Article

Suicide Loss Survivors: Navigating Social Stigma and Threats to Social Bonds

OMEGA—Journal of Death and Dying
0(0) 1–24

DOI: 10.1177/00302228211026513
journals.sagepub.com/home/ome
SAGE

Dorothy M. Goulah-Pabst[1]

Abstract

The complicated grief experienced by suicide loss survivors leads to feelings of abandonment, rejection, intense self-blame, and depression. Stigma surrounding suicide further burdens survivors who can experience rejection by their community and social networks. Research in the field of psychology has delved into the grieving process of suicide loss survivors, however the effects of suicide require more sociological study to fully understand and support the impact of the suicidal bereavement process on the social interactions and relationships of those left behind after death. This study aims to contribute to the body of research exploring the social challenges faced after the suicide of a loved one. Based on the analysis of powerful personal narratives through qualitative interviews shared by 14 suicide loss survivors this study explores the social construction of the grieving and healing process for suicide loss survivors. Recognizing that the most reliable relief is in commiseration with like experienced people, this research points to the support group as a builder of social solidarity. The alienation caused by the shame and stigma of suicide loss can be reversed by the feelings of attachment to the group that listens, understands and accepts. Groups created by and for suicide loss survivors should be considered a necessary tool to be used toward healing those who suffer from loss by suicide.

Keywords

suicide, suicide loss survivor, shame, stigma, healing, social challenges

[1]Department of Sociology, California State University Northridge, Northridge, United States

Corresponding Author:
Dorothy M. Goulah-Pabst, 14031 Weddington Street, Sherman Oaks, CA 91401, United States.
Email: dorothy.goulahpabst.946@my.csun.edu

"I believe that the person who commits suicide puts his psychological skeleton in the survivor's emotional closet" (Schneidman, 1972, p. x).

Introduction

A suicide loss survivor is an individual whose life is affected by the loss of a significant relative or friend due to suicide (Andriessen, 2009; Schneider et al., 2011; McIntosh & Drapeau, 2015 as cited in Rabalais et al., 2017). Numerous studies have been undertaken to estimate the population of suicide loss survivors in the United States. Estimates have grown from an average of 6 survivors per suicide in 1973, to as many as 135 in 2013, with an overall estimate of 5.5 million individuals exposed to a suicide within their own networks annually in the United States (Cerel et al., 2018). Feigelman et al. (2017), using the 2016 General Social Survey determined that 51% of American adults are exposed to at least one suicide during their lifetime and of the adults exposed, 35% are considered severely to moderately bereaved by the loss. The effects of death by suicide on those left behind are more prevalent than once thought.

According to the Centers for Disease Control and Prevention, suicide is the tenth ranking cause of death in the United States and the second leading cause of death for those 15–34 years of age (Kochanek et al., 2019). With an increase in the suicide rate in the US of 35% between 1999 and 2018 (with the greatest increase after 2006) it is clear that those left behind are increasing in number (Hedegaard et al., 2020). Those considered to be suicide loss survivors, in the past, included close family members but currently include those who are exposed to, affected by, or fully bereaved by a suicide (Bellini et al., 2018; Cerel et al., 2018; Honeycutt & Praetorius, 2016).

Suicide loss survivors suffer from increased feelings of abandonment, rejection, guilt, intense self-blame, depression, and fear that the death was in retaliation (Bailley et al., 1999; Barrett & Scott, 1990; Ellenbogen & Gratton, 2001; Nam, 2016, Schneider et al., 2011; Testoni et al., 2018). Stigma surrounding suicide further burdens survivors who experience rejection by members of their community and social networks. This rejection is based on prejudice and stereotypes supporting the idea that survivors are contaminated by, or share, mental health issues of the suicide decedent (Barone et al., 2019; Dyregrov, 2011; Kheibari et al., 2018; Sheehan et al., 2018). A medical record dated October 26, 1901, found in *Survivors of Suicide* (Cain, 1972), reports the phenomenon of suicide contagion in one family that lost at least 21 descendants to suicide over a period of 50 years. It has been considered that those who lose close relations to this form of death are more susceptible to suicide and suicide ideation due to the emotional strife caused by the suicide loss (Nam, 2016).

Isolation and alienation occur when experiential avoidance is used as a tactic to protect feelings and avoid reminders of the suicide thereby hindering the

process of grieving (Nam, 2016; Young et al., 2012). Survivors of suicide loss who seek professional individual therapy may find it challenging to find a provider trained in suicide loss bereavement, which includes not only complex bereavement but trauma and self-blame (Jordan & McGann, 2017; Ross et al., 2019). However, helping others through group or one-on-one peer support to overcome their grief has proven to reduce symptoms of one's own grief, such as depression and isolation, and can increase feelings of personal growth (Dyregrov, 2011).

How an individual experiences death and bereavement is greatly influenced by the social context in which the death occurs, and the intensity, duration, and symptoms of grief are adjusted to cultural and social norms (Jakoby, 2012; Thompson et al., 2016). Thompson et al. (2016) suggest that following a death and bereavement social relationships change. Macro-sociological changes take place in the grieving survivor's social status as well as micro-sociological changes in the survivor's relationships with their close friends and family members. Loss of a loved one includes not only the physical loss of the decedent, but the loss of support, foundation, companionship, guidance, validation, financial security, and the possible introduction of social isolation (Jakoby, 2012). Stigma associated with suicide causes many families to devise family secrets due to the inability to share the cause of death (Kneiper, 1999). The stigma associated with the aftermath of a suicide can be a barrier to seeking help and to the availability of help to cope with the loss (Dyregrov, 2011; Kheibari et al., 2018; Young et al., 2012). Further, institutionalized stigmatization takes place as the refusal of rituals due to religious beliefs as well as clauses in life insurance policies withholding payment upon death (Young et al., 2012).

Grief experienced after suicide is more complicated than grief after a non-suicidal death, involving severe stress due to traumatic bereavement (Nam, 2016). How one's family and friends respond to one's bereavement can mitigate or intensify a "sense of loss of status in the broader social domain" (Thompson et al., 2016, p. 174). Feelings of sympathy and admiration that usually accompany bereavement due to illness or accident were reported to be the least frequently experienced feelings for those who suffered loss by suicide, whereas feelings of guilt and depression were reported as most prevalent (Schneider et al., 2011). Although grief is "intrinsically social", grief after a loss by suicide often is not (Thompson et al., 2016, p. 175).

Complicated grief is brought about by the sudden shock of suicide and especially by the trauma of witnessing the act or finding the decedent (Kneiper, 1999; Nam, 2016). Persistent and intense grief can lead to negative health outcomes such as sleep disturbance, elevated blood pressure and suicide ideation with increased vulnerability to lifelong mental health issues and post-traumatic stress disorder making suicide loss survivors the largest group of victims at risk of physical and mental health declines (Andriessen, 2009; Bellini et al., 2018; Kneiper, 1999; Nam, 2016; Sanford et al., 2016; Young et al., 2012).

Jakoby (2012) points out that since the self is dependent on social relationships and interactions to fulfill its construction and meaning, those we hold close are crucial to our self-development and the maintenance of our reality. Death of someone close can mean a loss of one's own self-image, shaking the "foundations on which the self of the survivor is constructed and known" (Jakoby, 2012, p. 686). Loss by suicide can intensify these feelings. Suicide loss survivors are left with the task of making meaning of the death and often find themselves caught in the ruminations of why (Kneiper, 1999; Shields et al., 2017). Praetorius and Rivedal (2017) describe this task as delving into the "ocean of why" (p. 8). Shields et al. (2017) conclude that making meaning of the suicide is a complex process occurring within a social context making it a challenge for others to connect with the bereaved.

The strong and overwhelming thoughts and feelings that accompany loss by suicide are often ignored and hidden due to the stigmatization of suicide and social pressure to end grieving (Shields et al., 2017). While the difficulties experienced due to a suicidal death are often examined psychologically, this research examines the social interactional negotiations experienced after suicide loss, aiming to discover the social effects and alleviation of difficult emotions experienced by those bereaved by suicide. Each person affected by these losses must renegotiate their social interactions due to both their own suffering and the discrimination of others, to re-enter social life and recover their life's meaning. Uncovering the stigmatized interpersonal relationships, the methods used to mediate difficult social situations after the suicide or the avoidance or reluctance to engage in social interaction, will hopefully encourage a broader understanding of the needs of suicide loss survivors on a social scale, to disrupt stigmatization and discrimination. The purpose of this study is to grasp how suicide loss survivors navigate stigma, threats to social bonds, and difficult emotions associated with suicide loss and what coping strategies and meaning making processes contribute to their healing through social interactions.

Method

Participants

Participants were recruited using purposive snowball sampling beginning with an email sent to the founder/facilitator of a peer-led suicide loss survivor support group in the Los Angeles area. Suicide loss survivor groups were researched on the American Foundation of Suicide Prevention website. Other groups were approached but their programs were for recent loss survivors. The group contacted was the only drop-in survivor group in the area serving both recent survivors and those with more than two years of grieving. The original contact led to introductions to their associates and group participants who had experienced the loss of a loved one to suicide. Flyers were distributed at meetings and

delivered via email to eligible and willing prospective participants explaining the details of the research. Eligibility for participation required all participants to be over the age of eighteen and having experienced the loss of a loved one to suicide at least two years prior to the interview. Ten participants were recruited through snowball sampling beginning with the original contact and four participants were recruited from personal friends of the researcher, who experienced a loss from suicide, for a total of fourteen participants. All participants had experienced one-on-one therapy, or peer and mental health professionally led support groups for suicide loss.

The sample included 9 females and 5 males with the age at loss ranging from 19 to 78 with the median age of survivor at the time of loss being 50. Losses were experienced from 1985 through 2018. Two sets of two participants shared the same loss (November 1999 and May 2005). Losses included 2 fathers, 1 wife, 3 brothers, 2 mothers, 2 sons, 2 husbands and 1 nephew. Two participants were the parents of one deceased son (see Table 1).

Interviews

Personal narrative in the social sciences is widely used as a means of framing meaning, giving the researcher and the participant an understanding of what discourses are operating and the meaning and power that could be shaping our understanding of the situation as well as other people's responses to it (Thompson et al., 2016). The interview protocol included nine demographic questions and fifteen in-depth, semi-structured, open-ended questions drawn with a sociological point of view following a review of literature studying the grieving and meaning making of suicide loss survivors. Using interpersonal and social interactions as a baseline for the primary research questions, the interview questions were developed with the social dilemmas of suicide loss in mind. The questions concentrated on the survivor's ability to continue, reconnect, and initiate social relationships over time.

Aspects of dealing with others socially after a suicide loss were explored. Questions also examined the sharing of the news of the death, answering questions about the death and the reactions of others to the loss. Questions sought to understand and elucidate when and how or whether loss survivors were able to re-enter social life and what meaning making processes and coping strategies survivors of suicide loss were able to use through social interactions to deal with the loss (see Table 2).

Interviews ranged from 60–120 minutes, were audio recorded with permission of the participants, coded with pseudonyms for anonymity, transcribed verbatim, and printed for analysis. The first four interviews took place either at the participants' home/office or the researcher's home/office. As the 2020 pandemic restricted in-person meetings, the remaining interviews were conducted by telephone or video chat. Regardless of where the interviews took place all

Table 1. Biographical Details of Participants.

Survivor	Gender	Age of survivor at loss	Date of loss	Relation of decedent	Years since loss	Education	Religion	Ethnicity	Occupation
Chili	Female	53	May 2005	Father	15	Some college	None	European-Canadian	Retired early child education
John	Male	37	Apr 1998	Wife	22	High school	Atheist	Caucasian	Writer
Sarah	Female	23	Oct 1986	Brother	34	Masters	Nonpracticing Catholic	Caucasian	HS admin
Sasha	Female	19	Jan 1985	Mother	35	Some college	Wiccan	Jewish	Filmmaker
Doggo	Male	41	Jan 2004	Brother	16	2 Masters	Christian	Caucasian	Aerospace engineer
Roye	Female	57	Apr 2001	Son	19	MSW	Jewish	Caucasian	Therapist
Marta	Female	47	Jun 2005	Husband	15	Grad student	Nonpracticing Catholic	Italian-American	Media publicist
Anita	Female	54	Nov 1999	Son	23	Masters	Lutheran	Caucasian	Retired teacher
Ernie	Male	61	Nov 1999	Son	23	Doctorate	Lutheran	Norwegian-American	Retired pastor
Bob	Male	53	Oct 2001	Brother	19	Masters	None	Canadian	Photojournalist
Beth	Female	27	Jun 2008	Mother	12	Some grad school	None	Caucasian-Jewish	Production manager
Athena	Female	33	Apr 2017	Father	3	Some college	Agnostic	Bi-racial	Actress
Jon	Male	58	Jun 2018	Nephew	2	Some college	Unity Church	Caucasian	Fitness instructor/ designer
Rose	Female	78	May 2005	Husband	15	BA	None	German	Retired teacher/ food service

Table 2. Interview Schedule.

Demographics
Participant's age at loss; gender; date of loss; relation to decedent; years since loss; education; religion; ethnicity; occupation.
Navigating Interpersonal and Social Interactions After Loss
1. Can you tell me how and with whom you shared the news of the death (and its cause)?
2. What were some of the reactions you experienced upon sharing the news?
3. How did friends and loved ones react to your loss and grieving? How did they make you feel?
4. Can you describe your feelings when you were confronted with questions about the death?
5. Can you describe your feelings once the immediate repercussion of the death ended when life was expected to carry on?
6. How much time passed after the death before you were able to reach out for support, emotional and social?
7. Can you tell me what type of support you sought and what was most helpful?
Navigating Traditional Stigmas Associated with Suicide
8. How was your social life affected by the death and by your emotions about the death?
9. After the death how did you integrate yourself back into your social sphere? What types of activities did you engage in and what did you avoid?
10. How did your social life affect your emotions as time passed?
11. Do you think you gained or lost friends? How did this happen?
Meaning Making Processes and Coping Strategies Through Social Interactions
12. What did you find most helpful for dealing with the loss?
13. Can you describe any coping strategies that guided your recovery and healing?
14. How is your life different from those who do not experience a loss from suicide?
15. Is there anything else you would like to share about your experience?

participants were asked the same questions in the same order and encouraged to share as much as they were comfortable sharing. Some additional questions were asked on occasion to clarify or deepen understanding of a situation, such as 'what was your response to that'. Ethical approval for the study including the interview schedule was obtained from the Institutional Review Board of the institution the researcher was currently affiliated with at the time of the research.

Ethical Considerations and Challenges

Asking a suicide loss survivor personal questions regarding the loss of a loved one to suicide can cause mild to moderate to strong discomfort, including tearful episodes. Discussion of the loss can trigger repeated trauma and the challenging emotions of grief after suicide, due to stigma, shame, and unresolved emotions. When emotions during the interview made discussion difficult, time was given to the participant to gather their thoughts. They were offered the option of

continuing at another time or simply taking a break. All participants chose to continue the interview at the time. Participants signed a consent form informing them of the purpose of the study, inclusion requirements, time commitment and risks/discomforts. Each participant was informed that they would be asked to choose a pseudonym, were not required to answer any question they felt uncomfortable answering, that they could discontinue participation at any time and were given the telephone number of a suicide loss survivor crisis line as well as a website with listings for support groups. If the participant felt they needed private psychological support, it was indicated that the participant would be responsible for finding and paying for such support. All fourteen participants read and signed the consent form.

Data Analysis

Interpretative phenomenological analysis was employed for a thematic based analysis of the interviews to reveal the significant experiences of the participants as related to the interview questions (Smith et al., 1999). The analysis began with listening to the audio recordings carefully while transcribing the interviews verbatim including descriptions of the emotional state of the participant. Once transcribed with numbered lines, the interviews were read repeatedly and deliberately to identify themes corresponding to the questions asked, as well as additional thoughts revealed in the answers. Comments were highlighted with color codes to correspond to the primary research questions. Notes were written in extended right margins to accentuate the main themes participants' social experiences revealed (see Table 3). As the themes coalesced a second document was created for each participant with quotes as they pertained to each theme. These themes were then organized revealing similarities and differences of the participants' experiences with loss from suicide. Once the main themes had been identified, a final document was created with headings for each theme followed by illustrative quotes from the participants.

Table 3. Organization of Themes.

Primary research questions	Themes revealed
1. Navigating interpersonal and social interactions after loss by suicide	- Social retreat - Just carried on - Had to be strong
2. Navigating stigma	- Negative evaluation of self - Creating family secrets - Loss of relationships/threats to social bonds
3. Coping strategies and meaning making	- Recovery occurs through social solidarity - Supporting others

This data was then analyzed through the lens of symbolic interactionism and dramaturgy using Hochschild's (1979) theory of emotion work and feeling rules, Goffman's (1959) theory of dramaturgy, Scheff's (1990, 2003) symbolic interactionist theory of social bonds and Collins' (1990) interaction ritual chain theory and emotional energy theory. Examining the interpersonal relationships and social interactions through these frameworks contribute to a broadening of knowledge to advance social support and relieve stigma in the ever-increasing population of survivors of suicide loss.

Results

Eight cogent themes emerged that corresponded with the three major research questions. In terms of interpersonal and social interactions some survivors *socially retreated*, others *just carried on*, and some felt they *had to be strong*. The powerful stigma that is socially held around suicide was experienced by all the survivors interviewed causing *negative evaluation of self*, *family secrets* and *loss of relationships* and *threats to social bonds*. Finally, *coping strategies and meaning making* were exercises in *recovery* and creating new meaning in the individuals' lives through *social solidarity*.

Retreat

The loss of a loved one, by natural death or suicide, shifts the survivor's social identity and social context. Suicide loss survivors also suffer a loss of solidarity, with individuals becoming alienated from their group perhaps wanting to avoid it (Collins, 1990). Chilli lost her father to suicide in 2005 when she was 53 years of age. Her father suffered from painful irreparable back damage and refused surgery and a wheelchair. Chilli, an early childhood education specialist, had a husband and mother-in-law with chronic illnesses in her home at the time of the suicide. "I wasn't open to really being present . . . I sort of receded." Sarah lost her younger brother in 1986 when she was 23 years of age and embarking on a career in education. "It really killed any social life I had because I didn't want to do anything. . .I didn't have the energy . . . my social life was in a holding pattern." Sasha lost her mother to suicide in 1985, on the second attempt, when she was a 19-year-old college student. Her mother suffered from cancer and the prognosis was not good. "I cried a lot . . . I never went to class again. I just retreated into myself which was pretty deep." Doggo was 41 when he lost his brother, a doctor, to suicide after a protracted battle with mental illness in 2004. "I went into a pretty steep depression. I withdrew." Roye, a therapist, was 57 when her son, a doctor, took his life in 2001. "I really didn't want to see anybody because I knew . . . then everybody hugs you and you all start crying . . . it was too overwhelming to go anywhere where people would know me and rush up to me." In 1999, when Ernie was 61 years of age, he lost his son

to suicide. Ernie was a religious leader, living a very public life requiring him to travel and preach. "It took me several months to kind of get back to connecting with people again. I just withdrew from things for a few months." Beth was 27 years old when she lost her mother to suicide on a second attempt in 2008. "I don't have much of a social life . . . I'm definitely more of a loner. I think I hold myself back."

Using Collins' (1990) theory of interaction ritual and emotional energy which refers to short-term and long-term emotional outcomes as a continuum ranging from the high of enthusiasm, confidence and good feelings about the self, past a middle range to a low of negative self-feelings, lack of initiative and depression, the feelings expressed by Chilli, Sarah, Sasha and Doggo, "sort of receded . . . didn't have the energy . . . just retreated into myself . . . went into a pretty steep depression . . ." reflect the low emotional energy state described by Collins (1990). Low emotional energy, according to Collins (1990), is a "lack of Durkheimian solidarity" and individuals experiencing it are alienated from their group and want to avoid it (p. 33). This experience is also reflected in Ernie's retreat from his group and Beth's alienation and avoidance of social solidarity as described by her "loner" status.

Roye, on the other hand, "didn't want to see anybody because . . . everybody hugs you and you all start crying . . . it was too overwhelming." Hochschild's (1979) emotion management perspective explains Roye's inability to socialize and confront her group of friends and acquaintances. The motivation of what one *wants* to feel, mediates between feeling rules, what one *should* feel, and emotion work, what one *tries* to feel (Hochschild, 1979). Roye's difficulty mediating between the feeling rule of what she should feel (comfort from her friends) and the emotion work (trying to feel comfort from her friends) forces her to withdraw and avoid the feelings altogether.

Carrying on

Collins (1990) states that the loss of a loved one contributes to a desire to "keep up conventions" (p. 29). Chilli, having responsibilities in the home and at work found the need to not only retreat from her social milieu but "Life just kept going on . . . I just kept on doing my job and doing my whatever", to maintain equilibrium. John, whose wife took her life when he was 37 in 1998 found, "there was literally no escape" as he and his wife worked together and "I couldn't go to work and forget about it for 8 hours." Sarah, a budding educator, had no choice but to start her new job. "The funeral was on Monday, Tuesday I went back (home), Wednesday was the first day of this job at this school." Marta was 47 years old when she lost her husband to suicide in 2005. She had a secure and beloved life in a beach community in California when her loss occurred. "All of a sudden I found myself in northern New Jersey, the place that I wanted to get the fuck out of since high school . . . I'm with my

parents . . . I found jobs, I worked in the city, my parents looked after my son". Anita, married to Ernie and living the public life of a pastor's wife found that, "I was really pulled back into life very quickly" due to the obligations of church events. Bob was 53 when he lost his younger brother to suicide in 2001. "I had to get things done . . . the body to the funeral home . . . real estate agent . . . have sales . . . no will . . . I'm the one in charge." Beth "just kept moving forward . . . I kept working and saving money and planning my move . . . I kind of went through in a fog." Jon was 58 when he lost his nephew to suicide after a troubled childhood. "My work is very public so it's something I can't hide from . . . (I had to) swallow and push on." At the age of 78, Rose lost her husband (Chilli's father) to suicide. "I continued to entertain our group of friends which was really like family . . . we didn't talk about it. We just carried on. I stayed busy." Keeping up conventions, carrying on and maintaining our social reality allows the loss survivor to avoid questioning conventions and to escape realizing how arbitrary social order, and the loss of it is (Collins, 1990).

Being Strong

Suicide loss survivors often feel the need to put on a "performance . . . for the benefit of other people" (Goffman, 1959, p. 17). Beth felt she needed to protect others from the reality of her mother's death. "Some people just don't know how to react . . . I feel uncomfortable for making them uncomfortable. I felt like I had to be the strong one." Beth's father had lost his wife, Beth's stepmother, to suicide just twelve days prior to Beth's mother's death. Beth decided she needed to "be there more for him than I needed him there for me." Athena's loss of her father propelled her into a new role. "I was just showing up as a person who was full of gratitude and acceptance and strength . . . I felt that I needed to be that for my mother and my brothers."

Both Beth and Athena engaged in cognitive emotion work. Hochschild (1979) refers to emotion work as the act of "evoking or shaping, as well as suppressing, feeling in oneself" (p. 561). Cognitive emotion work is an attempt to change ideas and thoughts in order to change feelings (Hochschild, 1979). Although Beth was feeling "dread . . . you've just lost this very important person in your life" and Athena "was in absolute shock", they believed their family needed them to "be there". Feeling rules exist in our social life with guidelines directing "how we want to try to feel" (Hochschild, 1979, p. 563). Beth and Athena both felt the need to try to feel strong, suppressing their own grief in favor of helping their families navigate their own.

Athena remembers, "When I look back at the photos, I have on beautiful dresses, my nails are done." Goffman (1959) suggests that the managing of emotions includes the "consistency between appearance and manner" (p. 25). In Athena's case, her beautiful dresses and well-manicured nails helped her to exude the strong person she wanted to appear to be to her social milieu. When

Athena played the part of the strong sister, she was impressing on those around her that she felt as she appeared to feel. In Goffman's words, "the individual offers (her) performance and puts on (her) show 'for the benefit of other people'" (1959, p. 17). The performer practices this delusion for the good of those around them as Athena did for her family and those at the funeral. She also determined that her performance would deny "an opportunity for anyone to say anything to me about my father . . . anything disrespectful."

Navigating Stigma

Negative Evaluation of Self. Survivors can experience the stigma of suicide loss as shame, embarrassment, avoidance, and anger. These emotions and the threat to social bonds cause individuals to feel a lack of social acceptance. Feelings of worthlessness follow the suicide of a loved one. "We have a lot of pressure from the event", explains Chilli. "I think stigma shuts you down . . . the judgement that comes with it . . . not being worthy." John echoed Chilli's concern of not being worthy when he encountered rejection on a date, "she didn't feel comfortable seeing me again . . . (I'm) not going to be good relationship material." Roye felt like a failure not only as a mother but as a therapist, "they all knew I was a therapist, so I felt like I was a bad therapist cause how could I not save my own son?" Marta had been "the go-to girl", everyone came to her for help with their life situations. "I wasn't the go-to girl anymore . . . I was a damaged person . . . I wasn't of value . . . I felt useless and hopeless." Athena experienced what many suicide loss survivors do, the feeling that her loss would "reflect poorly on me . . . I wouldn't have been a good enough daughter that it would have been worth him staying."

Family Secrets. Sasha wasn't sure how to respond to questions about her mother's death. "I just said she died of cancer related . . . ". She "was just not wanting to have the conversation . . . not even my own family talked about it." Doggo still finds it difficult to be clear about his brother's suicide. "I will still say my brother died of bipolar disease . . . if they know anything about mental health then they know that means suicide." Doggo admits, "maybe the reason I said my brother died from bipolar was to manage . . . the stigma and embarrassment of saying he died by suicide." Marta confides, "I think I went so far as to say he died of cancer . . . with the suicide I felt like I got the cooties . . . some people just ran away from me." Although Anita was always honest about her son's suicide, she found that "many of them would be kind of shocked . . . they didn't quite know how to respond." On the other hand, if Ernie, Anita's husband, was confronted with the stigma that the suicide might be "a black mark on your family . . . I would take that right on . . . I would say NO . . . he struggled for as long as he could . . . he didn't have any more to give . . . I would speak up in a situation like that."

News of Jon's nephew's suicide was shared in the whispers and judgements of gossip in the rural home of his upbringing. "In a rural area like that, everyone knows . . . so there's all that whispering, and the gossip is always around." Bob's anger erupted when the Orthodox Church that his mother belonged to refused to bury his brother due to his suicide. "I called the priest a cocksucker . . . I said you fucking cocksucker!"

Loss of Relationships and Threats to Social Bonds. John found that some friendships vanished. "All of a sudden . . . the circle of friends I shared with my wife wasn't going to be a circle of friends anymore." Sarah remarked that "there was a certain reaction I was getting from people that was not a good one." Her experience with starting a new teaching job and seeking advice from the school counsellor regarding explaining her absence to the students illustrates this reaction. "She asked me how he died so I said (suicide) . . . It was almost like she couldn't get rid of me fast enough . . . I can still see this woman standing there and being dismissive of me." Sarah found that people would "stay away from me as though suicide was contagious." Not long after her loss, Athena shared her experience with a man she had been dating, "the guy completely disappeared." Although Beth will "never hide or deny it", when someone asks her about her mother's death, "I get a little anxious . . . if it does come out will they judge me for that?" Sarah sums up the feeling, "The stigma is hard, you might as well wear an 'S' for suicide."

Scheff (2000, 2003) asserts that shame arises from an individual's monitoring their own actions from the standpoint of the other, making it the most social of emotions. Scheff (2000) defines shame as "the feeling of a threat to the social bond" caused by "the *perception of negative evaluations of the self*" (p. 281). As illustrated above, the participants' experience of stigma around the suicide of their loved ones was generally felt as shame, embarrassment, avoidance, and anger.

Coping Strategies and Meaning Making

Private Therapy. Participants shared that private therapy positively affected them. "The therapist saved my life." Bob. "That young man helped me . . . really helped me a lot." Rose. "I don't think I would have survived what I went through without her." Beth. Anita and Ernie began counseling immediately after their son's death with his private counsellor. They were told, "You know your son died from a disease, some recover from alcoholism (depression) and some don't . . . some recover from cancer and some don't." Doggo had a different take on private therapy, "when you're trying to find a therapist find one that understands suicide and understands you . . . because if they don't understand suicide walk away." Jordan and McGann (2017) recognize that clinicians must be conscious of their own attitudes and reactions to suicide. Suicide survivors who are not able to find or receive professional help often

experience an increase in sorrow, lack of energy and feelings of abandonment as time passes. In this case time does not always heal.

Religion. Jon, Doggo and Ernie turned to their religious beliefs and prayer to re-assess their lives and losses. Doggo, after six months of losing his faith, "started attending Calvary Community Church" where he embarked on a spiritual life and social activities. Jon belonged to the Unity Church movement. "I went to my minister (immediately), to my spiritual leader and to two prayer chaplains . . . and that gives me a lot of support." Ernie, being a pastor, had a deep well of faith to draw on. "This did not kill my faith . . . it called forth other parts of it . . . especially the trust part. I grew deeper and stronger."

Back to Work. Getting back to one's life played a large part in Bob's recovery. "I could say getting back involved with my work . . . getting engaged in life again . . . and being present in things that I really love to do, that made life better again." Collins' (1990) interaction ritual chain theory posits that re-engaging and the restoration of group solidarity leads to "emotional energy" (p. 32). His contention that high emotional energy begets a feeling of enthusiasm for social interaction and a feeling of confidence bears itself out in Bob's experience (Collins, 1990). For three months Bob was locked in the grip of low emotional energy, which Collins (1990) contends results in "depression, lack of initiative, and negative self-feelings" (p. 32). Once Bob was able to engage with his work, feeling social solidarity, his emotional energy increased allowing him to feel enthusiasm for his life again.

Support Groups. Where the stigma and shame felt by suicide loss survivors are a threat to social bonds and social acceptance, the coming together of like experienced people can rebuild the bonds and sense of acceptance. Re-engagement in group solidarity can lead to increased "emotional energy" (Collins, 1990, p. 32). "Participating in the support group . . . took a lot of pressure off." Chilli found that she "had to be in a protected group to talk about . . . the details." She looked for "a specific group related to suicide." For John, "I talked it out a lot . . . we need to talk about it." John came "to understand . . . a lot of emotional healing seems to me . . . the process of it moving from here (head) to here (gut)." Sarah finds that "my involvement in suicide loss survivor groups . . . has been very healing for me . . . has been a springboard to . . . being more involved socially" because "it's a place where I can belong". Sasha "called AFSP (American Foundation of Suicide Prevention), they were having a walk . . . I volunteered . . . the second I got there my life changed . . . people were talking about suicide . . . I could say my mother killed herself . . . it felt so good because I was helping."

Doggo experienced discomfort but relief in a group. "I think it was helpful . . . it

was uncomfortable . . . I think you need to talk about your feelings . . . you need to get that out, you need to be with people who understand . . . it gave me a cocoon." Roye was told about Didi Hirsch's (a mental health services and suicide prevention center) eight-week grief group. "I was with eight or nine people that had experienced a suicide (loss) . . . going once a week for eight weeks helped me survive . . . we could talk about things you could never talk about with other people." Roye "felt comforted." Anita went to a convention of Compassionate Friends (a grief group for parents) nine months after her son's suicide. "There was a group of about thirty people who had all lost children by suicide . . . one of the most meaningful events or group things that I have gone to." Anita found that the "significant sharing" helped her realized "you're not alone". Her husband Ernie had the same experience. He found safety in groups, "to talk about that with other people . . . let's get it out . . . let's talk about it . . . let's be open!"

Beth's father "found the AFSP overnight walk . . . in Chicago . . . so we did the walk together." Beth "gradually started to volunteer . . . as a way to stay connected to the loss." She found that "doing the AFSP events . . . these other people can understand . . . the grief is very unique . . . that's definitely been very helpful." Athena "started going to two groups every Saturday." She has found that "out of everything I would say the groups have been, I mean just an absolute godsend . . . the friendships . . . the comradery . . . it's empowered me."

Twelve of the fourteen survivors interviewed participated in support groups specifically designed for suicide loss survivors and had overwhelmingly positive experiences. Survivors were able to redefine their identities in the social space provided by the survivor support groups. Being in a room with other suicide loss survivors offered a protected and safe environment in which to experience and share one's emotional and social upset. Their identity as a suicide loss survivor became one of inclusion rather than exclusion, one of acceptance rather than stigma, based on their shared experience.

Supporting Other Survivors. Athena's positive experiences with suicide loss survivor groups and the many deep friendships she developed through the groups inspired her to "have the conversation with civilians." Her life's mission "has now become to erase the stigma." Athena puts her experience to work in her writing to "normalize grief and to make grieving mainstream." Athena has gained strength and a sense of purpose combating the stigma and shame surrounding suicide and loss survivors. Through Athena's experience of increased emotional energy, group solidarity has enabled her to recover feelings of confidence and enthusiasm generating acts of altruism. Some participants have gone on to become active leaders in suicide loss groups (Sarah, Athena and John) and in the American Foundation of Suicide Prevention (Sasha, Sarah, John, Roye, Beth, Doggo, Anita and Ernie). Some have started non-profits of their own

(Roye and Athena) and many continue to attend meetings for suicide loss survivors to give hope to the newest survivors.

Post traumatic growth, the term describing increased levels of "personal development" after a traumatic experience, such as the loss of a loved one to suicide, is a positive outcome to a negative life experience (Smith et al., 2011, p. 413). John admitted that he gained friends and experiences and "there's whole areas of my life that I would not have explored if it had not happened." Roye, as a therapist, continues to work with AFSP and Didi Hirsch Mental Health Services. "I met some wonderful people through the organizations that I never would have met in a million years." Marta feels strongly that her "goal is to become a grief therapist". Through engaging in diligent selfcare in her search for relief, Marta "made the decision to become an optimist", studying the psychology of happiness, practicing yoga, meditation, talk therapy, group support, exercise and reclaiming her beloved beach community. Sasha has embarked on the production of a documentary bringing the family and friends of her deceased mother together to share thoughts and feelings of her life and death that had never been shared. Sasha is learning more about her mother in death than she did in life and the experience has created a closeness heretofore missing in her family relationships.

Discussion

This study presents an in-depth exploration of fourteen participants' emotional and social experiences induced by the loss of loved ones to suicide. Particular attention was paid to the social aspect of loss, bereavement and recovery. The findings reveal the highly social aspect of coping with the intense and complicated grief of suicide loss. Suicide loss survivors experience the taboo and stigma of society's judgement of suicide, compounding their grief, often causing them to retreat from their lives, even while they must carry on with the care of others and their careers. The suicide loss survivor can also feel the need to put forth a positive, strong attitude to protect themselves and their surviving family members from the social stigma of suicide.

From the symbolic interactionist perspective on loss of a loved one to death and the ensuing bereavement, "we find the concept of loss of self" (Charmaz, 1980; Jakoby, 2015, p. 117). Loss of self relates to the individual's social identity, their sense of where they belong in the world and how they might find their way again. Suicide, often considered an illegitimate or shameful loss, can leave the survivor feeling disenfranchised (Jakoby, 2015). "Stigma shuts you down . . . the judgement that comes with it . . . not being worthy." (Chilli). "They all knew I was a therapist, so I felt like I was a bad therapist cause how could I not save my own son?" (Roye). "Maybe the reason I said my brother died from bipolar was to manage . . . the stigma and embarrassment of saying he died by suicide." (Doggo).

Scheff (1990), states that the most crucial human motive is the preservation of the social bond. Suicide loss survivors' social identity and social context shift. Feelings of being evaluated negatively, either by others or oneself, can "manifest 'hiding' behavior" (Scheff, 1990, p. 288). "I cried a lot . . . I never went to class again. I just retreated into myself which was pretty deep." (Sasha). "I went into a pretty steep depression. I withdrew." (Doggo). "I didn't want to do anything . . . I didn't have the energy." (Sarah).

The change of one's ideological stance due to a change in one's social order can lead to the dropping of old feeling rules according to Hochschild (1979). In the case of loss by suicide and the loss of one's social order the dropping of old feeling rules can make room for new reactions to situations both emotively and cognitively (Hochschild, 1979). In some cases, there can be a refusal to perform the emotion management considered fitting to the situation (Hochschild, 1979). "I had to get things done." (Bob). "I continued to entertain our group of friends which was really like family . . . we didn't talk about it. We just carried on. I stayed busy." (Rose). "I just kept on doing my job and doing my whatever." (Chilli). It can also be the case that ignoring emotion management, and the possible denial of emotion can result in a more positive ritual interaction with one's friends, family and co-workers restoring group solidarity as per Collins' (1990) interaction ritual/emotional energy theory.

In suffering loss by suicide, survivors are not only dealing with the taboo of suicide, "something you do not talk about", but also the taboo of shame (Overvad & Wagoner, 2020, p. 2; Scheff, 2003). An individual who has suffered from the stigma of suicide loss may be ashamed of feeling shame, "creating a shame-shame spiral" (Scheff, 1990, p. 285). There is also the instance of feeling anger because one is ashamed, and then ashamed, because of one's anger, "creating a shame-anger spiral (Scheff, 1990, p. 285). Scheff (2000) defines shame as "the feeling of a threat to the social bond". It is caused by "the *perception of negative evaluations of the self*" (Scheff, 2000, p. 281). "Not being worthy." (Chilli). "I was a damaged person . . . I wasn't of value." (Marta). "I wouldn't have been a good enough daughter that it would have been worth him staying." (Athena).

The consequences of the social stigma of suicide and the ensuing shame, create complicated grieving generating severe stress due to traumatic bereavement (Nam, 2016). If emotions are the glue that hold society together as proposed by Collins (1990), then shame and the threat to social bonds, can pull it apart. The shame, stigmatization, and the threat to social bonds, experienced by suicide loss survivors are destructive forces requiring individuals, to make secret their most painful experience, tearing them from the very fabric of society that could necessarily help them maintain their equilibrium. Scheff (2003) explains that personal ideals are generally social ideals and the interior of the self where embarrassment and shame usually occur "is modelled on social interaction" (p. 253). Shame can only be felt when the self is observed through the eyes of

others (Scheff, 2003). If there is social stigma directed at suicide, loss survivors will judge themselves as stigmatized, resulting in shame for the actions of their loved one as well as their own shame at not having been able to prevent those actions.

Like prior research on suicide survivors in the fields of psychology (Begley & Quayle, 2007) and social work (Praetorius & Rivedal, 2017), fear of stigmatization was a common thread in the experiences of all fourteen participants. Every participant experienced the stigma surrounding suicide and suicide loss. In some cases, it caused the survivor to subtly hide the cause of death as when Sasha used "cancer related" and Doggo used "died from bi-polar" due to embarrassment or inability to discuss it. Although some did not hide the cause they found people "didn't quite know how to respond" as Anita shared. Some participants lost dating opportunities, and some lost friends. Some had to defend their loved ones' actions to those who called it a weak and thoughtless act. Rose was adamant in defending her husband, "Some people thought he was weak and wrong to do it, but I think it took great courage." There are clearly many misunderstandings about suicide. A few of the participants stood up to the stigma, with Bob, angered by the fact that the church would not bury his brother verbally attacking a priest. On the other hand, Ernie, a retired pastor, stood up to anyone who confronted him with the stigma of suicide leaving "a black mark on your family . . . I would say NO . . . he struggled for as long as he could." Ernie felt compelled to defend his son. Shame engendered by the stigma of suicide threatens social bonds that could be the stability needed to comfort and support those who have lost loved ones to suicide. Shame compels suicide loss survivors to withdraw from society, to carry on with their life, ignoring their pain, and to judge themselves harshly for not seeing the "red flags". "Why didn't I see those flags?" Chilli asked. "I mean the red flags were up . . . how red does it have to be?" Jon remarked. Bob laments, "Did I pay enough attention? Everybody can say, NO, no, you didn't pay enough attention, but you pay as much attention as you know how to at the time." Many suicide loss survivors spend the rest of their lives considering what they could have done differently to undo the pain of suicide.

Of all the coping strategies practiced by the participants in this research it appears one of the most effective strategies for recovery is the support group. To explain this effectiveness, Collins' (1990) interaction ritual chain theory's four elements apply. The first element is the necessity of there being two or more in a group. The second necessity is for all members in the group to be focused on the same activity or object with an awareness of one anothers' attention. This focus has the effect of producing "a ritual situation" (Collins, 1990, p. 31). The third element is the sharing of a common mood within the group, which Collins (1990) explains as, they get "caught up in each other's emotions" (p. 32). The fourth and last element is the production of feelings of solidarity. Collins' (1990) theory indicates that in the case of suicide loss survivor support groups, the

short-term emotion may be grieving, and the ritual work of the group would be "producing (or restoring) group solidarity" (Collins, 1990, p. 32). In a successful meeting there is an increased emotional energy due to successful social interaction (Collins, 1990). The emotional energy becomes attached to ideas "and thinking those ideas allows these individuals to feel a renewed surge of socially-based enthusiasm" (Collins, 1990, p. 34). "Participating in the support group . . . took a lot of pressure off." (Chilli). "My involvement in suicide loss survivor groups . . . has been very healing for me." (Sarah). "It gave me a cocoon . . . I felt comforted." (Roye).

Through an intensive desire to re-imagine life after suicide, all fourteen participants of the study were involved in talk therapy, either in a group or private setting. Some sought help while others were steered toward it. This study reveals that the ability to find a situation in which the suicide loss survivor is able to talk about the suicide amongst others who have the same experience increases the survivor's coping skills and ability to draw meaning from the event. Using Collins (1990) interactional ritual chain theory, feelings of attachment to the group produced or restored group solidarity and thereby social solidarity (Collins, 1990). Successful social interaction and the combatting of stigma, shame, anger, confusion and blame through the understanding of others with experience in the same loss, increases emotional energy allowing for suicide loss survivors "to feel a renewed surge of socially-based enthusiasm" (Collins, 1990, p. 34). The alienation of suicide loss can be reversed, and social solidarity renewed.

The research revealed other meaning making activities including the support and re-emergence of religious beliefs, re-engaging in activities such as one's career, and creation of a sense of purpose by volunteering and helping others overcome their grief and educating the public to combat stigma and shame surrounding suicide and suicide loss survivors. Although it was not my topic of research, the impact of post traumatic growth became evident in the interviews, with many of the participants expressing their own growth, resilience and meaning making in their lives after a loss by suicide. The trauma became transformational, aided by the comradery and support of the suicide loss survivor groups. Through the feelings of group solidarity expanding to social solidarity the participants of groups were able to heal and continue on with their lives, often on very different trajectories than prior to the loss. Further study of post traumatic growth would benefit the study of the sociology of grief in general and suicide loss survivors in particular.

This study uncovers how and why the unique and complicated grief experienced by suicide loss survivors is best shared in a social setting with like experienced individuals. Longitudinal studies following suicide loss survivors, their narratives over time and their journey toward healing would benefit the study of suicide loss. Due to the pandemic of 2020, many groups have been

moved on-line. The study of on-line suicide loss survivor groups and their efficacy is an important direction to continue researching on this topic.

Limitations

While the emotions and social difficulties experienced by the fourteen suicide loss survivors participating in this study were well represented, the research would have benefitted from a larger and more diverse sample. Including survivors from more diverse backgrounds would create a more complete picture of how different social strata and positionalities affect those bereaved by suicide. Investigations into how an individual returns to work when there is no time to grieve, and how to mourn a loss with young children or older adults to care for, could add to the social study of grieving a suicide loss. My choice to interview participants who were at least two years out from the suicide was intended to limit any possible emotional harm to the interviewees, however, interviewing survivors with more recent losses could provide insight into their immediate social needs and the difficulty of navigating their emotions and social life if it could be done with no harm to the participants.

Implications for Policy and Practice

Applying what has been revealed in this research to better serve those who have lost a loved one to suicide includes making more suicide loss survivor groups accessible to the public, intervening with loss survivors early in their experience of loss and changing society's understanding of suicide. Changing how society looks at suicide can be achieved by adding the word *suicide* to the lexicon of grieving and loss, and creating anti-stigma campaigns through public health networks, educational institutions and commercial and public media. Accessibility to educational materials and support groups through churches, funeral homes, doctor's offices, psychiatrists and therapists, schools at all levels and pharmacies could increase the acceptance of suicide and suicide loss as a part of life no less than death by disease or accident.

Conclusion

This study has explored the social construction of the grieving and healing processes for suicide loss survivors. Through the stigma and shame identified in all aspects of bereaving a loss to suicide, social judgement or acceptance are primary effects that can either hinder or mitigate the healthy grieving and eventual healing of those whose loved ones die by suicide. Recognizing that the most reliable relief is in commiseration with like experienced people, this research points to the support group as a builder of much needed social solidarity. The alienation caused by the shame and stigma of suicide loss can be reversed by the

feelings of attachment to the group that listens, understands and accepts. Groups that are created by and for suicide loss survivors should be considered a necessary tool for healing those who suffer from loss by suicide.

The findings of this research indicate that more study of support groups and the impact they have on the healing of suicide loss survivors is warranted. A longitudinal study of various groups across the country, in both rural and urban areas, would reveal a more complete assessment of the efficacy of the groups and how to best present them. It is concerning that the health care system in America does not always provide for those who need it most and that gap could be filled with non-profit peer-led groups to assist suicide loss survivors to find their place again in society.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Dorothy M. Goulah-Pabst https://orcid.org/0000-0001-8391-3320

References

Andriessen, K. (2009). Can postvention be prevention? *Crisis*, *30*(1), 43–47. https://doi.org10.1027/0227-5910.30.1.43

Bailley, S. E., Kral, M. J., & Dunham, K. (1999). Survivors of suicide do grieve differently: Empirical support for a common sense proposition. *Suicide and Life-Threatening Behavior*, *29*(3), 256–271. https://doi.org/10.1521/suli.31.1.83.21315

Barone, P. T., Bartone, J. V., Violanti, J. M., & Gileno, Z. M. (2019). Peer support services for bereaved survivors: A systematic review. *Journal Death and Dying*, *80*(1), 137–166. https://doi.org/10.1177/0030222817728204

Barrett, T., & Scott, T. (1990). Suicide bereavement and recovery patterns compared with non-suicide bereavement patterns. *Suicide and Life-Threatening Behavior*, *20*(1), 1–15. https://pubmed.ncbi.nlm.nih.gov/2336678/

Begley, M., & Quayle, E. (2007). The lived experience of adults bereaved by suicide. *Crisis*, *28*(1), 26–34. https://doi.org/10.1027/0227-5910.28.1.26

Bellini S., Erbuto, D., Andriessen, K., Milelli, M., Innamorati, M., Lester, D., Sampogna, G., Fiorillo, A., & Pompili, M. (2018). Depression, hopelessness, and complicated grief in survivors of suicide. *Frontiers in Psychology*, *9*, 198. https://doi.org/10.3389/fpsyg.2018.00198

Cain, A. C. (Ed.). (1972). *Survivors of suicide*. Charles C. Thomas.

Cerel, J., Brown M. M., Maple, M., Singleton, M., Van De Venne, J., Moore, M., & Flaherty, C. (2018). How many people are exposed to suicide? Not six. *Suicide and Life-Threatening Behavior*, *49*(2), 529–534. https://doi.org/10.1111/sltb.12450

Charmaz, K. (1980). *The social reality of death*. Addison-Wesley Publishing.

Collins, R. (1990). Stratification, emotional energy, and the transient emotions. In T. D. Kemper (Ed.), *Research agendas in the sociology of emotions* (pp. 27–57). State University of New York Press.

Dyregrov, K. (2011). What do we know about needs for help after suicide in different parts of the world? *Crisis*, *32*(6), 310–318. https://doi.org/10.1027/0227-5910/a000098

Ellenbogen, S., & Gratton, F. (2001). Do they suffer more? Reflections on research comparing suicide survivors to other survivors. *Suicide and Life- Threatening Behavior*, *31*(1), 83–90. https://doi.org/10.1521/suli.31.1.83.21315

Feigelman, W., Cerel, J., McIntosh, J. L., Brent, D., & Gutin, N. (2017). Suicide exposures and bereavement among American adults: Evidence from the 2016 General Social Survey. *Journal of Affective Disorders*, *227*, 1–6. https://doi.org/10.1016/j.jad.2017.09.056

Goffman, E. (1959). *The presentation of self in everyday life*. Anchor Books.

Hedegaard, H., Curtin, S. C., & Warner, M. (2020). *Increase in suicide mortality in the United States, 1999–2018* (NCHS Data Brief No. 362). U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/databriefs/db362-h.pdf

Hochschild, A. (1979). Emotion work, feeling rules, and social structure. *American Journal of Sociology*, *85*(3), 551–573. https://www.jstor.org/stable/2778583

Honeycutt, A., & Praetorius, R. T. (2016). Survivors of suicide: Who they are and how do they heal? *Illness, Crisis & Loss*, *24*(2), 103–118. https://doi.org/10.1177/1054137315587646

Jakoby, N. R. (2012). Grief as a social emotion: Theoretical perspectives. *Death Studies*, *36*, 679–711. https://doi.org/10.1080/07481187.2011.584013

Jakoby, N. R. (2015). The self and significant others: Toward a sociology of loss. *Illness, Crisis & Loss*, *23*(2), 110–128. https://doi.org/10.1177/1054137315575843

Jordan, J. R., & McGann, V. (2017). Clinical work with suicide loss survivors: Implications of the U.S. postvention guidelines. *Death Studies*, *41*(10), 659–672. https://doi.org/10.1080/07481187.2017.1335553

Kheibari A., Julie Cerel, J., & Sanford, R. (2018). Attitudes about suicide ideation among suicide loss survivors: A vignette study. *Psychological Reports*, *122*(5), 1707–1719. https://doi.org/10.1177/0033294118795882

Kneiper, A. J. (1999). The suicide survivor's grief and recovery. *Suicide and Life-Threatening Behavior*, *29*(4), 353–364. https://doi.org/10.1111/j.1943-278X.1999.tb00530.x

Kochanek, K. D., Murphy, S. L., Xu, J., & Arias, E. (2019). Deaths: Final data for 2017. *National Vital Statistics Reports*, *68*(9), 1-77. https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09-508.pdf

Nam, I. (2016). Suicide bereavement and complicated grief: Experiential avoidance as a mediating mechanism. *Journal of Loss and Trauma*, *21*(4), 325–334. https://doi.org/10.1080.15325024.2015.1067099

Overvad, A. T., & Wagoner, B. (2020). Grief after suicide: A study of taboo and metaphor. *Culture & Psychology*, *26*(3), 369–383. https://doi.org/10.1177/1354067X19861047

Praetorius, R. T., & Rivedal, J. (2017). Navigating out of the ocean of "why": A qualitative study of the trajectory of suicide bereavement. *Illness, Crisis & Loss*, *28*(4), 1–16. https://doi.org/10.1177/1054137317741714

Rabalais, M. A., Wilks, S. E., Geiger, J. R., & Bates, S. M. (2017). Prominent feelings and self- regard among survivors of suicide: Does time heal all wounds? *Illness, Crisis & Loss*, *25*(3), 262–276. https://doi.org/10.1177/1054137316627189

Ross, V., Kõlves, K., & De Leo, D. (2019). Exploring the support needs of people bereaved by suicide: A qualitative study. *Journal of Death and Dying*, *82*(4) , 1–14. https://doi.org/10.1177/0030222819825775

Sanford, R., Cerel, J., McGann, V., & Maple, M. (2016). Suicide loss survivors' experiences with therapy: Implications for clinical practice. *Community Mental Health Journal*, *52*, 551–558. https://doi.org/10.1007/s10597-016-0006-6

Scheff, T. (1990). Socialization of emotions: Pride and shame as causal agents. In T. D. Kemper (Ed.), *Research agendas in the sociology of emotions* (pp. 281–304). State University of New York Press.

Scheff, T. (2000). Shame and the social bond: A sociological theory. *Sociological Theory*, *18*(1), 84–99. https://doi.org/10.1111/0735-2751.00089

Scheff, T. (2003). Shame in self and society. *Symbolic Interaction*, *26*(2), 239–262. https://doi.org/10.1525/si.2003.26.2.239

Schneider, B., Grebner, K., Schnabel, A., & Georgi, K. (2011). Is the emotional response of survivors dependent on the consequences of the suicide and the support received? *Crisis*, *32*(4), 186–193. https://doi.org/10.1027/0227-5910/a000081

Schneidman, E. S. (1972). *Survivors of suicide* (A. C. Cain, Ed.). Charles C. Thomas.

Sheehan, L., Corrigan, P. W., Al-Khouja, M. A., Lewy, S. A., Major, D. R., Mead, J., Redmon, M., Rubey, C. T., & Weber, S. (2018). Behind closed doors: The stigma of suicide loss survivors. *Journal of Death and Dying*, *77*(4), 330–349. https://doi.org/10.1177/0030222816674215

Shields, C., Kavanagh, M., & Russo, K. (2017). A qualitative systematic review of the bereavement process following suicide. *Journal of Death and Dying*, *74*(4), 426–454. https://doi.org/10.1177/0030222815612281

Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing interpretive phenomenological analysis. In M. Murray & K. E. Chamberlain (Eds.), *Qualitative health psychology: Theories and methods* (pp. 218–240). Sage.

Smith, A., Joseph, S., & Das Nair, R. (2011). An interpretative phenomenological analysis of posttraumatic growth in adults bereaved by suicide. *Journal of Loss and Trauma*, *16*, 413–430. https://doi.org/10.1080/15325024.2011.572047

Testoni, I., Francescon, E., Do Leo, D., Santini, A., & Zamperini, A. (2018). Forgiveness and blame among suicide survivors: A qualitative analysis on reports of 4-year self-help-group meetings. *Community Mental Health Journal*, *55*, 360–368. https://doi.org/10.1007/s10597-018-0291-3

Thompson, N., Allan, J., Carverhill, P. A., Cox, G. R., Davies, B., Doka, K., Granek, L., Harris, D., Ho, A., Klass, D., Small, N., & Wittkowski, J. (2016). The case for a

sociology of dying, death, and bereavement. *Death Studies*, *40*(3), 172–181. https://doi.org/10.1080/07481187.2015.1109377

Young, I. T., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M., & Zisook, S. (2012). Suicide bereavement and complicated grief. *Dialogues in Clinical Neuroscience*, *14*(2), 177–186. https://doi.org/10.31887/DCNS.2012.14.2/iyoung

Author Biography

Dorothy M. Goulah-Pabst is a recent Masters graduate of the Sociology department at California State University at Northridge, in Los Angeles California. Her interest in grief and suicide is steering her research to Survivors of Suicide Loss, where she hopes to illuminate how the stigma of suicide creates social problems for those left behind.