



Research paper

Suicide exposures and bereavement among American adults: Evidence from the 2016 General Social Survey



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ABSTRACT

Background: We investigated lifetime suicide exposures and bereavement among a representative sample of American adults from the 2016 General Social Survey.

Methods: Questions on lifetime suicide exposures, bereavement and mental health status were administered to 1432 respondents. Suicide exposed and bereaved respondents were compared to non-exposed respondents on three different measures of mental health functioning with cross tabulations and means comparison tests.

Results: 51% of respondents had exposures to one suicide or more during their lifetimes, and 35% were deemed bereaved by suicide, having experienced moderate to severe emotional distress from their losses. Findings suggested more exposures and bereavements were associated with greater numbers of bad mental health days and more expectations of “having nervous breakdowns” but with no clear associations with CES-D scores.

Conclusions: These findings suggest suicide exposures and bereavement are far more pervasive than commonly thought, with more than half of the population exposed and a third bereaved. Health professionals need to more actively assess for suicide exposures and bereavements, and be vigilant for significant impacts of suicide even when the suicide decedent is not a first degree family relative, helping to reduce the mental health distress presently associated with these experiences.

1. Introduction

The question of gauging the extent of suicide “survivorship” has puzzled scholars and policy makers for nearly a half-century. In perhaps the earliest discussion of this issue, Edwin Shneidman, founder of the American Association of Suicidology, posited that for every suicide there were six “survivor-victims” whose lives were “thereafter benighted by that event” (Shneidman, 1973) (p. 22). Shneidman never collected any systematic survey data to support his claim (Linn-Gust, 2014, Fall), yet his assertion has stuck and to this day, his very conservative estimation still continues to be quoted in discussions of national suicide prevention strategies and public health messages about suicide.

The first fully empirical study of suicide exposures was a 1994 telephone-based survey that included 5238 respondents that oversampled minority households (Crosby and Sacks, 2002). This study found 7% of the national population exposed to a suicide *in the past year* of someone known to them, 20% of whom indicated that the decedent was a

relative. However, we cannot place great confidence in these findings for the following reasons. 1) the high non-response rate; 44% of potential respondents did not complete this survey. 2) many studies suggest suicide grief is an enduring feature in the life of the bereaved and needs to be investigated over their lifetimes (Jordan, 2001; Jordan and McIntosh, 2011).

The next most important theoretical moment in thinking about assessing the incidence of suicide and suicide bereavement comes from the work of Berman who pointed out that **knowing** someone who took their life by suicide may be substantially different than being **negatively impacted** by that person's suicide (Berman, 2011). The concept of the perceived negative impact from the death appears to be a very important criteria for assessing suicide bereavement.

More recent random digit dial studies (Cerel et al., 2013, 2016) have successfully transcended the problems inherent in the Crosby and Sacks study (Crosby and Sacks, 2002), addressing the issues of suicide exposures over the lifetime and assessing their perceived negative emotional impact but only examining adults in one state. In their first study,

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based on 302 adults in Kentucky with landlines, Cerel et al. (2013) found that 40% of their sample had been exposed to a suicide during their lifetimes, half of whom claimed they were significantly affected by the suicide death of that person. In the second, larger study of 1732 adult Kentuckians sampled from both landline and cell phones (Cerel et al., 2016), 48% had one or more suicide exposures during their lifetimes. Cerel et al. (2016), did not directly assess impact but in a different way found that 21.4% reported that the death had significantly disrupted their lives. Response rates for these studies were not ideal with 36% in the small study and 37% in the larger study.

Today, unfortunately, telephone-based surveys are doomed to low response rates as potential respondents may be reluctant to answer calls from unfamiliar phone numbers (Kempf and Remington, 2007). While this might not have been as much of a problem in the early 1990s, it is more prevalent today with the availability of more modern telephone equipment and the near ubiquitous use of cell phones with caller ID available to screen out unknown callers. Thus, telephone surveys leave us with lingering questions on whether the survey participants are similar to non-participants, especially when the numbers of non-participants equals or exceeds participants. Thus, only a face-to-face household survey is capable of gauging the true extent of suicide exposures and bereavement in the US population at large.

Another important moment in the development of useful conceptualizations on suicide exposures and survivorship was a theory that suicide survivorship exists on a continuum (Cerel et al., 2014). This conceptualizes that individuals exposed to a suicide may be expected to have shorter or longer-term bereavement effects throughout their lifetimes with some people exposed never going on to have an effect of the suicide and others experiencing life-long difficulties as a result of the suicide of someone close to them. At the extreme end of the grief difficulties continuum some individuals are seen as “stuck” in their grief, experiencing persisting or complicated grief.

Although this conceptual paper emphasized persisting grief problems it neglected to examine the subject of multiple bereavements, a potentially important subject that has been overlooked in most studies of grief and mourning. We are aware of only one study that examined this question (Feigelman et al., 2012) which investigated multiple child and other family member deaths following a child's suicide. Thus, in the present study, it was vitally important to explore the adverse mental health consequences associated with multiple distressing suicide losses.

Research evidence suggests many adverse mental health consequences from exposures to suicide and from suicide bereavement including the following: higher risks of deaths by suicide, more suicidal ideation and attempts, greater depression, anxiety, PTSD, and an assortment of other mental health problems (Berman, 2011; Bolton et al., 2013; Brent and Melhem, 2008; Cerel et al., 2013; Feigelman et al., 2016). Yet, considering that some of these findings have been obtained from clinical or less than fully representative population studies, it remains to be investigated whether adverse mental health will be found in a representative sample of adults exposed or bereaved by suicide.

Thus, the present study was able to deliberately assess the extent of lifetime suicide exposures in the population at large and of suicide bereavements and to examine their associations with adverse mental health. This was accomplished by the addition of 11 survey questions on suicide exposures and mental health status to the 2016 General Social Survey (National Opinion Research Center, 2017). We hypothesized that suicide exposed, bereaved and multi-bereaved persons would all be more likely to have more mental health problems, compared to non-exposed and non-bereaved individuals. We anticipated this would be manifested both in lifetime and presently occurring mental health difficulties.

2. Method

The General Social Survey has a venerable history, illuminating controversial and topical social questions for forty-five years (National

Opinion Research Center, 2017). Beginning from collecting yearly representative surveys of approximately 3000 adults, since 1994 the GSS changed to conducting bi-annual surveys. Eleven questions on suicide exposures and mental health were added to the 2016 survey, many of which had been employed in previous studies. All new questions were pre-tested both among samples of suicide bereaved survivors and GSS pre-test samples to fine tune items. GSS participation rates have been declining ever since the early 1990s when they ranged at about 80%; since then, they have declined to approximately 70%; the 2016 response rate of 61% was 8 points below the participation rate for 2014 (National Opinion Research Center, 2017).

To assess suicide exposures, respondents were asked this question, “Over your lifetime how many people have you known personally that died by suicide.” Assessing suicide bereavement was measured among those indicating one or more suicide exposures for the person they knew best that died by suicide. “Was that person's death emotionally distressing to you?” Answers were recorded on a five-point scale with the following answers, 1) “Yes, greatly, 2) Yes, to some extent; 3) Yes, but not much; 4) No; 5) Not sure. We coded people who were exposed to one or more suicide, who indicated being greatly or to some extent emotionally distressed by the death as being “bereaved by suicide”. We defined those experiencing multiple bereavements as this same group, who were also bereaved by a second suicide who reported that the second person's death evoked a similar “1” or “2” response of emotional distress.

The mental health assessment items were drawn from questions used in previous GSS surveys. These included the following: 1) Expectations of having a nervous breakdown: “Have you ever felt you were going to have a nervous breakdown”, assessing an individual's lifetime mental health perspective. 2) Current mental health assessment: “Now thinking about your mental health which includes stress, depression and problems with emotions for how many days during the past 30 days was your mental health not good?”, assessing an individual's perceived mental health during the past month.

GSS 2016 also included 5 questions from the frequently utilized 19-item CES-D depression scale (Radloff, 1977). Each question was presented to respondents on a four-point agreement-disagreement scale. How much time have you experienced this during the past week 1) All the time; 2) Most of the time; 3) Some time; 4) None of the time. The five CES-D items were the following: 1) “Feeling depressed”; 2) “Having restless sleep”; 3) “Feeling happy”; 4) “Feeling lonely”; and 5) “Feeling sad.” All five items were highly inter-correlated, one was reversed (happy), and together all yielded a 0.76 alpha coefficient. Scale scores ranged from a low of 5 to a high of 20. The modified CES-D scale was administered to 961 GSS 2016 respondents yielding a mean of 8.6 (2.7 SD). In Table 1 we present frequency data of all suicide exposure and bereavement variables of interest. Our four tables only present the weighted data totals (using “wtssall” weighting) and statistical test results, which represent the American adult population. Dichotomous associations involved cross-tabular testing, while continuous scores involved mean comparison testing with 95% confidence intervals.

3. Results

To examine our first question, what percentage of participants reported lifetime suicide exposure, we found that 51% of participants had at least one lifetime suicide exposure and 28% had lifetime exposures of two or more suicides (See Table 1). Examining the relationships to the suicide decedent (See Table 2), the largest single category of decedents (40%) were of friends' suicide deaths. 42% of the deaths were of remote relatives and acquaintances. First degree relatives' deaths (such as of children, parents, spouses, and of siblings' deaths) probably the most likely subgroup to inspire the strongest grief reactions, accounted for less than 10% of all the deaths.

Bereaved by suicide respondents (as defined by being greatly or to some extent emotionally distressed by the death) accounted for slightly

Table 1
Suicide Exposure and Bereavement Characteristics Among the GSS 2016 Sample.

	n	Weighted Percent
Total number of suicide exposures		
None	681	48.91
1	332	22.96
2	215	14.03
3 or more	204	14.09
Total	1432	100.00
Not exposed and non-bereaved respondents contrasted with those bereaved by suicide associated with the first suicide		
Not bereaved and Non-bereaved exposed	916	65.28
Bereaved	516	34.72
Total	1432	100.00
Multiple distressing suicide exposures		
Zero or only one	1231	86.01
Two or more	201	13.99
Total	1432	100.00
Type of suicide exposure		
Not exposed	681	48.91
Exposure	235	16.37
Bereaved	315	20.73
Multiple bereavements	201	13.99
Total	1432	100.00

more than a one third of all respondents (35%) (See Table 1). Multiple emotionally distressing suicide losses, consisting of at least two emotionally distressing suicides was reported by 14% of all respondents.

Table 2 presents data on the relationship between different types of suicide and their association with the person's suicide death. Type of suicide exposure was created by dividing the total number of respondents exposed to one or more suicides, 751 cases, into 235 cases where the suicide did not induce any substantial emotional distress. The largest number of cases, n = 315, were those where the respondent felt emotional distress from a single death and 201 additional cases were those where the respondent endured two or more emotionally distressing suicides. We expected that neighbors and acquaintances would be over-represented among those experiencing suicides without emotional distress. Correspondingly, we expected that suicides evoking emotional distress would be more likely to occur when a respondent had a relationship to the deceased as either, a friend or as a first degree family relative. Results were consistent with these expectations. Only 5% of first degree relatives reported emotional distress among merely exposed respondents, compared to 8% among the bereaved and 12% among the multi-bereaved. For friends, 27% reported emotional distress among the merely exposed subgroup, compared to 43% reporting emotional distress among the bereaved and 49% among the multi-bereaved. For

Table 2
Relationship With First Suicide Decedent and Type of Suicide (Weighted Data).

	Exposure		Bereaved		Multiple Bereaved		Total	
	n	Percent	n	Percent	n	Percent	n	Percent
Relationship to first suicide exposure								
1st Degree								
Relative	10	4.92	32	8.10	24	11.82	66	8.10
Other								
Relatives	61	26.95	72	23.34	50	25.01	183	24.95
Friend	61	27.35	141	43.37	99	49.38	301	39.88
CoWorker	16	5.49	15	5.53	9	4.29	40	5.18
Patient	0	0.00	2	0.86	3	1.45	5	0.74
Acquaintance/Neighbor	73	30.29	38	14.57	14	6.79	125	17.48
Other	14	5.00	15	4.23	2	1.27	31	3.67
Total	235	100.0	315	100.0	201	100.0	751	100.0

Bartlett's test for equal variances Chi-square(12) = 68.08, p = 0.027.

*Note: Percent in all cases refers to percentage of the column total. Weighted data information: n of strata = 5; n of observations = 751; n of PSUs = 10; Population size = 725.09689; Design df = 5.

neighbors and acquaintances, experiences of emotional distress ran in the opposite direction. For neighbors and acquaintances 30% of the exclusively exposed group reported emotional distress, compared to only 15% among the bereaved and 7% among the multi-bereaved group.

It is interesting to note among the small numbers of cases (n = 5) where the respondent lost a patient, all these cases generated high emotional distress. We examined the occupational affiliations of these 5 cases and found 3 reported their occupations as psychologist/psychotherapists, one as a medical doctor, and the other in nursing. This provisional evidence suggests that suicide deaths of patients may be more likely to evoke strong emotional distress among human service providers.

We then examined the relationships between feeling one was going to have a nervous breakdown and the number of suicide exposures, feeling bereaved by suicide and experiencing multiple bereavements (see Tables 3 and 4). All three yielded statistically significant associations with the chi-square statistic. Thus, those with no suicide exposures and the non-bereaved, where 32% thought they might have a nervous breakdown, the numbers rose to 51% for those exposed to 3 or more suicides, the suicide bereaved and those experiencing multiple bereavements.

Next, we examined the relationship between suicide exposures and numbers of bad mental health days experienced during the past month, with increases in each of these same variables, exposures to suicide, bereavement and multiple bereavement (Tables 3 and 4). Among the 351 respondents who reported never being exposed to a single suicide during their lifetimes, they indicated an average of 3.8 bad mental health days; compared to an average of 6.2 bad days for those exposed to 3 or more suicides. This association was not significant with the weighted survey data. Being bereaved was accompanied by rising means in the numbers of bad mental health days, rising significantly from 3 in the non-bereaved subgroup to 6 among the bereaved in the weighted data. Multiple bereavements was accompanied by an increase in bad mental health days to 7 days for these 199 respondents. Again, these differences were significant with the survey weights in place.

Associations between the truncated CES-D scale and suicide exposures and bereavement were inconsistent from what we had hypothesized (Tables 3 and 4). No significant associations were noted either with suicide exposures, bereavements, multi-bereavements and CES-D score variabilities, with weighted data testing using 95% confidence interval comparisons. There are probably three important reasons explaining these inconsistent findings, with the other overall results. For one, this abbreviated scale had a high depression threshold, consisting of experiences solely during the week prior to the interview. Second, the GSS 2016 survey did not perfectly match up the CES-D

Table 3
Mental Health Problems by Total Number of Suicide Exposures (Weighted Data).

Item 1. Have you ever felt you were going to have a nervous breakdown?										
Exposures	None		One		Two		Three or More		Total	
	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent
Yes	108	32.40	93	30.61	82	36.64	100	50.66	383	35.98
No	246	67.60	236	69.39	133	63.36	102	49.34	717	64.02
Total	354	100.0	329	100.0	215	100.0	202	100.0	1100	100.0

Uncorrected Chi-square(3) = 24.95, design-based $F(1.63, 8.16) = 7.03, p = 0.0199$

Item 2. Days of poor mental health in the past 30 days										
Exposures	None		One		Two		Three or More		Total	
	n	M (SE)	n	M (SE)	n	M (SE)	n	M (SE)	n	M (SE)
	[Conf Interval]		[Conf Interval]		[Conf Interval]		[Conf Interval]			
	351	3.80 (0.40)	327	2.81 (0.52)	213	3.50 (0.61)	200	6.15 (0.93)	1091	3.98 (0.67)
	[2.77 – 4.83]		[1.47 – 4.16]		[1.93 – 5.06]		[3.76 – 8.53]			

Item 3. CESD Scale Score										
Exposures	None		One		Two		Three or More		Total	
	n	M (SE)	n	M (SE)	n	M (SE)	n	M (SE)	n	M (SE)
	[Conf Interval]		[Conf Interval]		[Conf Interval]		[Conf Interval]			
	452	8.47 (0.13)	217	8.03 (0.26)	146	8.43 (0.24)	133	8.82 (0.36)	948	8.57 (2.74)
	[8.13 – 8.81]		[7.37 – 8.70]		[7.82 – 9.04]		[7.89 – 9.76]			

Note: Percent in all cases refers to percentage of the column total. “SE” = Standard Error. “Conf” = Confidence.

Table 4
Mental Health Problems by Respondents Bereaved, Multi-Bereaved by Suicide and Respondents Merely Exposed or Not Exposed to Suicide (Weighted Data).

	Not Exposed or Merely Exposed		Bereaved		Multi-Bereaved	
	n	Percent	n	Percent	n	Percent
Item 1. Have you ever felt you were going to have a nervous breakdown?						
Yes	174	31.82	209	41.07	98	50.00
No	414	68.18	303	58.93	103	50.00
Total	588	100.0	512	100.0	201	100.0

Uncorrected Chi-square(1) = 21.03, $F(1,5) = 24.28, p = 0.0044$ (NEorME vs. MultiBereaved)

Uncorrected Chi-square(1) = 10.12, $F(1,5) = 18.46, p = 0.0077$ (Not Bereaved vs. Bereaved)

	Not Exposed or Merely Exposed		Bereaved		Multi-Bereaved	
	n	M (SE)	n	M (SE)	n	M (SE)
	[Confidence Interval]		[Confidence Interval]		[Confidence Interval]	
Item 2. Days of poor mental health in the past 30 days*						
	583	2.99 (0.12)	508	6.02 (0.98)	199	7.60 (1.31)
	[2.67 – 3.31]		[3.49 – 8.55]		[4.23 – 10.97]	

	Not Exposed or Merely Exposed		Bereaved		Multi-Bereaved	
	n	M (SE)	n	M (SE)	n	M (SE)
	[Confidence Interval]		[Confidence Interval]		[Confidence Interval]	
Item 3. CESD Scale Score						
	616	8.34 (0.10)	332	8.56 (0.19)	134	9.01 (0.23)
	[8.09 – 8.60]		[8.08 – 9.05]		[8.43 – 9.59]	

Note: Percent in all cases refers to percentage of the column total. “SE” = Linearized Standard Error. Analyses tabled here compared the multi-bereaved with the group of those who were either nonexposed to or exposed only to a suicide (i.e., not bereaved). Those bereaved by only a single suicide were coded as missing in those analyses. “*” = Confidence Intervals do not overlap, indicating significant results.

respondents (n = 961) to our sampled suicide exposure population (n = 1432). We noted of our bereaved subgroup (n = 516) only 332 answered the CES-D scale and for the multi-bereaved (n = 201) only 138 gave answers to the CES-D questions.

4. Discussion

This study should put to an end the question of suicide exposure being an uncommon event. Suicide exposure is pervasive, touching more than half of the adult population and suicide bereavement

affecting more than a third of Americans. There are many more touched by suicides than commonly thought. With a total US population of nearly 325 million, 77% of whom are over the age of 18, we can calculate roughly, from the 35% figure, at least 90 million suicide bereaved adults now in the US population. This is equivalent to the populations of the 3 largest states, California, Texas and Florida combined (U.S. Census website, 2017). Even if we defined survivorship conservatively as only those greatly distressed by the death, we would still end up having some 18% of the adult population bereaved, about 45 million people, nearly double the current Australia national population. Given the immense size of this group, with many in need of help and support, expanded mental health services appear greatly necessary.

These large numbers of suicide bereaved probably represent a conservative estimate of the full extent of the suicide risk population. When we also count the numbers of people inclined to self-killing or harm after learning about a public figure's suicide, someone they were unacquainted with, we have even more imposing numbers of those at risk. Ever since the documentation of the copycat suicide spike after Marilyn Monroe's death, there have been various documented cases of people employing even the same suicide method as the celebrity's method (Ji et al., 2014). Vulnerable people are not only affected by suicides of public figures alone. They may be equally dispirited by the suicides of local role models, such as a high school principal or police chief's suicide.

In addition, findings add to the growing body of literature demonstrating that mental health problems accompany suicide exposures and bereavement and are likely to be most acute in the early years immediately after loss, but still endure years afterwards. This group of 501 bereaved respondents, ranging anywhere from less than a year to 67 years past their losses, (mean = 14 years), still had numerous identifiable mental health problems that distinguished them from the non-bereaved. This study also showed that deaths by suicide are long remembered and do not readily fade from the minds of the bereaved.

The lack of confirmation of associations between suicide bereavement status and the 5-item CES-D scale is indeed puzzling. Several previous studies of first degree relatives who experienced recent suicide losses of family members have shown highly elevated levels of depression among these bereaved (Feigelman, 2012; Murphy et al., 2003; Bolton et al., 2013). One of these cited studies (Feigelman, 2012) noted that depression levels appear to fade as time after loss extends beyond ten or more years after the loss. In the present study the majority of respondents were longer-time survivors who averaged 14 years since their losses. Also, fewer than 10% of this bereaved sample reported the loss of a first-degree relative. Even when we attempted to focus analytic

attention directly upon recently bereaved first degree relatives, who indicated extreme emotional distress from their losses, the numbers of available respondents shrank to fewer than 25 cases available for comparison when missing CES-D scores were also taken into account. Finally, this abbreviated CES-D scale has been shown to not perform as well at detecting distress as the full or even a 10-item version of the measure (Cheung et al., 2007). Thus, we were unable to adequately examine previous findings on levels of depression and survivorship among this sample of less closely related individuals who were more distant in time from their losses. This appears to be a worthy subject for future research.

An essential distinguishing feature of suicide bereavement is its sense of isolation. The bereaved feels abandoned by the death of their loved one. Then, they feel further isolated by suicide stigma and the greatly disturbing emotions it stirs up: guilt, self-blame, shame and embarrassment, leading the bereaved to have strong inhibitions to talk publicly about these deaths (Jordan and McIntosh, 2011). Survivors remain constantly vigilant and wary of social ridicule that is often expressed against them and their deceased loved ones (Feigelman, 2012). Many loss survivors are unaware of their substantial numbers in the population.

Yet, as we have discovered here, with their immense numbers, when more survivors come out from behind the shadows of stigma and shame, reaching out to find other hidden survivors like themselves, they will likely find more sources of compassionate support. Hopefully, this will allay some of their current grief and mental health problems.

5. Conclusions

This paper offers important new data, based upon nationally representative survey sampling, showing confirmation of findings obtained from single state investigations that suicide exposures and bereavement are far more common in America than previously thought. For the first time, we have also found that multiple-exposures and multiple-bereavements present additional mental health challenges to those exposed and bereaved and these affect significant numbers of at least 14% of the population.

Lack of recognition of the problem potential of suicide bereavements is a serious public health issue. First, from the vantage point of the bereaved themselves in learning of their presently unmet treatment needs and in addressing them. Second, from the perspective of health care practitioners, awakening stronger impulses among them to actively screen for exposure to suicide and suicidal ideation. Two studies demonstrate that primary care physicians are inclined to shy away from asking depressed patients whether they have any suicidal thoughts, with only one third of doctors willing to ask depressed patients about their suicidal inclinations (Feldman et al., 2007; Hooper et al., 2012) and no research exists on asking about exposures to suicide. If the present research has shown anything, it has demonstrated that suicide is too pervasive and important a part of the mental health landscape for it to be omitted. The time is now ripe for public health providers of all stripes—doctors, nurses, and social workers—to put assessments of suicide bereavements into their patient's life histories as important items to talk about in intake interviews.

At least two studies have shown that five to six years after a child's suicide most survivors arrive at a "new normal" in more or less successful coping adaptations, in perhaps one of the most challenging loss situations (Feigelman, 2012; Murphy et al., 2003). Most of the bereaved uncovered in this survey have passed the six-year post-loss point, nearly a decade ago previously. It is those who lost significant others below this six-year threshold who represent the most worrisome challenge to public health interests for their heightened suicide risk potential, their propensities for self-harm, and for their greater likelihood of experiencing various other mental health disorders and substance abuse. In this sample, 16% had sustained emotionally distressing losses of significant persons within the last six years. This represents about 40

million newly bereaved people when projected out to the whole population.

Friends are the largest single constituency among the bereaved, comprising about 40% of the GSS bereaved sample. Even if we used extreme emotional distress as the key element for defining bereavement, we would still find more than twice as many friends among the bereaved, compared to the numbers of first degree relatives. Yet, we know very little about the friends of the suicide deceased, whether they seek help from bereavement counselors, psychotherapists or are inclined to avert caregivers altogether. The evidence from peer support group studies shows friends do not affiliate in any significant numbers with peer support groups, which are predominately populated with the deceased's first degree relatives.

If most of these bereaved adults were receiving professional counseling or peer support for their losses this would be very reassuring information, but the evidence suggests this is not the case. In fact, support groups are the largest utilized form of treatment for most people bereaved by suicide, and these groups are often run by bereaved people with very little professional training except the motivation to help others like themselves (Cerel et al., 2009). The public health needs of people bereaved by suicide are greatly underappreciated and now there is data supporting a new growth of infrastructure for providing expanded mental health services for these neglected mourners.

5.1. Limitations of the present study

Our most serious limitation was not asking sufficient numbers of follow up questions on the treatments received and their perceived helpfulness as these bereaved attempted to manage their lives after loss. We do not know how many had no treatments at all, compared to those who had counseling, support group participation and/ or clergy help. Most of what is presently known about the bereaved comes from studies of clinical populations, studies where advertising may have been used to solicit volunteers, and telephone surveys where only a minority of the population were inclined to accept phone calls from unfamiliar numbers. All these methods greatly under-represent the untreated, some of whom make spontaneous recoveries. We need to know how many bereaved use therapies, how many do not and if therapies help. Future research is greatly needed to investigate the vast number of questions still remaining about suicide bereavement and its effects on the life course of the bereaved.

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