Families' Experiences of Suicide Victims in South Korea: A Phenomenological Study

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Research Article

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Abstract

Background: When a family commits suicide, family members experience feelings of hurt, denial, shock and anger, resentment, shame, and guilt. If left untreated, they become physically and psychologically vulnerable and the risk of suicidal ideation is high, so clinical intervention in the survivors of suicide is required. This study aimed to explore the experiences of families of suicide victims in South Korea.

Methods: This research was designed to a qualitative phenomenological study conducted by using Colaizzi's methods. Participants were 7 bereaved families living in Changwon City, South Korea. Data were collected through in-depth and individual interviews with participants from June to December 2018.

Results: A total of 25 meaning units, 11 theme clusters, and 5 themes emerged. The 5 themes of south Korean bereaved families' experience were: shock and confusion, pain of loss, disconnection interpersonal relationships, reality wanting to give up, and life to live.

Conclusion: The bereaved families are at high risk of suicidal thoughts or suicide attempts, so active individual professional counseling should be provided for them.

Background

Suicide occurs at any time during the life cycle and is a leading cause of death worldwide [1]. The suicide mortality rate in Korea (per 100,000 population) was 25.6 in 2016, which has been gradually decreasing since 26.9 in 2019 [2]. Compared to the Organization for Economic Co-operation and Development (OECD) developed countries, Korea is the country with the highest suicide rate [3].

The causes of suicide are various, including psychiatric symptoms, interpersonal relationships, money loss, physical illness, loneliness, work-related problems, chronic poverty, assault, and studies [4]. While growing up, youth experiences wounds and anger due to the death of their family or assault, or attempt suicide; death in such a family environment is recognized as a solution [5]. In particular, suicidal behavior occurs when person who commits suicide fails to resolve problems with their family; thus, family suicide has a significant influence on the life of the surviving family after the suicide [6].

Due to suicide, family members of the victim experience hurt, betrayal, shock, anger, resentment, shame, and guilt [7]. Families who have experienced the suicide of a child in their teenage years are severely psychologically disturbed and exist in social and psychological isolation for a long time due to grief. It lacks social and emotional support to those left behind after the suicide of a family [8]. If the families of suicide victims are left unattended, they become more physically and psychologically vulnerable in the future, and the risk of suicide may increase among such families [9].

However, no significant differences in terms of depression, anxiety, and suicidal behavior were observed among the family members of suicide victims, when compared with the bereaved family members of ones who had died of natural or accidental causes. Nevertheless, families of suicide victims have been

reported to experience higher levels of rejection, shame, stigma, criticism [10], and complex grief than bereaved families of ones who had died of natural or accidental causes [9]. They also conceal suicide event because of the fear of social stigma [6], so it is expected to cause difficulties in nursing care or therapeutic approaches for them. Therefore, it is necessary to administer differentiated nursing interventions to the families of suicide victims; for this, a comprehensive and in-depth understanding of the psychological and physical pain of the survivors of suicide is required.

Previous studies in foreign countries were conducted on the families of suicide victims enquired about social stigma [6], mental health and sadness reactions [10], complex sadness and suicidal thoughts [9], and Internet support group intervention [11]. Various research designs have been employed in different studies. However, there are only a few prior studies [12–14] on the families of suicide victims in Korea. These studies prioritized counseling or family therapy interventions focusing on mourning their grief; no nursing approach examined the total experience of the surviving family members of the suicide victim.

Colaizzi's analysis method [15] is appropriate for phenomenological qualitative research methods, which analyze the experiences of families of suicide victims to reveal the meaning of the experiences and understand them in depth. Therefore, this study aimed to examine, in detail, experiences of suicide victims' families and the nature of their experiences according to the phenomenological research method of Colaizzi [15]. The purpose of this study is to understand and describe the meaning and nature of the experiences of suicide survivors. The research question to be addressed in this study is: what is the experience of suicide survivors?

Methods

Participants

Participants included persons who had lost family members and had participated in the "Support program for families of suicide victims" of the K Health Center in Changwon City. They were adults over 20 years of age who voluntarily agreed to participate in the study after learning about its purpose and procedure. In qualitative research, two sampling principles are applied: appropriateness and sufficiency of sampling.

Appropriateness refers to the participant who can provide the best information for the study, and sufficiency is the collection of data to reach saturation in order to provide a sufficient and rich explanation of the research phenomenon [16]. In a qualitative study, there is no limit to the size of the data, but six to eight units are required when composed of a homogeneous group. In this study, nine participants were finally selected (Table 1).

The researcher himself is the most important research tool for qualitative research [16]. The researchers include a professor of psychological nursing, who has had more than five years of work experience at the Suicide Prevention Center and one professor of nursing whose work has been published in journals and who has conducted qualitative research in the past. We attended qualitative research classes on

phenomenology and grounded theory in graduate school and read books and papers related to qualitative research in order to increase our knowledge of it. We have also participated in several seminars related to qualitative research.

Data collection

Data were collected through in-depth interviews for approximately six months from June to December 2018. In order to build the researchers' credibility at the beginning of the interview and to encourage the participants to speak naturally, the first questions were: "How are you doing these days?". We then proceeded to ask open-ended questions: "Please tell us about your feelings regarding the suicide?"; "Are you having a hard time living as a suicide survivor?" By narrowing the scope to specific questions such as, participants were encouraged to voluntarily tell their own stories. When the responses were unclear in meaning, several follow up questions were asked until the responses were clarified. When no further new content emerged from the interviews, and in the data analysis, when concepts and categories of the same type appeared repeatedly, data saturation was achieved.

Each interview lasted for approximately 90–120 minutes, and the interviews were conducted in the interview room of the public health center—a place where there was no interference from others and that had a free and comfortable environment. The interviews were recorded with the consent of the participants. The recorded content was transcribed in the participant's language (Korean); additional concepts and contents that were not clear were also confirmed. Finally, the participants were asked to check the contents. After the interviews were completed, a reward was provided to the participants.

Data analysis

The collected data were derived from research results using the Colaizzi analysis method [15]. First, we recalled the expressions, appeals, and situations of all participants, and tried to decipher the overall feeling and meaning of the contents by repeatedly reading the transcribed contents of the interview. Second, we independently extracted meaningful statements related to the phenomenon. Subsequently, after discussion, we constructed a meaningful statement by underlining the contents that were commonly emphasized in the statement and the sections judged to be essential. Third, while considering the meaning of the extracted sentences and phrases, the hidden meaning in the context was found and restated or summarized in our language. Fourth, the meaning was constructed through a process where we examined the validity of the meaningful statement and ensured that the meaning derived from the re-statement did not deviate from the original data. Fifth, the composed meanings were grouped and organized into theme clusters, and theme clusters were regrouped and derived as themes. Sixth, participants' experiences were categorized as a sub-topic, subject, and collection of subjects according to the subject, and the essential structure was constructed by integrating common elements of the investigated phenomenon. Finally, in order to secure the validity of the analysis results, the researcher

showed the described contents and the phenomenological analysis results to the research participants and confirmed whether they agreed.

The rigor of the study was secured by applying the criteria suggested by Lincoln and Guba [17] to verify the quality of the study and increase its validity and reliability. First, the researcher used a recorder during the interview to ensure credibility, and analyzed whether he/she correctly understood the content stated during the interviews. In addition, after all the interviews were completed, the interview contents were summarized, and the participants went through a procedure to confirm that the summarized statements matched their experiences. Moreover, the interview contents were transcribed immediately after the interview, and efforts were made to organize the entire process of the interview accurately. The analyzed results were checked by nursing professors and linguists with extensive experience in qualitative research and interviews, who then provided feedback on them. Furthermore, for transferability, participants who could sufficiently express their experiences were selected, and interviews were conducted until the research data were saturated, and additional interviews were conducted for areas that were not investigated adequately, to find common experiences. In order to secure auditability, all interviews, data analysis, and analysis tables of the coding process, journals, and memos were kept as records so that they could be cross-checked, if necessary. Finally, confirmability increases the objectivity of data by maintaining the standards of reliability, suitability, and auditability, and does not manipulate any involvement or intentional situations when participants talk about their experiences.

Results

Data analysis of the experiences of families of suicide victims revealed 25 formulated meanings. These were collated into 5 themes and 11 theme clusters through a process of tying them with similar meanings (Table 2).

Theme 1. shock and confusion

The fact that a loved one suddenly died of suicide has disrupted the daily lives of families of suicide victims. Everything was mixed up in the face of a great tragedy. The families felt more confused by the incomprehensible reasons for the suicide.

Theme cluster 1. an irresistible disaster

Participants were stressed by the confusing situation of sudden bereavement and experienced adverse physical reactions such as insomnia, urinary disorders, tremors, and memory loss. They could not easily believe or realize that their loved one abruptly committed suicide and wanted to deny their death. Even though the family thought that they had done their best when they looked back on their lives and did not do anything bad enough to be punished in this manner, their anger soared because they could not accept the reality of being subjected to this tragedy

“My child died, and I felt weird. I have strange thoughts, I can't sleep... I was shaking again today. I also experienced incontinence and couldn't take care of myself today. I think it's because my body is so shocked. In other words, I cannot believe and accept what has happened.” (subject 7).

“If there is a god, I'd rather get sick or have some kind of an accident and break my leg. Because this is an insurmountable problem; I feel a lot of anger, anger…I just need to live, I just need to live.” (subject 4).

Theme cluster 2. a vain death

Participants thought that the deceased, who inflicted pain and sorrow to the surviving family members without realizing that they were loved by their family, was selfish. Families were often angry with the deceased; they were often weighed by the reason of the suicide. Though the victim’s pain disappears when they commit suicide, the surviving family members are angered at having to live in greater pain. They think about why the deceased chose to commit suicide and feel sorry that it was a vain choice, not a matter of value enough to control life.

“If my child thought of us, he wouldn’t have done that. I thought our baby was selfish. Honestly, I tried countless times to die. I didn't commit suicide because of my daughter and husband. My kid just let go of everything. I'm so angry about that. It's so sad that he didn't know that we loved him so much.” (subject 2).

“My wife ran two stores, so she couldn't close them, and was in debt... Later, she took out a lot of loans. I don't think that kind of situation is the reason for this suicide. I don't understand how she committed suicide even if it was a little difficult situation. She didn't leave a will. Ridiculous, It's embarrassing.” (subject1).

Theme 2. pain of loss

The suicide of a family member instantly changed the daily life of the bereaved family into one with difficulties and pain. They thought that the wound would remain throughout their lives and that they would not overcome the grief of losing the deceased. They thought they could not fathom the victim’s pain or protect them. Therefore, they blamed themselves and considered themselves sinners because of internalized self-stigma.

Theme cluster 1. a desperate longing

Participants suddenly recalled the memories they had with the deceased during their lives and were obsessed with these memories. They did not consciously recall the deceased, but when alone, they soon missed the deceased and returned to their state of pain again. They were heartbroken by the fact that they could no longer see the deceased, hear their voice, or smell their odor; this was the most painful experience for the bereaved family members.

“If this event hadn't happened... In the past, my son took us to a famous soup restaurant in Changwon. He said that Mom and Dad, you have to wait in line and eat. I thought that my son can take me anywhere. It's something he can't do anymore now. If there's anything I don't know, my son taught me everything to make me comfortable. I didn’t know how to use a cell phone. My son taught me everything. He was better than a teacher for me.” (subject 6).

“Even if I forget it, when I enter the house, everything returns to reality. Even if I go outside and have fun while talking and having a cup of tea, it’s too futile when I come home.” (subject 5).

“I miss my son so much. The hardest thing is that I can’t see my son again in my life. I had raised my son carefully. I still sometimes think that he will come out of his room. It seems like he will come back from the academy and say, I'm home. Now, I can't see him anymore, and the fact that he's not in this world is the hardest thing.” (subject 4).

Theme cluster 2. blaming oneself

Participants remembered the time they spent with the deceased, regretting that they were not able to prevent suicide. Before the suicide, the deceased behaved differently than usual and exhibited warning signs of suicide, but they confessed that they could not stop it because they were not aware that it indicated suicidal behavior. Families continued to recall actions they thought were indifferent toward the victims. They condemned themselves, thinking that they missed the opportunity to reverse victims’ death, and the suicides were their fault.

“My wife had been lying at home for a month or two before her death. She said she had no appetite, and she didn't eat. If I think about it now, I should have taken better care of her. She said she wanted to take a break, and said it would get better after the break. I just thought so and didn't pay much attention to her. I knew she was having a hard time, but I didn't know she would do that. Why didn't I know it? I regret my behavior.” (subject 1).

Theme 3. disconnection in interpersonal relationships

Participants were deeply wounded by the attitudes of those who comforted them; these families lived alone, fearing social prejudice against suicide. They wanted to hide the suicide incident from people and/or were reluctant to express the grief of loss outwardly. The surviving family members confined their social contacts within their bereaved families and cut themselves off from society.

Theme cluster 1. comfort left by wounds.

Participants were hurt by acquaintances who deprecated suicide, saying that the surviving families do not need to waste money and time at the funeral, and it is shameful to report a suicide in their surroundings. They were displeased with the pitiful attitude of others, who acted as if something unspeakable had happened. Far from consoling the desperate family members, acquaintances treated

the death of the deceased as a bystander; this was embarrassing and stunning for the surviving family members.

“An acquaintance living in Namhae told us that there is no need for a ritual such as a funeral. But when his son committed suicide, he properly arranged the funeral. I heard that he had paid 100 million won to the temple and worshiped the Buddha. He told us not to waste money on mourning the dead, and everything was useless.” (subject 2).

“After a long time, I met someone, and she looked at me with a pity. It was more hurtful than comforting. When someone's parents die, people don't overreact. But when my child died, she asked me ‘are you okay?’. It made me more uncomfortable. So, I just don't want to contact people unless they are very close. Such attitude is uncomfortable. The death of a parent or a child, it can all happen. We may experience both. I can’t stand people reacting specifically to my son’s death. It's confusing when I think of myself as someone who should be comforted like this.” (subject 5).

“After my wife died, I thought that relatives or acquaintances would unilaterally comfort the remaining family members. Some people told me how hard it must have been for my wife to commit suicide. Those words hurt us while we were depressed.” (subject 1).

Theme cluster 2. the stigma of a being bereaved

Participants were conscious of the negative evaluation of suicide in Korean society and feared that they would be known as bereaved families. They could not cry openly and had to hide their feelings because they could not prevent the suicide of their closest family member and felt ashamed that they were living their lives after the death of the deceased.

“It was rumored that my son's friend informed the school about the suicide. Other than that, no one knows. Neighbors living next door don't even know this. My son became a sinner, and we also became sinners. People may say that our daughter belongs to a bereaved family. In Korea, if someone commits suicide, it hurts their family.” (subject 2).

“It would be okay if I had died, the older one. I can’t talk to anyone about my child’s death. Is this a good thing? Even now, I don't cry at home because I'm afraid people will find it out. I cry, but I don't make a loud noise.” (subject 7).

“I don't meet anyone.” (subject 3).

Theme 4. reality of wanting to give up

The bereaved family thought they had lost the “present” they had with their family and the “future” that they would experience over the next days. They lived extremely helplessly in a reality where hope was lost; they also wanted to escape this painful reality by committing suicide by following their deceased family members.

Theme cluster 1. acceptance of suicide

Earlier, the participants thought that suicide was a frightening and terrifying thing that had nothing to do with them but could happen to anyone easily. However, now, the participants think that it could be their own fate. After the death of their family member, they were able to understand the suffering of the deceased, who had no choice but to consider suicide as an escape from suffering as they could not live with the pain. They felt themselves close to committing suicide and experienced thoughts of wanting to die.

“In the past, when I heard news of celebrities’ suicide, I used to think, ‘Why did they die?’ However, after my wife’s suicide, I can understand how one could commit suicide. I thought my wife must have had a hard time. I was afraid of committing suicide and dying, but after my wife's death, I thought I could die too.” (subject 3).

“Not long ago, I went to the beach and saw the ocean water overflow. I just wanted to dive and drown. I felt like I was going to die easily. I think of dying a lot these days. Although, actually, I didn't do that, but I wanted to jump off the 16th floor yesterday. The home owner put a safety net on all windows. Other houses don't have it, but this house has safety nets installed. So, I thought that I chose this house well.” (subject 2).

“Even now, I just think I want to die like my son.” (subject 7).

Theme cluster 2. loss of direction in life

The participants lost their hope and desire to live because of the death of their family members. They were spending their days meaninglessly in a reality that seemed to be trapped in a tunnel with no end. They came to realize the finiteness and the futility of life, and in their deep sorrow, they could do nothing.

“What are you going to do by being alive? I have no reason to live without him. Even so, I'm really trying to eat and live again because I have a fixed-term job at this city hall... My son died, but I want to buy and eat valuable ingredients. Even if I didn't learn anything much, I’ve lived without acting badly to the other people. Why has it happened?” (subject 7).

“There are many times when I'm blank. I also remember making memories with my son a lot, and I keep changing my mind several times a day. I have regrets and resentments, and then I am not just doing anything, day by day. I'm just sad.” (subject 5).

Theme 5. life to live

Participants tried to accept the terrible reality and return to the past. They tried to adapt to the world without the deceased and live a new life in their own way.

Theme cluster 1. burying the pain

As the participants recalled the deceased, they were sucked into an uncontrollable abyss of sorrow; hence, they tried to immerse themselves in work or live busy daily lives. They consciously focused on work and stopped thinking about the deceased, trying not to face pain.

“It's okay when I work. Only when I work. It did not last long. Also, I think where my won will come from, but I forget it when I work.” (subject 2).

“I go to the temple when I have time. When I am at home, I think of my child and feel frustrated. At that time, after bowing, my feelings subside. I have a puppy too.” (subjects 4).

“No matter how close I am, it is correct to distance myself from other people. For now, I'm only talking with my daughter and my husband. I try to train myself harshly and have a strong heart. When a tough thought comes up, I stop it. I work with my mind focused and don't want to think about anything else. If I think of my son, I may make mistakes.” (subject 2).

Theme cluster 2. reconciliation with dark feelings

Participants were reluctant to talk with their families because they thought that their families would be hurt by the loss of the deceased; however, they gradually began to talk about the death of the deceased and their feelings. They tried to accept the death of the deceased with their hearts, while confronting their memories and photos.

“These days, I talk to my children. ‘Why did your mother become like this?’ I also talk about the part where I am struggling. In the past, I didn't tell my kids at all.” (subject 3).

“I want to accept my son's death with my heart. If I'm sad, I cry, and if I want to see him, I look at his pictures. I am doing what my heart tells me to do. I see pictures if I want to see my son, and I cry if I want to cry. My son died. He went to heaven. I would like to accept that fact as it is. That's why I want to see him more now.” (subject 4).

Theme cluster 3. new hope

Even though the whole family had suffered a terrible thing like the Blue Army, they were trying to get out of despair while concealing each other's pain, thinking about the family member who would be more affected. They were anxious about losing another family member, and they tried to take better care of each other. They believe that they have the strength to endure the difficult time because of the surviving family, and the comfort and support they provided each other. They were planning their future careers, holding on to new hopes, and gaining the strength to live again.

“I’m more concerned about child's father than myself. Even that day, my husband sank to the floor. He seems to be okay with his work, but he is hurting a lot now.” (subject 2).

“My husband suddenly lost 7–8 kgs. I’m very worried about him. He only keeps thinking of our dead son. He says he doesn't know how to raise our other child. He says he's doing his best right now, but he doesn't

know what to do. But we still have a second child, so we try to strengthen ourselves." (subject 5).

"When my wife was alive, I planned to spend time with her when I retire, but now, I wonder how I will survive my remaining life? I plan to work more. I thought about starting a company based on what I was doing when I retired. When my son graduates, I plan to get my son a job at my company and work with him." (subjects 3).

Discussion

This study applied a phenomenological research method to explore and understand what kind of lives bereaved families experience after the suicide of a family member. Consequently, 5 themes, 11 thematic collections, and 25 meanings were derived; we will discuss each topic based on the revealed phenomenon.

In the first theme, "Shock and Confusion," the participants recall their experience of the unexpected death of the deceased; they were fiercely angry and denied the reality like an unbearable disaster. The shock experienced by the families of suicide victims leads to anger, which is often characterized by being severe enough to be incomparable to the general loss suffered by the family [7]. In particular, children's suicide is a violent act for parents, causing unacceptable shock, embarrassment, and fear [13]. Feeling betrayed is a common initial reaction to a family member's death, and it is a phenomenon that appears the same, although there are differences in time in the early stages after the loss of the family [7]. Surviving family members repeat unanswerable questions about why the deceased committed suicide to understand their motives or beliefs [13]. In this process, close family members feel deeply betrayed by the deceased for not seeing their relationship [7] as meaningful; they are angry [18] or resentful toward the deceased [7]. In shock and confusion, the bereaved families at the beginning of the bereavement have no one to call for help; they experience significant delays in cleaning up the scene of death or finding adequate support. In this period of emotional turmoil, practical help and guidance is required by bereaved families for decision-making and support services with high accessibility [19].

In the second theme, "Pain of Loss," the participants experienced unbearable pain due to the entanglement of feelings such as longing and guilt. Bereaved families of suicide victims experience more difficult and complex emotions along with sadness than normal bereavement [12]. The bereaved family who hears or witnesses a sudden report of the death, despairs of a loss and suffers from the absence of an existence that can only be filled by the deceased [20]. They blame themselves, feeling guilty for failing to prevent the deceased from committing suicide [18]. Bereaved families of suicide victims are believed to have contributed to the death of the deceased through abuse, neglect, denial, or failure to provide adequate assistance [21]. They themselves are condemned by the stereotype that their family was neglected and that they could not save him because they missed the suicide warning [22]. Guilt is a typical emotion experienced by the family members of suicide victims. It has a negative effect on their lives and makes it difficult to live in reality [23]. They regard themselves as sinners and act to punish themselves. Regret for their actions can increase guilt and leave more scars reality [23]. Bereaved families

will have to accept weaknesses, such as guilt and regret, and evaluate themselves positively. It will be necessary to help the family express their feelings with enough time to mourn them reality [24].

In the third theme, “Disconnection in interpersonal relationships,” the participants feared prejudice against suicide; thus, they tried to hide the news of the death, and became passive in interpersonal relationships. The bereaved family members do not want to share the pain with each other, which is related to the desire of not making the other family members suffer from more pain [12]. Previous studies also showed that family members were reluctant to talk about the pain with other family members and felt hurt and angry while talking to family and friends [19]. The critical gaze of others on letting the deceased choose death and consolation that forced mourning were also wounds for the bereaved family [12]. The bereaved family members recognized the public stigma of suicide; they experienced negative gazes and often internalized their stigma [22]. Social prejudice and shame can mark the family with a scarlet letter, causing them to blame themselves. This can interfere with the mourning process and prevent the proper use of support systems for the families [21]. Bereaved families want the people around them to acknowledge the lives and suicides of their loved ones. Therefore, a guideline or education is needed to respond to the families of suicide victims [19]. In addition, in order to resolve the prejudice against the families of suicide victims, both social perception and the surviving family stereotypes must change.

In the fourth theme, “The Reality of Wanting to Give Up,” the participants identified with the deceased, felt that death was near, or thought that they could commit suicide like the deceased [12]. Bereaved families accept suicide as a solution to stop suffering, and attempt to understand suicide from the perspective of the deceased [25]. They become desperate and helpless realizing the irreversibility of death, and understanding that the future they had planned with their family had disappeared. These families fear the world, as their belief in life disappears, and they feel empty [12]. It has been reported that one-third of survivors take suicide seriously and attempt suicide themselves [26]. The bereaved family is physically separated from the deceased but is mentally more closely attached. The loss of a loved one can destroy attachments and lead to suicide among the surviving family members [12]. This is a period when the risk of suicide events is high; thus, there is a high risk of suicide for the bereaved family [13]. Continuous monitoring and safety systems should be established for the survivors of suicides [27]. In particular, since mourning is a process of healing, counselors should support the expression and acceptance of the pain and sadness of the bereaved family [12].

In the fifth theme, “Life to Live,” one participant tried to control their negative emotions or sadness by keeping themselves busy in daily life. In Lee and Choi’s study [12] families of suicide victims tried to live separately from the deceased while practicing meditation, yoga, or religious activities. Ross et al [19]. tried to help bereaved families by ensuring that they did not engage in maladaptive coping behaviors such as working excessively or drinking too much. Bereaved families perceive themselves as having to endure suffering by being busy in life, in order to be separated from the pain of suicide in their family [19]. Moreover, the participants recalled memories of the deceased and attempted to reconcile with the buried dismal feelings while talking about the deceased. The memory that afflicts the bereaved should be renewed not as that of loss, but as ones that commemorate the deceased. This makes them turn negative

experiences into positive ones, so that they can overcome their pain [20]. In addition, the participants approached new hopes by making plans for the future and had the will to take care of the remaining family members. The bereaved family members try to protect the rest of the family despite suffering, because they fear that one of them may commit suicide like the deceased [12]. The bereaved family members seek a way to comfort each other, strive to play the role of the deceased, oppress the painful feelings, and choose to dedicate and sacrifice their lives for the rest of the family [27]; bereaved families should accept their loss and begin to find meaning and purpose in life, which allows them to grow spiritually [19].

This study has several limitations. First, participants' characteristics vary by age, gender, and relation to diseased, which makes it difficult to generalize the results to other bereaved families. Second, it is difficult to draw out rich individual experiences because of the small number of participants.

Conclusion

Families of suicide victims feel of guilty, anger, hopelessness, and suicide thought and suffer in silence because of the fear of social prejudice. Organized and individual consultation to prevent suicide for the bereaved family should be provided by a specialist and perceptions of suicide stigma must be changed.

Declarations

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Author's contributions

LE and LS conceptualized and designed the study. The guide for semi-structured interviews was composed by LE and LS. Interviews were carried out by LS. LE and LS contribute to the analysis. LE wrote the manuscript.

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Availability of data and materials

The datasets used during the current study are available from the corresponding author on reasonable request.

Ethics approval and consent to participants

Ethics approval was granted by the Institutional Review Board of Kyungnam University (1040460-A-2018-020). Written informed consent was obtained from all participants on the first page of the questionnaire.

All procedures were carried out in accordance with the ethical standards of the institutional and national research committee, the 1975 Helsinki declaration, and its later amendments or comparable ethical standards.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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Tables

Table 1. General characteristics of participants

Number	Age	Sex	Job	Religion	Bereavement period	Relation to diseased
1	60	Male	Office workers	None	15 months	Husband
2	49	Female	Business	Buddhism	2 months	Mother
3	51	Male	Office workers	None	2 months	Husband
4	45	Female	Instructor	Buddhism	7 months	Mother
5	42	Female	Office workers	None	1 month	Mother
6	64	Female	None	Buddhism	5 months	Mother
7	65	Male	Retirement	Buddhism	5 months	Father

Table 2. Families' experiences of suicide victims

theme	theme clusters	meaning unit
Shock and confusion	An irresistible disaster	A wave of impact appearing on the body
		An undeniable death of the deceased
		Anger at a terrible tragedy
	A vain death	Selfish choices excluding family members
		An incomprehensible reason for suicide
Pain of loss	A desperate longing	The deceased alive in memory
		An irreplaceable vacancy
		A farewell that I can't see again
	Blaming oneself	Blame oneself for not recognizing suicide signs
		Regret for careless behavior
Disconnection interpersonal relationships	Comfort left by wounds	A person who depreciates suicide
		Glance of pity from unfamiliar person
		An attention blaming the family's carelessness
	The stigma of a being bereaved	Fear to remain in scarlet letters
		Shame to live life
Reality wanting to give up	Acceptance of suicide	Be able to understand one’s suicide
		Coming over of suicidal thoughts
	Loss of direction in life	Despair of an irreversible reality
		The disappeared future
Life to live	Burying the pain	Have a busy day
		Control one’s emotion
	Reconciliation with dark feelings	Tell the deceased
		Face painful memories
	Looking at a new hope	Take care of the rest of the family
		Plan for the future (New life plan)