Sequelae of Bereavement Resulting From Suicide

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Although clinical experience suggests that individuals who have been bereaved as a result of suicide may be especially vulnerable to adverse sequelae, such as unusually severe grief or increased risk of committing suicide themselves, the idea that this type of bereavement is special has received only limited systematic investigation. The authors review the literature on the subject, with special attention to the clinical and research evidence about whether bereavement resulting from suicide is different from bereavement due to other types of death, and make suggestions for further clinical and epidemiological research on this question.

(Am J Psychiatry 1990; 147:279–285)

The loss of a family member or an intimate friend due to suicide has long been considered an especially stressful life experience. From a public health perspective it is also, unfortunately, not an uncommon experience: more than 30,000 suicides occurred in 1988 (1). More than one-fourth of these suicides were of persons aged 24 or younger who, it may be expected, left at least several surviving family members, including children. Clinical reports have strongly suggested that individuals who have been bereaved because of suicide undergo an especially difficult and distressing form of grief and are also at increased risk for other kinds of adversity following their bereavement (2–4). One of the first clinicians to call attention to this problem suggested that "the person who commits suicide puts his psychological skeleton in the survivor's emotional closet—he sentences the survivor to a complex of negative feelings and, most importantly, to obsessing about the reasons for the suicide death" (2, p. 22). However, despite such clinical impressions, the idea that bereavement due to suicide differs from bereavement due to other types of death does not appear to have been widely accepted. A reflection of this attitude is that research studies on bereavement usually have not even assessed the impact of this type of death. Although several reviews of the subject (5–8) have concluded tentatively that bereavement due to suicide is indeed especially stressful, these reviews have focused primarily on uncontrolled clinical reports, they have not included the full range of research findings that might bear on the issue, and they have varied in their critical attention to the research methodologies of the reported studies.

In this paper we review what is known about bereavement due to suicide compared with bereavement resulting from other kinds of death. We consider 1) whether there is a difference in terms of the grieving process of the bereaved individuals, 2) the social and psychological adjustment of the bereaved after the suicide, 3) their family backgrounds, 4) their mortality rate, particularly in terms of their own risk of suicide, and 5) the attitudes of others in society toward the family members of a person who has committed suicide. Finally, we discuss some methodological problems with the research to date and suggest considerations for further research.

BEREAVEMENT DUE TO A DEATH OTHER THAN SUICIDE

"Normal" bereavement is marked initially by painful pining and anxiety upon remembering the deceased person, along with sleep disturbance, crying, social withdrawal, difficulty concentrating, and loss of capacity to adopt a new object of love (9–11). Over varying lengths of time, usually measured in months to several years, bereaved persons gradually reengage in their social world. Few of them seek psychiatric help. Although bereavement has sometimes been taken as a paradigm of depression, it rarely leads to major depressive illness and is not regarded as a psychological illness in itself. There is an increase in indicators of morbidity, such as use of medical services and consumption of cigarettes, alcohol, and tranquilizers, but there is no clear evidence for an increase in the incidence of specific medical illnesses. There does appear to be an increase in mortality among certain groups, especially elderly men who do not remarry (6, 12).

Various types of adverse psychological outcomes, or so-called "pathological grief," occur in a substantial number of the bereaved; the exact proportion depends upon how this disorder is defined. These adverse out-

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The authors thank Sheldon Gaylin, M.D., and Roberta Ness, M.D., for their assistance.

comes may include a persistant focus on the deceased person, ongoing depression, or chronic illness behavior and may be due to such factors as the nature of the relationship with the deceased individual or the suddenness of the death (13–17).

All of these findings come largely from research on bereaved spouses. By contrast, research on bereavement in children and in the elderly is sparse. Studies of the bereavement responses of children to the loss of a parent (18–20) suggest that such a loss is often a major trauma and may cause behavioral and emotional problems that persist for years. The eventual development of adult psychopathology has been shown to correlate with the quality of home life and personal adaptation subsequent to the loss of a parent during childhood (21).

The response to unnatural types of death has also been only slightly studied, although some reports have suggested that such deaths, including suicide, may lead to specific psychological effects on bereavement (22). There has been one study of bereavement following the murder of a child, sibling, or spouse (23). All of the 15 adult subjects had previously experienced the nonhomicide death of a relative and thus could compare their own two grief experiences. Unanimously they reported persistant fearfulness, anger toward the murderer, and intrusive repetitive images of the murder as they imagined it to have happened. These responses, the subjects felt, were quite distinct from their experiences of grief after the nonhomicide deaths.

Other reports have dealt with reactions to the death of a child from severe burns (24), the death of adult children in traffic accidents (25), and the death of adult children from cancer (26). Each of these reports documented a psychological response appropriate to the particular type of death, such as severe feelings of guilt associated with a child's having been burned, more intense grief and guilt among parents whose children died while driving alone in their own cars, and less intense grief, with more sense of relief, if a child's death from cancer followed a long and debilitating illness. These clinical reports suggest that the type of death may affect the psychology of the grieving process in specific ways.

THE GRIEVING PROCESS AFTER SUICIDE

Several studies have explored whether the grieving process after suicide has distinctive features. In one study (27), at a time 6–8 months after the suicide of a husband or wife, family members were given a semistructured interview about the effects of the death on their emotions, living situations, health, and coping. The author found that most individuals, upon learning of the suicide, felt shock, disbelief, sadness, guilt, and anger. Over time, more than half experienced crying spells, depression, deep unhappiness or apathy, or persistent anxiety, and several of the bereaved experienced suicidal ideation of their own. The physical health of most of these individuals remained the same.

Subsequent to the initial shock, the bereaved began a prolonged period of searching for an explanation for the tragedy. About half felt that a suicide in the family was a stigma and were unwilling to discuss the event with others, least of all with their children. These individuals experienced less relief and less sadness, but more anger and guilt, than did the other respondents. Few individuals requested help from mental health professionals. In commenting on the number of participants in the study—39 of 82 possible respondents—the author reported that the group which could not be contacted for interviewing contained more black families (only one of seven was interviewed) and more women. The author noted that many of the deceased men had been socially isolated and that many of the surviving family members, such as the spouses, had moved back to their families of origin.

Several aspects of this study are worth noting. One is the reported searching for an explanation for the tragedy, which frequently occurs in the anecdotal literature on bereavement due to suicide but is notably absent from most clinical reports on bereavement due to death under other circumstances. Second, the author's reports about family difficulties and the social isolation of the spouses suggest that family history may contribute in an important way to the aftermath of suicide. Third, the numbers and identities of the respondents raise the possibility that social isolation or the spouses' returning to their families of origin may have affected the recruitment of subjects and caused a selection bias. Finally, a methodological weakness of this study was the absence of any comparison group of families that experienced deaths other than suicides.

Another study (28) examined the impact of suicide versus natural death on 108 elderly bereaved individuals 2 months after the deaths. An interview and five standardized scales were used to assess depression, overall mental health, and psychological distress due to grief. The authors found significant differences on most measures between the bereaved groups and a nonbereaved control group. However, the two bereaved groups differed only in that those whose bereavement was a result of suicide showed a higher degree of anxiety. Because of the low study response rate of 35%, individuals who had refused to participate were recontacted by telephone. They reported that they were coping well with their loss; however, these nonparticipants were older, less educated, and in poorer physical health than the group that participated.

To our knowledge, this has been the only study of elderly persons whose bereavement was due to suicide; its design incorporated comparison groups, statistical controls for intergroup differences, and data on nonparticipants. However, the group that was bereaved because of suicide was younger, was occupationally less skilled, and included more women than the other groups. The nonparticipants, too, differed as a group from the participants. Finally, there were no follow-up

data; as the authors pointed out, the bereaved were still in the relatively early stages of grief, when other differences might have been less striking than their acute reactions to the deaths. Thus, the findings of this study are of unclear significance.

The process of grieving after suicide has been portrayed in clinical case reports as having certain common and uniquely disturbing aspects. One is the persistence of frightening and disturbing images of the death, whether that scene was actually witnessed or is imagined (29). One report (30) mentioned the "triple loss" with which the spouse is left to deal: the death itself, the implicit rejection by a loved one who preferred death to ongoing companionship, and disillusionment about a person whom the survivor had admired. A psychiatrist whose wife committed suicide described struggling during the rest of his life to integrate the "existential sequestrum" of his knowledge that his beloved wife chose to end her life (31). Suicidal ideation has been noted to occur in some individuals who are bereaved because of suicide (32).

Although the major focus of this paper is on bereavement due to a suicide in the family, the process of grieving after suicide may also be exemplified by the experiences of other individuals who have an intimate connection with a person who commits suicide. An example of such a connection is a psychotherapeutic relationship. Among staff members and patients in psychiatric treatment settings, the suicide of a patient has been found to produce marked feelings of shock, guilt, and anger (33–37). Some patients have become increasingly fearful about their own suicide potential. Psychotherapists have reported that the suicide of a patient elicited in them shock, grief, and anger, along with guilt and self-questioning about whether they had missed something important that the patient was saying (38–41). With striking unanimity therapists have said that formal and informal consultation with colleagues is one of the most important and helpful actions to take in coping with a patient's suicide.

On the other side of the equation, there have been several reports about patients whose psychiatrists committed suicide (42–44). All of these patients felt shocked, angry, and abandoned. In addition, they experienced demoralization and doubts about their own prospects for being helped, because they perceived the fallibility of their therapists in having committed suicide. The patients seemed to have perceived a double loss: that of the therapist as an individual and that of their faith in therapy itself.

In summary, reports about the grieving process after suicide associate it with certain apparently special experiences, including a sense of shock, a need to search for an explanation, and difficulty in sharing one's feelings about the suicide. Feelings of guilt may be strong and may persist. Such impressions, although based on reports of uncontrolled studies, are consistent, and their face validity is supported by numerous articles in the media and in current literature as well as in professional journals. The single controlled research report (28) failed to show any difference associated with bereavement due to suicide except for a higher degree of anxiety, but the significance of this result is unclear.

SOCIAL AND PSYCHOLOGICAL ADJUSTMENT AFTER SUICIDE

Three studies have compared social and psychological adjustment after suicide and after other types of death. In one study (45, 46), 20 widows whose husbands had committed suicide were compared, 1–2 years after the deaths, with 20 widows whose husbands had died suddenly under other circumstances. Approximately 25% of the potential subjects could be contacted and consented to participate. There was no difference between groups in terms of overall social adjustment; however, among the widows who had been bereaved as a result of suicide there was significantly more guilt and resentment as well as more social isolation. More than half of the men who had committed suicide had made previous suicide attempts, and 40% of their widows had separated from them before the time of their deaths. It was the author's impression that the widows of the men who had committed suicide had undergone fewer role changes since their spouses died, perhaps because many of these women had withdrawn emotional attachment from the spouse before the suicide and had developed a social life and an identity apart from the spouse. In contrast, the widows whose husbands' deaths were not suicides remained more dependent on the spouse up to the time of death; for them, therefore, the death was more disruptive. The author did not comment about whether marital problems might have contributed to the suicides. The conclusions of this study were weakened by some inconsistencies in the presentation of data and by the low response rate; the latter raises again the issue of potential selection bias.

Another study (47) explored whether individuals who have been bereaved because of suicide tend to isolate themselves socially after the death and, if so, whether this behavior might affect their health over the following year. Questionnaires were sent to 20 widows 1–2 years after their husbands had committed suicide and to 19 widows 1–2 years after their husbands had died in accidents. The widows were asked about their physical health, coping strategies, and the degree to which they discussed the spouse's death with close friends or counselors. Half of the questionnaires were returned; there was no difference in response rate between the widows who had been bereaved because of suicide and the others. While fewer health problems were found among widows who confided in others about their feelings toward the death, there was no difference in frequency of confiding between those who had been bereaved as a result of suicide and the other widows. There were no data about the nonresponders.

A recent study (48) compared 13 widows whose husbands had committed suicide with 13 whose hus-

bands had died in accidents. Potential subjects were contacted by mail and by telephone 4–24 months after the deaths; half of those contacted agreed to participate. At a mean of 15 months after the deaths, the subjects were interviewed and completed questionnaires about the family's response to the death, its functioning, and its support network both before and after the death. Scores on the questionnaires revealed no differences between the groups in their satisfaction with the family's functioning before and after the husband's death, on the degree of life stress experienced, or on psychiatric symptoms. However, the interviews revealed that the widows of men who had committed suicide became more emotionally distant and avoided their families; they also more often concealed the cause of death from other family members. In the suicide group, but not in the accident group, there was an atmosphere of guilt and blaming that involved both the widow and the children; this was due to feelings within the family and to blameful attitudes of other family members. It must be noted, however, that only those who could be reached approximately a year after a death were asked to participate in this study.

In a study of 100 suicides (49), 44 surviving spouses were assessed by means of a semistructured interview on various aspects of their personal, family, and social adjustment 5 years after the deaths. For 10 of the spouses who had died, information was obtained from death certificates, terminal hospital admission charts, and surviving relatives. In addition, the interviewers evaluated outcome by comparing the spouses' situations at the time of the suicides with their situations when they were interviewed. Outcome was rated as better for about half of the spouses and worse for the other half. Better outcome for the bereaved spouses was associated with alcoholism, disturbed personality traits, or previous suicidal behavior on the part of the deceased or with marital separation at any time. The authors thus inferred that the better outcome for some spouses after suicide might have resulted from the removal of the burden of living with a disturbed individual.

All of the studies we have just mentioned concerned social and psychological adjustment after the suicide of a spouse. The impact of a parent's suicide on the psychological and social adjustment of children has been the subject of only one study (50), which drew on the database of the 100 adult suicides mentioned previously. Twenty parents who committed suicide left 36 children who met the study conditions of being older than 2 years of age and of living with the deceased at the time of the suicide. Each surviving parent was interviewed about the child within a few weeks of the death and again 5–7 years later. Information from these interviews, along with school reports, yielded an assessment of the child's overall functioning, school performance, psychological symptoms and treatment, and relationships with the rest of the family. No direct clinical assessment of the children was attempted. A high rate of disruption prevailed in the bereaved children's home lives before the suicide: marital separations had occurred in half of the families, one-third of the parents had at some time been in trouble with the police, and one-third of the children were not living with both parents on the day of the suicide. After the suicide, one-third of the children showed behavior problems, persistent anxiety, aggressive behavior, or signs of withdrawal. At the time of the second interview, half of the children were functioning adequately and half inadequately. Poorer functioning in the children was associated with the parents having had marital separations, trouble with the police, or evidence of personality disturbance before the suicide. Unfortunately, the indirect nature of the assessments of the children in this study limits the types of conclusions that can be drawn, and the use of only two points of assessment, separated by years, omitted data on a large portion of the children's lives.

In summary, the studies on psychological and social adjustment after suicide are weakened by various methodological problems. They do, however, suggest that the suicide of a spouse is often preceded by a marital separation, which may be protective for the spouse who survives. It is unclear whether those who were available and who chose to participate in these studies constituted a self-selected group with greater independence and greater willingness to leave a troubled marital situation. The results of the study of children, while sketchy, suggest that the suicide of a parent may produce severe effects in some children, but the lack of a comparison group and of additional information about development prevents us from determining to what extent the children's problems predated the suicide.

MORTALITY ASSOCIATED WITH BEREAVEMENT AFTER SUICIDE

The only existing data, to our knowledge, on mortality associated with bereavement after suicide concern the risk of suicide among the survivors. Other potential causes of increased mortality in this group do not appear to have been investigated. One study (51) investigated whether bereavement is a cause of suicide among the widowed. Among other findings, the authors discovered eight suicides among widowed individuals whose spouses had also committed suicide. In contrast, only one suicide occurred among widowed individuals whose spouses had died under other circumstances. This led the authors to conclude that bereavement resulting from suicide is a special risk factor for suicide among the widowed. The statistical basis of their assertion is, however, unclear.

In another epidemiological study that included some data on mortality after suicide (52), 95,647 widowed persons were followed up. During a 1-month period, there were two cases in which the suicide of one spouse was followed by the suicide of the surviving spouse. Unfortunately, the authors did not study the incidence

of suicide among the widowed during a period longer than 30 days, nor did they investigate whether the spouse of an individual who commits suicide is at increased risk in general.

Looking at the question retrospectively, one may ask whether individuals who either attempt suicide or commit suicide have histories of exposure to suicide in their family or social backgrounds. Such questions tend to be applied to children and young adults rather than to spouses. In one such study of 12- to 19-year-olds who committed suicide (53), families, friends, and teachers were interviewed about the deceased youngsters. By contacting families immediately after the suicides, the authors achieved an 83% response rate. Compared with a matched control group of nonsuicidal friends, those who committed suicide had been exposed significantly more often to suicide attempts or threats by relatives or friends. The authors concluded that "exposure to suicide or suicidal behavior of relatives and friends appears to be a significant factor in influencing a vulnerable young person to commit suicide." A crucial aspect of this study was that the researchers were able to obtain a high response rate by making immediate contact and, presumably, by winning the trust of the respondents.

In another study (54), a comparison was made between the charts of 243 psychiatric inpatients with family histories of suicide by first- or second-degree relatives and the charts of 5,602 patients without such a family history. Half of those with family histories of suicide had attempted suicide one or more times, compared with one-fourth of the control group. In addition, half of the patients with family histories of suicide received diagnoses of affective disorder, compared with only one-fourth of the patients with no family history of suicide.

Taken together, these studies contribute some evidence that bereavement due to suicide may be associated with an increased risk of premature death due to suicide. Methodological weaknesses of the studies include relatively small effects (especially in the epidemiological data) and retrospective information gathering. In addition, the data do not allow distinctions to be made among the relative contributions of several different factors that might predispose toward suicidal behavior, such as familial affective disease, familial suicidal tendencies, and bereavement itself.

SOCIAL RESPONSES TO INDIVIDUALS BEREAVED BECAUSE OF SUICIDE

Family members of persons who have committed suicide have often stated in anecdotal reports that they are blamed and shunned by members of the community and by other members of their own families. Social psychologists have sought to assess the reality of these perceptions by giving fake newspaper reports of deaths to volunteer subjects and then asking about their reactions and attitudes toward the bereaved. In one such study (55), the subjects rated the parents of a child reported to have committed suicide as less likable and more to blame for the death than the parents of a child reported to have died from a viral illness. A similar study (56) included accident as one of the alternative hypothetical causes of death; again, the parents were more often blamed for the suicide than for the other deaths.

Finally, there have been two studies of college students who knew a person who had experienced the death of a friend or a relative during the previous 1–3 years (57, 58). In the first study, a structured interview of these students revealed that they found it more difficult to talk with those who had been bereaved because of suicide, and more difficult to express sympathy to the family of a person who had committed suicide, than was the case with individuals who had been bereaved because of accidents or natural deaths. In the second study, the students tended to attribute more blame to those who had been bereaved because of suicide. They also reported that these bereaved individuals had received more mixed messages from others after the suicide.

These reports corroborate the feelings of suicide victims' family members that they are more blamed and avoided than are the relatives of persons who die under other circumstances. This suggests the likelihood of social reinforcement of the self-blame and guilt that already preoccupy the bereaved person.

DISCUSSION

The data suggest that there are differences between bereavement due to suicide and bereavement due to other types of death. However, these data are far from conclusive.

By comparison with reports about grief in general, reports on grief after suicide emphasize a specific content in the preoccupations of the bereaved: there is first a sense of shock and then a process of searching for the meaning of the tragedy. Being close to such an event appears to have a profound emotional impact. The suicide remains an incomprehensible fact about a loved one. Although such reports are highly consistent in the literature on bereavement due to suicide and have high face validity, it would be important to know whether controlled studies confirm that this kind of emotional impact is distinctively associated with bereavement due to suicide.

Suicide of a family member may also be a risk factor for suicide of the bereaved individual. The fact that some suicidal individuals have a history of exposure to suicide does not prove, of course, that bereavement due to suicide is a risk factor for all such bereaved persons. Nevertheless, this finding of a risk factor has been reported in well-designed studies, and it is consistent with clinical observations. Thus, it is at least a plausible idea and worthy of further investigation.

There may be significance in the numbers and iden-

tities of the individuals who could be located for interviews on this subject and who agreed to participate in the studies. It appears that a number of spouses and their children either moved back to their families of origin after the suicide or had separated before the occurrence of the suicide. Whether this happens more frequently among individuals who are bereaved because of suicide than among other groups is a question that is raised by the studies we have mentioned, but it is not answered by the data.

Finally, there is a highly consistent set of findings that social attitudes are more blaming toward individuals who have been bereaved because of suicide. In this sense, these individuals are set apart socially from other bereaved people.

Our review suggests that in the design of future research, it is crucial to avoid the potential selection bias of including only family members who are available after a period of months to years in the area where the suicide occurred. Making contact within a short period after the suicide would reduce the likelihood of missing families that move away. In addition, such rapid contact, if presented as an attempt to be helpful, might maximize the family's willingness to participate; it would also provide a basis for long-term follow-up study. Future research also should include comparison groups of individuals whose bereavement has resulted from deaths that were not suicides and should include repeated assessments of the bereaved over time.

In addition, our review strongly suggests that future studies should include assessments of family history, of the degree of preexisting family disruption, and of the family's socioeconomic situation after the death, since these factors may play a significant role in determining the course of life for bereaved individuals after a suicide in the family. Specific ways in which such factors may have an influence are suggested in a review of epidemiological studies of mortality after bereavement (59). These include 1) homogamous mating of individuals who are vulnerable to stress, to self-destructive behavior, or to suicide itself, 2) a shared social environment of stress or morbidity in the family predating the death, 3) a change in life circumstances after the death that would place the bereaved at risk, such as the absence of financial support or of personal care that had been provided by the deceased, 4) a change in the health practices of the bereaved, such as increased use of alcohol or decreased attention to early evidence of disease, and 5) genetic transmission of factors related to depressive illness, to suicide, or to other potential risks.

We note that our recommendations complement the conclusions of a study by the National Academy of Science's Committee for the Study of Health Consequences of the Stress of Bereavement (6). This study identified the following general problems with current research on the process and outcome of bereavement: limited study of risk factors for adverse consequences of bereavement, too little attention to the impact of bereavement on family members, lack of attention to outcome beyond the first year of bereavement, and a tendency for researchers to make idiosyncratic decisions about the selection of predictor variables and the measurement of outcomes, rendering it difficult to compare studies.

While awaiting the results of systematic studies, clinicians may use knowledge that we already possess to help the individual who has been bereaved because of suicide. We have found no comparative studies that examine the types of help that these individuals prefer or the comparative efficacy of different types of therapy that they may receive. However, there are anecdotal reports about support groups. Some observers have found that the members of "suicide survivor" peer groups feel a profound sense of relief at being able to tell their stories (29, 60, 61) and that there may be improvement over time in symptoms of depression, emotional lability, concentration, and capacity to function as parents or students. In thinking of such a referral, one must bear in mind that those who participate in such groups may be self-selected individuals who are particularly articulate, communicative, and willing to share their difficulties.

The following might be useful guidelines for persons who work with individuals bereaved as a result of suicide. First, these survivors never resolve their feelings entirely. Therefore, overly ambitious therapeutic goals in this direction may frustrate rather than help the bereaved individual. Therapists should be particularly attuned to conscious and unconscious feelings of guilt due to anger or to perceived failures to save the deceased person (62, 63). Second, some of these bereaved individuals may respond positively to peer group experiences. Third, a family history of suicide should be asked about in interviewing any patient, since some patients may be reluctant to reveal this information. Such a family history may be related to current feelings of distress. Finally, if a patient commits suicide while in therapy, one should make an active effort to talk with the family. Such support at this crucial time may have long-lasting benefit for the family members, not to mention the clinician. We hope that future research will add to our understanding of those who have been bereaved as a result of suicide and will suggest additional ways of helping them.

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