

Life after Death: Coping in the Aftermath of a Suicide

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abstract

Victimology is an emerging, evolving field of knowledge in which «new» victims are discovered, researched and provided with assistance. Suicide survivors, those intimately or directly affected by a suicide, face formidable difficulties in coping with a suicide. These difficulties range across the grieving process, limited social support after a suicide and the impact upon family relations. Therapy may help survivors adapt to the suicide and construct a meaningful life that may include nurturing an ongoing bond with the deceased. Victimology has important contributions to make regarding the understanding and treatment of this neglected group whose struggles and needs are becoming increasingly evident.

key words

Suicide, Victimology, secondary victims, recovery.

resumen

La Victimología es un campo de conocimiento emergente y en evolución en el cual se van descubriendo «nuevas» víctimas, investigando sobre ellas y proporcionándoles atención. Los supervivientes del suicidio, aquellas personas afectadas de forma íntima o directa por el suicidio, se enfrentan a grandes dificultades a la hora de afrontar lo sucedido. Estas dificultades abarcan el proceso de duelo, el apoyo social limitado tras el suicidio y su impacto sobre las relaciones familiares. La terapia puede ayudar a los supervivientes a adaptarse y a construir una vida dotada de significado que puede incluir la integración de un vínculo permanente con la persona fallecida. La Victimología puede contribuir de forma notable al entendimiento y tratamiento de este grupo olvidado cuyas reivindicaciones y necesidades se están haciendo evidentes de forma creciente.

palabras clave

Suicidio, Victimología, víctimas indirectas, recuperación.

Victims in the current usage of the term are people who are beset by loss, injury or hardship from any cause (Karmen 2004). The decriminalization of suicide means that those grieving in the aftermath of a suicide may not become involved with the criminal justice system, but in many cultures significant stigma related to suicide remains (Cerel, Jordan et al. 2008). The suffering of suicide survivors, those intimately or directly affected by a suicide, can be intense and may remain with them for the rest of their lives (Jamison 2000). This article describes the situation of survivors and suggests ways that victimology can contribute to the goals of understanding survivors and assisting them.

An accumulating array of data indicates that suicide survivors face debilitating sequelae in the aftermath of a suicide. Indeed, the situation faced by survivors is the most prominent public health problem related to suicide (Dyregrov 2011). Survivors are at risk for negative health, social and economic outcomes, including suicidal ideation, suicide attempts and completion. Compared to those not exposed to suicide, survivors are 1.9 times more likely to consider killing themselves, 2.9 times more likely to develop a suicide plan and 3.7 times more likely to have made a suicide attempt (Maple, Cerel et al. 2014). Survivors are deemed to be the most prominent mental health casualties of suicide (Pompili, Lester et al. 2008).

Most research on survivors has focused on psychological and social dimensions. Survivors experience elevated levels of guilt, rejection and abandonment by the deceased, strain and avoidance in relationships among family members and friends, trauma reactions and complicated or prolonged grief disorders. The heightened risk of suicidal ideation, attempts and completions is found among both biological and non-biological family members, perhaps due to a modeling effect (Jordan 2009). For some survivors, the suicide never goes away. Perhaps years later, a survivor may wake up and ask, «Why?» Attending a support group for suicide survivors, one mother of a son who had killed himself was dumbstruck at the severely emotionally damaged state of the parents. It seems that they bear a wound which will never heal. An estimated 20% of mothers becomes significantly depressed within 6 months of the suicide of a child (Jamison 2000).

Suicide is a violent death. The survivor may have been present at the time of the suicide or discovered the body. Long afterwards, the survivor may ruminate upon the suffering of the deceased just prior to death. Such recurring thoughts and experiences elevate the survivor's risk of developing symptoms of acute stress disorder or posttraumatic stress disorder. Symptoms include reliving the experience repeatedly, losing control or becoming numb emotionally, being irritable or unable to concentrate or being unable to sleep or eat regularly (Jordan 2009).

One way to develop a meaningful understanding of the experience of suicide survivors is to compare their experiences with those who are bereaved by other causes of death. Implications to the bereaved as a result of four types of death may be envisioned as four concentric circles, like a bull's eye target. The closer to the center one gets, the more challenging the sequelae for the bereaved. The outermost circle includes features found in all kinds of death such as sorrow, pain, missing the deceased and yearning to be united. The second circle includes features found in unexpected deaths such as shock and a sense of unreality. The third circle has features of bereavement common to violent deaths such as the experience of trauma and the shattering of a sense of personal invulnerability. The innermost circle has features of bereavement due to suicide such as anger, aggression, feelings of abandonment and rejection (Andriessen 2014). For some survivors, the trauma of losing a loved to suicide can be nothing short of catastrophic. Coping with the suicide of a loved one may be the most challenging ordeal a person ever has to face. Grief takes a longer time to subside among survivors than people bereaved by deaths from other causes. In one study, the differences in the character and extent of grief between survivors and other bereaved became non-significant only in the third year following the suicide (Pompili, Lester et al. 2008). Table 1 lists practical, psychological and social sequelae for survivors, by percentage of survivors who indicated that difficulty (McMenamy, Jordan et al. 2008).

Table 1. Frequency of Moderate to High Levels of Practical, Psychological and Social Difficulties among Survivors of Suicide

Practical Issues
Impairment of daily activities (work or home): 61%
Psychological Issues
Depression: 75%
Guilt: 73%
Anxiety symptoms: 64%
Anger and irritability: 53%
Sleep disorders: 53%
Trauma symptoms: 55%
Intense sadness and yearning for your loved one: 84%
Social Issues
Difficulty talking about the suicide within the family: 61%
Difficulty sharing grief within the family: 64%

An ongoing discussion in the literature is whether grief due to suicide is different from other forms of grief. Part of the problem seems to be a lack of consensus regarding what would constitute sufficient evidence that suicide be-

reavement is indeed different. Research on this issue needs to catch up with the experience of survivors who, having grieved the deaths of loved ones from different causes, clearly indicate that bereavement due to suicide is different compared to that of deaths they have grieved from other causes. Following an overview of the grieving process, three prominent attributes associated with bereavement due to suicide will be considered: the character of the grief, the social response to the survivor and the impact that suicide has upon the family (Jordan 2001).

The Grieving Process

Grief is a universal phenomenon which is socially shaped and patterned. People grieve in very different ways in different cultures. It is the natural consequence of a loss in which there is an emotional bond. Grief may persist for several years and extend to an individual's emotional, physical, cognitive, spiritual and social well-being (Wilson and Marshall 2010). Grieving is profoundly personal and may provoke feelings of confusion, intense anxiety, depression and helplessness. Grief work is a cognitive process of coming to terms with a loss, of reviewing the time preceding and following the death and of going over memories of the deceased. Grief work requires effort. It is active and ongoing (Pompili, Lester et al. 2008). Traumatic grief involves the near-total shattering of the individual's assumptive world, defined as an individual's sense of identity and interrelationships between oneself, others and the world. This significant disarray in one's understanding of how the world works and one's own place in it is how some survivors describe their experience. The loss may be revisited and reconfigured throughout the lifetime of the bereaved (Sands 2008).

Grieving is oriented around reconstructing an individual's identity and one's understanding of one's relationship with others and the world. Grieving individuals seek to make sense of the loss and to find meaning in it. Four primary tasks of grieving include accepting the loss, processing the pain of the grief, adjusting to a world without the deceased and configuring an ongoing connection with the deceased in the context of a life without the deceased (Hall 2014).

A review of the content of survivor support group conversations resulted in 6 themes regarding the grief process for survivors:

- 1) Experiencing the emotional rollercoaster of the grief experience: disbelief, numbness, confusion, chaos of the mind, guilt, anger, resentment, depression, worry, regret, powerlessness, frustration, violence, horror, loneliness, abandonment and even relief.
- 2) Coping with the loss by taking an adaptive attitude, survivors remained in control and engaged in life. Some survivors were able to reframe the

suicide as having positive implications for their lives, pursued positive activities (socializing, exercise) and monitored negative coping (alcohol/drug use).

- 3) Dealing with the stigma of suicide. One parent spoke only once in 20 years of the suicide of his son, and that to a counselor.
- 4) Forging a sense of meaning from the suicide: For some survivors, the search for why is never resolved. Others chose to focus on mental health issues and difficulties in managing the stresses of life. Many came to a point of deep compassion regarding the loved one's choice to end overwhelming suffering.
- 5) Engaging in self-reflection on issues of meaning, responsibility, relationship and identity. Survivors may be more self-aware, stronger and resilient as a result.
- 6) Moving forward, in part by accepting the unacceptable. It can take many years to process the grief, and it may be reawakened by events, memories and anniversaries (Gall, Henneberry et al. 2014).

Especially for survivors, suicide is a confusing death, one which may uproot a survivor's sense of place, belonging and connection with others in a way that is quite distinct from other causes of death. Suicide violates fundamental principles of self-preservation. Survivors show higher levels of guilt and blame for the death. For example, having been shocked by the decision of a loved one to commit suicide, the survivor may come to doubt whether any two people ever can come to truly understand each other and whether it is possible to ensure the safety of those we love (Jordan 2015). Disruption to a survivor's assumptive world may precipitate family dysfunction, negative health outcomes and performance on the job, strained social interactions and depression (Sands 2008). Significant variables predicting the course of the grief process for survivors include kinship relation, the closeness and character of the bond to the deceased and the length of time since the suicide. Closeness of relation brings with it an elevated risk of symptoms of complicated grief (Andriessen 2009).

Prolonged or complicated grief is characterized by a preoccupation with the deceased, avoidance, disbelief, numbness, detachment, excessive irritability and anger. Complicated grief is linked to negative beliefs about the self and the future, long-term somatic and psychiatric morbidity and suicidal ideation, even after controlling for depression. Suicidal ideation is associated with an increased risk of long-term complicated grief and depression. Complicated grief is more likely to be experienced among survivors who lost a child to suicide. Mutual support was linked to an increase in the risk of complicated grief (Groot and Kollen 2013).

Other prominent aspects of the grief experience of survivors are guilt (blaming oneself) and blaming (others). Guilt and blame both are attempts to make sense of the suicide. The rationale appears to be that if suicides are preventable, then if someone had taken adequate action, the death could have been avoided. The adults closest to the deceased may be blamed for the death. As such, the situation of survivors may differ considerably. For example, children may not be blamed for the suicide of a parent (though children may and often do blame themselves), but parents may be blamed for the suicide of a son or daughter. The lingering social stigma and ignorance regarding suicide may lead to many unkind rumors (Jamison 2000).

The social stigma pertaining to suicide presents a particular hurdle for survivors. Survivors receive less social support and are less likely to ask for it compared to those grieving other types of deaths. Survivors are judged more negatively. Suicide is the only type of death in which survivors are asked to explain the death. Survivors were more isolated and were perceived by people in their social network as being more psychologically disturbed, less likable, more blameworthy, more ashamed, more in need of professional mental health care and more likely to remain sad and depressed (Jordan 2009).

Due to the social nature of the grieving process, it is entirely unsurprising that survivors would participate in their own stigmatization, leading to social ostracism, a distortion of communication, self-isolation, and a cycle of misunderstanding and avoidance (Cerel, Jordan et al. 2008). Self-stigmatization may elevate distress and hinder the grieving process among survivors (Maple, Cerel et al. 2014). A total of 76% of those bereaved by accidental death stated that changes in social interaction after the death had been of a positive nature. Only 27% of suicide survivors answered similarly. Suicide survivors were the only group who lied to others about the cause of death (Jordan 2001).

Stigma is especially injurious because of the importance of social support in the grieving process. Social support is a significant factor in the course and outcome of grieving after any type of death, especially for suicide. Adapting to loss involves restoring a sense of coherence to one's life narrative, and that restoration often proceeds in the context of extensive, informal conversations and shared stories. How do I make sense of the death? How do I adjust my relationship to the deceased? How do I carry on with my own life now that this has happened? These are the central questions that bereaved ask themselves, and the answers often are pursued through conversations with others (Stroebe and Schut 1999). Grief is shaped by what is communicated to survivors and by the particulars of the death (Corden and Hirst 2013). The absence of social support to survivors complicates the grief work of the survivor in what may be termed «disenfranchised grief» (Sands 2008).

In addition to being self-inflicted, suicide is also violent and often unexpected. Survivors may witness a violent death or discover a mutilated body. They often do not have the chance to prepare themselves for the death or to say goodbye to the decedent. Police and insurance investigators may inflict secondary victimization through their insensitive questioning and handling of the case (Jamison 2000).

Suicide and the family

The family is a natural area of focus prior to and after a suicide. The suicide itself may be an expression of distress and conflict within the family. Families in which there is a suicide are more likely to show signs of divorce, domestic violence, substance abuse, mental health problems and dysfunction prior to the suicide. Disarray in the family may lead members to blame themselves and/or each other for the suicide. However, it simply is not the case that suicide is proof that a family is dysfunctional (Jordan 2015).

Whatever the character of family dynamics before the suicide, a family may be hard pressed to recover in the wake of a suicide. A grieving parent may not be emotionally available to other family members. The suicide may have swept away a family's collective understanding of its ability to predict and manage events. As such, family members need to develop a new understanding of family dynamics and roles that takes the reality of the suicide into consideration. Even with professional assistance, it may be a formidable challenge for family members to discuss the loss, share their grief and turn to each other for support. Furthermore, the social network of the family may not be available after a suicide. Family members themselves have an increased risk of substance abuse, suicidal ideation and depression after a suicide (Jordan 2015).

Family conflicts and dysfunction prior to the suicide may be reflected upon by family members after the death and may lead to future family splits. The surviving parent may not be in a position to bring the family together. Those parents grieving the suicide or drug overdose of a child were more likely to suffer from grief, complicated grief, stigma and trauma than parents whose child died due to natural causes or an accident. Moreover, parents whose child had a history of suicide attempts were at risk for elevated guilt and blame after the suicide (Maple, Cerel et al. 2014). Families of suicidal people (especially suicidal children and adolescents) have more problematic interactional styles and disruptions of attachment within the family. A dysfunctional family may serve as both a predisposing and a precipitating factor in a subsequent suicide. Twice as many survivors reported that family relationships had grown more distant than reported them growing closer after a suicide. Families in which there had been a suicide show poorer scores on enmeshment, conflict and cohesion. Suicide-affected families may ex-

perience the shutdown of open communication, disorganization and breakup, substance abuse, intra-family violence, sexual abuse, disruption of role functioning of family members, conflict regarding bereavement coping styles, unstable family coalitions and intergenerational boundaries and unstable relationships between the family and social networks. The long-term impact upon families after a suicide may include thwarted development of the family, unstable communication and faulty transmission of a family world view to future generations. These sleeper effects may be unique to suicide and may make a subsequent suicide harder for the family to deal with. Especially in the family, suicidal bereavement is unusual due to its modeling effect. Suicide becomes an acceptable option. The mourner has an elevated risk of suicidal behavior and completion. Especially early parental loss is associated with later suicidal behavior (Jordan 2001). Family difficulties in the wake of a suicide include cohesion, adaptation, family communication, support, intimacy, guilt and blaming. Prior to the suicide, families with minor children experienced chronic turmoil, marital separation, trouble with the law and domestic violence (Cerel, Jordan et al. 2008).

Outcomes of grief processes

In grief, the focus of survivors is to rebuild their lives and come to terms with the decision of the deceased to kill him/herself. The latter may be particularly difficult if the relationship prior to the death had been conflicted or unsettled (Maple, Cerel et al. 2014). After the suicide, prolonged symptoms among survivors similar to PTSD such as emotional numbness, flashbacks, irregularity of sleeping and eating, irritability, may indicate the need for psychological therapy. The goals of therapy may include containing the trauma. Another goal is to learn to choose to engage in grief work («voluntary grieving») in ways and doses that are manageable for the individual. Therapy also may help the survivor perform a psychological autopsy of the deceased in order to construct a durable biography of the life of the deceased. A broad understanding of the life of the deceased as well as the events which culminated in the suicide may contribute to releasing the survivor from any feelings of responsibility for the suicide. Through therapy the survivor may learn to manage social interactions that may have changed in the aftermath of the suicide. Members of the survivor's social network may be awkward, if not judgmental and blaming, in their interactions with the survivor.

A further goal in therapy may be to assist the survivor in reconfiguring an enduring bond with the deceased. It is neither necessary for a fulfilling future nor perhaps possible for the survivor to erase from his/her life the possibly years-long, complex, deep bond shared with the deceased prior to the suicide. Quite the contrary, managing to incorporate ties developed with the deceased,

ties which take into account the suicide and its sequelae, into an ongoing bond may facilitate the healing process and the future psychological well-being of the survivor. A final, overall goal of therapy is to help the survivor return to living. This goal may require the survivor to reconstruct his/her world so as to be able to affirm life and to find pleasure, meaning and purpose in a future life path in the absence of the deceased (Jordan 2015).

Potential outcomes of the grieving process include positive growth, the creation of a durable biography of the deceased and reconfiguring a place for the deceased in the ongoing life of the bereaved. Interpersonal outcomes of grieving include maintaining relationships and restoring the functioning of the family as a unit (Stroebe and Schut 1999).

The challenge of survivors is to come to terms with the violent, seemingly irrational nature of a suicide death and to incorporate the suicide into their understanding of themselves and others so as to affirm and engage in life. Recovery after a suicide does not mean returning to a pre-loss state of functioning. The fact of the suicide has removed that possibility. Rather, recovery is used in a functional sense and refers to being able to function socially, emotionally and behaviorally in light of the suicide. Being able to function is not synonymous with the cessation of grief. As survivors are quick to indicate, in significant ways, the grief may never end (Sands 2008).

One potential outcome of the grieving process is continuing bonds. Continuing bonds is a reorganization of one's relationship with the deceased to allow for an abiding connection. This new relationship may see the deceased as a role model, a listener, a presence in one's dreams or part of a ritual. It is estimated that half of bereaved people sense the presence of the deceased (Hall 2014). Continuing bonds may facilitate adaptation to the loss by assisting the survivor in dealing with feelings of abandonment, rejection or betrayal of the survivor by the deceased. Configuring the bond with the deceased may involve writing a letter to the deceased, engaging in a guided imagery or empty chair conversation or a ritual at the gravesite. Creating a durable biography of the life of the deceased which incorporates stories contributed by people who knew the deceased may be particularly meaningful to survivors, in part because of its emphasis upon the life of the deceased rather than upon the manner of death. Unfortunately, constructing this biography and collecting such stories may be more difficult due to the stigma of suicide. The biography of the deceased helps the survivor gain perspective on the entire life of the deceased and to dis-identify with the choice of suicide by the deceased. This focus on the life values and focus of the deceased lies along the survivor's path of affirming and living his/her own life. How to make sense of the suicide and to make one's own peace with it while renewing and committing oneself to a sense of purpose in life remain a significant part of the healing that survivors engage in (Jordan 2009).

Meaning-making

A suicide represents a beginning of sorts for a survivor along a path to reconstructing one's own life without the deceased and to make sense of the life and death of the deceased. The survivor defines his/her needs and ascribes a meaning to suicide generally and to the suicide of their loved one (Dyregrov 2011). A central part of this process is reconstructing the survivor's assumptive world. The magnitude of the loss may inhibit this process, especially if the loss calls into question the survivor's notion that life is predictable or that the universe is benign. A failure to find meaning is associated with protracted, higher levels of complicated grief, depression, anxiety and anger. The process of constructing meaning is iterative and interactive. The impact of this disruption of core belief systems on developmental processes may be a distinguishing feature of suicide survivors. Due to the confusing nature of a suicide, the efforts by survivors to make meaning of the suicide may be characterized by a waning interest in the matter rather than a definitive resolution (Hall 2014).

Reconstructing the survivor's understanding of the world often means delving into the details of the suicide in the attempt to make sense of it, often referred to as a psychological autopsy. Part of this examination may include an assessment of the survivor's own role in the suicide as well as the survivor's inability to prevent the suicide. The resulting sense of guilt for not having prevented the suicide may impede the survivor's progress in working through his/her grief and reconstructing and committing him/herself to living a life without the deceased. Developing a narrative understanding («telling a story») of the life and death of the deceased may prove useful in reconstructing the assumptive world of the survivor. The psychological incoherence that may follow in the wake of the suicide can be regained, though in a manner that takes into account the absence of the deceased and the implications of that absence for the survivor (Jordan 2009).

Making sense of the suicide was associated with lower levels of distress for survivors in the first year following the loss. Being able to discern a benefit from the suicide was associated with enhanced adjustment 13-18 months after. The existence of positive meanings for the survivor was associated with positive adjustment to bereavement. Meaning-making may emerge through narratives or stories that the bereaved tell themselves (self-stories) and others, often about relationships, particularly with the deceased. Indeed, in some senses the deceased is a co-author of the stories told about them. Psychology arguably would be enriched by paying more attention to the manner in which these stories are part of an adaptive response to loss by survivors.

Successful meaning-making is related to improved outcomes in the grief process. Unsuccessful meaning-making, together with a close, post-loss

attachment to the deceased, is associated with prolonged, complicated grief, suicidal ideation and possible suicide completion. The violent, senseless nature of a suicide presents significant, perhaps insurmountable challenges to the attempt of a survivor to forge a sense of meaning in the wake of the death (Sands 2008).

Survivor Support Groups

Survivors developed a support system infrastructure in the United States starting in the 1980s, often because they felt they had nowhere to turn for understanding and support. Anyone who has spent time in a support group is overwhelmed by the amount of suffering among survivors. At one meeting attended by the author, the attempt to have everyone introduce him/herself was abandoned because a number of people attending the meeting were crying (and, thus, unable to speak). Survivors may feel that the mental health establishment failed the deceased prior to the suicide and is now failing them as well. Most commonly, support group meetings take the form of open meetings facilitated by survivors. Annual memorial services, fundraisers, outreach to survivors, newsletters, school and community presentations and the broadening of the network are examples of activities through which survivors connect and interact. National organizations train suicide survivors to facilitate meetings and provide outreach services. The organizations also inform mental health professionals of the unique situation facing suicide survivors (Jordan 2015).

Many survivors want to speak with other survivors. It is estimated that one-fourth of survivors attend survivor support groups at some point (Maple, Cerel et al. 2014). Advice which comes from other survivors is deemed to be credible. The give and take of the conversations is helpful to everyone involved, especially at a time when the newly bereaved may feel overwhelmed. Survivors may benefit more from talking about an unexpected loss such as suicide rather than one that was expected (Stroebe, Stroebe et al. 2002).

Postvention

Postvention are those activities undertaken in the wake of suicide or a suicide attempt in order to facilitate recovery among the survivors and to mollify any negative consequences related to the suicide or suicide attempt (Andriessen 2009). Similar to many types of victim assistance, a prominent part of postvention is providing information to survivors. Information that is useful for survivors includes the medical aspects of the suicide, the grief process and the effect that the suicide may have on family members and on the functioning of

the family as a whole. Adult survivors often request information on assisting surviving children and on how to manage communication issues within the family.

Postvention also tries to address survival needs. These needs may encompass a range of practical, economic and legal issues, quite in addition to psychosocial assistance and advice. The low level of psychosocial functioning among survivors may be such that those rendering assistance need to be more proactive regarding initiating and maintaining contact compared to working with those who are bereaved from other causes of death (Dyregrov 2011).

Postvention also has a role in helping organizations respond to the suicide of a member of the organization. Organizations such as schools, companies and churches, while formerly ignoring the suicide of a member, have begun to respond because many leaders realize the necessity for a collective response. A suicide may call into question the organization's mission, procedures and focus. There also is the risk of suicide contagion. A collective response helps the relevant public grieve in appropriate ways, make sense of the suicide, re-commit to living their own lives and perform more effectively their roles in the organization. Suicide in an organizational context may provide the impetus to educate people about suicide, thereby reducing the likelihood of suicides in the future (Jordan 2015).

Table 2. Frequency of Moderate to High Levels of Helpfulness by Resource Type

General grief support group: 27%
Suicide grief support group: 94%
Individual therapy: 80%
Pastoral counseling with clergy: 65%
School-based services: 50%
Books on suicide and grief: 85%
Church or religious group: 66%
Psychotropic medication: 69%
Internet Web sites: 72%
Advocacy organizations: 78%
Couples or family therapy: 69%
Talking one-to-one with another suicide survivor: 100%

Not all survivors are alike, and a variety of formats for postvention activities arguably increases the likelihood of reaching particular survivors when needed. Helpful formats include online support, bibliotherapy, individual counselling, group support, community support, rituals and psycho-educational information (Hall 2014). Table 2 shows a list of services for survivors by percent-

age of survivors who found these sources to be helpful (McMenamy, Jordan et al. 2008).

A role for victimology

Victimology has unique strengths that researchers and practitioners can draw upon to further an understanding of the situation of suicide survivors and to improve services provided to them. One problem has to do with the definition of who a suicide survivor is and, following from that, how many survivors there are in various populations around the world. Victimology has a good track record of conducting victim surveys in various countries. These skills are needed to provide solid data regarding the numbers and characteristics of suicide survivors.

Secondly, nearly all articles on survivors focus on the psychological and social consequences of suicide. Very little research has focused on the financial outcomes of being a suicide survivor. In addition, victimology has elaborated upon the relationship between the victim and the perpetrator. What is the relationship between the decedent and the survivor? Did the survivor affect the course of the suicide? Are some people more likely to be survivors than others? If so, what are the characteristics of these survivor-prone individuals (Lester 2001)?

Suicide and the implications to those who are left behind are topics which are becoming increasingly more prominent, especially in developed, Western countries. The fact that most suicides occur in low- and middle-income countries where there are little data and few services for survivors points to the challenges ahead (World Health Organization 2014). Societies will emerge as role models to the extent that they are able to reduce the number of suicides, and the most prominent public health problem regarding suicide is dealing with the consequences of suicide to survivors. Victimologists have skills they can bring to bear on behalf of suicide survivors, and such efforts would help address the struggles of survivors, a group whose needs are all too clear.

References

- Andriessen, K. (2009). «Can Postvention Be Prevention?» *Crisis* 30(1): 43-47.
- Andriessen, K. (2014). «Suicide Bereavement and Postvention in Major Suicidology Journals.» *Crisis* 35(5): 338-348.
- Cerel, J., J. R. Jordan and P. R. Duberstein (2008). «The Impact of Suicide on the Family.» *Crisis* 29(1): 38-44.

- Corden, A. and M. Hirst (2013). «Economic Components of Grief.» *Death Studies* 37: 725-749.
- Dyregrov, K. (2011). «What Do We Know About Needs for Help After Suicide in Different Parts of the World?» *Crisis* 32(6): 310-318.
- Gall, T. L., J. Henneberry and M. Eyre (2014). «Two Perspectives on the Needs of Individuals Bereaved by Suicide.» *Death Studies* 38: 430-437.
- Groot, M. d. and B. J. Kollen (2013). «Course of Bereavement over 8-10 years in first degree relatives and spouses of people who committed suicide: longitudinal community based cohort study.» *British Medical Journal* 347: 1-11.
- Hall, C. (2014) «Bereavement theory: Recent developments in our understanding of grief and bereavement.» *Bereavement Care* 33, 7-12.
- Jamison, K. R. (2000). *Night fall fast: understanding suicide*. New York, NY, USA, Vintage Books.
- Jordan, J. (2009). «After Suicide: Clinical Work With Survivors.» *Grief Matters*(Autumn): 4-9.
- Jordan, J. R. (2001). «Is Suicide Bereavement Different? A Reassessment of the Literature.» *Suicide and Life-Threatening Behavior* 31(1): 91-102.
- Jordan, J. R. (2015). *Grief After Suicide: The Evolution of Suicide Postvention. Death, Dying and Bereavement Contemporary Perspectives, Institutions, and Practices*. J. Stillion and T. Attig. NY, NY USA, Springer Publishing: 349-362.
- Karmen, A. (2004). *Crime Victims*. Belmont CA, Wadsworth/Thomson Learning.
- Lester, D. (2001). «Suicidology: A Victimology Perspective.» *Crisis* 22(3): 89-90.
- Maple, M., J. Cerel, J. R. Jordan and K. McKay (2014). «Uncovering and Identifying the Missing Voices in Suicide Bereavement.» *Suicidology Online* 5: 1-12.
- McMenamy, J. M., J. R. Jordan and A. M. Mitchell (2008). «What do Suicide Survivors Tell Us They Need? Results of a Pilot Study.» *Suicide and Life-Threatening Behavior* 38(4): 375-389.
- Pompili, M., D. Lester, E. D. Pisa, A. D. Casale, R. Tatarelli and P. Girardi (2008). «Surviving the Suicides of Significant Others.» *Crisis* 29(1): 45-48.
- Sands, D. (2008). *A study of suicide grief: Meaning making and the griever's relationship world*. Ph.D. dissertation, University of Technology, Sydney, Australia.

- Stroebe, M. and H. Schut (1999). «The Dual Process Model of Coping with Bereavement: Rationale and Description.» *Death Studies* 23: 197-224.
- Stroebe, M., W. Stroebe, H. Schut and E. Zech (2002). «Does Disclosure of Emotions Facilitate Recovery From Bereavement?» *Journal of Consulting and Clinical Psychology* 70(1): 169-178.
- Wilson, A. and A. Marshall (2010). «The Support Needs and Experiences of Suicidally Bereaved Family and Friends.» *Death Studies* 34: 625-640.
- World Health Organization (2014). *Preventing Suicide: a global imperative*. W. H. Organization. Geneva, Switzerland.

