

HOW THEY DIED, TIME SINCE LOSS, AND BEREAVEMENT OUTCOMES

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ABSTRACT

This analysis explores associations between differing death circumstances and the course of bereavement among a sample of 540 bereaved parents. Comparisons were made between parents whose children died by suicide ($n = 462$), those losing children from other traumatic death circumstances ($n = 54$), and others whose children died from natural causes ($n = 24$). Results were mixed, showing suicide survivors with more grief difficulties and other mental health problems on some criteria, though most findings showed no substantive differences between these subgroups. Results also showed, in the first years after loss, repeated suicide attempts and prior negative relationships with the decedent were associated with greater grief difficulties. However, as more time passed, all death circumstance differences were overshadowed by the importance of the time span since loss. This data also suggested that between 3 and 5 years usually marks the turning point, when acute grief difficulties accompanying a suicide loss begin to subside.

INTRODUCTION

Following the classical self-help group model, suicide survivor support group meetings often begin with participants sitting in a circle. Usually, they start with a brief “go around,” where each member gives his or her first name, mentions the name and relationship of the person that died, the length of time since the death occurred, and the manner of death. The sharing of these facts serves to create an immediate bond between participants. As Lawrence Shulman describes it, “support groups bring people together to help each other address tabooed topics,” what Shulman calls the “all in the same boat” phenomenon (Shulman, 2006). At support group meetings, usually much time, attention, and importance is devoted to discussing the manner of a loved one’s death.

Bob Abrams, (pseudonym) a 54-year-old accountant, who lost his 23-year-old son 2 months earlier, described to his support group the experience of discovering his son’s body. “Betty (his wife) and I came back home from grocery shopping; we pulled the car up to the back of the house and there was David hanging by an electrical extension cord from the branch of a tree in our back yard. I had no idea how long he had been there. All I could think of was cutting him down as fast as I could, and trying to do CPR on him; which I did do. (I’m a trained ambulance corps volunteer in our local community.) Betty called 911 and I just kept at doing CPR on him till the ambulance came. When they came, they pulled me off David and told me he was already dead.” As he recounted this experience, Bob’s legs shook and there was a quiver in his voice. He said, “I will never forget the shock of discovering David dangling from that branch in our back yard.”

At another support group meeting the facilitator asked participants whether anyone experienced any “flashbacks.” Karen Acres (pseudonym), a first-time participant, volunteered, “whenever I hear a train whistle it sends shudders down my spine as I recall my husband’s death. About 2 months ago he jumped in front of a commuter express train. His body was shredded into thousands of pieces. After the incident the railroad people let me go down on the tracks at the death scene. All I could see there were tiny fragments of his clothes and blood-stained mush, although I did find a piece of his St. Christopher’s medal. I’ve tried to return to the scene, but the railroad people threatened to arrest me if they ever see me there again. The coroner’s office doesn’t want to do DNA testing of his remains. Although his car was parked at the train station, I can’t help thinking that he is still alive somewhere and that some day he’ll walk in the door and tell me he found a stand-in for him that day.” Stillness fills the room as Karen’s sadness is keenly felt by all participants. Reggie Michaels (pseudonym) finally breaks the silence by saying “I know how you feel about wanting to go back to the tracks. My wife and I lost our son 8 months ago in a similar situation. Oddly, we found it comforting to go back again, too. We set up a little shrine along the fence near the tracks; we found that very helpful. We also went to a psychic several times; I can give you her name if you want it.”

Survivors, whether to a suicide or other untimely deaths, attach a great deal of importance to the manner of the death of their loved ones and to how it may be affecting their grieving process.

In the popular press, especially since 9/11, much has been written about grief complications arising for survivors from the loss and mutilation of bodies of lost loved ones. In the bereavement literature much has been written about post-traumatic stresses arising from violent deaths (see Asro, 2001; Ehntholt & Yule, 2006; Tang, 2006; among many others).

This appears to be well understood in the suicide bereavement literature with one of the primary bereavement difficulties assessment tools consisting of a measure of post-traumatic stress, the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979). It could be claimed, perhaps, that all suicide deaths comprise violent self-killings. Yet, if we take suicide survivor behavior at face value, it suggests that some suicides are more violent than others, and possibly, by their more violent and troublesome characteristics, likely to generate more grief difficulties.

Thus, the questions we wish to explore here are: do grief process outcomes vary when the circumstances of untimely deaths differ, and how do they differ under these diverging circumstances?

STUDY AIMS, PREVIOUS RESEARCH, AND HYPOTHESES UNDER INVESTIGATION

This study has two overall aims. First, we intend to investigate whether among parents sustaining untimely losses of children whether there are differences in bereavement outcomes, depending upon the different causes of death: suicide, other traumatic death cases, and natural deaths. Past research suggests some confusion and controversy over whether suicide survivors stand at a higher risk for having more grief difficulties compared to other survivors of traumatic deaths. Some early and recent studies have noted suicide survivors standing at a higher risk of their own psychic difficulties, complex grief, and suicidality compared to other bereaved populations (Agerbo 2005; Bailey, Kral, & Dunham, 1999; Calhoun & Allen, 1991; de Groot, de Keijser, & Neeleman, 2006; Farberow, 1991; Sequin, Lesage, & Kiely, 1995). And in another study conducted among college students sustaining losses of family members and friends, Currier, Holland, Coleman, and Neimeyer (2006) found traumatic losses (homicide, suicide, and accidental deaths) were associated with greater grief distress than those sustaining anticipated or sudden natural deaths.

Yet, these assertions have not been consistently supported in all available studies. An early study, comparing 40 widows whose husbands completed suicide with 40 others whose husbands died by natural and accidental causes, found few adjustment differences between these two subgroups (Demi, 1984). More recently, with longitudinal data comparing suicide bereaved with others bereaved

from traumatic homicide and accidental deaths, Murphy and her colleagues found no differences in psychic difficulties, complex grief, and suicidality (Murphy, Johnson, Wu, Fan, & Lohan, 2003; Murphy, Tapper, Johnson, & Lohan, 2003). In addition, Sveen and Walby completed a qualitative review of 41 studies of suicide survivors and survivors of other modes of death. They found suicide survivors much like the other death survivors in terms of general mental health, depression, PTSD, anxiety, suicidal behavior, and general grief difficulties. Yet, the suicide survivors reported higher levels of rejection, shame, stigma, the need for concealing the cause of death, and blaming (Sveen & Walby, 2008). Thus, confusion surrounds the question of whether suicide survivors stand at a higher risk for grief difficulties compared to other survivors of traumatic deaths and perhaps even to natural death survivors. Provisionally, in view of all the mixed evidence, we began our study with an expectation that parent suicide survivors would show greater grief difficulties, more PTSD, and greater mental health difficulties compared to other traumatic and natural death survivors.

The second aim of our investigation probes into the subgroup of suicide survivors exclusively, and investigates whether the different death circumstances associated with the suicide are associated with differing outcomes in grief difficulties. As we reviewed the past research record, we found limited work devoted to explaining why some suicide survivors have more grief difficulties than others. Jay Callahan (2000), in one of the few studies completed with suicide survivor support group affiliates, found that direct confrontations with the death, either in witnessing the act, finding the body, or in seeing the body at the scene of the death increased grief difficulties for survivors. The Callahan study was conducted among a mixed group of survivors consisting of parents, children, spouses, partners, and other close relatives.

Another study, completed among a small Australian sample of suicide bereaved parents, found that grief difficulties and distress are likely to be greater when survivors were unprepared for the suicide death of their child (Maple, Plummer, Edwards, & Minichello, 2007). These findings lead us to speculate that more surprised parents and those whose child's death represented a first suicide attempt would be likely to experience greater grief difficulties than other parent survivors who were less surprised at their child's death and where the decedent had made several prior suicide attempts prior to completing suicide.

In addition, and consistent with Kosminsky's (2006) claims, we anticipated greater grief difficulties to occur when survivors reported more conflicted or uncertain relationships with the decedent prior to the suicide.

Accordingly, we expected that the following subgroups would show higher grief difficulties:

1. parents that had closer contact with the body at the death scene;
2. more surprised parents whose child's suicide represented a first suicide attempt; and

3. cases where a conflict relationship between the decedent and the parent had preceded the death.

DATA SOURCE AND METHODS

This study aimed to better represent suicide survivors in the community-at-large who utilize survivor of suicide support groups. Thus far, only one survey research has been conducted specifically with this population (Callahan, 2000). With the listings of support groups from the American Association of Suicidology (AAS) and the American Foundation of Suicide Prevention (AFSP), we attempted to include support group members from most regions of the country. Initially several facilitators were contacted and were asked either to furnish their membership lists or to publicize information about the study at meetings, in their newsletters, or on their electronic list serves. Typically, support group facilitators posted announcements in their newsletters calling for volunteers to participate in a confidential and anonymous survey of survivors. Volunteers were directed to contact the first author who was identified as both a sociologist and a survivor of his son's suicide.

For the sake of analytic simplicity, we confined this study to parent survivors of child loss. In the bereavement literature it often mentioned how losing children represents a truly formidable challenge for survivors to adjust to, which may perhaps be as daunting, or even more so, than the challenge of dealing with violent death issues. As interesting and important as investigating this question would have been, we did not have sufficient resources to probe the different types of loss relationships, which would have necessitated having a much larger sample for comparative analyses than the one we eventually acquired. We refer readers to the following sources for a fuller appreciation of the parent bereavement issue (see Finkbeiner, 1996; Murphy, 2008; Rando, 1986).

In seeking a contrast population to the parent suicide survivors investigated here, we sought to include other parents who lost children to other sudden death causes, such as automobile accident-related deaths, drug overdose deaths, accidental drownings, homicides, and so forth. We also sought to include cases of child deaths from natural causes, that is, from brain aneurisms, cancers, heart disease, AIDS/HIV, and so forth. To represent these other groups of other traumatic and natural death cases we also made similar contacts with chapters of Compassionate Friends groups from where we acquired cases of additional parent suicide survivors and of parents losing children from other-than-suicide-death causes. The Compassionate Friends groups, found throughout the nation, are general bereavement support groups, that are open to parent survivors of all types of untimely child deaths.

We also sought to include suicide survivors utilizing Internet based support groups. Two such groups were contacted and furnished respondents: The Parents of Suicide Support Group and the Parents Grieving Children of Suicide Group.

The present survey is one of the first to investigate survivor support affiliates using the Internet.

Several newsletters and list serves played crucial roles in circulating information about our survey: the SPAN USA list serve, the Friends For Survival Inc. Newsletter, and the "Surviving Suicide" Newsletter published by AAS. These reached large audiences of survivors and clinicians. In addition, several bereavement counselors and psychologists also asked to distribute copies of the survey among their patients. Also, many survivors spontaneously offered names of additional respondents who they thought would want to complete the survey.

When the data collection concluded, 754 surveys were sent out and 540 surveys were returned, yielding a response rate of 72%. We thought this was a more than satisfactory return rate, considering the difficulty of conducting surveys on grief issues and considering the length of research instrument, a 27-page mailed survey form. Typically in mailed questionnaire surveys responses rates usually fall below the 60% mark (Hopkins & Gullickson, 1992; Kaplowitz, Hadlock, & Levine, 2004; Smith, 1995).

CHARACTERISTICS OF THE SAMPLE

Our mostly support-group-based sample included 540 respondents. Females outnumbered males by a huge margin, 85% to 15%. Seventy-three percent of respondents were between the ages of 46-65; 19% were 66 or over, and 8% were of ages 45 or under. The sample also over-represented upper-status respondents: 33% had household incomes of \$90,000 or higher; 43% had incomes between \$40,000 and \$90,000; and 24% with incomes below \$40,000. Fifty-one percent of our respondents reported having managerial or professional occupations; 41% reported completing 4 or more years of college; 42% reported some college and 17% had high school degrees or less schooling. Thirty-six percent reported having a Protestant affiliation; 26% Catholic; 10% Jewish, and 19% were affiliated to other faiths and the remaining 9% had no religious affiliation. The sample was predominately White and American born; 95% of respondents were born in the United States, 94% were White, with 6% from all other races. Respondents came from every state in the United States, and seven others were from Canada.

Of the 540 cases, survivors of suicide outnumbered all others at 86% (462 cases); there were 45 cases of accidental death survivors; 24 natural death survivors; 4 survivors of homicide deaths of their children, and 5 cases of survivors of deaths under ambiguous circumstances. Nine percent had sustained their loss within the last 12 months; 40% between 1 and 4 years earlier; 30% had lost a child between 4 and 10 years ago; and the balance, 21%, had lost a child more than 10 years ago. At least 12 respondents reported sustaining multiple untimely death losses in their families of either two children to suicide, the loss of a child and a partner to suicide, or some other combination of accidental and/or natural death losses of nuclear family members.

Decedents ranged in age from 8% being reported as 15 years old or younger at their deaths, 20% between ages 16 and 21, 36% between ages 22 and 28, 17% between ages 29 and 35, and the remaining 10% over age 36. Clearly, adolescent and young adult deaths predominated in our sample, with over 80% of respondents reporting the loss of a child between ages 16 and 35.

MEASUREMENTS

To measure grief difficulties we used an abbreviated version of The Grief Experience Questionnaire (Barrett & Scott, 1989). The original GEQ scale consisted of 55 items. Following the lead of Bailey, Dunham, and Kral (2000) who performed a factor analysis of the scale, and identified eight distinct factors within it, we selected the items with the highest factor loadings for each of the eight factors on our 16-item abbreviated scale. Our abbreviated scale yielded an alpha coefficient of .87. Though we had no way of verifying how closely this abbreviated scale correlated with the full 55-item scale, we did find it correlated highly with the Impact of Events Scale (Horowitz et al., 1979) and the Complicated Grief Scale (Prigerson, 2002), with correlation coefficients above .70.

In addition to the brief GEQ scale all respondents were asked to complete two other widely employed measures of grief difficulties and PTSD: the 12-item Complicated Grief Scale (Prigerson, 2002) and the 14-item Impact of Events scale (Horowitz et al., 1979).

An index of personal psychological problems was created for this study from several questions that had been given to respondents in the Mid-Life Development Survey (MIDUS), a national survey of the middle-aged and older American population (Wethington, Kessler, & Brim, 1998). The survey asked respondents to self-rate their mental or emotional health: "how about your mental or emotional health? Is it poor, fair, good, very good or excellent?" They were also asked a depression screener question, "During the past year was there ever a time when you felt sad, blue or depressed for 2 weeks or more in a row? 1) yes; 2) no; 3) not depressed because of anti-depressant medication." Survey respondents were also asked to count the number of days in the past 30-day period where they were unable to go to work or carry out normal household activities (and had to cut back) because of mental health difficulties. In addition, they were also asked a life satisfaction question: "At present, how satisfied are you with your life? A lot, somewhat, a little or not at all/none at all." We administered these same questions to our respondents and found responses associated with one another with correlation coefficients ranging from .18 to .51. Summing the responses together of:

1. poor or fair mental health reports;
2. self-reported depression;

3. one or more days lost to work or housework during the past 30-day period;
and
4. life satisfaction reports of little or not at all satisfied

placed respondents along a continuum from zero to four along our mental health problems scale, which yielded a Cronbach's alpha of .70.

The mean response of our respondents on the personal psychological problems scale was 1.6, out of a possible 4 ($n = 518$). For the national sample of Mid-Life Survey women over 46 years of age (and thus represented over 75% of our survey respondents), the reported mean was .5 ($n = 1051$). Stark contrasts can also be noted between the psychological functioning between our bereaved respondents and the national middle-aged sample of women of the same age group: 68% of our female respondents reported themselves as depressed on the screener question, compared to 31% in the national sample; 50% of our female respondents rated their mental health as poor or fair, compared to 10% in the national sample; and 34% of our female respondents found little to no satisfaction in life, compared to only 8% in the national sample. For our bereaved male respondents, contrasts to the representative sample of middle-aged males, showed virtually similar contrasting differences.

All respondents were asked to categorize the cause of death of their child into the widely understood scheme, applied by the National Center of Health Statistics from the U.S. Standard Death Certificate form:

1. accidental death;
2. natural causes;
3. homicide;
4. suicide; and/or
5. death under ambiguous circumstances or pending investigation (National Center for Health Statistics, 2008).

Among those indicating a suicide death, they were asked the method employed. We asked all respondents sustaining suicide losses a series of questions to gauge their immediate exposure to the death event. First, respondents were asked a yes-no question "whether they witnessed the act of suicide itself." Then they were asked a second yes-no question "whether they found the body or were present when the body was discovered." And last, they were asked a final question, "whether they saw the deceased's body before it was buried or cremated." Then, from these responses we created a scale based on a respondent's immediate exposure to the suicide death. The scale had three positions on it.

The first was extreme close exposure to the event; those that either witnessed the actual suicide or had found the body (total $n = 151$). In the second position on the scale were those respondents ($n = 210$) that did not find the body but reported seeing it prior to burial or cremation. And in the lowest exposure category

($n = 104$) were those respondents that reported not finding the body, nor seeing it prior to burial or cremation.

Respondents were also asked to the best of their knowledge to count the number of prior suicide attempts their child had made before completing suicide. In addition, respondents were asked to describe their relationship to the child immediately prior to the death into one of five categories:

1. extremely positive;
2. somewhat positive;
3. unclear or uncertain;
4. somewhat negative;
5. extremely negative.

They were also asked to describe on a 5-point scale their sense of surprise at the suicide death of their child:

1. extremely surprised;
2. very surprised;
3. somewhat surprised;
4. slightly surprised; and/or
5. not at all surprised.

While the primary basis of this analysis came from the quantitative survey data we collected, important qualitative data supplemented the survey. The survey also included a number of open-ended questions where respondents could offer more information on the nature of their particular bereavement experiences. For example, respondents were asked to enumerate any help offering experiences that assisted them in better managing their grief. They were also asked about hindering events that had created greater obstacles. In addition, many respondents offered lengthy comments and qualifications to survey questions. A few others offered journals and memoirs that they had compiled following the losses of their children. Participant observation data was also collected by the first author from the following sources:

1. telephone conversations with respondents;
2. observations conducted at survivor healing conferences; and
3. support group meetings that extended over a 5-year period. These supplemental materials gave additional substance and depth to the survey data.

RESULTS

In Table 1 we present the bivariate relationships between different types of child loss events and various grief difficulties and mental health problems experienced by parent survivors. We expected survivors in natural death cases to experience the least grief difficulties and mental health problems compared to suicide survivors and all-other-traumatic-death cases. From the past mixed

Table 1. Differences in Grief Difficulties and Mental Health Problems by Cause of Death

Scale	Suicide		Accidental/homicide/ ambiguous deaths		Natural causes		F	df	sig	Eta- squared			
	Mean	Standard deviation	N	Mean	Standard deviation	N					Mean	Standard deviation	N
Grief Difficulties													
Grief Experiences' Questionnaire	40.18	11.12	426	32.95	13.19	44	28.88	6.37	17	15.68	2, 484	<.001	0.060
Complicated Grief	28.02	9.01	437	26.65	8.71	49	24.60	7.69	20	1.81	2, 503	0.16	0.000
Impact of Events	33.52	8.86	420	31.60	10.22	45	30.65	7.85	23	1.93	2, 485	0.15	0.007
Mental Health Problems													
5-point Problems Scale	1.67	1.3	447	1.31	1.33	51	1.15	1.23	20	3.01	2, 515	.05	0.011
Suicide Thoughts Scale	1.79	1.12	456	1.62	1.13	53	1.39	.94	23	1.84	2, 529	.16	0.006

Source: Survivors Child Loss Survey, 2006-2007.

research record it was an open question whether the suicide survivors would show more grief difficulties and mental health problems than other traumatic death survivors.

Four homicide death cases and five ambiguous deaths in the sample were included in the same category with accidental death survivors, comprising the group of other traumatic death survivors ($n = 54$).

We found one instance where suicide survivors showed significantly greater grief difficulties (with the brief GEQ scale) than the other two subgroups. An ANOVA test showed the brief GEQ means for suicide survivors (with a mean of 40), significantly higher than the mean for other traumatic death survivors (with a value of 33), and for natural death survivors (with a mean of 29). Post-hoc tests with the Scheffe paired comparison statistic also showed the suicide survivors significantly higher in grief difficulties compared to other-traumatic death survivors and natural death survivors. Yet, when we ran these same grief difficulties comparisons with different indicators of grief problems and PTSD, the Inventory of Complicated Grief Scale (Prigerson, 2002), and the Impact of Events Scale (Horowitz et al., 1979), those results yielded no apparent differences between these subgroups. On the other two grief problems indicators the ANOVA tests showed only slight differences between all subgroups.

Our 5-point indicator of mental health problems yielded statistically significant differences showing higher problems for the suicide survivors with a mean of 1.67 compared to the means for other traumatic death survivors (with a value of 1.31) and a mean of 1.23 for natural death survivors. Yet, when we ran the Scheffe paired comparison test, no significant differences were noted between any of the groups. Comparisons on the 5-point suicide thoughts scale between these three subgroups did not show any significant differences in suicidality between any of these three subgroups, as well.

Overall, Table 1 showed somewhat mixed results. Suicide survivors showed statistically significant elevated levels of problems on two of the five criteria investigated here. However, on three other criteria, the ICG scale, the IES scale, and suicidality, none of the three groups investigated—suicide survivors, other-traumatic death surviving parents, and natural death survivors—were found to have any distinguishing features in terms of their grief difficulties and mental health problems.

In the next set of bivariate analyses we focus upon the subgroup of 462 suicide survivors. We present the relationships between grief difficulties and the methods of suicide, whether the survivor was present at the death scene, found the body, had seen the body prior to burial, the relationship between the survivor and the decedent prior to the suicide, whether the decedent made prior suicide attempts, and the level of parental surprise at their child's death.

We employed single factor ANOVA tests to compare the means of grief difficulties (with our abbreviated GEQ scale) among the subgroups of interest. As Table 2 suggests, no significant differences were noted in parents' grief

Table 2. Differences in Grief Difficulties by Suicide Death Characteristics (*N* = 462)

Suicide method	Means	SDS	<i>N</i>	<i>F</i>	<i>df</i>	sig.	eta-squared
Suicide method							
Gunshot	39.87	11.46	206	0.70	6, 20	0.64	0.01
Hanging	40.66	10.05	134				
Overdose	42.45	15.67	20				
Asphyxiation	37.46	11.52	28				
Jumping	41.08	10.33	12				
Drowning	38.22	11.2	9				
Other	42.89	10.24	18				
Decedent made prior suicide attempts							
First attempt	39.23	10.82	279	4.01	2, 422	0.02	0.19
Second attempt	40.21	9.68	75				
Third or greater	43.41	13.41	71				
How surprised were you at the suicide death?							
Extremely	40.22	10.46	226	0.56	2, 423	0.57	0.00
Very	39.42	11.94	117				
Somewhat/not at all	41.11	11.86	81				
Exposure to the body prior to burial or cremation							
Not find/Not see	37.50	10.97	96	3.46	2, 423	0.03	0.016
Saw body before burial	40.87	10.67	189				
Found body	40.93	11.80	141				
Previous relations							
Positive	39.50	10.75	349	12.5	1, 423	0.001	0.029
Negative/Uncertain	44.28	12.23	76				

Source: Survivors Child Loss Survey, 2006-2007.

difficulties when we contrasted the different methods of suicide. And, again, when we compared self-inflicted gunshot as a cause of death vs. all other suicide deaths (not displayed in Table 2), the grief difficulties means showed great similarity.

Witnessing the suicide was an extremely rare event with only seven of our respondents reporting being present at the time of the suicide. A much larger number ($n = 144$), approximately a third of all suicide death cases, reported finding the deceased's body, usually at the family residence. (In many of these cases the decedent took his/her life when other family members were at home asleep or in another part of the residence at the time of the death.) We combined the seven death witnessing cases with the 144 others that found the body into a total group of 151 cases.

We anticipated that respondents who found the body (or who had directly witnessed the event) would experience the highest levels of grief difficulties. We anticipated intermediate levels of grief difficulties for those who did not find the body but who had seen it prior to burial or cremation. We found the largest number of our respondents fell into this category ($n = 210$). And we expected the lowest levels of grief difficulties for those who neither found the body nor had seen it prior to burial or cremation ($n = 104$). Table 2 displays the ANOVA test results with the means for each subgroup. Our hypothesis was supported with the ANOVA test at the .03 significance level. The Scheffe paired means comparisons test showed those who had neither seen nor found the body were significantly different from the group that had seen the body prior to burial or cremation. This result was somewhat but not entirely in keeping with our expectations since finding the body did not appear to put a respondent at any greater likelihood for experiencing more grief difficulties.

Table 2 also shows the grief difficulties means for parents reporting on whether their child's suicide represented a first, second, or a subsequent attempt. Two-thirds of these respondents perceived their child's suicide as a first attempt; and 18% more perceived it as a second attempt, and the balance (16%) judged their child was making his or her third or more frequent suicide attempt when they died. Having a child make a third or greater suicide attempt was associated with significantly greater grief difficulties. The Scheffe paired comparison test showed that parents whose child had made two or more suicide attempts were distinctly different from those children who had never before attempted.

Respondents were also asked to describe their relationship to their child prior to the death. Parents reporting negative or uncertain relationships prior to their child's death also reported more grief difficulties, with a mean of 44 on the abbreviated GEQ scale, compared to a mean of 39 for those reporting varying degrees of positive relationships with their children. The ANOVA test confirmed this relationship at the .001 significance level, and the Scheffe paired comparison test also confirmed this association. In another comparison we contrasted the GEQ means for parents reporting different level of surprise at their child's death. While more than three-fourths of all parents reported considerable

or extreme surprise at their child's death, differences in being surprised vs. having little or no surprise at the death or expecting it, were not associated with variations in grief difficulties.

We computed these same bivariate ANOVA tests of grief problems with the Inventory of Complicated Grief as the dependent variable by a decedent's prior suicide attempts, closer exposure to the body and the death event, poor prior relations with the decedent, and surprise at the death. Results were generally consistent with those from the brief GEQ tests with one exception: prior suicide attempts was non-significantly associated with grief difficulties with $p = .07$. Otherwise, these same associations prevailed. These analyses are not displayed in our tables.

Next, Table 3 shows the multiple regression analysis of GEQ scores for parent suicide survivors by four potentially important bivariate predictors: time since the death, the number of prior suicide attempts, heightened exposure to the death event, and previous relations with the decedent. The regression results showed the time span variable to be the largest contributor to this model, with a beta weight of $-.25$. When the time span variable was removed, the explained variance dropped considerably from 11% down to 5%, showing its importance in accounting for differences in grief difficulties. We also ran the same regression equation with the time span variable alone, omitting each of the other predictors, and the explained variance diminished minimally, by a single percentage point, again suggesting the limited explanatory powers of these other factors in the same multi-variate model with the time span variable. We computed these same multi-variate models in two equations with the Inventory of Complicated Grief and The Impact of Events Scales as dependent variables replacing the brief GEQ scale. The findings yielded identical results with 11% of the variance explained,

Table 3. Multiple Regression Analysis of Grief Difficulties (GEQ Scores) by Time Since Death, Number of Prior Suicide Attempts, Exposure to the Body at Death, and Prior Relations with the Suicide Decedent

Independent variables	Correlation coefficient	Number of obs = 420 $F(4, 415) = 12.67$ $R\text{-squared} = .11$	
		Beta	<i>P</i>
Years since death	-.32	-.25	.0001
Number of prior attempts	.13	.08	.09
Exposure to the body	.10	.09	.06
Prior relations with decedent	.17	.15	.002

Source: Child Loss Survey, March 2006/May 2007

mostly all from the time since loss variable. (These analyses are not displayed in any of our tables.)

We suspected some of the variables under investigation were potentially important during the early phase of suicide bereavement. To investigate this possibility we computed the same equation for the 211 suicide cases whose children's deaths took place within the time frame of the first 4 years after the loss. Within this narrower sample frame of relatively recent suicide survivors, the regression equation showed two statistically significant predictors: number of prior suicide attempts (with a beta of .13) and poor relations with the decedent (with a beta of .22) faring significantly in explaining differences in grief difficulties, with these two accounting for 9% of differences in grief difficulties. Surprisingly, during this first 4-year time frame, the time span variable did not yield a significant association with grief difficulties. In a further test, not presented here, we widened the time frame to the first 5 years and observed the time span variable once again becoming a significant predictor. During the early loss period, the exposure to the body variable appeared to be redundant when it was included in this same model with these other significant predictors of grief difficulties. Both prior suicide attempts and poor previous relations with the decedent appeared to offer modest explanatory value—explaining 9% of the variance of grief difficulties—during the first years after loss.

We further investigated the relationship of the time span variable in regression analyses with each of the three indicators of grief difficulties included in this survey: the abbreviated GEQ scale, the Inventory of Complicated Grief, and the Impact of Events scale. We do not present these data in the tables, though we summarize these multiple regression findings. In each case, with one of these three

Table 4. Multiple Regression Analysis of Grief Difficulties (GEQ Scores) by Time Since Death, Number of Prior Suicide Attempts, Exposure to the Body at Death, and Prior Relations with the Suicide Decedent among Four Years or Less Post-Loss Survivors

Independent variables	Correlation coefficient	Number of obs = 211 <i>F</i> (4, 415) = 5.30 <i>R</i> -squared = .09	
		Beta	<i>P</i>
Years since death	-.11	-.09	.17
Number of prior attempts	.18	.13	.05
Exposure to the body	.07	.05	.47
Prior relations with decedent	.27	.22	.002

Source: Child Loss Survey, March 2006/May 2007

variables as the dependent variable, and time span as the independent variable, when we narrowed the sampling frame to include only those survivors where 4 or fewer years had passed since their loss, the time span variable yielded a non-significant association with grief difficulties. This suggests relatively high grief difficulties during the early loss period. There simply was little variability overall in grief difficulties for survivors during this early loss interval. Yet, as we altered the sample frame to include more survivors, who spent at least 5 years since their loss, we noted significant associations between time since loss and grief difficulties. As we expanded the sample frame still further, to include all suicide survivors, the relationship showed that the longer the time span after loss, the lower the grief difficulties scores.

Figure 1 below shows the plots of each of these three associations of years since the death against the different numeric means of grief difficulties. It should be noted that this figure is based on cross-sectional data. It includes information on different survivors placed along a continuum of different time periods since their loss. It is not based on a single group of survivors that were studied repeatedly over the range of the period depicted. Interestingly, the plot shows a slight upward spike in grief difficulties for survivors on two of the three grief difficulties criteria between the first 12 to 24 months after loss. Yet, after that point

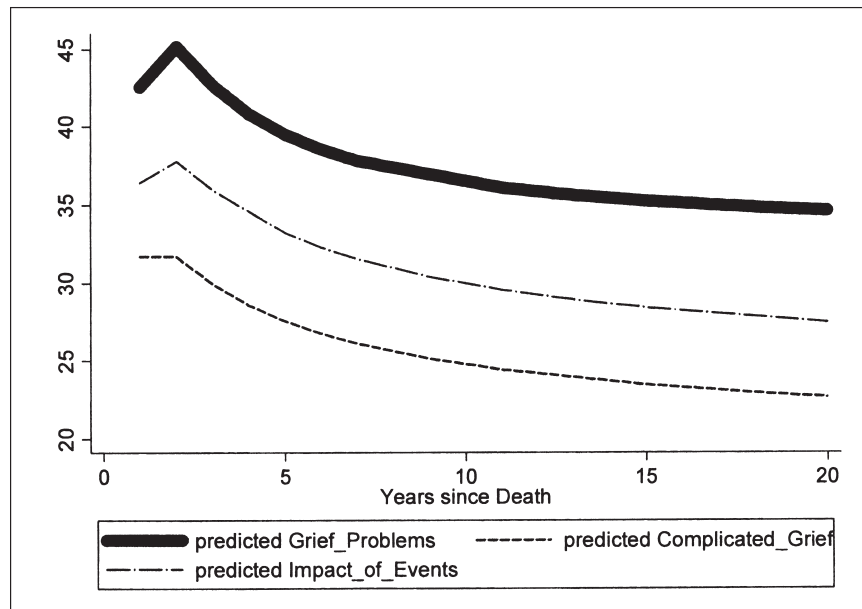


Figure 1. Lowess-Smooth functions of grief problems variables by years since death.

steady declines on all three grief difficulties criteria are shown. Whether we consider the GEQ, the Inventory of Complicated Grief, or The Impact of Events scale, the plots for each criteria show the steepest declines in grief difficulties taking place between the third and fifth years after loss. After 5 years, the declines in grief difficulties scores appear to become more gradual ones.

DISCUSSION

The present study offers mixed evidence on whether suicide survivors stand at a higher risk for grief difficulties and other mental health problems compared with other parent survivors losing children to other-traumatic and natural deaths. While the evidence showed suicide survivors experiencing greater difficulties on the brief GEQ scale, the pattern was not carried through to the other accepted instruments measuring grief problems: the ICG and the IES scales. This finding adds confirmation to the findings of Sveen and Walby (2008), who noted in their literature review of controlled studies, comparing suicide survivors to survivors of other modes of death that studies that used the GEQ, a suicide-specific measure of the grief response, were more likely to find suicide survivors had more difficult or intense grief responses on some variables, though not greater general mental health difficulties. Likewise, in our sample, while suicide survivors showed significantly higher mental health problems than the other subgroups on the ANOVA tests, the association was a weak one, not carrying across to pairwise post-hoc Scheffe significance comparisons.

These findings are also convergent with other results we obtained where we conducted multivariate analyses of grief difficulties, looking at the impact of type of death and social stigmatization (Feigelman, Gorman, & Jordan, forthcoming). In these multivariate regression analyses the type of death variable itself was only modestly associated with grief difficulties when it was included in multivariate analyses. The data suggested that suicide survivors (and other traumatic death survivors as well), encountered greater numbers of harmful and strained relations with their significant others—and it was primarily because of these experiences, and not the type of death event per se—that led to their greater grief difficulties. This evidence suggests that whether a child dies from a fatal auto accident, a drug overdose, or other common untimely deaths, the loss tends to evoke similar problems of isolation and social stigmatization among significant others, which in turn exacerbates grief difficulties. These findings will need further confirmation in longitudinal research before they can be fully understood.

But, for now, one plausible explanation for these mixed results, as well as the conflicting findings in the general body of studies comparing suicide bereavement to other forms of loss, is that suicide bereavement may be different in what Jordan (2001) has called the thematic or qualitative content of the grief. That is the subjective experience of the loss reveals certain themes that are more prominent and perhaps more long-lasting for suicide survivors than after most other types of

deaths. Available research evidence suggests that these themes include the issues of shame or stigmatization, feelings of rejection or abandonment by the deceased, and a heightened sense of responsibility for the death among survivors (Jordan, 2001; Sveen & Walby, 2008). The assessment of these thematic and subjective aspects of the grief is poorly accomplished with generic measures of mental health, or even grief. In contrast, methods that specifically focus on the aspects of grief that are more prominent for suicide survivors, including interviewing of survivors rather than paper and pencil measures, are more likely to reveal these subtle differences (Jordan, 2001; Sveen & Walby, 2008).

Although clinical experience suggests that survivors attach great importance to witnessing the death, or finding the body as experiences that complicate their grief difficulties, when we evaluated the importance of this factor with our survey data we found it offered only a modest association with differences in grief difficulties. Post-hoc means comparisons tests suggested that viewing the body prior to burial or cremation (compared to not seeing it at all before burial) was a stronger predictor of stress than was finding the body. Multivariate regression analysis showed this exposure to the body factor became redundant in the models we tested with other correlates including the time since loss, a child's prior suicide attempts, and previous relations with the decedent.

These findings are somewhat at odds with the results obtained by Callahan (2000), who found the exposure to the body variable as a most significant correlate to grief difficulties in his survey. In his study he found the exposure variable superceded the time since loss as the most significant single correlate in his multivariate analyses. Any number of reasons might explain the discrepancies between our results and his: the slightly different question wordings between our two studies; the use of the full GEQ scale applied by Callahan and the abbreviated scale employed here; the longer time span covered in this study as compared to Callahan's shorter time frame study; and the fact that his survey studied a mixed group of survivors while ours studied parents exclusively. More research will be needed to better explain these discrepancies. Presently our research leads us to conclude that as the time interval after the loss widens, the trauma inducing aspects of close exposure to the death and seeing the body are reduced.

Although Maple and her associates' (2006) small sample of Australian parent survivors suggested that grief difficulties were more pronounced when parents were greatly surprised at their child's death than when they were less surprised, we found no associations between differences in parental surprise and levels of grief difficulties. Our results are also consistent with Callahan's (2000) findings on this same subject. Yet, when we looked at the number of prior suicide attempts that the deceased had made, we did find that greater surprise was associated with fewer prior suicide attempts. We also found that those children with more prior attempts were associated with parents encountering greater grief difficulties after the completion. We speculate that when a child makes a greater

number of attempts it tends to inspire greater feelings of survivors guilt and blameworthiness about the death.

This study has also identified two important points for clinical practice with the suicide bereaved during their early years of dealing with loss. As Kosminsky's clinical experiences have demonstrated (2006), prior conflicts with the decedent can impede a survivor's healing. We have obtained empirical confirmation for this from our survey data showing greater grief difficulties for those survivors who had uncertain or negative relationships with their children who died than those parents who reported positive relationships prior to the death. Our data point to the importance of assessing for and addressing this point in clinical interventions during the early years of bereavement.

Clinicians working with the bereaved may already be well aware of how a patient's prior relationships with their deceased relatives can become grief "sticking" points. Yet, as these precepts have been verified by this survey research, the knowledge base for clinical applications is thereby extended. The prior suicide attempt history of the decedent appears to another useful marker for the possible identification of greater grief difficulties, especially as it may occur during the early post-loss years. It seems likely that a troubled relationship with the child and previous suicide attempts are both markers of a child with serious psychiatric illness and may contribute to an increased likelihood of guilt, remorse, and self-blame in the mourning process after the suicide. In a very important sense, survivor parents whose child had a history of prior psychiatric illness and a more problematic relationship with parents may be grieving not only the loss of the child through death, but the many years of a prior lost and troubled relationship with the deceased. It may be that suicide survivors in which the deceased struggled with psychiatric illness for a considerable period before the suicide have an exceedingly complex set of thoughts and emotions about the suicide, ranging from relief that the ordeal is over, to guilt over feeling that relief, to great sorrow over the troubled life of the deceased and lost dreams of a more "normal" parent-child relationship.

The present investigation has demonstrated the importance of the time span since death as the strongest single predictor of grief difficulties differences among child death survivors over the course of the life cycle. The type of death event, the method of suicide, the discovery and viewing of the deceased's body, the prior relationship to the decedent, and multiple suicide attempts were secondary in importance behind the time span variable when we looked at our entire sample, which ranged from .08 of a year to 27 years in terms of years since the suicide. This conforms with the general findings in thanatology that, for most people, bereavement distress decreases with time (Ott, Lueger, Kelber, & Prigerson, 2007).

Of equal importance, however, are our findings that in the first 4 years of bereavement after suicide, there is either little decrease, or even evidence of an increase of grief distress of parent survivors. Time since the death does not appear to matter much in this early phase of bereavement, whereas factors such as

the number of previous attempts, and the perceived quality of the relationship with the deceased were significantly related to outcome. This fits with an understanding that among the most prominent concerns for suicide survivors is the need to make sense of the death. This need to construct a narrative that helps to explain the reasons for the suicide appears to be one of the most important thematic issues for survivors (Jordan, 2001), and a perceived negative relationship with the deceased may only increase this felt need, particularly for the parents of the deceased.

Last, another important corollary of this finding about the impact of time since the death were our results showing—with three different problems indicators—that the steepest declines in grief difficulties occur during the third to fifth years after loss. These results are potentially important to survivors and are convergent with Murphy et al. (2003) findings from their longitudinal study of parent survivors who found years 3 and 4 to be the crucial loss acceptance turning points. In this first-ever study of survivors who were as far along as 27 years since the death, our results demonstrate continuing declines in grief difficulties taking place over the longer course. These findings deserve further confirmation in future research to see if the same grief adaptation patterns we found for parent suicide survivors will change in similar ways for survivors of a child's natural death and for other traumatic death survivors. Taken together, these findings can help clinicians to identify parental suicide survivors who are particularly at risk for a complicated mourning trajectory and for whom skillful and compassionate intervention may be needed.

Taken together, the findings from this research suggest that suicide survivor parents may show some differences from other types of losses in the qualitative or thematic experience of their grief, and that there are some variables that may begin to help clinicians differentiate which survivors are at greatest risk for grief difficulties. The supposition that suicide survivors are a homogeneous population is a widely held, untested and, in our opinion, likely false assumption. Rather, our data suggests that survivor parents who had a difficult relationship with their child prior to the suicide, whose child had made more than one prior attempt to the completed suicide group are likely to have a more difficult time in their mourning process. It may well be that future research with more nuanced measures of exposure to the body at the time of the death, than we were able to apply in our broad-based survey, may show that exposure differences—in witnessing the death or in finding the body—could be additional contributors to grief difficulties during the early years after loss.

Finally, the limitations of this study need to be taken into consideration when evaluating the implications of our findings. While this is perhaps the largest sample of parental survivors of suicide loss ever studied, it is nonetheless a convenience sample that may not be representative of all survivors. Although the response rate was a most acceptable one for this type of study, we simply do not know whether these conclusions apply to all parent survivors, or just to those who agree to participate in survivor research, a group that, for example, may

be more distressed than non-participating survivors. Second, we have used simple, and in some cases, single item measures in this study. Future research might benefit from the inclusion of more complex measures of some of the key variables under scrutiny here. Last, as a cross-sectional and correlational study, we can only demonstrate the associations between different predictor variables and greater bereavement difficulties, not the direction of causality. Longitudinal designs in survivor research would help greatly in furthering our understanding of the likely complex and circular causality between the loss experience itself, the development of psychological difficulties, and diverging bereavement outcomes.

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