

## Experiences of suicide bereavement:

a qualitative study exploring the role of the GP

### Abstract

#### Background

Suicide is a major public health issue. GPs are often on the front line in responding to a suicide. They are called on to support individuals and families in the aftermath of suicide yet there is a dearth of research, particularly from patients' perspectives, on how to provide optimal care for those grieving a suicide in the primary care setting.

#### Aim

To improve GP management of suicide bereavement by exploring the lived experiences of affected individuals, focusing on the GP's involvement in the grief process.

#### Design and setting

A qualitative approach was adopted using focus group interviews with individuals from suicide bereavement support groups at three locations across Ireland.

#### Method

Support groups were contacted by letter. Fifteen interested participants formed three focus groups. Interviews were audiorecorded and transcripts were analysed thematically using the framework method.

#### Results

Three major themes dominated: the need for acknowledgement — of the loss and of the lived life of the deceased; the role of stigma in the aftermath of the loss; and the need for proactive provision of direction and support during the grief journey. The GP was identified as ideally positioned in the community to cater for the needs of the bereaved.

#### Conclusion

Suicide can result in prolonged, complex grief generating specific patient needs. Stigma may function as a barrier to help seeking. The GP should consider initiating contact with the bereaved. Recommendations have been made to support GPs in their care of the suicide bereaved.

#### Keywords

bereavement; family practice; general practitioners; grief; qualitative research; suicide.

### INTRODUCTION

Suicide is a serious public health problem. It has been suggested that a minimum of six individuals are deeply affected by every suicide.<sup>1,2</sup> Loss by any means engenders feelings of sadness and loneliness. These feelings are often magnified in individuals bereaved by suicide or 'survivors of suicide', by feelings of guilt, confusion, rejection, abandonment, shame, and anger.<sup>3-7</sup> Suicide bereavement may produce a markedly different mourning process from natural loss.<sup>5</sup> It is a risk factor for development of complicated mourning, described as prolonged, unresolved grief often interfering with functioning.<sup>8,9</sup> It can precipitate fragmentation of family units<sup>5</sup> and predispose to poor mental health.<sup>5,10,11</sup> Individuals bereaved by suicide have a higher risk of developing major depression, post-traumatic stress disorder, and suicidal behaviour.<sup>3,4</sup> The grief of survivors of suicide is also amplified by stigma, which has a profound impact on social interactions and help-seeking behaviour.<sup>3,12,13</sup>

The complexity of grief after suicide is well documented and there is increasing focus on suicide postvention; that is, support for families and communities after a suicide.<sup>14</sup> The current literature points to a need to develop a unique, proactive approach to the provision of support and assessment of the psychological wellbeing of survivors of suicide.<sup>2,9</sup> Effective postvention can be viewed as contributing towards suicide prevention in suicide survivors of suicide<sup>15</sup> and the need for a 'bottom up' approach

incorporating the experiences of the bereaved, to the creation of postvention programmes, has been identified. However, there is a paucity of research on the role of the GP in caring for survivors of suicide. GPs have the potential for early direct contact with the bereaved and thus have an important role to play in suicide postvention. GPs, through their unique position in the healthcare system and in the community, with extensive knowledge of individual patients and families, are well positioned to support survivors of suicide and navigate problems associated with the grief process. This study aimed to look at the lived experiences of the suicide bereaved with a view to exploring their support needs, looking specifically at the role of the GP in the process.

### METHOD

A qualitative approach was adopted using thematic analysis of semi-structured focus group interviews. Research participants were recruited through voluntary bereavement support groups identified by Console (the National Suicide Charity) and Living Links (the National Outreach Programme for the Suicide Bereaved). The bereavement groups were contacted and provided with written information about the project. Interested group members were invited to take part in the project.

Adults of all ages from all socioeconomic groups were included. The study included individuals linked with professional supports and those who were not. Participants

**M Nic an Fhailí**, BMedSci, MICGP, MRCPI, GP; **NJ Flynn**, MICGP, DCH, GP; **S Dowling**, MSc, MICGP, DipObs, DCH, DipMedEd, GP, Department of Research, South East GP Training Scheme, University Hospital Waterford, Waterford, Ireland.

#### Address for correspondence

Mairéad Nic an Fhailí, Department of Research, South East GP Training Scheme, University Hospital Waterford, Dunmore Road, Waterford, Ireland.

**E-mail:** maireadnf@gmail.com

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### How this fits in

Suicide results in complex grief with very specific care needs. GPs are frequently expected to attend to the needs of survivors of suicide and yet there is very little research to support them in that role. This study aims to provide GPs with recommendations for care of the suicide bereaved in the primary care setting by exploring the lived experiences of those individuals.

represented experiences from different suicide cases.

Individuals who were bereaved during the past year were excluded as they were still in the acute grief period.<sup>3</sup> Children aged <18 years were excluded due to complexities relating to parental consent and ethical considerations. Research participants were not requested to disclose the identity of their GP at any stage during the project.

The focus groups were conducted at three locations across Ireland (Donegal, Dublin, and Waterford) to reduce geographical bias and to capture an array of perspectives relating to different GPs and support services. The interviews, led by two researchers, took place in venues used by participants for their support group meetings.

A goal of 1 hour was set for each discussion and participants were informed when 1 hour had passed. In all sessions participants opted to remain engaged until the discussion reached a natural conclusion.

Sessions were audiorecorded with permission. Each participant was asked to provide a brief synopsis of their suicide bereavement and then three open-ended questions were posed to the groups. Areas of enquiry were:

- sources of support at the time of the loss and experiences of interaction with the GP at the time;
- needs at the time of the loss and continued care needs; and
- any difficulties encountered with the GP and suggested recommendations for GPs going forward.

The researchers facilitated discussion by offering verbal prompts but no additional structured questions were added. A bereavement counsellor was available after each session for debriefing if required.

The framework approach<sup>16</sup> to qualitative data analysis was adopted. Framework takes a theme-based approach to analysis,

reducing data through summarisation and synthesis while retaining links to the original data. Focus group interviews were transcribed. Researchers read the transcripts of the audiomaterial individually and devised a thematic framework independently of one another by highlighting emerging recurrent ideas. An emphasis on repetition within the text helped to define the development of theme headings. Broader themes were determined following discussion between the researchers. Data were lifted from their original context in the transcripts and placed into charts under the various theme headings. This allowed for comparison of themes within and between focus groups. Final analyses of the data looked at the relationship between concepts identified throughout the process and led to the three final themes documented in the results section.

### RESULTS

Three focus group interviews were conducted. Each group consisted of five participants, all of whom were relatives of an individual lost to suicide. The timing of the suicides occurred between 1980 and 2011 (Table 1). The major themes identified in the interviews are set out in Box 1.

#### Acknowledgement

The first major theme identified was the need for acknowledgement. The need to acknowledge the suicide was consistent and emphatically addressed across all interviews. Participants shared their relief and sense of validation when they received acknowledgement from GPs, friends, and colleagues alike. The need for continual acknowledgement throughout life was highlighted. Participants also felt strongly that it was important to acknowledge the lived life of the deceased to avoid defining the individual by the way in which they died. The physician's acknowledgement of a suicide was identified as an opportunity to explore the consequences of loss and to fulfil the need to be listened to.

#### Stigma

Stigma surrounding suicide was perceived by most participants. This was discussed extensively across all focus groups. It was emphasised, in particular, by participants from a rural background. Group members perceived prejudice from members of their community. This contributed to social withdrawal, self-isolation, and inability to access care. Participants reported feeling unable to attend their GP because of a sense of shame. Coping with this shame

**Table 1. Breakdown of focus groups**

Participant	Sex of participant	Losses experienced, <i>n</i>	Relationship of participant to the deceased	Sex of deceased	Location of focus group
1	Male	2	Brother <sup>a</sup> Brother <sup>b</sup>	Male Male	Donegal
2	Female	1	Sister	Male	Donegal
3	Female	4	Sister Sister Aunt <sup>a</sup> Aunt <sup>b</sup>	Male Male Male Male	Donegal
4	Male	1	Father	Male	Donegal
5	Female	2	Daughter Sister-in-law	Female Male	Donegal
6	Male	1	Father	Female	Waterford
7	Female	1	Sister	Male	Waterford
8	Female	1	Mother-in-law	Female	Waterford
9	Female	1	Mother	Male	Waterford
10	Female	1	Mother	Male	Waterford
11	Female	1	Wife	Male	Dublin
12	Male	1	Brother	Male	Dublin
13	Female	1	Mother	Male	Dublin
14	Female	1	Mother	Male	Dublin
15	Female	1	Mother	Male	Dublin

<sup>a</sup>Same deceased individual. <sup>b</sup>Same deceased individual. Participant 1 lost two brothers. Participant 3 was an aunt by marriage to the deceased.

in the context of a busy waiting room, full of members of the local community, was felt to be too difficult for some. There was agreement across the groups that, in these cases, a house-call or an arrangement to attend the surgery at a quiet time, such as the first appointment of the day, may be appropriate to alleviate distress. Participants identified feeling that stigma, numbness, and the complexity of their grief functioned as limiting factors in allowing them to identify whom to approach for help. Two participants in separate focus groups commented that the sense of stigma was amplified by the GP's use of the term 'committed suicide' as they associated the word 'committed' with a crime. A preference for use of the phrase 'died by suicide' was identified.

#### **Need for the GP to provide direction and support**

All participants agreed that a proactive approach from a GP would be appreciated. There was a consensus that the GP should be the first to get in touch rather than leaving the responsibility for contact with the bereaved. There was a strong sense that GPs, due to their pivotal role within the community, are well placed to care for

the bereaved and to point them towards additional sources of support in the locality.

Many participants reported attending their GP for a review of their physical health or for administrative purposes such as the provision of sick certificates after their loss, and they felt this interaction provided the GP with an opportunity to introduce holistic support and direction. The therapeutic value of being listened to emerged as a recurrent theme. There was a sense that the suicide bereaved must be given ample opportunity to talk and be listened to. Participants stressed that the very process of listening, even without the provision of solutions, was healing.

There was an insistence in all groups that GPs were thought to be too eager to medicate. It was strongly emphasised by many participants that they did not want to be medicated through their grief. However, they felt that attending their GP may mean they would have to comply with a medication-based therapeutic strategy. Although all participants reflected on the positive role their bereavement group and other non-medical resources played in their grief journeys, they emphasised their desire to retain the GP as a continuing source of support in their healing process.

## Box 1. Themes arising from focus groups with survivors of suicide

### Need for acknowledgement

#### 1. Acknowledgement of the loss

*'I do feel it is important for the GP to acknowledge the loss, because that person was so important to you'* (Bereaved sister, Donegal)

*'Dr always asked when I went down, how I was, he always mentioned [my son] ... "How many years is it now? When was the birthday?"'* (Bereaved mother, Dublin)

#### 2. Acknowledgement of the lived life of the deceased

*'He came in the door and he sympathised with all of us, and then he said, "Do you know what I remember most about [\*]? The time he came in when he was about 6 with a stone up his nose." He talked about him, he remembered him ... that he was a person.'* (Bereaved mother, Dublin)

### Role of stigma in the aftermath of loss

#### 1. Profound effect of stigma and its role as a barrier to help seeking

*'I was at a festival in the town, and I remember going thinking I hope no one is looking at me, I was embarrassed as well ...'* (Bereaved aunt and sister, Donegal)

*'I think if the stigma wasn't so bad, I think maybe things might be a little different, you feel stigmatised yourself ... It's like IBS [irritable bowel syndrome], nobody wants to know about it.'* (Bereaved daughter and sister-in-law, Donegal)

*'[You are] so numb with grief and shock and disbelief, and you don't think about looking for support.'* (Bereaved mother-in-law, Waterford)

#### 2. Practical implications for the surgery

*'I can't remember why he wouldn't come to the house, but he never actually went to the house to make a call. So eventually we arranged with him for [my wife] to go in the backdoor, so that no one could see her.'* (Bereaved father, Waterford)

### Need for GP to provide direction and support

#### 1. Preference for proactive approach to contact by the GP

*'Well they [GPs] do play a major part in our community ... I think they are hugely important in our lives.'* (Bereaved mother, Dublin)

*'On the day he had heard it through the grapevine ... he didn't wait for us to contact him ... He phoned and he said how sorry he was ... And could he come over. So he did. Now straight away that just makes such a difference.'* (Bereaved mother, Dublin)

*'They [GPs] need to have the courage to come to you and say "well look, I'm here when you are ready". It's such a comfort.'* (Bereaved mother, Waterford)

#### 2. Need for GP to provide awareness of support organisations

*'GPs should make it their business to know what services are available in the locality.'* (Bereaved brother, Dublin)

*'In each of our cases, it was pure luck we found this [bereavement group]. It wasn't through any doctor' ... 'Funny you should say that, there was a sign up in the doctors' surgery for this group, he never mentioned it.'* (Bereaved mother and father in discussion in Waterford)

#### 3. Role of doctor as drug — need for active listening

*'He [my GP] just sat and listened ... he was fully present, completely present.'* (Bereaved mother, Dublin)

*'He listened and the listening was powerful. Being fully present, he didn't offer me any solutions, he didn't try to answer the why, he didn't try to medicate me ... He didn't try to fix me. He just accepted me, just the way I was and he listened.'* (Bereaved mother, Dublin)

#### 4. Importance of appropriate prescribing: desire not to medicate grief

*'Eventually I went down to him, he never offered me medication ... he just sat and listened.'* (Bereaved mother, Dublin)

#### 5. Need for continuity of care

*'He did give me names of organisations within the parish and there is this bereavement support group and counsellors ... But then said, but I'm still here.'* (Bereaved mother, Waterford)

Final recommendations for GPs outlined in Box 2 summarise key themes from the research and incorporate specific suggestions from individual participants that did not fit with broad theme headings but are relevant to the recommendations section.

## DISCUSSION

### Summary

This study identified specific care needs in survivors of suicide and helped to define the role of the GP in suicide bereavement through use of the focus group technique.

### Strengths and limitations

To the authors' knowledge, this study is the

first in Ireland to explore the experiences of survivors of suicide using focus group interviews. The geographical spread of the focus groups facilitated exploration of an array of experiences relating to different suicide cases and allowed the authors to capture experiences of bereavement from both urban and rural perspectives. The groups were deliberately designed to contain participants who were known to one another because it is accepted that the formation of naturally occurring groups is generally best to facilitate discussion on sensitive topics.<sup>17,18</sup> In the Donegal group two participants had experiences of the same suicides (Table 1). All other participants in the study were bereaved by

## Box 2. Recommendations for the GP coping with the suicide bereaved

- Understand the grief process in suicide and be aware of the effects of stigma
- Use the term 'died by suicide' in place of 'committed suicide'
- Be aware of a potential shift in family dynamics following loss by suicide
- Be vigilant about assessing the mental health of the bereaved. Tag the notes of family members when a suicide occurs. Note the anniversary and birthday of the deceased and be aware that these times may precipitate mental ill health in the survivors
- Always acknowledge the loss and mention the deceased by name where possible
- Actively listen
- Make yourself aware of voluntary and professional support services in your local area
- Bear the complexity of suicide–grief in mind when scheduling visits to the surgery: allow time, facilitate patients who do not wish to wait in the waiting room, and consider house calls where necessary. Consider developing a practice policy to train ancillary staff to facilitate these visits
- When considering medication, try to ascertain if this is something the patient wants and, where appropriate, make sure the patient is correctly educated about their medication and the potential delayed onset of effect
- Be proactive: be the first to contact the bereaved
- Be aware of your own limitations and emotional barriers and, if you feel unable to provide optimal care to the suicide bereaved, it may be reasonable to suggest a suitable colleague as an alternative

separate suicides. The participants in all groups encouraged one another to partake in discussion and all three discussions ran over time, suggesting that the participants felt free to discuss matters of genuine importance to them. There was strong agreement within groups and consistency between groups on major themes, indicating that the fundamental care needs of survivors of suicide are shared. Although the study is small, thematic concordance across the groups suggests that similar themes could emerge from a larger study. In keeping with a general overrepresentation of females in the literature on suicide bereavement,<sup>19</sup> females outnumbered males in this study and there is scope for further work addressing the needs of male survivors of suicide. A significant limitation, repeated across the literature on suicide bereavement,<sup>19</sup> is the fact that all participants were people who sought help through their bereavement groups and the study did not capture the experiences of those who may never come to the attention of any formal supports. The study did not categorise participants according to demographic data and further studies are required to allow for focus on particular patient subgroups.

### Comparison with existing literature

The study encapsulates the universality of human suffering. The grief responses expressed by the participants were reflective of complex grief patterns reported in the international literature.<sup>3,5,9</sup> Participants reported feelings of anger, guilt, shame,

remorse, and a pervasive sense of uncertainty about why their loved one died by suicide. The experience of stigma was identified as a defining element of the bereavement process, echoing previous reports of suicide bereavement in the literature.<sup>3,12,13</sup> Stigma posed a barrier to help seeking and participants reported that feelings of shame created practical barriers to attending the GP. They reported feeling self-conscious at the idea of sitting in a doctor's waiting room and many opted not to attend for that reason.

There was greater emphasis on the role of stigma in the Donegal and Waterford discussions. It emerged during the discussions that participants in these groups predominantly represented experiences within smaller rural communities. Participants in Dublin were all from urban communities.

Much of the discussion around stigma focused on the fact that participants found it hard knowing that neighbours and colleagues were aware of the exact nature of their loved one's death. Perhaps details of a suicide are more likely to permeate a small community and this may result in an increase in perceived stigma. Dunn and colleagues<sup>10</sup> observed that there may also be a difference in the way in which survivors of suicide believe they are stigmatised versus actually being the object of stigma.

Much of the literature centres on the perception of survivors rather than on the attitudes of the public, and further research in this area could help to unravel the components of stigma. Certainly the

difference between urban and rural experiences is worthy of further exploration.

### **Implications for research and practice**

The study did not seek to identify differences in patterns of help seeking between males and females, but it was noted that only one of the four males in the study sought professional assistance to cope with his loss whereas all females in the study engaged with professional help. This observation, which could be expanded on in future research, could motivate GPs to explore care needs with male survivors of suicide in particular, and to consider using routine visits to the surgery as a means of prompting survivors of suicide to express their emotional and psychological issues. Another consideration for GPs in consultation with survivors of suicide is the appropriateness of medicating patients in their grief. A recurring theme of concern around over-prescribing of medication emerged strongly in this study. Many participants were reluctant to attend their GP about their grief for fear of 'medicalising' it. They wanted to talk and were fearful of receiving a prescription instead. This recognises the potential for the 'drug doctor', described by Balint,<sup>20</sup> who facilitates healing by listening and acknowledging a patient's distress. Emphasis on this approach could alleviate potential pressure on the GP to devise a solution to every problem.

Evidence for the efficacy of suicide bereavement support groups is lacking<sup>21</sup> but, in keeping with a study by Groos and

colleagues,<sup>22</sup> participants in this study repeatedly emphasised the therapeutic effects of participation in a suicide bereavement group, describing the power of healing through shared experiences in a nurturing environment. All participants found their support group by word of mouth after a long delay, exposing the need for increased integration of voluntary and professional services, and the need for a professional individual to guide survivors of suicide towards additional care resources at the appropriate time. Participants recognised the suitability of the GP to fulfil this signposting role and identified the huge potential for a proactive approach from the GP following loss by suicide. Participants really valued the GP initiating contact with them in the aftermath of their loss, a finding echoed by a study in the US by Van Dongen.<sup>23</sup>

This study aimed to take a snapshot of experiences from across Ireland and provide a foundation for guidance to GPs on the management of suicide bereavement. The recommendations devised to facilitate GPs in their care of survivors of suicide are simple and applicable to everyday practice. There is scope for more detailed work addressing how factors such as socioeconomic status, age, and relationship to the deceased could impact on GP care in the grief journey following suicide. The GP can play a meaningful role in suicide postvention and building on this concept is critical in the knowledge that suicide postvention is a form of prevention for the future.

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### **Provenance**

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### **Competing interests**

The authors have declared no competing interests.

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