Chapter 19

Emerging Survivor Populations

Support After Suicide Clusters and Murder–Suicide Events

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Abstract: This chapter presents postvention for two emerging, yet understudied, suicide survivor populations. More specifically, the chapter addresses the needs and requirements related to bereavement, support, and evidence-informed interventions after suicide clusters and murder–suicide. Internationally, there is professional and public interest in suicide clusters. There are indications of an increasing trend in suicide clusters associated with the rise of modern communication systems. Yet, the research in this area and information on effective responses to those affected are limited. Murder–suicide events are also relatively rare, but internationally there has been a noticeable increase over the last 10 years. The effects of murder–suicide are extremely intense and long lasting for those who are left behind. Intensive specialized support is required to support survivors, in particular in coping with their posttraumatic reactions.

Introduction

Suicide clusters and murder–suicide are rare events. However, both events involve several victims, and therefore the impact on bereaved individuals, families, and communities can be severe and long lasting. Often, the media tends to report extensively on such, statistically speaking, rare events, which may put the events and the bereaved in the spotlight, and which may increase the risk of copycat behavior (Pirkis & Nordentoft, 2011). Regarding both types of events, well-planned responses and evidence-informed interventions are needed to identify the survivors and to provide appropriate support on a short- and long-term basis.

Support After Suicide Clusters

Over the past number of years there has been increasing interest in how to respond to and prevent clustering of suicides, both from the general public and from professionals. There are some indications that there is an increase in clustering and contagion effects in suicidal be-

havior associated with the rise in modern communication systems (Larkin & Beautrais, 2012; Robertson, Skegg, Poore, Williams, & Taylor, 2012). Suicide clusters have been referred to in various ways, such as a temporary increase in the frequency of suicides within a small community or institution, relative to both the baseline suicide rate before and after the point cluster, and the suicide rate in neighboring area (Gould, Wallenstein, & Davidson, 1989). An operational definition is provided by Larkin and Beautrais (2012):

> A suicide cluster is a series of three or more closely grouped deaths within a three month period that can be linked by space or social relationships. In the absence of transparent social connectedness, evidence of space and time linkages are required to define a candidate cluster. In the presence of a strong demonstrated social connection, only temporal significance is required. (Larkin & Beautrais, 2012, p. vi)

Suicide clusters have a significant impact across a whole community leading to anxiety and fear within that community of further suicides. This can be a result of a contagion effect in that suicidal behavior may facilitate the occurrence of subsequent suicidal behavior, either directly (via contact or friendship with the index suicide) or indirectly (via the media) (Haw et al., 2013). Incidents of clustering are associated with significant trauma for the bereaved at an individual, familial, and community level. This impact spans across all spheres of society, within schools, colleges, workplaces, sports, and community organizations (Arensman & McAuliffe, 2015).

Suicide Clusters Identified by the Irish Suicide Support and Information System

The Suicide Support and Information System (SSIS) developed by the National Suicide Research Foundation in Ireland combines proactive facilitation of support for families bereaved by suicide, with information gathering on consecutive cases of suicide and open-verdict deaths following the conclusion of a coroners' inquest (Arensman et al., 2013). The SSIS identified two independent suicide clusters in the Cork region in 2011 (Arensman et al., 2013). One cluster involved 13 suicides occurring over a 3-month period from April to June 2011, with a second cluster involving seven cases between September and October 2011. For the first cluster, the expected number of suicides for the same period and geographic area would have been 1.86. However, the observed cluster represented a 6.9-fold increase in suicides. For the second cluster, the expected number of cases for the same time period and geographic area would have been 0.52, while the observed cluster represented a 13.4-fold increase in cases.

In the first of those identified suicide clusters, with the exception of one individual, all were male ($n=12$), with a mean age of 47 years. The majority of the deceased were married or cohabiting, while nearly half were living with a partner and children, and the majority were unemployed. Regarding work sector, nearly half had worked in sales or business or in the construction or production sector. More than one third had received a psychiatric diagnosis and two thirds had been diagnosed with a physical illness.

The second cluster involved seven people – three men and four women – with a mean age of 39 years. Of these, almost half were married or living with a partner and children; the others were single. All of the deceased were in paid employment, with nearly half working in the construction and production sector, followed by nearly one third in the agricultural sector. Over half had a history of self-harm as well as a psychiatric diagnosis. The information gathered with respect of gender, relationships, work status, and place of work, along with psychiatric and physical well-being, can inform responders in targeting services to where they may be needed, and in identifying those who may need support.

Identifying the Survivors and Meeting Their Needs

To be bereaved by suicide is a hugely traumatic experience for any individual, family, or community, and can impact an individual in many ways. The manifestations of grief touch on their feelings and cognitions, along with influencing their behaviors and resulting in physical sensations (Jordan & McIntosh, 2011). As a result of the numbers of persons dying, and the number of the bereaved, a suicide cluster has an even greater impact across a community (Arensman & McAuliffe, 2015). Manifestations of grief impact on people at different levels of intensity, ranging from those who are mildly impacted by a suicide death within their community, to those who are directly bereaved by the death and may experience complicated grief. Shear et al. (2011) suggested that complicated grief may derail or impede healing after loss and lead to a period of prolonged and intensified acute grief which may lead to significant distress and impairment in work and social functioning. It is important to understand that within a cluster of suicides there is a pattern of numerous individual suicides, with each individual contributing to the collective trauma experienced by the whole community (Arensman & McAuliffe, 2015), which results in a need to respond at an individual, familial, and community level.

When responding to clusters of suicide, or indeed murder–suicide events – that is, the unlawful killing of one or more individuals, followed by the suicide of the perpetrator – a range of supports and interventions will be required to be able to comprehensively meet the needs of all of those affected. Using the iceberg analogy, there may be differences in the needs among people within a community. A service delivery model (**Figure 19.1**) is appropriate to responding to a suicide that has an impact on a community (Petrus Consulting, 2006). This includes the death of a well-known person within a community, a celebrity, sports person, or other person whom people from the community may identify with. It may also inform responders as to what is needed to support the community after a cluster of suicides.

The service delivery model (Petrus Consulting, 2006) distinguishes different intervention levels, ranging from a broad population-based approach, including education and training in areas of mental health promotion and suicide prevention, to delivering comprehensive information on support services and information relating to depression and other mental health difficulties within the workplace, schools, and colleges, sports organizations, and community services. The population level also includes informing and training media professionals, as there is growing evidence that irresponsible reporting of suicide in the media can potentially lead to copycat suicides and could thus act as a tipping point on which a cluster could begin or be exacerbated (Pirkis & Blood, 2001; Stack, 2005). This broad population-based approach should be implemented across communities and is also considered to contribute to preventing suicide. Moreover, it is considered that there are four levels of support required to address the needs of people suffering from mild distress up to complicated grief reactions.

Level 1 addresses the provision of directories of services, booklets, other relevant literature, web-based resources rituals, helplines, and texting support services. Level 2 ensures that community support organizations and self-help groups are available and that their existence and availability is highlighted and advertised. Level 3 is about ensuring that appropriate counseling services for adults, children, and families are available, and that those delivering such services are appropriately trained and accredited, with required supervision and professional indemnity insurance in place. Finally, level 4 is about having available and accessible mental health services and psychotherapy in place for the cohort of bereaved who may require these services as

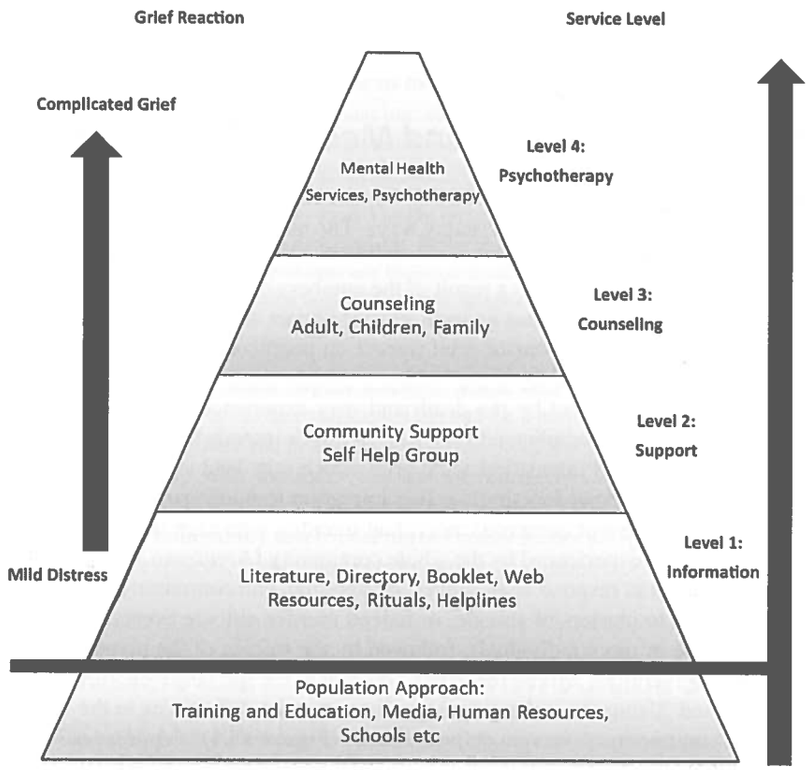

Figure 19.1. Service delivery model. Source: *Review of General Bereavement Support and Specific Services Following Suicide Bereavement*, by Petrus Consulting, 2006, Dublin, Ireland: National Office for Suicide Prevention. © 2006 by Petrus Consulting. Reproduced with permission.

a result of their complicated grief reactions, which have the potential to impact on both their physical and mental well-being. During the occurrence of a suicide cluster, movement and referral between the differing levels of support should be seamless, with open and clear communication between all services providing support at times of crisis.

Responding to Potential Suicide Clusters

Box 19.1 summarizes the key elements in responding to suspected suicide clusters. One of the key elements is preparedness. It is suggested that communities should plan for three overlapping phases of action to prevent and respond to suicide clusters (Commonwealth Australia, 2012). These phases address preparedness, intervention/postvention and follow-up, which are further broken down into eight recommended steps across the three phases.

Box 19.1. Responding to suicide clusters

Phase 1: Preparedness
- Identify a lead agency or steering committee to develop and host the plan
- Identify relevant available contacts and resources

Phase 2: Intervention and/or postvention
- Establish the facts
- Provide ongoing and accurate information
- Identify individuals, groups, and areas of greater risk
- Respond to risks and immediate support needs

Phase 3: Follow-up
- Link with longer-term suicide prevention work
- Revise and update the community plan

When a suicide cluster is identified, it is crucial that there is an agreed multiagency, interdisciplinary approach taken to respond to and support the community in such circumstances. Proper structures to ensure the activation, implementation, and wind down of such approaches must be in place. It is also important that responses to clusters or murder–suicide are designed for the circumstances of the specific event, as they will be different as a result of scale, impact on a community, and resources available. An agreed template for responding to suicide clusters, such as a recent practice resource (Public Health England, 2015), provides additional evidence-informed guidance.

The identification of all people and groups in a community who may be impacted by a suicide cluster is central to responding, and there are many templates available that can be used to identify where resources and responses should be targeted. One such model used is that of circles of vulnerability (Lahad & Cohen, 2004; Public Health England , 2015), which can assist in identifying those in a community who may be at elevated risk of developing mental health difficulties or engaging in suicidal behavior. The circles of vulnerability model looks at varying types of proximity people may have had to the deceased, and particularly focuses on geographic, psychological, and social proximity.

The more vulnerability factors identified for an individual, the greater the possible risk the person is placed at. The closer to the intersecting circles the person moves, the greater the risk and the more acute the need for support and referral to appropriate services. Identifying those at potential risk and providing support and intervention may reduce the possibility of copycat deaths or contagion. In this context, Berkowitz and colleagues (2011) recommend screening for suicide risk and presence of depression among young people affected by the suicide of a friend or somebody close.

Geographic proximity refers to the physical distance between a person and the incident, such as for eyewitnesses, those who found the deceased, first responders, and exposure through extensive media coverage (Lahad & Cohen, 2004). *Social proximity* refers to the relationship with the deceased, such as family members, friends, romantic partners, social circle, close working colleagues, and close connections through social media (Lahad & Cohen, 2004). *Psychological proximity* covers the psychological closeness a person feels to the deceased irrespective of kinship (family ties) or other type of relationship (e.g., colleagues or friends) and may include, for example, people with similar cultural and/or religious beliefs, or role models (Lahad & Cohen, 2004).

Obtaining information on the psychological and social proximity of a survivor in relation to the deceased is particularly important as what is implemented at this juncture can be very beneficial for the bereaved in the medium to long term. According to Andriessen (2009), the provision of support to the survivors is a form of suicide prevention among those who are bereaved

by suicide. The provision of support, information, and signposting to services is beneficial and welcomed by the bereaved. Hawton et al. (2008) found that assistance on practical matters, such as ways of coping, arranging funerals, and supporting children, can be beneficial for the bereaved. Similarly, providing outreach on a proactive basis has been shown to lead to earlier uptake on treatment among the bereaved and greater attendance to survivor group meetings (Cerel et al., 2008). By responding at an individual, familial, and community level to suicide clusters, support and information can be provided to those immediately affected by the loss of their loved one. At a community level, by taking a public health approach targeting schools and colleges, workplaces, sports organizations, and other areas where people are impacted either by an individual suicide or a cluster, appropriate support can be provided.

Support After Murder–Suicide Events

There is a paucity of research that systematically examines the phenomenon of murder–suicides (or homicide–suicide) in contemporary society (Joiner, 2014; Samaritans, 2014). Yet, paradoxically, when these events occur they often receive extensive media coverage. Murder–suicide is commonly referred to as a two-stage sequential act in which a person kills one or more individuals and then takes their own life thereafter (Logan et al., 2008). In line with Nock and Marzuk (1999), the suicide should take place within 24 hr of the murder(s) for an event to be considered murder–suicide. International research reports prevalence rates of murder–suicide ranging from 0.05 to 0.52 per 100,000 (Flynn et al., 2009; Krulewitch, 2009). A review by Eliason (2009) showed that people involved in murder–suicide were commonly male perpetrators, older male caregivers, and those with depression and substance abuse issues.

Marzuk, Tardiff, and Hirsch (1992) classified different types of murder–suicide, including *familial suicide,* which refers to the killing of one's child(ren) and spouse or partner, followed by suicide. *Filial suicide* refers to the killing of one's child(ren) followed by suicide. Such deaths may also be referred to as *filicide,* when involving children aged 1 to 18 years; *infanticide,* when involving children up to 1 year; and *neonaticide,* when involving children within the first 24 hr of birth. Furthermore, *extrafamilial suicide* refers to the killing of one or more others (usually not related) followed by suicide.

Impact on Survivors

Research into the impact of murder–suicide on survivors is limited. However, there is growing evidence for specific aspects of sudden violent deaths, including murder–suicide, which contribute to the long-lasting impact of these tragic events on survivors (Boelen, 2015; Boelen, de Keijser, & Smid, 2015; Joiner, 2014; Jordan, 2008; Nakajima, Ito, Shirai, & Konishi, 2012). These studies address the impact on survivors of various sudden violent deaths, including survivors of murder–suicide.

Traumatic Aftermath

Loss of a family member or multiple family members by murder–suicide is often sudden, violent, and usually unexpected. Depending on the situation, survivors may need to deal with the police or handle press inquiries. While they are still in shock, they may be asked whether they want to visit the death scene. Sometimes officials will discourage the visit as too upsetting. However, the impact of the traumatic experience can be compounded if people feel that they do not have a choice (Jordan, 2008; Zisook & Shear, 2009).

Stigma and Isolation

Murder–suicide and individual suicide can isolate survivors from their community and even from other family members. This is further compounded by the stigma around mental disorders, which are often associated with murder–suicide and suicide, in particular in countries where suicide is still criminalized (World Health Organization, 2014). Therefore, survivors may be reluctant to acknowledge or disclose the circumstances of such a death. Differences among family members regarding how to publicly discuss the death, can further complicate providing mutual support among family members, which may prolong the grieving process (Jordan, 2008).

Mixed Emotions

Murder–suicide can evoke intense anger from survivors directed toward the perpetrator. Often there are conflicting emotions due to the perpetrator having suffered from a mental disorder, but at the same time having engaged in an extremely violent act, such as in filicide suicide. This may induce intense feelings of anger, rejection, and abandonment (Jordan, 2008; Zisook & Shear, 2009).

Research showed that survivors of violent and unexpected loss, such as cases of murder–suicide, had more symptoms of prolonged grief disorder (PGD) and posttraumatic stress disorder (PTSD) compared with people losing a family member due to illness (Boelen, 2015). This study also provided evidence for factors mediating the impact of violent loss and the sudden nature of loss on the severity of PGD, PTSD, and depression, such as peritraumatic distress – that is, distress at the time of the trauma, dissociation, and helplessness. In this regard, increased levels of dissociative responses and acute helplessness may explain exacerbation of postloss psychopathology (Boelen, 2015). In a related study, Boelen et al. (2015) identified specific cognitive behavior processes mediating between violent loss and elevated PTSD severity, including unrealness, catastrophic misinterpretations, depressive and anxious avoidance, and negative cognitions about the self and the future.

Consistent with these outcomes, Kaltman and Bonanno (2003) found that violent loss was more strongly associated with severe PTSD symptoms and enduring depression over 25 months following bereavement. However, this association was not found for suddenness of the loss. A review by Nakajima et al. (2012) reported that the prevalence of complicated grief among survivors of violent death, including murder–suicide, ranged from 12.5 % to 78 %. Severity of complicated grief was associated with more comorbid mental disorders, greater lack of readiness for the death, greater difficulty in making sense of the death, higher level of negative appraisal about the self and others, and more social stressors (Nakajima et al., 2012).

While the biological basis of the symptomatology of PTSD is still unclear, the interplay of somatic and environmental factors can increase the severity and duration of PTSD and complicated grief (Nakajima et al., 2012). PTSD in particular, was considered to contribute to the development of complicated grief by suppressing function of the medial prefrontal cortex and the anterior cingulate cortex, which works at facilitating the normal mourning process (Nakajima et al., 2012).

Impact on Communities

So far, limited research has been conducted into the impact of murder–suicide on communities, including schools, workplaces, and health and social services (Joiner, 2014; Logan et al, 2008). However, a number of studies addressing sudden violent deaths and suicide clusters have high-

lighted the impact of these events on communities. In this context, the circles of vulnerability model (Public Health England, 2015) can also assist in identifying those within a community who may be at elevated risk of developing mental health difficulties or engaging in suicidal behavior after an incident of murder–suicide.

In cases of filicide suicide, surviving siblings and peers can be severely impacted by the sudden and violent loss of their brother or sister or friend. Specific challenges for surviving siblings and peers are how to cope with feelings of guilt and responsibility following the death, difficulties in interpreting warning signs, recognizing reactions to grief, and directing affected children and adolescents to appropriate services for help, should they feel suicidal themselves (Hazell, 1991; Hacker, Collins, Gross-Young, Almeida, & Burke, 2008). Professionals who are directly or indirectly involved in the aftermath of a murder–suicide, such as mental health and primary care professionals, representatives from a local crisis center, and law enforcement, may be at increased risk of developing PTSD symptoms, in particular if they have not received relevant training (Everly & Flynn, 2006; Hacker et al, 2008; Jordan, 2008).

Impact of Media Reporting of Murder–Suicide

Feelings of depression and hopelessness present before the homicide and suicide are often the impetus for both (Gould, 2001). In covering murder–suicides, it is important to be aware that the tragedy of the homicide can mask the suicidal aspect of the act. Importantly, research identifies the need for sensitive and factual reporting to minimize harm and increase awareness (Samaritans, 2014). First of all, the graphic nature of reporting incidents of murder–suicide can trigger copycat cases: The effects of exposure on suicidal behavior and violence are well-documented. Secondly, there is a risk that sensationalized media reporting of murder–suicide can distort the facts. Finally, media professionals should consider the vulnerable reader who might be in crisis when they read the story: Coverage should not be glorified or romanticized, should emphasize consequences of the event for others, and list sources of help (Joiner, 2014).

Responding to Murder–Suicide and Recommended Interventions

With regard to recommended supportive interventions for survivors of murder–suicide, so far, no controlled evaluations have been conducted. Therefore, it is currently only possible to rely on uncontrolled evaluations for survivors of a range of violent deaths. An element of the grieving process that is considered to be particularly important is *sense making* in violent loss, such as murder–suicide, in particular when a father or mother takes the lives of his or her child(ren) (Gillies & Neimeyer, 2006; Keesee, Currier, & Neimeyer, 2008; see also Chapter 7 in this volume). Sense making relates to a constructivist conceptualization of bereavement and proposes that (a) individuals bring a set of existing beliefs about themselves and the world to the loss experience; (b) the experience of loss can violate or fracture these basic assumptions; (c) restoration entails a struggle to adapt one's personal world of meaning to make sense of the loss, with violent losses being more challenging to comprehend; (d) complications in grieving result when the bereaved individual is unable to make sense of the loss within the context of their current system or meaning (Gillies & Neimeyer, 2006; Neimeyer, Baldwin, & Gillies, 2006).

Keesee et al. (2008) identified that among mothers and fathers who had lost a child due to violent and unnatural death, including murder–suicide, reduced sense making was a significant predictor of concurrent, complicated grief symptoms, independent of the level of violence involved. Increased symptoms of complicated grief were strongly associated with increased levels of distress. Specific challenges in the process of making sense of the losses following murder–suicide are associated with trying to find an answer as how a parent can take the lives of their own child(ren) and feelings of extreme anger associated with a child or children being taken away from the surviving parent or other family members (Joiner, 2015).

Considering the link between violent death and complicated grief, eye movement desensitization and reprocessing (EMDR) is a recommended intervention for alleviating trauma, which is strongly associated with loss due to violent death (Jordan & McIntosh, 2011; Solomon & Rando, 2007). EMDR was developed by Shapiro (1995) who identified that bilateral stimulation – that is, stimulation on both sides of the body, whether in the form of eye movements, tapping, sound, or other forms, released traumatic material from the brain in a way that made the material workable (Shapiro, 1995; Solomon & Rando, 2007). Parnell (2007) underlines that survivors of violent deaths, including murder–suicide, may benefit from EMDR in that this may provide some relief from recurrent traumatic intrusions, and therefore may contribute to stabilizing the survivor to engage in bereavement counseling or other psychotherapeutic interventions. However, as indicated before, research is lacking to identify best practice and effective psychotherapeutic interventions for survivors of murder–suicide.

Conclusions and Implications for Research and Practice

Reviewing the literature on the impact and aftermath of suicide clusters and murder–suicide for survivors and other persons who may be affected, there is a need to prioritize high-quality research addressing the short- and long-term effects of these events on those affected. The available research shows a number of commonalities in responding to suicide clusters and murder–suicide; however, there are also important differences between these two phenomena. Community response plans are recommended, addressing key stages, such as preparedness, evidence-informed intervention/postvention, and follow-up up to at least a year after the deaths, to improve the response to suicide clusters and murder–suicide. The circles of vulnerability model can assist in identifying those within a community who may be at elevated risk of developing mental health difficulties or engaging in suicidal behavior. In terms of grief reactions including prolonged and complicated grief, little is known about best practice and evidence-informed interventions, in particular for survivors of murder–suicide. So far, sense making and EMDR have been the only interventions developed for survivors of murder–suicide based on the available literature, with limited evaluation in terms of outcomes for survivors.

It is recommended to prioritize research into developing and evaluating the efficacy of specific interventions for survivors of murder–suicide based on high-quality studies, including randomized controlled trials.

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Chapter 20

Lack of Trust in the Health Care System by Suicide-Bereaved Parents

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Abstract: Approximately 62 % of individuals who die by suicide had contacted the health care system within a year prior to their death. It is conceivable that bereaved parents, who have lost a child to suicide, lose trust in the health care system. This may prevent them from seeking professional treatment when needed, and reduce their prospect of recovery. This chapter presents the construct of trust in the health care system and a review of empirical evidence regarding the level of trust in the health care system in suicide-bereaved parents. It concludes with recommendations for future research in this area.

Introduction

The suicide of a child can be a devastating event that puts parents at high risk of developing psychological problems, such as depression, anxiety, and posttraumatic stress disorder (Murphy, Johnson, Chung, & Beaton, 2003). Suicide-bereaved parents are also at high risk of taking their own lives (Qin, Agerbo, & Mortensen, 2002) and dying prematurely (Tal Young et al., 2012). Research shows that an average of 62 % of suicide victims, aged 35 or less, had contacted the health care system within a year before their suicide (Luoma, Martin, & Pearson, 2002). After losing a child to suicide, it is conceivable that some parents' trust in the health care system will be shaken or that they will have low expectations regarding clinicians' ability to help, especially if their child had had contact with health professionals. This attitude may prevent the bereaved to seek help when needed, and consequently, reduce their chances of recovery. To date, there is scarce research regarding trust in the health care system in suicide-bereaved populations.

Trust in the Health Care System

Trust in the health care system is an attitude that refers to the patient's confidence that clinicians will provide their services competently, responsibly, honesty, ethically, and with concern (Hall, Dugan, Zheng, & Mishra, 2001). The construct of *trust in the health care system* intrinsically includes the elements of the patient's vulnerability and their expectation that health care providers will act in the patient's best interests. When measuring the performance of clinical interventions, the scientific literature uses the words *trust, satisfaction,* and *faith* as synonymous;