



## Knowledge Exchange Seminar Series (KESS)

### Towards an Understanding of the Role of Bereavement in the Pathway to Suicide

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#### Key Points

1. Suicide bereavement is associated with increased depression and risk of suicide. The increasing rate of suicide in Northern Ireland presents a major challenge to health and social care policy.
2. To date policy development on the topic has been hampered by a lack of local evidence. Contextually specific research reports are now emerging to strengthen the evidence-base.
3. The findings from our own study suggest that people bereaved by suicide include extended family members and members of the wider community, who can experience lengthy periods of depression and anxiety.
4. Bereaved family members and significant others, may require more nuanced, multi-dimensional interventions, provided over extended periods of time, in order to facilitate varied and complex grief processes.
5. A focus on empowerment, education and information may provide results that are as effective as increasing access to psychological services – these approaches should exist in tandem.

#### Biography

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## 1. Introduction

This briefing focuses on bereavement in relation to suicide. We have chosen to focus on these issues for two main reasons. Firstly, given the unique cultural context of Northern Ireland bereavement is potentially an important social issue affecting mental health. Secondly, the rising suicide rates in Northern Ireland and the resulting increase in the number of bereaved relatives is of particular concern given the association between bereavement by suicide and the risk of suicide itself (Crosby & Sacks, 2002). We examine primary data from the Understanding Suicide study in order to provide a practical, policy-driven contribution to the growing knowledge base surrounding suicide in Northern Ireland. Our data is drawn from a mixed methods research study, incorporating both quantitative and qualitative approaches. Therefore, the content includes descriptive statistics, in combination with composite case studies based on data gathered during over 100 hours of interviews with families across Northern Ireland. We begin by providing a brief overview of the policy context which suicide is addressed within in Northern Ireland, contextualising it with published national and international literature (Section 2). Section 3 develops the current knowledge based on the findings of the Understanding Suicide research. The paper concludes with suggestions for practical application of the findings (section 4).

## 2. Context of Death by Suicide in Northern Ireland

Death by suicide and the consequences of death by suicide, are widely recognised as one of the most pressing public health issues faced by the world (Cutcliffe, 2011). The cost of suicide is high, both in economic and human terms (Institute of Medicine, 2002; Schneidman, 2004). Economic analyses place the cost of each suicide somewhere between £1.1m and £1.5m. In Ireland, the direct (e.g. public services), indirect (e.g. loss to workforce) and human (e.g. pain and grief) costs were calculated at 1% of GDP in 2001/2 (Kennelly, 2007). While the complex nature of collating suicide statistics means the magnitude of an upward trend in suicide in Northern Ireland should be interpreted with caution, it nevertheless remains alarming. Suicide is therefore a major issue for the Northern Ireland Executive. Once a taboo subject which attracted low public and political interest, it has increasingly become the subject of public debate, with frequent calls for action. A number of factors have contributed to the increased prominence of this topic in the public arena, not least community anxiety surrounding the rising rates. Increased advocacy and lobbying efforts and the climate of austerity have

also led to mounting concerns about access to, and quality of mental health services. Lobbying groups have successfully impacted on facilities for people experiencing a mental health crisis who present at Accident and Emergency through the introduction of the Card Before You Leave Scheme, although concerns remain about a systemic lack of confidence in the system. In parallel, there has been prominent reporting on suicide in both the national and local press. In combination, these and many other factors may mean the social context of NI has changed in a way that has significantly raised both the impact and public awareness of the risk of suicide in our communities.

## 2.1 Policy Responses

In common with many other countries, the Northern Ireland Executive responded to rising suicide rates by developing a suicide prevention strategy. The *Protect Life Strategy*, first launched in 2008 and refreshed in 2012, remains the Executive's policy response to the rising rates. The current document is dated as running until May 2014; however, the authors' understand discussions about the substantive future of this policy are on going. Alongside Protect Life, a cross-sectorial Mental Health & Wellbeing Promotion Strategy has been under development since the first strategy lapsed in 2008. This extended period of deliberation has created somewhat of a policy void, and has had a bearing on funding structures, professional and departmental collaboration, direction and action on the ground, resulting in increased pressure on the Protect Life strategy to deliver on all aspects of mental health promotion (Leavey et al., 2009). However, there are a wide range of related policy initiatives that address emotional wellbeing. These include the Shared Future policy, Victim's Strategy, Pupil Emotional Health and Wellbeing (PEHAW) iMatter initiatives, Investing for Health (and Health improvement Plans), Think Family, Families Matter, Health Action Zones for Belfast, the Belfast Healthy City Initiatives and locally focused regeneration efforts targeted at socioeconomically disadvantaged areas. These policy initiatives provide a landscape in which developing appropriate support choices for suicide bereavement should be well facilitated.

Early attempts to develop a response to rising rates of suicide may have initially been hampered by the lack of a locally sensitive evidence-base. This has begun to shift as local research into the area has been recently funded and is now being published (Leavey et al., 2009; Forbes et al., 2012; Public Health Agency, 2011; Jordan et al., 2010; O'Neill et al., 2014). One of the continuing challenges of developing effective, evidence-based policy to reduce the incidence of suicide lies in the complex set of risk factors that may contribute to a suicide. While there is a substantial literature on the causes of suicide, they have tended to focus on the link between mental illness and suicide (e.g. Foster, T., 1998; NCISH, 2014). These limit the effectiveness and reach of strategic prevention efforts to those engaged with mental health services (Hjelmeland & Knizek, 2010). By contrast, studies that examine social factors continue to be overlooked. For example, local efforts to account for the rise in suicide in Northern Ireland have been restricted by the lack of data available on social issues. In this seminar series, Tomlinson (2013) stated that a full appreciation of social factors behind completed suicides could sharpen 'the understanding of risk and the disconnect between mental health services and those in psychological crisis' (p.10).

## 2.2 The Ripple Effect

One area in which there is substantive agreement in the literature relates to the association between bereavement, and in particular bereavement by suicide, and increased risk of death by suicide (Jordan &

McIntosh, 2011). Research, including a study carried out in Northern Ireland (Forbes et al., 2014) has repeatedly shown that the so-called contagion or transmission of suicide is a real phenomenon (Jordan & McIntosh, 2011). This effect can impact both on families and the wider community. The literature suggests that while individual acts of suicide can threaten our personal sense of stability, rising rates of suicide can threaten community stability (Harder et al., 2011). In addition, at an ecological level, the increasing rate of suicide, in combination with the high public visibility, can be seen as potentially increasing the belief within some communities that suicide is an acceptable way of dealing with problems (National Institute for Mental Health, 2003). Northern Ireland therefore has a number of unique contextual community issues relevant to the issue of contagion, which require further in depth analysis.

## 2.3 Responding to Risk

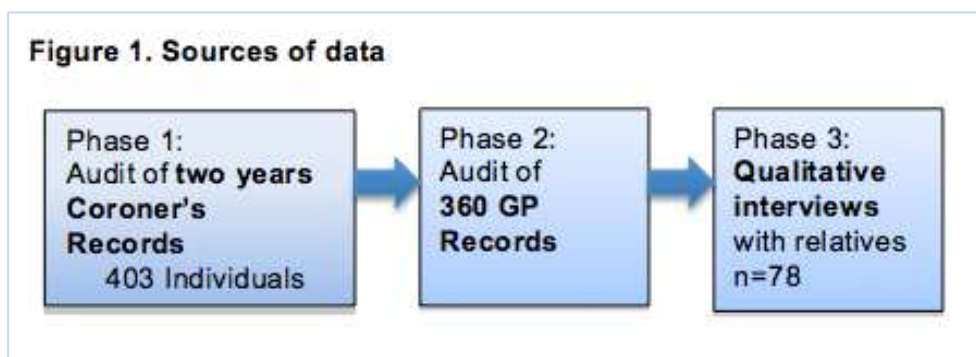
As a consequence of the known elevated risk, one of the key areas identified as being important to prevention of further deaths by suicide is the appropriate management and support of those bereaved by suicide; this is known as postvention (Andriessen, 2009). In the first version of the Protect Life Strategy, postvention was neglected. This has been rectified in the refreshed policy; one of the areas now recognised for action is to ensure 'that accessible information and timely support is available across the statutory, community, and voluntary sectors to support people bereaved by suicide' (Moore, 2012; DHSSPS, 2014). In Northern Ireland, specialist suicide prevention policies have been established in each of the Health and Social Care Trusts. This follows good practice established by other countries (Agee, 2010). Services are also provided by a range of voluntary sector organisations. However, attention has recently been drawn to the need for regulation within the voluntary sector (Forbes et al, 2012; Leavey et al, 2009). Despite consultation processes being undertaken in 2013, as yet no formal procedures have been introduced by the executive to evaluate these services.

## 2.4 Supporting Survivors

Surviving the suicide of another person is distressing and, undoubtedly, some survivors will need support to cope with the devastating consequences. There is continued disagreement in the literature about how many people are affected by each suicide, however the most recent estimates suggest that as many as 7% of people are exposed to bereavement by suicide every year and that 60 people are intimately affected by each suicide death, including nuclear and extended family, friends, colleagues, and classmates (Pitman et al., 2014) One of the problems with provision of services lies in identifying those most in need. Some researchers now suggest we should not assume that the consequences of all suicides are the same or that the level of impact of the death is associated with the closeness of the relationship with the deceased (McIntosh and Jordan, 2011). As a result, survivor provisions should be based on not only on kinship proximity but also on those who had a close association or attachment.

## 3. Findings

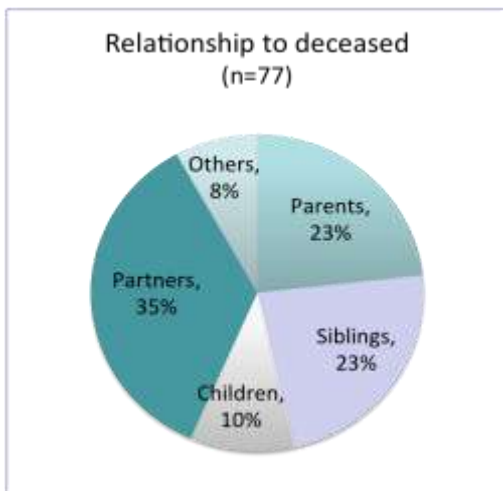
Death by suicide is a complex matter. The findings presented here relate to analyses of data from 3 separate sources (see Figure 1). It can be difficult to accurately represent this data in a briefing of this kind without overly simplifying the



experiences of individuals. As a consequence, to reflect both the individual nature of the deaths, while capturing data useful to policy makers, we present only a short selection of broad headline findings (further and more detailed publications are forthcoming). Where relevant, the sections commence with a brief outline of descriptive statistics to quantify the issue for the reader. We then present composite vignettes based on real life case studies which capture some of the ways in which the complexities of these issues were described to us by relatives.

### 3.1 List of bereavement issues in the 404 suicidal deaths:

We analysed data from the sources listed in figure 1 to identify those who had experienced a bereavement prior to death by suicide. Across 403 cases of suicide we were able to identify 61 (15%) in which bereavement played a part in the psychological sequela prior to death. In 30 of these cases the bereavement was recent. A further 7% (n=27) were exposed to a suicide or suicidal behaviour prior to their death. The proportions are likely to be underestimated, given that these sources of data cannot provide a complete picture of all the social circumstances facing these individuals prior to their death. At present, we have thus been unable to carry out additional risk ratio analyses to identify any prominent individual characteristics present in those who had experienced a bereavement.



### 3.2 Bereavement after a suicide

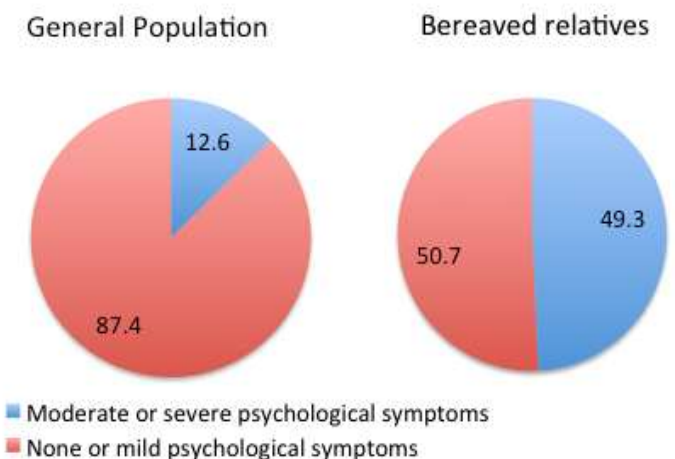
The 77 individuals who agreed to participate in an interview as part of the Understanding Suicide project represented a variety of kinship to the deceased (see figure 2). The largest group were partners of the deceased (35%), followed by parents (23%), siblings (23%), offspring (10%) and others such as cousins, nephews and in-laws (8%). Interviews took place between 18 months and 5 years after the death by suicide.

**Figure 2. Characteristics of the bereaved relatives**

Participants completed the Hospital Anxiety and Depression Scale (HADS). The results are illustrated in Figure 3. A score of 10 or above on this psychometric scale indicates moderate or severe psychological morbidity. In the general population, approximately 12.6% would typically fall into this bracket of need. Among our research participants, the figure was 49.3% indicating the importance of addressing the needs of this population.

We asked participants of our study to indicate if they, or anyone they knew, had become suicidal after the death, 48% (n=30) of them replied that they had. We

**Figure 3. (HADS) scores; general population compared to suicide bereaved.**



also gathered information on help seeking and found that 39% (n=24) undertook no formal help seeking. Of those who did seek help (61%), a small proportion relied on the GP alone (17%), and a further proportion attended only community based organisations for support (19%). A quarter of the sample who sought help had accessed both these sources of support (25%). Some of those who did not seek help felt they did not need it, these individuals showed a degree of personal resilience, many reported they felt they had done all they could to support their family member and/or they understood why the suicide had taken place. Others reported how they *'just got on with it'* by drawing on informal sources of support from family and friends. However, informal support could not always be relied upon as 26% (n=16) of those interviewed reported communication breakdown within the family following the death. Further examination of the qualitative data showed that some of those who did not seek help felt they may have benefited from support. The reasons they offered for not seeking support varied, often they did not know where to go and for some there was a clear reluctance to engage in suicide specific services. Others rejected the medical model, either because it had failed to help their relative, or because they wanted more than just medication. The following composite vignette is drawn from a number of real life cases and is designed to illustrate some of the key features relating to the complexity of these feelings after a bereavement by suicide.

### Composite case:

When Emma's husband died by suicide she was told that she and all her family are now *'more likely to be suicidal'*. She described how this *'blew her head away'* because *'she had never had thoughts like that'*. But became so distressed that *'she definitely contemplated it'*. She didn't find a local suicide support group helpful, because *'everyone was talking about me and the rumours'*. But she had a *'good chat to the counsellor there, he was someone neutral, and a very good listener who was obviously trained in suicide. He was like 'This is going to take time. You need to be aware that you are more susceptible so be aware of your feelings.'* She liked his *'educational approach'* and was *'craving information'* so she did *"any course that could make (her) understand why (her husband) did this and how (she) could stop (her) children from being vulnerable in the future'*.

### 3.3 Wider Impact on The Community and Wider Social Network

At the conclusion to our interviews, we asked family members to complete a diagram to estimate how many people were affected by the death of their loved one. To help them we categorised people into family members, friends, co-workers, health care

Figure 4. Number of people affected by a death by suicide (average figures)



workers and members of the community.

For the 64 deaths whose relatives we interviewed, a total of 3004 people were described as being affected. Figure 4 shows the average number of connections in each social network type reported by our participants. The impact tended to cluster around the most prominent social circles frequented by the person who died. For example, as expected, deaths among those who were active in community groups including sports clubs, impacted on large numbers of individuals within that network. The numbers affected tended to vary according to the age of the person who died, with older people tending to have less people listed and young people the most. Qualitatively, we were able to identify that the degree of impact also varied. For example, a number of 'role model' male deaths were described by families as having a particularly negative impact on the community. We have included a composite vignette that illustrates these cases.

### **Composite Case**

William lived in a rural town. He was in the local band and through his business connections was well known. His brother described how he was 'called the backbone of the town' and said 'People in the community were devastated...because 'he was really well thought of'. He recalled a conversation in the local pub where a man said to him. 'You know what has really shaken us all? If he can do that, anybody can do it.... He was rock solid'. The impact of his brother's death was particularly hard because the family were not able to share some of the facts about the death and said. 'I don't think people totally understood the reasons'.

## **4. Summary and Recommendations**

The implication of a suicide rate that has risen at the rate seen in Northern Ireland and with the degree of public visibility could be called a public health crisis. Managing the response to it and preventing further rises should be a clear priority for all those in government. Our data draws attention to the damaging impact of bereavement on the lives of the people of Northern Ireland. We believe the issue of bereavement needs to be given further prominence within the broader suicide prevention policy and should potentially be embedded as a distinct postvention policy. Nevertheless, we are mindful that the current resources crisis means there is a need for continued frank discussion about the future direction of all publicly funded policy. There are a number of ways in which we think this may be usefully achieved: First, the government should be mindful not to fall into the familiar trap of global suicide research by undertaking repetitive research (Hjelmeland & Knizek, 2010). Developing evidence based services and interventions that meet the needs of those affected by the deaths is a challenge not only in NI but globally. We suggest that the best way forward at a policy level is, wherever possible, to support international and national research collaborations to enable evidence from other countries to be usefully adapted and applied here. In a resource-limited environment, these collaborations can help to develop innovative responses (Adams, 2007). However, we advocate that in instances where research evidence from other countries is applied in NI, this is done with a parallel programme of evaluation.

Our own findings from the NI context suggest two key elements of postvention policy are advised. First, we should prioritise access to support services for all those affected by death by suicide, regardless of their kinship to the deceased. Much of the current focus in care provision is on the immediate family and there has been a longstanding neglect of the wider reverberations of suicide on the extended social circle. Second, we

should also be mindful of the broader community impact of the rapid rise in suicide. As this study shows, there is a broad community impact to these deaths which are similar to those reported in the Lancet earlier this year (Pitman et al, 2014). In responding to both these issues we believe there is an important role for family, community and academics to engage in public education programmes which serve to develop the communities understanding of the issue of mental health and bereavement in a way which helps to manage fear about risk of suicide. The educational approach taken by the professionals with many of our participants was helpful in empowering individuals in their bereavement. It is important not to disempower people around the issue of suicide as to do so can further provoke fear and anxiety that are disabling and may contribute to a misunderstanding of the suicidal mind.

Finally, much of the paper is concerned with highlighting the coping challenges of those bereaved and the impact of bereavement on those who died. However, our study also showed there is considerable natural resilience and with adequate support it is entirely possible to help individuals find meaning and a degree of suicide-related resilience. We would particularly encourage future programmes of research and intervention to focus on the development of evidence based suicide-related interventions that can build resilience within families and communities.

### References

- Adams, J., Gurney, K., & Marshall, S. (2007). *Patterns of intentional collaborations for the UK and leading partners*. Leeds: Evidence Ltd.
- Agee, M. (2011). A New Zealand Perspective on suicide bereavement in *Grief after Suicide*, editors Jordan, J. and McIntosh, J., (Eds) (pp 487-494) Hove: Routledge
- Andriessen K. (2009). Can postvention be prevention? *Crisis*,;30:43–47.
- Crosby A. E. and Sacks J. J. (2002). Exposure to suicide: Incidence and association with suicidal ideation and behavior. *Suicide and Life Threatening Behavior*. 32(3):321-8.
- Cutcliffe, J. R., (2011). Introduction p1 *Routledge International Handbook of Clinical Suicide Research*. Abingdon: Routledge
- DHSSPS. (2012). *Protect Life. A Shared Vision. The Northern Ireland Suicide Prevention Strategy 2012-March 2014*. (Refreshed June 2012). Belfast: Department of Health, Social Services and Public Safety (NI).
- Forbes, T., Sibbett, C., Miller, S., and Emerson, L. (2012). *Exploring the Community Response to Multiple Deaths of Young People by Suicide, Belfast*. Centre for Effective Education, Queen's University Belfast.
- Foster T., Gillespie K, McClelland R, Patterson C. (1999). Risk factors for suicide independent of DSM-III-R Axis I disorder. Case-control psychological autopsy study in Northern Ireland. *Br J Psychiatry*. Aug; 175:175-9.
- Harder, H., Rash, J., Holyk, T., Jovel, E., Harder, K., (2011). Indigenous youth suicide: a systematic review of the literature pp 378-401 *Routledge International Handbook of Clinical Suicide Research*. Abingdon: Routledge



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- Hjelmeland, H., Knizek, B. (2010). Why we need qualitative research in suicidology. *Suicide Life Threatening Behaviour*, 40(1):74-80.
- Institute of Medicine. (2002). *Reducing suicide*, Washington, DC: National academic press
- Jordan, J. and McIntosh, J., (2011). The impact of suicide on adults in *Grief after Suicide*, editors Jordan, J. and McIntosh, J., (Eds) (pp 43-92) Hove: Routledge
- Jordan J., McKenna H., Keeney S., Cutcliffe J., Stevenson C., Slater P., McGowan I. (2012). Providing meaningful care: learning from the experiences of suicidal young men. *Qualitative Health Research*. Sep;22(9):1207-19. doi: 10.1177/1049732312450367. Epub 2012
- Kennelly, B. (2007). The economic cost of suicide in Ireland. *Crisis*, 28(2), 89-94
- Leavey, G., Galway, K., Rondon, J. & Logan, G. (2009). *A Flourishing Society: Aspirations for Emotional Health and Wellbeing in Northern Ireland: Aspirations for Emotional Health and Wellbeing in Northern Ireland*. Niamh (NI Association for Mental Health), [www.niamhwellbeing.org](http://www.niamhwellbeing.org).
- Moore S. (2012). *Evaluation of the implementation of the NI Protect Life Suicide Prevention Strategy and Action Plan 2006-2011*. Belfast: Department of Health, Social Services and Public Safety (NI).
- National institute for Mental Health in England, (2003). *National suicide prevention strategy for England Annual report on progress*. London Department of Health
- NCISH. (2014). *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Suicide in Primary Care in England: 2002-2011*. Manchester: University of Manchester.
- O'Neill S, Ferry F, Murphy S, Corry C, Bolton D., (2014). Patterns of Suicidal Ideation and Behavior in Northern Ireland and Associations with Conflict Related Trauma. *PLoS ONE* 9(3): e91532. doi:10.1371/journal.pone.0091532
- Pitman A., Osborn, D., King, M., Erlangsen., A. (2014). Effects of suicide bereavement on mental health and suicide risk. *The Lancet Psychiatry*. June;1(1):86-94
- Public Health Agency. (2011). *All island evaluation of Applied Suicide Intervention Skills Training*. <http://www.publichealth.hscni.net/publications/all-island-evaluation-applied-suicide-intervention-skills-training-assist-summary-report>
- Rogler L. & Cortes D. (1993). Help-seeking Pathways: a unifying concept in mental health care. *American Journal of Psychiatry*. 150(4):554-61.
- Schneidman, E. S. (2004). *Autopsy of a suicidal mind*. Oxford: Oxford University Press.
- Tomlinson, M. (2013). *Dealing with Suicide*, KESS Seminar series. Belfast: Stormont Assembly

