence as due to an angry spirit (ngozi) of a person who was murdered who visits the guilty family in search of revenge, causing one death after another until the family agrees to compensate the bereaved one. Therefore, suicide is also prevalent in African societies.

Suicide rates have increased tremendously across the world. According to Organisation for Economic Co-operation and Development (OECD) (2017), suicide rates are defined as the deaths deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome. Statistically each year, nearly one million people die by suicide globally, the equivalent of one death every 40 seconds (WHO, 2010). Over the last 45 years, suicide rates have increased by 60% worldwide (WHO, 2010). The suicide rate for the world as a whole is estimated at 11.6 per 100 000 inhabitants. Suicide is considered one of the most important causes of death worldwide by the WHO (2002), particularly in young and middle aged people and young men. According to the American Foundation for Suicide Prevention (AFSP) (2016) for every woman who dies by suicide, four men die by suicide but women are three times more likely to attempt suicide. The male-female ratio of suicide is estimated to be highest in the European region (4%), Africa (0.5%), South East Asian region (1.9%) and East Mediterranean (1.1%) (Varnik, 2012).

Suicide rates differ in respect of age, and according to AFSP (2017), in 2015, the highest suicide rate (19.6%) was among adults between 45 and 64 years of age. The second highest rate (19.4%) occurred in those 85 years or older. Younger groups have had consistently lower suicide rates than middle-aged and older adults. In 2015, adolescents and young adults aged 15 to 24 had a suicide rate of 12.5% (AFSP, 2017). Suicide rates by race or ethnicity in 2015 was highest amongst the Whites (15.1%), the second highest rate (12.6%) was among American Indians and much lower and roughly similar rates were found among Hispanics (5.8%), Asians and Pacific Islanders (6.4%) and Blacks (5.6%) as recorded by the AFSP (2017).

Knowledge about suicide and suicide attempts in Africa is important. According to Mars et al (2014) findings from other reviews suggested that suicide is an important public health issue in Africa, with reported figures highly likely to underestimate the true incidence. Crude estimates suggested there are over 34 000 suicides per year in Africa with an overall incidence rate of 3.2 per 100 000 populations (Mars et al, 2014). Literature based estimates for specific countries were most discrepant from GBD estimates for South Africa (higher), Zimbabwe (lower), Uganda (lower), Malawi (lower) and Tanzania (lower) as noted by Mars et al (2014).

According to WHO (2014) suicide deaths in Zimbabwe have reached 2 281 or 1.79% of total deaths and suicide rate among men is about four times higher than that among women. The Newsday (2015) reported that the Zimbabwean National Statistics Agency records indicate a worrisome trend in the increase of suicides over the last few months. A research carried out by Varume Svinurai/Vukani Madoda (2015), a non-governmental organisation revealed that 55% of suicide cases in Zimbabwe were committed by men.

Any discussion of suicide, a serious public health, will be incomplete without taking into consideration the perspective of the bereaved, or in other words, the 'suicide survivors' (WHO, 2002). Suicide survivors have to cope with serious and long lasting psycho-social sequelae of the loss, including increased risk of suicidality. For every death by suicide, there are at least 6 bereaved people left behind (American Association for Suicidology, 2004), deeply impacted by the loss. The friends and family commonly referred to as 'survivors,' remain faced with the challenge of coping with this tragedy. McIntosh (2003) defined suicide survivors as "the family members and friends who experience the suicide of a loved one" (p. 146) and Andriessen (2009) defined a survivor as "a person who has lost a significant other

(or a loved one) by suicide, and whose life is changed because of the loss” (p. 43). Jordan and McIntosh (2011) in their definition acknowledged the wide range of experiences of the bereaved: “a suicide survivor is someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person” (p. 7).

People bereaved by suicide often experience complicated bereavement. Krysinska (2003) documented that some bereavement experiences are ‘more intense or unique to suicide’ (p.213). However, other studies suggest that suicide bereavement involves qualitative differences as compared to other bereavements, that the bereavement process involves different aspects, contains unique themes (Jordan, 2001), is often more complex and takes longer to “move on” (Fielden, 2003). These studies suggest that elements such as shame, blame, guilt, and stigma are often more present in the process of suicide bereavement than bereavement from other causes. Additionally, survivors may exhibit higher levels of problematic grief and heightened risk for physical and/ or mental health complications, including suicidal ideation (Mitchell et al., 2004).

There can be many other feelings in addition to grief including shock, social isolation, anger, search for meaning and guilt. Jordan & McIntosh (2011) have proposed a framework encompassing various levels of grief reactions. According to this framework, in suicide bereavement one can recognize reactions present in bereavement after all types of death, such as sorrow and yearning to be reunited with the deceased, reactions characteristic for bereavement after unexpected deaths, e.g., shock and sense of unreality about the death, and elements of bereavement after violent deaths, e.g., trauma of finding a mutilated body and shattered illusion of personal invulnerability.

In addition to these shared reactions, suicide survivors experience features which seem unique to suicide bereavement, such as anger at the deceased for “choosing” death over life and the feeling of abandonment. There is also accumulating clinical and empirical evidence pointing to the existence of subgroups of suicide survivors. For example, it has been reported by Sveen and Walby (2008) that survivors’ reactions differ as a consequence of previous history of suicidality of the deceased and the expectation of death. The often sudden and sometimes unexpected nature of death can also be extremely traumatic for those who lived with or knew the person. In addition to the mix of emotions, bereavement following suicide often contains a prolonged search for an explanation for the person’s death (Clark, 2001).

This can make the grieving process more complex and draining, as often no one can never really be certain of what the person was thinking or feeling when they chose to end their life. The search for an understanding of the suicide often leads us to think more deeply about our relationship with the person and can make the loss even more profound.

Bereavement following a suicide is different for everyone but usually leads to adjustments in one's life and the way in which one views themselves and relationships with others (Andriessen, 2009). Postvention can be defined as "activities developed by, with or for suicide survivors, in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behaviour" (Andriessen, 2009:43). As such, postvention strategies aim to tackle the needs of the bereaved, and can be operationalized from two complementary perspectives: the clinical perspective, i.e., the perspective of mental health professionals and services, and the public health perspective of policy development and general population strategies. With such facts in mind, it can be noted that death by suicide has greater impacts on suicide survivors (family and friends) therefore support and therapeutic resources should be available for these people.

### **1.3 Statement of the problem**

The loss of a loved one to death is widely recognized as a challenging stressor event, one that increases risk for the development of many psychiatric conditions (Jordan, 2001). When a loved one dies by suicide, the impact on anyone who was close to the person can be intense and overwhelming and can leave one deeply saddened. Several studies have confirmed that exposure to the suicide of a loved one is associated with an elevated risk of suicide completion in survivors Jordan (2001). Crosby and Sacks (2002) reported that people who had known someone who died by suicide within the past year were 1.6 times more likely to have suicidal ideation, 2.9 times more likely to have suicidal plans, and 3.7 times more likely to have made a suicide attempt than those who did not. At the same time suicide survivors might be consumed by guilt, wondering if they could have done something to have prevented their loved one's suicide and facing lots and lots of questions and what ifs (Jordan, 2001). Suicide bereavement becomes an issue that needs to be addressed since it affects many people. The current study only focuses on the causes and risk factors of suicide as well as victims of suicide (those who have attempted suicide). The impact it has to the people left behind has been paid a deaf ear leaving people bereaved by suicide alone, with no one to share their experiences with which has made people not to understand much about suicide.

#### **1.4 Purpose of the study**

The purpose of the study is to understand feelings of suicide survivors as well as to have knowledge on how to behave with a person who has lost a loved one from suicide. According to the American Association of Suicidology (AAS) (2004) there is considerable evidence that survivors feel more isolated and stigmatised than other mourners and may in fact be viewed more negatively by others in their social network. Many members of the community do not know how to help, and therefore avoid contact with the bereaved, a response that Dyregrov (2003) has labeled “social ineptitude” in the network. Krynska (2003) says it is important to be patient with survivors and to let them speak at their own pace. It is also better to use the name of the loved one who committed suicide rather than saying ‘he’ or ‘she’, so as to acknowledge that the deceased was a real person. This will comfort the survivors.

According to SOSAD (2010) caring and supporting a loved one who has been bereaved by suicide can be difficult. But even by just being there and offering a listening ear and a shoulder to lean on, you can help. It is very important for relatives, friends and the larger community to support people through the grieving process (SOSAD, 2010). Those bereaved by suicide need, at some time or other, the opportunity to talk about the suicide and the person who died. The support of friends and relatives can make a huge difference to the bereaved person’s capacity to manage their grief. The study also aims to educate people on suicide and come up with interventions to help those bereaved by suicide so that those bereaved by suicide have much of an opportunity to discuss their grief as other bereaved people.

#### **1.5 Research Questions**

- a) What are the emotional challenges faced by people bereaved by suicide?
- b) What are the behavioural challenges faced by people bereaved by suicide?
- c) What is the impact of suicide on social relationships?
- d) What are the coping strategies or post-traumatic growth after suicide?

#### **1.6 Significance of the study**

Despite a growing number of resources for survivors, failing to successfully intervene may have detrimental effects. If suicide survivors are not initially helped, the resulting grief and “psychache” may eventually precipitate further suicides. The significance of the study is to actively listen without judgement, criticism or prejudice to what the survivor says. Krynska

(2003) suggests that in order to provide the most beneficial support, listeners must put aside any preconceived notions they may have about suicide. This study also aims to reduce stigma by educating the general public about suicide which will help in understanding what suicide survivors go through. Although people may feel uncomfortable discussing suicide and its aftermath, survivors of loved ones endure great pain and are in need of compassion.

### **1.7 Assumptions**

Many assumptions have been raised pertaining death by suicide. One of the assumptions is that there is stigma associated with suicide. Suicide survivors are not supposed to talk openly about the cause and nature of death. There is a stigma attached to suicide, partly due to the myths surrounding it therefore suicide survivors face challenges in trying to cope with the loss of a loved one. Another assumption is that the discussion of suicide is a taboo subject especially in relation to other forms of death. The suicide survivors often find it difficult to admit that their significant other died by suicide, and people are uncomfortable talking about the suicide with survivors. Eventually, those bereaved by suicide have less of an opportunity to discuss their grief compared to other bereaved people.

### **1.8 Delimitations**

- The research will only be carried out in Nehosho Suburb because it is accessible.
- The study will focus on the bereavement experiences faced by suicide survivors.
- The study will only focus on people who have lost their loved ones to suicide for information.

### **1.9 Limitations**

- Suicide survivors may not feel comfortable talking about the death of their loved one.
- The survivors may withhold information pertaining to the death of a significant other.
- Survivors may fear coming out and talking openly due to the stigma from the society which may hinder information collection.

### **1.10 Definition of terms**

- a) Bereavement – the process of mourning a loved one.
- b) Grief – emotions experienced during mourning.
- c) Suicide – self kill or self-inflicted death.

d) Suicide survivors – relatives or friends who have lost their loved ones or significant others to suicide (people bereaved by suicide).

e) Postvention – needs that are considered to be vital for those bereaved by suicide to cope with their situation.

### **1.11 Chapter Summary**

This chapter was an introduction to the study and the primary focus of research. Through the background of the study, purpose of the study, significance of the study, key terms to be used in the study and the problem statement the main aspects of the research were presented to bring to light what the study entails and what it seeks to achieve.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 Introduction**

Death by suicide is very hurtful and ignites so many negative effects on those bereaved by suicide. Mourning after a suicide can become a profoundly isolating experience, one that may have a significant and quite deleterious impact on the survivor's relationships with family and friends. Cerel, Jordan, and Duberstein (2008) have noted three types of communicational distortion that may occur in families and social networks after a suicide. These include the development of blame for the suicide, the perceived need to keep the suicide a secret (particularly from children and people outside the family), and social ostracism and self-isolation among survivors. The emergence of angry blaming can severely impact the cohesiveness of a family and should be considered a significant warning sign of family distress after a suicide. Likewise, the choice to keep the nature of the death a secret may distort other areas of family intimacy and warp longer-term developmental processes in the family.

### **2.2 Causes and risk factors of suicide**

Suicide is something that is difficult to explain and accept so there are many causes and risk factors. According to the Financial Gazette (2015) evidence pointed out to a third year male electrical engineering student at the University of Zimbabwe who recorded a video on how he wanted his estate should be distributed and that his body be cremated and also a Midlands State University student who also committed suicide by drinking a poisonous substance in front of the institution's administration block but these cases were just a tip of the iceberg because some of the cases have gone unreported to really come up with an exact figure of suicides in Zimbabwe (The Herald, 2017). Different methods are used in committing suicide. According to Mars et al (2014) predominant methods for suicide are hanging, use of firearms, medicine overdose, and alcohol overconsumption, drugs overdose, drowning, burning, jumping, and cutting leading to extensive bleeding. According to them, in countries like Zimbabwe, South Africa and Namibia medicine overdose is a common suicidal method whereas in Uganda use of pesticides is marginally common. Mars et al (2014) note that antidepressants, antimalarials and psychotropic medications were most frequently used medications for suicides. In Zimbabwe most people hang themselves and people in rural areas self-poison themselves with agricultural pesticides (Financial Gazette, 2017).

Risk factors are those characteristics associated with suicide and according to the CDC they could be a combination of individual, community, relationship and societal factors. According to Mars et al (2014) mental health problems were reported to play a role in up to 11% of suicides. Physical health problems were reported, for example in Tanzania, the rate of HIV was double amongst those who died by suicide when compared to the national prevalence for sexually active adults. Alcohol and/ or drug use was a prominent risk factor, with one study reporting that alcohol was involved either directly or indirectly in as many as 80% of suicides (Mars et al, 2014).

Studies in South Africa also found that approximately 40% of individuals who died by suicide tested positive for alcohol on blood assays. Mars et al (2014) also posit that interpersonal and social difficulties including family conflict, friendship or relationship problems and unwanted pregnancies also lead to suicide. The Herald (2017) reported that most cases of suicides among women are tied to domestic problems with infidelity being at the top. However, the increase of suicides in Zimbabwe are also linked to social constraints and economic hardships as well as psychological problems leading to violence and suicides (The Herald, 2017).

### **2.3 Challenges faced by people bereaved by suicide**

People bereaved by suicide face different behavioural, emotional and social challenges. According Jordan and McIntosh (2011) there is a distinction between “suicide survivorship” and “exposure to suicide”. The former applies to the bereaved who had a personal and close relationship with the deceased (e.g., a friend or a family member), the latter reflects a situation of a person who did not know the deceased personally but who knows about the death through reports of others or media reports (e.g., suicide of a celebrity) or who has personally witnessed the death of a stranger (e.g., train drivers or police).

#### **2.3.1 Behavioural challenges**

According to Jordan (2008) there is also considerable evidence that suicide survivors experience more stigmatization from their social networks than survivors of most other types of death. Cvinar (2005) says although some of this may be outright condemnation, much of it is also the social ambiguity created by suicide bereavement. Many members of the community do not know how to help, and therefore avoid contact with the bereaved, a response that Dyregrov (2003) has labeled “social ineptitude” in the network. Survivors

may also “self-stigmatize” and avoid contact with friends and family out of a sense of shame and guilt around the death. Dunn and Morrish-Vidners (1987) in Jordan (2008) suggest that all of these factors may make the usual sources of social support, both within families and from the larger community, more problematic after a suicide which is also a negative effect on the suicide survivors.

Empirical research is divided on whether or not suicide bereavement is significantly different to other forms of traumatic death (Sudak et al. 2008; Cvinar 2005; Sveen & Walby 2008; Begley & Quayle 2007). What is not disputed is the reaction of others to those bereaved by suicide and the subsequent stigma that this places on the bereaved. In a review of studies on suicide bereavement, Sveen & Walby (2008) conclude that people bereaved by suicide report levels of rejection, shame and blame that are higher than other bereaved people. Begley & Quayle (2007) attribute the stigma experienced by those bereaved by suicide to the uneasy social interactions following the death of a loved one, rather than a person’s actual experience of the death, and report that this gets worse with time. This is supported by Thomas Joiner’s reflections on his father’s suicide: “My feelings about suicide stem partly from people’s reactions to my dad’s death” (Joiner 2005: 1). He continues to describe how many people were so preoccupied with their misunderstandings of suicide that their usually generous and compassionate interactions were replaced by awkwardness and avoidance following the death (Joiner 2005).

Research by Maple et al. (2010) found that following the suicide of a child, parents felt ‘silenced’ by others’ reactions, and that this inhibited their grieving process. Social conventions “that do exist (for discussing suicide) encourage the position that suicide is neither acceptable, appropriate nor justifiable, avoiding recognition of the event” (Maple et al. 2010: 247). Similarly, Ratnarajah and Schofield found that children bereaved by their parent’s suicide felt shamed and criticised by others, which consequently had “major negative impacts on the family’s sense of security with the social network” (2008: 626). The long-term impacts of this stigma, including personal, financial and health effects, can often be underestimated by society and the ongoing healing of the bereaved can be left unsupported. People bereaved by suicide malfunction behaviourally because of the grief that they are going through.

Many studies have also found elevated rates of psychiatric disorders in people bereaved by suicide. Among these studies are the following, which have found that survivors of suicide

loss experience: greater rates of bipolar disorder in persons exposed to the suicide of a parent (Tsuchiya, Agerbo, & Mortensen, 2005), greater depression across all kinship losses (Kessing, Agerbo, & Mortensen, 2003), greater depression in adolescent and young adult losing a friend, greater depression in bereaved mothers, greater depression and substance abuse in youth losing a parent (Brent, Melhem, Donohoe, & Walker, 2009), greater psychiatric morbidity in elderly parents losing a child (Clarke & Wrigley, 2004) and lastly greater rates of complicated grief disorder (Holland & Neimeyer, 2011; Melhem et al., 2004b). As the process of grieving unfolds it is common for people to start to focus more on the purpose of their lives, their relationships, thoughts, hopes, beliefs and sense of future. According to Jordan (2001) grief is not a sign of poor coping skills, but rather a healthy part of the healing process. Usually the intensity of grief will rise and fall with small periods of relief between emotional times. According to Krynska (2003) suicide bereavement has certain characteristics that comprise the suicide survivor syndrome and may be linked to an increased risk of suicidal ideation and behaviour.

### **2.3.2 Emotional challenges**

A report by Philip Mataranyika in the Financial Gazette (2017) highlighted that bereavement experiences surrounding suicide are usually the same across cultures. In Zimbabwe most people bereaved by suicidal deaths experience guilt, anger, shock, horror and trauma beyond that experienced by those whose loved ones die naturally or normal deaths. However, the stigma and shame associated with suicide prohibit Zimbabwean mourners to seek help and other people to help the bereaved since they feel that association with the bereaved may bring bad luck or bad omen making the suicide survivors social misfits.

Disbelief is a common reaction to any sudden death for it is difficult to grasp and absorb such a profound and unplanned-for occurrence. With suicide, there is often strong disbelief. It seems impossible to some loss survivors that a person they knew intimately could have been thinking of ending their life without the survivor being aware of it (U.S. Department of Health & Human Services, Office of the Surgeon General, & National Action Alliance for Suicide Prevention, 2012). It violates the assumptive world or belief system that the bereaved had about their loved one, themselves, and the world as they knew it. In addition, there can be denial that the death was by means of suicide, which is often relatively short-lived but for some, may endure for a lifetime. Death by any means often compels the bereaved to consider the deepest existential questions about life, death, and why certain things transpire.

With suicide, the search for the answer(s) as to why their loved one died is central to the experience of many loss survivors (U.S. Department of Health & Human Services, Office of the Surgeon General, & National Action Alliance for Suicide Prevention, 2012). The complexity, troubling nature, and frequent absence of the answer(s) can be a heavy burden for the suicide bereaved. According to U.S. Department of Health & Human Services, Office of the Surgeon General, & National Action Alliance for Suicide Prevention (2012) it is not unusual for loss survivors to feel compelled to conduct their own personal “inquest” or “psychological autopsy” into the death, focusing on learning as much as possible about what led to the death; the mental state of the deceased; and when, where, and how their loved one died. The bereaved might also be preoccupied with discovering who knew what, who saw what, who did what, etc. Finding answers, and/or accepting the elusiveness of those answers, is commonly a difficult but necessary part of the journey for the bereaved by suicide. Shame is another emotional challenge faced by suicide survivors (U.S. Department of Health & Human Services, Office of the Surgeon General, & National Action Alliance for Suicide Prevention 2012).

Shame can be exacerbated by other themes, especially feelings of self-blame, guilt, and perceived abandonment by the deceased. According to U.S. Department of Health & Human Services, Office of the Surgeon General, & National Action Alliance for Suicide Prevention (2012) people bereaved by suicide commonly assign responsibility for their loved one’s death to a particular person, event, or circumstance. They might ask, “Is my loved one responsible?” “Am I responsible?” “Is God responsible?” Assigning responsibility can also be driven by the loss survivor’s need to make sense of the incomprehensible.

According to Jordan (2001) blaming can be understood as a means of restoring a sense of order in the world—and of protecting the self from feelings of self-blame. Guilt is also a precedent emotional challenge and people bereaved by any kind of death might feel guilty about what they believe they should, would, or could have done or not done to prevent the death. There are also instances where a survivor points to a single and even factual event that preceded the suicide (“We had a fight”; “I left him alone”) and insists on a simple causal connection between that event and the suicide, even though suicide is multicausal involving numerous interrelated contributing factors and in its essence is a very complex and enigmatic human behaviour (AFSP, 2015).

According to the AFSP (2015) besides the fears that accompany all kinds of deaths such as fear of being alone or of financial insecurity the bereaved by suicide often fear that they or another family member or friend will also die by suicide. The conviction that suicide could happen to anyone, or that suicide “can come out of the blue,” can leave loss survivors wary and hyper-vigilant over the safety of other loved ones. Fear and hyper-vigilance can be particularly troublesome for clinicians who have lost a client to suicide.

#### **2.4 Impact of suicide on social relationships**

While an individual suicide is often a solitary act, family and friends are almost always left behind to grieve, try to understand the reasons for the death, and learn to carry on with their lives. According to Cerel et al (2008) these difficulties included decreases in cohesion (defined as “emotional bonding that family members have toward one another”) and adaptation (defined as “the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress”). There is also disruption in family communication where there are communicational distortions surrounding the death, support and intimacy. Mostly elders do not find time to bond with their children or other family members because of guilt and children isolate themselves from everyone and experience great turmoil from different stressors. In encapsulated families, psychopathology and conflict was generally observed only in the deceased, not in other family members. In chaotic families, clear evidence of psychopathology in multiple family members and/or turmoil prior to suicide was present (Cerel et al, 2000).

#### **2.5 Postvention strategies or coping strategies**

Postvention can be defined as “activities developed by, with or for suicide survivors, in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behaviour” (Andriessen, 2009: 43). If the deceased was a parent or family member, talking to the children about the death may be one of the most difficult tasks you face. Suicide is a complicated form of death and requires honesty with children. However, the explanation provided should fit the child's age and level of understanding. If one is reluctant to talk to a child about suicide, what it means and why it happened, keep in mind that children are likely to hear it from other sources, which will lead to even more confusion, fear, and distress (Tesh, 2007). Furthermore, talking to children can help erase misconceptions or concerns that somehow they are blame for what happened (Tesh, 2007).

Suicide survivor support groups and psychotherapy seem to be promising forms of help addressing the wide variety of problems and needs of the survivors. The former may be helpful for suicide survivors in general, while the latter might be helpful especially for survivors who develop psychological and/or psychiatric problems (Jordan and Mcmenamy,2004).Other intervention strategies include support-related activities (e.g., support groups, online resources, national suicide survivor days), awareness raising activities via dissemination of brochures, books as well as public walks and art exhibitions, and fundraising activities.Andriessen and Krynska (2012).The bereaved are encouraged to seek help from other people especially professionals before the problems with their grief becomes unbearable and other people at large are encouraged to talk with these people and treat them like other bereaved people from any other type of death.

## **2.6 Suicide in Zimbabwe**

The Financial Gazette (2017) reported that most people affected by suicide isolate themselves from the society in fear of criticisms of the nature of death their loved one would have chosen. The stigma surrounding suicide in Zimbabwe does hinders the bereaved from getting any help in fear of being blamed as well as being labelled as social misfits. In the newspaper, families, religious and traditional leaders have a pivotal role to play in curbing suicides as well as helping the bereaved cope with the deleterious impacts of suicide. It is reported that Pastor Augustine Deke of the City Life Centre Church in Gweru offers counselling to families affected by suicide. He says that the church should be at the forefront of giving hope to the bereaved in their predicaments (Financial Gazette, 2017). Families should also come together and work together in helping each other cope with suicide. Some people with complicated grief are referred to mental institutions for more professional expertise (Financial Gazette, 2017). However not all people admit that they are facing challenges so they just bottle up their emotions and end up having severe psychological problems which in some cases leads to suicide.

## **2.7 Theoretical framework**

Aside the above mentioned negative effects of suicide, suicide survivors also encounter difficult bereavement experiences. Kubler-Ross (1969) in Feldman (2010) coined a five stage theory of bereavement which include denial, anger, bargaining, depression and acceptance. Denial was defined by Kubler-Ross as “the world becomes meaningless and overwhelming. Life makes no sense.” In case of suicide denial is the psyche’s response to the unknown because it is difficult to process and cope with something that one does not understand.

Centre for the Advancement of Health (2003) and Bonanno and Kaltman (2001) have concluded that, typically, bereavement may disrupt normal functioning. Firstly, people may become cognitively disorganised in the first months after the death, with these difficulties including: a preoccupation with the loss; a search to make sense of the loss and find meaning in it; a struggle to accept that the loss has actually occurred; a sense of lost identity with the person who died; and uncertainty about the future which clearly explains the denial stage.

Kubler-Ross (1969) says anger is also prevalent during grief because the survivors blame themselves for not knowing or being aware of the signs given by the deceased which leads to pain. Another link between anger and suicide is that the survivor might feel angry about “secondary losses,” such as being left to raise children without a spouse, facing financial difficulties, or living unaccompanied through retirement (Jordan & McIntosh, 2011b). It is common for the bereaved to assign responsibility for their loved one’s death to a particular person, event, or circumstance. They might ask, “Is my loved one responsible?” “Am I responsible?” “Is God responsible?” Assigning responsibility can also be driven by the loss survivor’s need to make sense of the incomprehensible. Blaming can be understood as a means of restoring a sense of order in the world and of protecting the self from feelings of self-blame.

According to the AFSP (2015) people bereaved by any kind of death might feel guilty about what they believe they should, would, or could have done or not done to prevent the death. The answer many survivors of suicide loss arrive at when they ask “Am I responsible?” is “Yes.” People naturally believe in the power of their love and caring to protect their loved ones. In the case of suicide, it is not unusual for people to believe that this power “should” have been able to save their loved one’s life. And in hindsight, they may be able to see actions that could have been taken (or avoided) that might have made a difference. This can contribute to a powerful kind of “magical” or counter-factual thinking about the preventability of the death that can haunt loss survivors for a very long time. There are also instances where a survivor points to a single and even factual event that preceded the suicide (“We had a fight”; “I left him/her alone”) and insists on a simple causal connection between that event and the suicide, even though suicide is multi-causal involving numerous interrelated contributing factors and in its essence is a very complex and enigmatic human behaviour (Jordan & McIntosh, 2011b).

According to Jordan & McIntosh (2011b) abandonment and rejection is common for bereaved people to feel “left all alone” when someone dies of any cause. Suicide is sometimes seen as the most powerful form of abandonment or rejection possible, because from the point of view of the bereaved, the deceased “chose” death over continuing to live in relationship with the survivor (AFSP, 2015). The suicide bereaved may also feel that the deceased avoided the opportunity to reach out to them or rejected help that was offered. These feelings of abandonment result from strong feelings of anger at the self or anger at the deceased. The bargaining stage leaves the survivor with no choice but to think repeatedly about how they could have stopped or avoided the death (Kubler-Ross, 1969).

The suicide of a loved one frequently unleashes an emotional tsunami of guilt and self-reproach in survivors. Suicide can be understood as shattering the assumptive world of the survivor, meaning the foundational beliefs about one’s world (Jordan, 2008). According to Jordan (2008), most survivors overestimate their own role in contributing to the suicide or in failing to prevent it. Survivors are frequently unaware of or minimize the many other factors that may have contributed to the suicide, including the fact that up to 90% of people who die by suicide meet criteria for a psychiatric disorder (Robins, 1981 in Jordan, 2008). The survivor can only assume but will never know the true reason(s) for death. This intense need to conduct a personal psychological autopsy is a hallmark of bereavement after suicide. It helps the survivor to make sense of the death and place in perspective the role the survivor played in the suicide. It may also help survivors come to terms with the incomplete knowledge and unanswerable questions that accompany many suicides since they are bargaining on behalf of their loved one (Jordan, 2008).

Depression in case of death by suicide connotes deep sadness experienced by the survivor as they try to relate to the problem (Kubler-Ross, 1969). They might exhibit diagnostic levels of complicated grief, depression, or posttraumatic stress that would require professional treatment (American Psychiatric Association (APA), 2013). In addition, there is growing evidence that mourning resulting from suicide is highly depressive and results in complicated grief (also known as prolonged grief disorder) which is a syndrome characterized by intense and unremitting yearning for the deceased, coupled with trauma-like symptoms such as numbing, feeling life is meaningless without the deceased, and difficulty accepting the death (Prigerson and Maciejewski, 2005). There is also recent evidence that suicide survivors are more likely than natural death survivors to show symptoms of complicated grief (Groot et al., 2006).

In their seminal book on suicide bereavement and caring for loss survivors, Jordan and McIntosh (2011c, p.11) conclude saying, “Compelling evidence now shows that exposure to suicide carries with it the risk for a number of adverse sequelae. Perhaps the most disturbing of these risks is the elevated likelihood for suicide in a person exposed to the suicide of another individual.” Depression is a stage that encompasses denial as well as anger that in turn leads to different chronic illnesses and psychological problems to the suicide survivors. Lastly there is acceptance which in this case does not necessarily mean that the survivor acknowledges that everything is fine but rather it means that they have accepted the reality of the situation in order to adapt to ‘the new normal’ (Kubler-Ross, 1969).

Research confirms the legitimacy of Kübler-Ross’s reaction stages. According to Kubler-Ross (1969), however, not every survivor experiences all these reactions. Moreover, not all survivors go through these reactions in the same order. Death, like many other developmental processes, is influenced by a variety of factors, including one’s personality and coping style, the type of support received from family members and health professionals, and the nature of death. According to the AFSP (2015) coordinated, comprehensive community response, useful information, compassionate assistance from first responders (police, funeral insurances, faith leaders etc.), practical assistance (cleaning, notification about death and making funeral arrangements etc.), support from social networks and communities, help from skilled mental health professionals and other service providers, peer support and family support is needed to help those bereaved by suicide to cope with the loss. Yet Kübler-Ross’s model is useful for understanding the emotions of survivors and for supporting anyone suffering from loss.

## **2.8 Knowledge gap**

The evidence clearly suggests that suicide can be one of the most catastrophic of losses, one that requires extra vigilance and outreach as well professional intervention (Jordan, 2008) but this has been ignored. A portion of the considerable empirical evidence to support this assertion has been reviewed here. Much research has been done on the causes of suicide but the bereavement experiences have only been mentioned but no interventions have been developed to help the bereaved which has saw the increase in psychological problems, mental health problems, suicidal ideations or even suicide making it the thirteenth leading cause of death worldwide (WHO,2014).More research is needed to determine the extent of the impact of suicide on survivors who are at greatest risk for developing complications after the death, and in identifying effective interventions to help those who are suffering the

most. Jordan and McMenemy (2004) have called for a research program focussing on what survivors already do to cope, as well as the study of the existing support resources that have evolved (such as peer-led support groups). From that foundation, specific and targeted interventions for survivors can be developed. This empirically grounded base, along with a growing awareness of the bereavement experiences, can promote the growth of compassionate and effective support resources for those who lose a loved one to suicide (Jordan, 2008).

## **2.9 Chapter Summary**

The chapter explores the challenges faced by suicide survivors in their quest to understand and accept that they have lost a significant other to suicide. A theoretical framework by Kubler-Ross has been explained to fully underpin the underlying bereavement experiences of the deceased. This theory has five stages that explore in depth what suicide survivors go through during their grief. In Zimbabwe, it is a taboo to talk about suicide hence the stigma surrounding suicide has hindered those bereaved by suicide to come in the open and get help professionally, spiritually or traditionally which has led to psychological ailments precipitating more suicides. However, the chapter also looked at the postvention strategies to help the bereaved to cope with their situations socially, individually as well as in families.

## **CHAPTER 3: RESEARCH METHODOLOGY**

### **3.1 Introduction**

The chapter focused on the research methodology. The research is qualitative in nature therefore the chapter explored on the research design, sample and sampling techniques to be used, target population, research instruments to be used, data collection procedures and ethics to be considered when conducting the study.

### **3.2 Research Approach**

The research study was qualitative in nature and it sought to answer the question on the bereavement experiences of people bereaved by suicide. In the handbook of qualitative research, Denzin and Lincoln (2005) described qualitative research as involving "...an interpretive naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them." A qualitative research question mainly focuses on "W" questions that are 'Where? When? Where? Why? Who?' Qualitative research attempts to broaden and/or deepen our understanding of how things came to be the way they are in our social world and studies behaviour in natural settings or uses people's accounts as data. No manipulation of variables is encountered and focuses on reports of experience or on data which cannot be adequately expressed numerically. The research also focuses on description and interpretation and might lead to development of new concepts or theory, or to an evaluation of an organisational process and it employs a flexible, emergent but systematic research process (Hancock et al,2007).

This research paradigm was suitable for the study undertaken because the participants had no fear of being criticised by people since the researcher would undertake the research in the confines of their own spaces for free association and comfortability. A qualitative research helps in gaining insight of the problem in natural settings, gives the researcher an opportunity to explore the depth of the problem and the complexity of the inherent phenomenon (Hancock et al,2007).The ability to fully understand what the suicide survivors go through was the ultimate goal of this study hence conducting the research in the participants' space allowed a deeper relationship between the researcher and the problem thereby coming up with adequate and effective coping strategies.

### **3.4 Research design**

The research study used the Interpretive Phenomenological Analysis (IPA). IPA has two components. It is phenomenological, attempting to understand how participants make sense of their experiences (it does not assume that participants' accounts refer to some verifiable reality) but it recognises that this involves a process of interpretation by the researcher (Hancock et al, 2007). It looks at subjective states so it takes an insider perspective. According to Hancock et al (2007) IPA is interpretative, it recognises negotiation between researcher and researched to produce the account of the insider's perspective, so both researcher and researched are "present".

IPA is often combined with the constant comparison method and elements of content analysis (Hancock et al, 2007). The IPA research design gave a detailed analysis of the problem; it was focussed on the problem and was not time consuming as the researchers related to previous literature review for guidance in their own research. Because the design is both phenomenological and interpretative, it addressed two concerns at the same time.

### **3.4 Target population**

This refers to the group of people who are to be reached to participate in the study (Hancock et al, 2007). In the research the targeted population were people bereaved by suicide who randomly reside in different parts of Nehosho. The target population age group was specifically people above 18 years both male and female which helped to come out with valid research findings.

### **3.5 Sample and sampling technique**

The sampling methods that were used in the study were snowballing and purposive. Purposive sampling was used in this study because it focuses on a small number of samples. Purposive sampling is the process that involves conscious selection of certain participants of the study (Keele, 2009). The sampling method is not representative of the population hence the samples will be selected according to common interest which in this case was suicide bereavement experiences, which enabled the researcher to answer the research questions (Hancock et al, 2007). According to Hancock et al (2007) this type of sampling does not generalise concepts but rather aims to get the in-depth meaning of the problem in order to help the participants cope with the problems they are facing and in this case the researcher's aim was to help those bereaved by suicide to cope up with their situation through exploring

their bereavement experiences. The research also aimed to educate other people on what suicide survivors go through after their loss.

The study also used the snowballing sampling technique which is a non-probability technique that is used by researchers to identify potential subjects in studies where subjects are hard to locate as posited by Keele (2009). This sampling method is used when the sample is rare or is limited to a very small subgroup of the population. The method also depends on observation so the process is much like asking other people or participants to nominate another person with the similar problem being studied (Keele, 2009). Because suicide is a sensitive topic to discuss, the researcher mainly depended on referrals in order to obtain sufficient number of samples for data collection. The number of the participants was not predetermined but would be determined by data saturation.

### **3.6 Research instrument (s)**

The study focused on using interviews as a standardised instrument frequently used in conducting research as noted by Goodwin (2011). The researcher used interviews with open ended questions as methods of acquiring data on the bereavement experiences of suicide survivors . Qualitative researchers usually employ “semi- structured” interviews which involve a number of open ended questions based on the topic areas that the researcher wants to cover(Hancock et al,2007). The open ended nature of the questions posed, defined the topic under investigation but also provided opportunities for both interviewer and interviewee to discuss some topics in more detail.

According to Hancock et al (2007) open ended questions are responses which are to be analysed qualitatively, they may be included in questionnaires even though the majority of the questionnaire will generate quantitative data. The open-ended questions usually require that responses, which reflect the opinions of the respondents, be written in blank spaces (Hancock et al, 2007). The researcher asked questions to suicide survivors and observed how they associated with each other and other people in their communities. The interview was comprised of a section on demographic data where aspects like sex, age and status were covered. The second section up to the fourth section focused on questions which were formulated guided by a major research question based on the behavioural challenges, emotional challenges and social relationships.

### 3.7 Data collection procedures

The researcher sought permission to conduct data collection from the Department of Psychology at the Midlands State of University and was approved by the Supervisor who provided guidelines and direction on how to effectively collect data.

### 3.8 Data analysis

When presenting the results of research, the objective was communication hence the presentation will be tailored to suit the audience. Responses were analysed using descriptive and interpretative thematic analysis. According to Woods (2011) thematic analysis is a way of seeing as well as coding qualitative information. Thematic analysis allows the researcher to present data in an orderly manner giving the audience a chance to fully grasp the idea without any confusion or misunderstanding (Elliott and Timulak, 2005). The thematic structure can be set out at the beginning, either as a list or in diagrammatic form. In this way, one can show how the categories of data are used to construct a case that the overarching themes are the main findings of the study (Hancock et al, 2007).

There are different phases used when analysing data using thematic analysis. In this research study, focus was on phases of thematic analysis propounded by Braun & Clarke (2006).

PHASE	DESCRIPTION OF THE PROCESS
1.Familiarising yourself with your data	Transcribing data, reading and re-reading the data, noting down initial ideas.
2.Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3.Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4.Reviewing themes	Checking if themes work in relation with the coded extracts (Level 1), and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5.Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions

	and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back to the analysis of the search question and literature, producing a scholarly report to the analysis.

**Table 1.0**

Further “evidence” to support the findings was provided by using direct quotations from respondents. Key quotations should be selected to illustrate the meaning of the data which will also aid in understanding the themes that would have been presented (Hancock et al, 2007).

### **3.9 Ethical considerations**

Ethics are essential in conducting a research because they guide the researcher in not violating the rules and regulations of the Institution and not to violate participants’ rights. This research was very sensitive so the researcher acknowledged with respect ethics such as informed consent, confidentiality, disclosure and non-maleficence so that the data collected would not end up in wrong hands and used for wrong reasons.

#### **3.9.1 Confidentiality**

The right to confidentiality included the right to keep information relating to the participants private. Confidentiality of information about people bereaved by suicide is important because of the risk of stigma and discrimination in respect of suicide (WHO, 2010). In this light, no names will be used for anonymity.

#### **3.9.2 Informed consent**

This was also an important ethic in dealing with suicide survivors or those bereaved by suicide. The participants informed on the topic of the research as well as what it sought to achieve and ways to cope with their situation.

#### **3.9.3 Disclosure**

Disclosure to others is allowed when a person with authority to do so gives consent for disclosure or when disclosure is required by the law, required for legal proceedings or is

ordered by the court (WHO, 2010). This ethic was clearly explained to the participants to shatter any doubt about the credibility of the research.

#### **3.9.4 Non-maleficence**

This was observed and conveyed to the participants that the study actions were not intended to harm or bring harm to the participant and others.

#### **3.9.5 Pre-testing**

Pre-testing refers to a range of testing techniques which are used prior to field testing, techniques such as pilot tests and dress rehearsals (Australian Bureau of Statistics (ABS), 2001). Pre-field testing is important because it aims to identify sampling errors and to suggest possible solutions to minimise or improve occurrence of these errors. The ABS (2001) suggests that when developing a pre-testing plan the researcher should consider the resources needed to conduct the pre-test, timeliness of results, stage of development process and the aims of the test. Only 10 participants were used in this study because the research design used does not allow the researcher to use many participants as it will be difficult to analyse and come up with valid and reasonable findings.

#### **3.10 Chapter Summary**

This chapter presented the research methodology that was followed in carrying out the study. Since the study was qualitative in nature, no numerical evidence was needed but data collected would be clearly illuminated using the IPA design, which focused on thematic analysis for a better understanding of the topic of research.

## CHAPTER 4: DATA PRESENTATION AND ANALYSIS

### 4.1 Introduction

This chapter focused on data presentation and analysis. It aimed to answer the research questions and bring to light the research findings. Data was presented and analysed in form of themes that were deduced from the research findings and data collected was transcribed to verbatim using the English language. Many people bereaved by suicide suffer emotionally trying to understand why the deceased made the decision of ending their own lives. They also experience behavioural changes that include loss of weight, loss of appetite as well as illnesses like stroke which are caused by extreme stress. However, they also try to put the negative impacts of suicide behind them through adopting some coping strategies for them to move on.

### 4.2 Characteristics of respondents

A total of ten people participated in the study. These participants were chosen because they were all bereaved by suicide. The participants were aged between 18 – 60 years and they were all black Africans who were fluent in English and Shona languages. The table below shows the socio-demographic status of the participants.

Participant Number	Sex	Age	Education Level	Number of children	Marital status	Occupation	Status of the deceased loved one
1	Female	46	Diploma	3	Widowed	Clerk	Husband
2	Female	22	O' Level	2	Separated	Unemployed	Father
3	Male	18	Grade 7	0	Single	Unemployed	Father
4	Female	30	O' Level	1	Single	Teacher	Sister
5	Male	27	A' Level	0	Single	Technician	Friend
6	Female	18	O' Level	0	Single	Unemployed	Friend
7	Female	25	Degree	0	Single	Unemployed	Cousin
8	Male	43	Diploma	2	Married	Driver	Friend
9	Female	22	O' Level	1	Married	Unemployed	Father
10	Male	18	Diploma	0	Single	Waitress	Sister

**Table 2.0**

Participants provided their age and from the table the oldest was 46 years old and the youngest was 18 years old. There were six female participants and four male participants. Therefore, it is evident that female participants were many then male participants because male members are not very much extrovert as compared to their female counterparts. In terms of education, most of the participants were educated except for one participant who had primary level educational background. From the table, five participants were employed whilst the other half was unemployed. All the participants had lost someone to suicide which made the participants suitable for the study.

### **4.3 Emotional challenges faced by people bereaved by suicide**

The loss of a loved one to death by suicide is a challenging stressor event that increases the risk for the development of many emotional challenges that may lead to psychiatric conditions. People bereaved by suicide suffer from intense feelings of guilt or feelings of responsibility for the death, a ruminative need to explain or make sense of the death, strong feelings of rejection, anger at the deceased and shame about the manner of death.

#### **4.3.1 Guilt**

Guilt is a major emotion that people bereaved suffer from because the loved one feels they have failed the deceased. This is supported by the following:

*'I felt confused, so shocked and I felt bad that I did not see it coming. I thought I knew him but it seems I did not know and I feel like it is my fault because I failed him and I will not be able to live with it because it consumes me all the time I think about him.'* P2

This shows that the feelings of guilt people bereaved by suicide are overwhelming which makes the bereavement process painful. Similarly, another participant reviewed that:

*'I feel guilty for my husband's death because maybe I did not listen to him well or maybe he got angry over something I said or did. If only I had paid attention to his feelings and movements he would be here today.'* P1

From the quote, one can deduce that it is confusing to really accept that the deceased made their choice to die which is not the survivor's fault. Guilt can also be experienced when the people bereaved by suicide feels like they betrayed the deceased for moving on as stated by one participant where she says:

*'Because it was painful to think about my friend dying by suicide, I tried to distract myself from those thoughts to be able to move on so I kind of feel guilty for no longer feeling the pain.'* P5

This clearly shows that suicide bereavement is mostly characterised by guilt. Therefore, many people experience guilt as they try to understand the reason for the death of their loved one.

#### **4.3.2 Shame**

Suicide is viewed as a tabooed factor and therefore people feel that a mistake was done and the people are being judged for it. This is evidenced where one participant says:

*'I could not tell my family and children about how my husband died but eventually I had to tell them but we agreed to keep it a secret because what would people say about us and particularly him.'* P1

People bereaved by suicide have a sense of shame due to the mode of death hence they isolate themselves from other people. People bereaved by suicide also shun themselves from the world according to the research findings and this is shown where it says *'Since his death I stay indoors and stay close with my family because I am afraid what people say behind my back and about my family'* P9, which helps to explain why people bereaved by suicide 'self-stigmatise' themselves out of sense of shame surrounding the death and also avoid any discussion concerning the death with other people in fear of outright condemnation.

#### **4.3.3 Abandonment**

Another theme that surrounds suicide bereavement is abandonment. People bereaved by suicide feel abandoned because they would not know the cause of death. This is shown where one participant says:

*'I feel that I have suffered a great loss. I lost my husband, the father of my children, my friend and my partner. We had plans but how am I supposed to do that now that I am alone? He left me all alone to do everything by myself and I feel terrible.'* P1

This explains that the suicide survivors feel rejected or abandoned because they feel that the deceased loved one chose death over them or over life. These feelings of abandonment can, in turn, lead to strong feelings of anger at the self or anger at the deceased because according to one participant:

*'If he really loved me and our family he would not have chosen to die this way leaving me to face all the things alone. I feel so lonely and I feel that I should have done something to stop him.'*P1

These profound feelings of abandonment also result in feelings of unworthiness by people bereaved by suicide.

#### **4.3.4 Anger**

People bereaved by suicide often feel angry. According to one participant:

*'I feel angry at him because he would have told me if he had problems or if I had made him angry in any way than to end his life like he did not have anyone. I also feel angry at myself because I could not prevent the death. If only I had known, if only I had followed him, none of this would have happened.'*P1

This explains that people bereaved by suicide feel angry at their loved one for taking their own life and secondly they feel angry at themselves for failing to prevent the death.

Another participant expressed anger due to the fact that the deceased chose to hurt many people by committing suicide. She says:

*'I cannot live with myself because of what she did. How could she decide to hurt us like that? What did we do wrong, where did we go wrong? It is so sad that she had to die this way.'*P4

This anger makes the bereavement process difficult since the suicide survivors fail to accept the loss.

Anger is also shown when the survivor feels that the deceased has left them with secondary losses such as financial difficulties and raising children. This is evidenced where one participant says:

*'Now that he is gone I do not know where to start. We had plans, our house is incomplete, I wanted my son to go to a good school but I could not afford because he is not there to help me achieve that. If only he had not died, all would have been okay.'*P1

This anger if not dealt with positively, can extend the grief longer than it should be which can lead to complicated grief.

#### **4.3.5 Blame**

Suicide bereavement can also lead to blame which can also affect one's normal functioning. This is shown where one participant says:

*'When I think about the relationship we had, I cannot imagine that we would be separated that way. I ask myself all the time if it is my fault, God's fault or his own fault but there is no one to answer that.'* P8

Assigning responsibility can also be driven by the survivor's need to make sense of the incomprehensible.

Blaming can be understood as a means of restoring a sense of order in the bereaved's lives as well as to protect the bereaved from feelings of self-blame. One participant reviews that:

*'I guess I have nothing to do except to think that only he and God know the truth. I cannot continue thinking that it is my fault.'* P7

Blame can be negative in that it complicates the grieving process as the bereaved tries to make sense of the loss and it can also be positive in that the bereaved accept the loss and start to move on and make sense of the loss.

#### **4.4 Behavioural challenges faced by people bereaved by suicide**

Suicide bereavement triggers different behaviours in suicide survivors or people bereaved by suicide. Many people suffer from different behavioural changes including crying, lack of concentration and physical reactions which cause somatic distress such as worsened illnesses or increased number of health problems including palpitations, shortness of breath, insomnia, poor appetite and digestive problems. As with emotional manifestations of grief, behavioural manifestations appear to occur predominantly early during the bereavement period and only a minority of people bereaved by suicide suffer enduring behavioural problems like bipolar disorder, mental illness and chronic diseases like heart problems.

##### **4.4.1 Crying**

People have their own ways of expressing grief but people bereaved by suicide find it hard to share and say out their thoughts to other people therefore they cry. One participant discloses that:

*'When he died, I was in tears the whole time and I could not go on. Whenever I think about him I find myself crying. I also feel sad thinking that people judge him because of his death and they also judge my family too and it makes me cry so much because I cannot do anything.'* P3

People bereaved by suicide mostly resort to crying in trying to come to terms with the loss.

Another participant states:

*'I cry a lot when I think about my children. How do people see them and what do they say behind their backs? I cannot protect them from people all the time. I fear they are not coping well.'* P1

Another participant says:

*'It's been three years since his death but I cannot stop crying every time someone talks about him or when I see him or go to the places we used to go together.'* P1

Since death by suicide is different from any form of death, people bereaved by suicide cry constantly due to the nature of death, the feelings of guilt and blame as well as fear of stigma from other people in trying to explain how their loved one died.

#### **4.4.2 Physical reactions**

The research findings suggested that after someone has died, people left behind will feel physically unwell. Some of the people bereaved by suicide lose appetite or binge eat, gain or lose weight as a form of distraction due to distress. One participant states:

*'I could not find time to eat because I felt I could not go on and I just did not feel hungry or feel the taste of the food.'* P10

And another participant says:

*'I resorted to eating too much to take things off my mind which made me gain so much weight during the early days of bereavement.'* P6

This suggests that people bereaved by suicide suffer from behavioural effects which makes differences in their bodies.

The grief experienced by people bereaved by suicide is intense such that it makes them feel like their losing control of their mental health. This is evidenced where one participant says:

*'I felt like my head was spinning and like it was a dream that I could wake up from. Actually I think I was temporarily mentally disturbed. The stress was excruciating and I had to be admitted in hospital for high BP and mild stroke. I could not sleep. That was a painful experience.'* P1

Because of the grief loss survivors become less resilient to illnesses like high Blood Pressure (BP), mild strokes and colds. Other people may even have insomnia and suffer from depression. These physical reactions have an impact on the wellbeing of the bereaved people.

#### **4.4.3 Lack of concentration**

People bereaved by suicide easily lose concentration and find it hard to finish work in time as well as to follow in conversations be it at home or work. Lack of concentration can also cause minor accidents like dropping things, burning things as well as breaking things. This is shown where it says:

*'At work or at home it was difficult to concentrate. I found myself slacking at work, making so many mistakes. When I tried to cook at home I would end up breaking things and burning food. At least I am happy because my children were there to support me and keep me company though I could not really focus on what they said.'*

P1

Another participant stated that:

*'Sometimes I would be dismissed at work earlier because I did nothing but gaze in space and burst into tears. I am very grateful because I still have my job. I would have lost it during those difficult times.'* P6

With that in mind, it can be noted that lack of concentration is one of the emerging themes in suicide bereavement. This in turn affect the day to day living of loss survivors.

#### **4.5 Impact of suicide on social relationships**

People bereaved by suicide suffer from maintaining social relations. They have difficulties in establishing new relationships and keeping existing ones. This is evidenced where it says:

*'After my husband dies I felt no need to meet around with people because I was ashamed about how he had died and how I would respond to people when they asked about his death. Being around people gave me a fright.'* P1

Suicide also has deleterious impacts on family communication and functioning. One participant says:

*'During the early days of the death no one in the family talked about the death. I was blamed for it by my spouse's relatives which strained our relationship even three years after my husband's death. We do not talk anymore and they do not offer any slightest kind of help to me and my children.'* P1

Suicide by bereavement also affects social relations of the bereaved people with the community. This is shown where it says:

*'I often look at how people look at me when I move around the community. It is as if I have some kind of deadly contagious disease. No one really wants to associate with me and I really feel alone.'* P2

The above quotes show that suicide also affects social relations of loss survivors. They feel lonely after being left alone by their loved ones and by people in their social circles.

#### **4.5.1 Family system**

The family system changes after the loss of a loved one and this change can either be positive or negative. Negative impacts include lack of family cohesion and compassion for each other. This is evidenced where a participant says:

*'No one in the family really cares about anyone. Since the death each one of us has moved on and lost contact with each other. It is like he (the deceased) went with the family unity, joy and love for one another.'* P10

Another participant states that:

*'I do not know when last I visited my family or when last they visited me. They all have abandoned us. They do not want anything to do with my family because of the suicide. Well it is not like I care about them anyway. I will not visit them either.'* P1

However, exposure to suicide does not produce only damaging effects to the bereaved but it can also help the family come together and support each other during the bereavement process. This is shown where one participant says:

*'I am grateful to my family because it seems like the death brought us together. They support me with their love and comfort. I feel that I am not alone. They are my pillar of strength.'* P7

From the research findings suicide bereavement can yield either good or bad results amongst families. It can either destroy the family or increase cohesion, mutual support or open communication thereby forming a close-knit family system.

#### **4.5.2 Family functioning**

Suicide affects family functioning in such a way that the suicide bereaved people might feel angry and may fear responsibility and leadership in the family. One participant states that:

*'I fear that I am not doing what my husband used to do. I feel like I have failed my children. I cannot do this alone. If only he was there I would not be worried about where my son will find a father-figure.'* P1

Family functioning is also disrupted as people in the family blame each other for the death leading to conflict as well suicidal behaviour amongst some of the family members. This is evidenced where one participant says:

*'My husband's relatives blame me for the death and they say I am the one who brought this calamity on their family. They constantly pick fights with me and we are always in conflicts.'* P1

However, suicide has positive effects on family functioning as people put their differences aside to be able to maintain the family name and standard so that they are not seen as failures due to the loss. This is evidenced where it says:

*'Of course I was hurt by the death but my family has been supportive and have maintained the peace that was always there. We comfort each other and they help me when I face difficulties either financially or materially.'* P1

This show that people bereaved by suicide need their families to stand by them and reassure them for a better tomorrow. If the family does not stand together it divides and falls apart.

#### **4.5.3 Social networks**

Suicide can also affect suicide bereaved people's social networks. One participant states that:  
*'I have changed my phone number to avoid talking to many people because I know they will ask about the death. I have also deleted all my social media accounts because I have no strength to explain myself to people.'* P9

These complicated social interactions lead to misunderstandings, avoidance and withdrawal between the suicide bereaved and their social networks.

However suicide can also aid in creating good social relationships whereby the bereaved people have open conversations with people in the community as well as their friends. This is evidenced where it says:

*'I have gotten encouraged by my family, friends and colleagues to be strong for my children and move on. This has really helped me a lot.'* P1

Social networks are important in helping people bereaved by suicide to cope during their trauma times.

#### **4.5.4 Stigma**

Suicide survivors experience much stigma from other people than survivors of other types of death. This is evidenced where it says:

*'The people around me always give me these glaring looks and I feel like they judge my husband by his death. The label 'suicide' connotes evil and anyone who is associated with it is castigated from the society which is unfair because people who die by cancer or accidents do not suffer the way I do.'* P1

From the research findings, stigma is still present when it comes to death by suicide and it makes the bereavement process more difficult than any other form of death bereavement.

#### **4.6 Coping strategies of people bereaved by suicide**

This section focuses on the needs that people bereaved by suicide commonly have and the type of responses that may be helpful as they recover. Support from family and friends, other people who have encountered the same experiences and professional help is a necessity for people bereaved by suicide. The services provided may be classified as immediate, short-term or long-term intervention programmes.

##### **4.6.1 Counselling**

The use of counselling as a coping strategy is important when dealing with bereavement. It often is difficult for people to talk about suicide so it takes much courage for people bereaved by suicide to talk about the loss. This is evidenced where it says:

*'I felt that talking about it will make me free and make me accept the loss and move on.'* P10

Another participant says:

*'Sometimes being able to talk to someone who listens and supports you feels great and helps to accept the loss.'* P5

One participant also states that:

*'When I started talking about the death I felt relieved and like a huge weight had been lifted off my shoulders.'* P4

Counselling helps foster good communication and help the bereaved to cope with the bereavement experiences.

#### **4.6.2 Spirituality**

Spirituality is an integral part of the bereavement process. This is evidenced where one participant says:

*'I believe everything happens for a reason and God is in control of everything. I have learnt to live with the loss through God's help.'* P2

Another participant reviews that:

*'Facing this death has brought me closer to God because I felt he had a reason for it even though my husband ended his life but I see God in my life and helping my family.'* P1

Another participant also says:

*'Believing in God, going to church and having other people pray for me and with me has helped me so much to face this difficulty in my life.'* P3

Spirituality helps in accepting and living with the burden of suicide death. Knowing and believing in God as well as the knowledge of someone praying concerning one's life helps a lot during suicide bereavement.

#### **4.6.3 Available support systems**

Having people who are supportive during suicide bereavement is important and it fosters good relations amongst the bereaved and the caregivers. Support from the community, social networks (friends and colleagues) and family is important during the bereavement period.

##### **4.6.3.1 Community support**

Coordinated and comprehensive community support is important during and after death. This is evidenced where it says:

*'I am happy that people in the community were there for me and most of them drop by my house just to check on me and my family. This is very helpful to me.'* P1

Another participant also states that:

*'I never thought it would be comfortable living in the same community but the people are very supportive such that others come to help me with practical assistance something my family fails to do.'* P3

Support from the community helps the grieving process become less heavy as people bereaved by suicide feel that they are not alone but they can rely on other people other than their families and friends.

#### **4.6.3.2 Social networks support**

Support from social networks is also critical and is highly needed by loss survivors. This is shown where it says:

*'Keeping contact with my friends, colleagues and church mates helped me to understand that I was not alone. They always had me in mind and at heart.'* P5

This largely helps the bereaved to often communicate with others and move on.

#### **4.6.3.3 Family support**

Reaching out to family is important for people bereaved by suicide because as a family they comfort each other and they listen to each other when one is willing to talk and they also offer as shoulder to lean on when one cannot or do not want to talk. This is evidenced where one participant says:

*'My family is so supportive that sometimes they call, text and even drop by to check on me. Some even spend the holidays here and cook for me. This makes me feel loved and comforted.'* P1

Family support helps the bereaved to cope with the loss and to be reassured that other people care for them.

#### **4.6.4 Acceptance**

Acceptance is an essential step in suicide bereavement. When one accepts the death it becomes easier to continue with their lives. This is evidenced where one participant says:

*'It was difficult at first to really come to terms with the death but eventually after all these years I have come to accept that my husband is gone. I have accepted it and I see I am managing well with the help of others.'* P1

Accepting the death of a loved one due to suicide does not necessarily mean that the bereaved people do not care about the deceased but it means they are willing to move on with their lives.

#### **4.6.5 Remembering the deceased in a good way**

Positive memories of the deceased help the people bereaved by suicide to have hope and deal with grief. This is shown where one participant says:

*'Now when I think of my husband I do not feel sad but I just remember all the good times we had together. My children and I laugh at what he used to do. We remember him as a good person despite him ending his own life.'* P1

Good memories about the deceased help the bereaved to forget about the suicide and focus on the good things and good deeds the loved one did.

#### **4.7 Chapter Summary**

The chapter described the forms of coping strategies that are helpful to people bereaved by suicide. Having available social support systems in form of family, friends and colleagues help the bereaved to feel wanted and not judged or stigmatised because of the nature of the loss. Spirituality is also vital during the bereavement period and it brings a sense of comfort and livelihood. Being able to accept the loss will result in being able to move on and heal. Remembering the deceased in a good way improves coping with the loss. Counselling also helps the bereaved to talk about their challenges during the bereavement period. These coping strategies are highly valued and important for people bereaved by suicide.

## **CHAPTER 5: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS**

### **5.1 Introduction**

This chapter described how suicide bereavement was different from other forms of bereavement from other forms of death. Somewhat conflicting findings exist in the literature as to how much the type of death affects the experience of grief and the subsequent resolution. Suicide survivor reactions do not differ significantly from other types of bereavements. However, suicide bereavement involved qualitative differences as compared to other bereavements, contained unique themes and the bereavement process involved different aspects, was often more complex and took longer to move on. Elements such as blame, shame, guilt and stigma were often more present in the process of suicide bereavement than bereavement from other causes. People bereaved by suicide exhibited higher levels of problematic grief and heightened risk for physical and mental complications.

### **5.2 Emotional challenges faced by people bereaved by suicide**

There was clear indication of lasting emotional responses to suicide bereavement. These emotions included anger, blame, guilt, fear, disbelief, isolation and numbness. According to Newton (2014) it seemed that the impact extended to thinking about the deceased over time, experiencing a strong emotional response when thinking about the deceased now and being reminded of the deceased in different ways (e.g. passing places associated with the deceased person such as where they lived or worked, anniversaries etc.).

The research findings showed that people bereaved by suicide suffered immensely from guilt. According to Wanyoike (2015) guilt is the feeling that loss was preventable but they did not do anything. The loved one feels they have failed the deceased. Jordan (2008) asserted that most people bereaved by suicide overestimated their own role in contributing to the suicide or in failing to prevent it. People bereaved by suicide were frequently unaware of or minimised the many other factors that may have contributed to the suicide of their loved one. Therefore, many people experienced guilt as they tried to understand the reason for the death of their loved one.

Shame was also another emotion that emerged from the research findings. Suicide is viewed as a tabooed factor and therefore people feel that a mistake was done and the people are being judged for it (Wanyoike, 2015). People bereaved by suicide had a sense of shame due to the mode of death hence they isolated themselves from other people. According to Jordan (2008)

people bereaved by suicide 'self-stigmatised' themselves out of sense of shame surrounding the death therefore avoided any discussion concerning the death with other people in fear of outright condemnation. The National Action Alliance for Suicide Prevention (NAASP) (2015) suggested that people bereaved by suicide struggled with the moral standing of their deceased loved one, or of themselves (good vs. bad). This could include constructions about the deceased's eligibility for redemption (heaven vs. hell, forgivable vs. unforgivable), character (strong vs. weak, selfish vs. generous, cowardly vs. courageous), normality ("crazy" vs. sane), and value (significant life vs. wasted life). Shame also can be exacerbated by other themes, especially feelings of self-blame, guilt, and perceived abandonment by the deceased.

The research showed that people bereaved by suicide suffered from abandonment. The causality of suicide was multi-determined and often difficult to ascertain so Jordan (2008) postulated that reflective of this uncertainty was the confusion felt by many survivors about whether to view suicide as a choice or an act to which the deceased was driven by mental illness or life circumstances. This ambiguity may then contribute to distress about whether the survivor's feelings such as fury at the deceased are 'appropriate'. According to the NAASP (2015) suicide is sometimes seen as the most powerful form of abandonment or rejection possible because from the point of view of the bereaved, the deceased 'chose' death over continuing to live in relationship with the survivor. The suicide bereaved may also feel that the deceased avoided the opportunity to reach out to them or rejected help that was offered. These feelings of abandonment can, in turn, lead to strong feelings of anger at the self or anger at the deceased because suicide will be construed as either wilful rejection or an abandonment of the survivor. Profound feelings of unworthiness about the self can also be felt by people bereaved by suicide (Jordan, 2008).

Research findings brought out that suicide ignites feelings of anger in the suicide bereaved people. According to Wanyoike (2015) anger is experienced in two dimensions. Firstly, people bereaved by suicide feel angry at their loved one for taking their own life and secondly they feel angry at themselves for failing to prevent the death. The NAASP (2015) assert that anger is often caused by feelings of guilt, blame, abandonment and preventability. Another link between anger and suicide as reviewed by the NAASP (2015) was that the survivor might feel angry about 'secondary losses,' such as being left to raise children without a spouse, facing financial difficulties or living unaccompanied through retirement. This anger if not dealt with positively, can extend the grief longer than it should be.

The theme of blame was also discovered through the research findings. Centre for the advancement of health (2003) reviewed that blame because of the death disrupted normal functioning. According to the NAASP (2015), it was common for the bereaved to assign responsibility for their loved one's death to a particular person, event or circumstance. They might ask, 'Is my loved one responsible?' 'Am I responsible?' 'Is God responsible?' Assigning responsibility can also be driven by the survivor's need to make sense of the incomprehensible. Blaming can be understood as a means of restoring a sense of order in the bereaved's lives as well as to protect the bereaved from feelings of self-blame. Blame can be negative in that it complicates the grieving process as the bereaved tries to make sense of the loss and it can be positive in that the bereaved accept the loss and start to move on and make sense of the loss.

### **5.3 Behavioural challenges faced by people bereaved by suicide**

Most people bereaved by suicide suffered from physical reactions. Their health deteriorated because the suicide bereaved suffered from stress. Most people found it difficult to eat and maintain their bodies hence losing weight tremendously. Other health problems included insomnia, shortness of breath and heart diseases (SPINZ, 2003). People bereaved by suicide also resorted to crying as a form of pacification and as a way of keeping their emotions to themselves. However, these behavioural changes were predominant in the first months after bereavement and only a small minority suffered enduring behavioural changes.

People have their own ways of expressing grief but people bereaved by suicide found it hard to share and say out their thoughts to other people hence they spent much of their time crying. The National Suicide Prevention Alliance (NSPA) (2015) postulated that being bereaved by suicide had been described as 'grief with the volume turned up.' People bereaved by suicide mostly resorted to crying in trying to come to terms with the loss. Since death by suicide is different from any form of death, people bereaved by suicide cried constantly due to the nature of death, the feelings of guilt and blame as well as fear of stigma from other people in trying to explain how their loved one died (Colt,2006).

After someone has died, people left behind will feel physically unwell. According to the NSPA (2015) due to the shock and disbelief caused by death, people bereaved by suicide often lost appetite or binge ate as a form of distraction. Other people start to lose weight due to distress. The NSPA (2015) asserted that people bereaved by suicide felt as if they were losing control of their mental health because of the intensity of the grief. Because of the grief,

loss survivors became less resilient to illnesses like high Blood Pressure (BP), mild strokes and colds. Other people even had insomnia and suffered from depression. However, Bonanno and Kaltman (2001) acknowledged that there was evidence to suggest that a small minority of the suicide bereaved suffered from severe and chronic grief with their enduring symptoms essentially fitting the existing psychiatric diagnostic categories of anxiety and PTSD. These physical reactions have an impact on the wellbeing of the bereaved people.

People bereaved by suicide had problems in concentrating hence ended up making mistakes. According to the Suicide Prevention Information New Zealand (SPINZ) (2003) in the early stages of the bereavement loss survivors experienced difficulties in their workplaces. They easily lost concentration and found it hard to finish work in time as well as to follow in conversations be it at home or work. They also got lost in thought and perseverated in reliving the events that led to the death, searching for meaning and explanation and opportunities by which the death might have been prevented or avoided (SPINZ, 2003). Lack of concentration also caused minor accidents like dropping things, burning things as well as breaking things. This in turn affected the day-to-day living of loss survivors.

#### **5.4 Impact of suicide on social relationships**

The extent and quality of the support offered to people bereaved by suicide by their family, friends and other social relations determined their healing process and duration of the bereavement period. According to Newton (2014) support from social relationships is critical in suicide bereavement because when they talk about it they try to forget about the nature of death of the deceased. A sense of having a shared experience, being able to talk informally and frequently in a safe and conducive environment seemed to be very important.

The family system changes after the loss of a loved one and this change can be either positive or negative. According to Jordan (2008) mourning after a suicide can become a profoundly isolating experience, one that may have a significant and quite deleterious impact on the survivor's relationships with family. Cerel et al (2008) have noted three types of communication distortion may occur in families after a suicide. These include development of blame for the suicide, the perceived need to keep the suicide a secret (particularly from children and people outside the family) and social ostracism and self-isolation among survivors. According to Jordan (2008) the emergence of angry blaming can severely impact the cohesiveness of a family and should be considered a significant warning sign of family distress after a suicide. Likewise, the choice to keep the nature of the death a secret may distort other areas of family intimacy and warp longer term developmental processes in the

family. According to the NAASP (2015) poor communications in the family strained relationships between immediate family members and it promoted family dysfunction. Relationships between the nuclear and extended families also can be damaged or even ended after a suicide (NAASP, 2010). In addition, different individuals in a family system commonly employed different methods of coping with grief, and the resulting misunderstandings can create tension in families. However, exposure to suicide did not produce only damaging effects to the bereaved but it also helped the family come together and support each other during the bereavement process. It also increased cohesion, mutual support and open communication thereby forming a close-knit family system.

Suicide affected family functioning in such a way that the suicide bereaved people felt angry about 'secondary losses' such as being left to raise the children alone and financial difficulties (NAASP, 2015). There was fear of responsibility and leadership in the family. Family functioning was also disrupted as people in the family blamed each other for the death, leading to conflict as well as suicidal behaviour amongst some of the family members. However, suicide had positive effects on family functioning as people put their differences aside to be able to maintain the family name and standard so that they are not seen as failures due to the loss.

Suicide also affected suicide bereaved people's social networks. According to Cerel et al (2008) survivors may incorrectly expect to be judged harshly by others and thus withdraw from social networks, a process referred to as self-stigmatisation (Cerel et al, 2008). Together, these problematic social transactions may create a cycle of misunderstanding, avoidance and withdrawal between survivors and their networks that only exacerbates the mourning process as reviewed by Cerel et al (2008). However, suicide also aided in creating good social relationships whereby the bereaved people had open conversations with people in the community as well as their friends.

### **5.4.1 Stigma**

Suicide survivors experienced much stigma from other people than survivors of other types of death. The stigma historically associated with suicide in most Western societies came from the belief that suicide was criminal or sinful, a sign of character weakness or the result of evil forces in possession of the individual (Colt, 2006). By extension, the family of someone who died by suicide had also been viewed as tainted or culpable and therefore deserving of being shunned or punished. In contemporary times, there was probably less outright condemnation of suicide, but harsh institutionalised judgements from the past have left a lingering discomfort in many people about how to respond in a way to the suicide bereaved.

Though societal views are changing, suicide stigma continues to be a powerful and active force in interactions between loss survivors and their communities (Cvinar,2005).Research suggested that, in fact, stigma negatively affected the tendency of people bereaved by suicide to seek help, the strength of their social connections and their sense of isolation (McIntosh and Feigelman,2012).When stigma contributes to lack of support or sympathy or to unkindness or even cruelty from other people, it can contribute to secondary wounds that may have a profound impact on suicide bereaved people. However not all people stigmatise people bereaved by suicide but they support them and help them cope with their loss.

### **5.5 Coping strategies of people bereaved by suicide**

While participants' experiences in the immediate aftermath generally fit with existing literature on suicide bereavement, they did not fit with the individual's perceptions of what effective coping was. People bereaved by suicide sought support from their families, friends and other social relations to cope with the loss. However, according to SPINZ (2003) a significant proportion (approximately one in two) of the bereaved people by suicide reported that the distress and trauma of their loss were such that they needed additional support beyond that provided by their family and friends, they actually needed professional help and social support.

The use of counselling as a coping strategy was important when dealing with bereavement. SPINZ (2003) reviewed that individual counselling was vital as a support service to people bereaved by suicide. Most people who were bereaved by suicide found counselling to be helpful in their journey (Feigelman et al, 2012; Jordan et al, 2011; McMenamy et al, 2008).According to Jordan (2008) individual counselling may be most necessary when the

survivor is deeply traumatized and at risk for suicide themselves, when they develop complicated grief or other psychiatric disorder; or when there other complicating circumstances (e.g. A hostile family environment in which the suicide bereaved is blamed for the suicide).Jordan (2008) also stated that a variant of individual therapy that may be very useful is conjoint family therapy for survivor families. When facilitated by a competent clinician, such meetings can provide invaluable psychoeducation about the causes of suicide and its impact on the family system, and to help promote open communication and good bereavement self-care for all members of the family (Jordan, 2008).

The study revealed that spirituality was an integral part of the bereavement process. Individualisation of faith means the person is the authority, beyond religion and medicine and their self-awareness and search for meaning is what is important (Doka, 2002). The study by Walsh et al (2002) sought to address some of these problems and identified spiritual (not just religious) belief as an important factor in assisting grief and that it may be more useful in identifying those who are having difficulty readjusting to life after loss. Religious psychotherapy may result in better outcomes and less reported symptoms of depression (Joanna Briggs Institute, 2006). According to the NSPA (2015) people bereaved by suicide have said that they felt certain that God understood and loved the person who died, even if other believers find that hard to accept. Spirituality helped in accepting and living with the burden of suicide death.

Study findings outlined that having people who were supportive during suicide bereavement was important and it fostered good relations amongst the bereaved and the caregivers. Support from the community, social networks (friends and colleagues) and family was important during the bereavement period. Coordinated and comprehensive community support was important during and after death. According to NAASP (2015) the stress experienced by the suicide bereaved was often unnecessarily aggravated by this 'hit-or-miss' response from the community. Highly coordinated response from community caregivers that involve proactive outreach to loss survivors was important and it helped the grieving process become less heavy as people bereaved by suicide felt that they were not alone but they could rely on other people other than their families and friends (The Joanna Briggs Institute,2006).

Support from social networks was also critical and was highly needed by loss survivors. According to NAASP (2015) observations of many people bereaved by suicide suggested that significant members of their social networks were often stunned into silence and inaction by

the suicide, greatly reinforcing the survivors' sense of isolation. Interventions should take into account the quality of the social support that the bereaved receive and help improve the availability and resourcefulness of social networks on their behalf, including familiar settings such as school, workplace and place of worship. According to NAASP (2015) caregivers who regularly come in contact with the suicide bereaved to comfort them, including faith leaders or pastors, peers, school personnel, colleagues (from church, work or other support groups) was vital because the bereaved got solace and were able to move on past their loss.

Reaching out to family was important for people bereaved by suicide because as a family they comforted each other and they listened to each other when one was willing to talk and they also offered a shoulder to lean on when one could not or would not want to talk. According to the NSPA (2015) providing offers of practical help such as support to do shopping or drop by with a cooked meal and even a simple text to let the person know that they are in thought was be really appreciated. A family oriented approach to suicide bereavement shows great promise in helping to mitigate long lasting effects of suicide (NAASP, 2015).

Accepting the death of a loved one due to suicide does not necessarily mean that the bereaved people do not care about the deceased but it means they are willing to move on with their lives. According to NSPA (2015) there was a possibility that one accepted the person's death as the choice they made given the situation that they were in. People who have been bereaved after a friend or relative have been suffering and may feel some sense of acceptance that they decided to end their life. The opportunity to find some personal understanding and acceptance of the suicide is important and SPINZ (2003) reviewed that this could help the suicide bereaved to put the death into perspective and continue with their lives.

Positive memories of the deceased help the people bereaved by suicide to have hope and deal with grief. According to SOSAD (2010) talking together about the good memories and the good times one had with the person who died was as helpful and uplifting as anything else and the more time passed the more of these good memories one will have for themselves and be able to share. The NSPA (2015) suggested that making opportunities to remember the person by means of talking about the person, looking at pictures and videos of them, going to places that remind you of them, creating a box with physical memories (tickets, cards, pictures etc.), writing a journal about them or continuing doing activities you did together.

Good memories about the deceased help the bereaved to forget about the suicide and focus on the good things and good deeds the loved one did.

## **5.6 Conclusions**

In conclusion, it can be noted that people bereaved by suicide often have emotional challenges during their bereavement period. Emotions such as guilt, shame, anger, fear and abandonment are prominent in suicide bereavement. Most of these emotions are predominant during the early days of bereavement but some of them extend even years after the death of the loved one. If the bereaved people do not get emotional support they might suffer from chronic emotional distress.

People bereaved by suicide not only suffer emotionally but noticeable behavioural changes also occur. Some of the behavioural challenges include extensive crying which often leads to loss of appetite resulting in loss of weight which makes the survivor prone to illnesses such as high BP, mild strokes and colds. Some people even lose concentration and find it difficult to blend and follow in conversations. They also find themselves lost in thought leading to burning of things, breaking and dropping of things off guard.

Apart from emotional and behavioural challenges, people bereaved by suicide also fail to maintain social relations in fear of stigma. Loss survivors depend on family, friends and other social relations to be able to cope with the loss. Social support is vital for the suicide bereaved because they do not feel alone but feel comforted that other people are there for them. Some of the people avoid the public eye because they feel ashamed of the nature of death and feel that they are to be blamed for not preventing the death hence they self-stigmatise themselves which also results in the bereavement process taking longer than expected.

People bereaved by suicide employ different coping strategies to heal and move on with their lives. Most of the people go for counselling, seek spiritual support, rely on available social systems, accept the death and also remember their loved one in good ways which makes the bereavement process easier. Talking it out with other people and agreeing to be helped allows the bereaved to look forward to the future with optimism. However not all of the people seek help in fear of what other people will think of them and what they will say about them. Some prefer to get in contact with other people who have suffered the same fate as them since talking to other people like them brings understanding and decreases stigma and labelling.

## **5.7 Recommendations**

This section reviewed the recommendations that should be given to the bereaved people as well as the general public in dealing with cases of suicide to avoid stigma and prejudice towards people who have been bereaved by suicide.

### **5.7.1 Information needs**

Studies have variously suggested that those bereaved by suicide have a range of needs for information including: details about the location, manner and timing of the death; information about the rights of families bereaved by suicide; factual information about suicide and mental illnesses with which suicide may be associated; information about how to cope with grief and about how others bereaved by suicide have coped during the years following a family suicide; information about the impact of suicide on families and strategies for enhancing family communication and functioning after suicide; advice about how and what to tell children about the suicide death of a close family member, and how to protect them from risk of suicidal behaviour; ready access to written information, including a reading list of books about suicide, a list of resources including websites, support group meetings, and local and national bereavement and suicide support organisations (SPINZ,2003).

### **5.7.2 Support needs**

According to SPINZ (2003) studies suggested that those who are bereaved by suicide have a variety of needs for social and professional support.They ranged from opportunities to talk about their experience with others who have been bereaved by suicide; access to individual counselling, therapy or psychotherapy as needed, without cost being a barrier; support from their General Practitioner, and from religious leaders and clergy (The Joanna Briggs Institute, 2006).

### **5.7.3 Help and advice about practical matters**

According to Hannigan and Gaffney (2010) those who are bereaved by suicide have a wide range of needs for advice and help about practical matters and other forms of assistance. These matters include: assistance in getting a house or property cleaned after a death by suicide; retrieving property from police; arranging and paying for a funeral; insurance matters; information about the process of police investigation, the coroner's inquest, and other official procedures; obtaining the suicide note or message; and related issues. Some studies suggested that needs for assistance with practical matters may have been under-recognised (SPINZ, 2003).

#### **5.7.4 Educational needs**

People bereaved by suicide need to be educated about suicide and how to grieve as well as how to face the future. The general public should also be educated on matters concerning suicide. Postvention programmes should be implemented at schools, churches as well as workplaces so that people are educated about suicide risk factors, who is at risk of suicide, how to help and behave around people who are bereaved by suicide. Education about suicide will reduce the stigma that surrounds suicide itself.

#### **5.8 Chapter Summary**

Suicide bereavement is a complex subject to deal with hence that is why there is still stigma surrounding it. People have not yet accepted that death by suicide is like any other form of death. The chapter described the needs of the suicide bereaved, their challenges and their coping strategies. There was also mention of recommendations towards dealing with suicide and these include educating people about suicide, provide some reading material for both the people bereaved and the general public, providing support in all areas and all places such as schools, churches and workplaces.

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## APPENDICES

### APPENDIX 1: RESEARCH INSTRUMENT

#### INTERVIEW GUIDE

MY NAME IS CHIKWANDE MUTSAWASHE JILL, I AM A STUDENT AT MIDLANDS STATE UNIVERSITY

Date..... {2017}

This research is entitled “**Experiences of bereavement and coping strategies among people who have lost their significant others to suicide**”. It explores on the psychological experiences which have been divided into two namely emotional and behavioural challenges of suicide bereavement. The study also addresses the coping strategies from the day they lost their loved ones to the present day of the interview. Information gathered is for educational purposes and therefore is kept confidential.

*NB: Participation Is Entirely Voluntary*

#### **Instructions.**

- Do not write personal details not asked for e.g. names addresses or phone number
- Put an X where appropriate.
- Please answer all questions
- Give appropriate answer were required

#### **SECTION A-DEMOGRAPHIC INFORMATION**

1. Gender: Female [ ] Male [ ]
2. Age: 18-21 [ ] 22-30 [ ] 31-39 [ ] 40-49 [ ] 50-60 [ ] 61-69 [ ]
3. Ethnicity: Black African [ ] Caucasian African [ ] Coloured [ ]
4. Nationality: Foreigner [ ] Indigenous [ ]
5. Language: English [ ] Shona [ ] Ndebele [ ] Chewa [ ] Ndau [ ] Other [ ]

**\*If other please indicate.....**

6. Do you have children? Yes [ ] No [ ]
7. How many? 1 [ ] 2 [ ] 3 [ ] Above 3 [ ]

**\*If above 3 please indicate.....**

8. Do you have any educational background? Yes [ ] No [ ]
9. Which level of education do you have? Primary [ ] Secondary [ ] Tertiary [ ]
10. Are you employed? Yes [ ] No [ ]
11. Religion : Christianity [ ] Other [ ]
12. How long has it been since the loss? 3-12 months [ ] 1-2 years [ ] 3-10 [ ]  
10-more [ ]
13. What was the sex of the loved one you lost? Female [ ] Male [ ]
14. What was your relationship like with the loved one?
15. How close were you to the person who died?

## **SECTION B: PSYCHOLOGICAL CHALLENGES OF PEOPLE BEREAVED BY SUICIDE**

### **B1: EMOTIONAL CHALLENGES**

1. What are the common emotional effects of the death?
2. What do you think are the emotional demands of death by suicide?
3. Have you told anyone about the emotional challenges you face and how has it made you feel concerning the loss?
4. What goes through your mind when you think about the loss and your current situation?
5. What kind of feelings or emotions do you have when you think of and acknowledge the loss?
6. What is most difficult about your bereavement experience and why?
7. Can you tell me about the specific emotional changes that you experienced just after the loss and the ones you experience now?
8. Have you at times felt like you are not coping with the loss? Please explain.

### **B: 2 BEHAVIOURAL CHALLENGES**

1. What are the common behavioral challenges you face concerning the loss?

2. Has there been any change in your behaviour since the loss? Please explain.
3. Do you think you have changed after the loss? If yes, please explain how people judge your behaviour after the loss.
4. Is there positive or negative change in your behaviour since the loss? Please explain.
5. How were you able to adapt to life after the death?

### **SECTION C: SOCIAL RELATIONSHIPS OF PEOPLE BEREAVED BY SUICIDE**

1. How are your communication patterns with others (children, friends and family)?
2. How has the death affected you and your family socially?
3. How is the family functioning after death?
4. How are you viewed by people in the community and how has it affected your social relationships?
5. What are the most common challenges you face in the community or at work as a result of the death?
6. How have you dealt with death-related rituals of other people?
7. How do people at your congregation relate to you after the death?
8. Is there any available support for you socially?

### **SECTION D: COPING STRATEGIES OF PEOPLE BEREAVED BY SUICIDE**

1. What has helped you or is helping you during the bereavement process?
2. What in your opinion shows that you are coping well with the loss?
3. What do you think helps you control the impact of the loss?
4. How do you maintain functionality at home, work, school or anywhere?
5. How have you dealt with stigma surrounding your loss?
6. Do you believe that spirituality helps in dealing with the loss of a loved one?
7. What is your response to other people who have suffered the same loss as you?
8. Do you think you can educate others about death and why?