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The voices of survivors of suicide : experiences with forms of support after a suicide loss

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Experiences with Forms of Support
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ABSTRACT

The purpose of this exploratory qualitative study was to identify forms of support available to and utilized by survivors of suicide, to identify barriers to receiving support, and to gather suggestions and/or critiques regarding survivors' experiences with the supports they received. In-depth interviews were conducted with 13 individuals who had lost a loved one to suicide at least one year prior to the interview. The interviews explored the participants' experiences with accessing resources, formal and informal supports, negative experiences, and resource recommendations for other survivors of suicide. The findings from this study emphasized how coping with such a profound loss can be a unique experience for each individual; and there can be significant similarity, indicating that survivors of suicide are not alone in their grief. The participants of this study identified a crucial need for increased societal acceptance and understanding of issues related to mental health, suicide, and grief.

THE VOICES OF SURVIVORS OF SUICIDE: EXPERIENCES WITH FORMS OF

SUPPORT AFTER A SUICIDE LOSS

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CHAPTER I

Introduction

"Each way to suicide is its own: intensely private, unknowable, and terrible. Suicide will
have seemed to its perpetrator the last and best of bad possibilities, and any attempt by
the living to chart this final terrain of life can be only a sketch, maddeningly incomplete."
— Kay Redfield Jamison, Night Falls Fast: Understanding Suicide

Suicide can sometimes seem like an unspeakable topic although unfortunately, suicide touches the life of many people in the United States and around the world. Losing a loved one to suicide can be tragic and agonizing for the family members, partners, and friends left behind. Survivors of suicide are often neglected as our society tends to look away or whisper when a suicide death and the issues leading up this tragic act are being discussed, leaving the survivors on their own to varying degrees to find resources and support from not only mental health professionals but also their community. The purpose of this study was to highlight the voices of survivors of suicide regarding their experiences with various forms of support to cope with their loss.

One reason for conducting this study was to potentially inform social workers of some of the specific experiences and needs of survivors of suicide by hearing directly from individuals who have experienced this type of loss. The current research focusing on survivors of suicide is limited as research on suicide tends to target issues pertaining to suicide prevention. As research and awareness for suicide prevention increases, it is necessary to also shine light on survivors of suicide and provide this large population with resources and support. Suicide is currently one of the top ten leading causes of death overall in the United States, touching the lives of at least 85% of the population (Young, 2012). In addition to grief, survivors of suicide loss can experience complicated grief, physical and mental health symptoms including an increased risk for suicidal thoughts and behavior (Crosby, 2002). The emotional sequelae of losing a loved one to suicide

calls for the attention of social workers who could play an important role in providing survivors of suicide loss with information, connecting them to resources, and offering individual, family, or group therapy. This large population deserves effective resources that are accessible and meet the needs of individuals with diverse sociocultural identities. Researchers focusing on survivors of suicide often face barriers to reaching this population including ethical dilemmas and recruitment challenges due to stigma. Many empirical studies to date have small and unrepresentative sample sizes with little consideration given to diverse and marginalized populations.

This study was a qualitative exploration with semi-structured interviews used to gather the narrative data from thirteen individuals who have lost a loved one to suicide. Research participants were asked specifically about experience with formal and informal forms of support, access to resources, responses from others including stigmatization, and recommendations for improving support for survivors of suicide loss. This study explored these aspects beginning with a review of the literature, explanation of the methodology used in this study, the findings from the thirteen survivors of suicide who were interviewed, and finally a discussion of the data. It was my hope that this information could help survivors of suicide feel heard and could inform current and future social workers of the importance of further learning about the needs of this population that is sometimes neglected.

CHAPTER II

Literature Review

The current study explores forms of support available to and utilized by survivors of suicide loss, focusing on their perceptions of what was helpful and unhelpful as they coped with their grief and moved through their individual bereavement process. This literature review

consists of six sections related to death by suicide, the impact of a suicide death on the survivors, and forms of support available to survivors of suicide loss. The first section of this chapter reviews current suicide statistics in the United States. Section two provides a brief overview of historical perspectives on the topic of suicide. Section three presents debates in suicide literature. Section four describes common bereavement experiences for survivors of suicide loss. Section five discusses the current research on forms of support for survivors of suicide loss. This section is divided into three subsections including, first responders, ongoing supports, and barriers to resources. The chapter concludes with the major limitations of the current literature relating to survivors of suicide loss.

Suicide Statistics

Suicide is a serious public health issue; a tragedy that impacts the family members, friends, and loved ones of the approximately 800,000 individuals around the world who complete suicide each year (World Health Organization, 2016). Suicide rates have been increasing steadily in the United States from 1999-2014 for ages 10-74 years old with the greatest increase being females aged 10-14 years old and males aged 45-64 years old (Curtin, 2016). Suicide is currently one of the top ten leading causes of death in the United States overall. It is the second leading cause of death for ages 44 and under and the fifth leading cause of death for ages 45-54 (Curtin, 2016). According to AFSP Facts and Figures (2016), Americans attempt suicide an estimated 1.1 million times annually and nearly 43,000 Americans die by suicide every year. In 2014, firearms were the most common method of death by suicide, accounting for 49.9% of all suicide deaths, followed by

suffocation, including hangings, at 26.7% and poisoning at 15.9%.

There are specific populations who appear to be more commonly impacted by suicide. Death by suicide is associated with a diagnosable mental health or substance use disorder almost 90% of the

time. Depression and bipolar disorder are two of the most common diagnoses connected with suicide attempts. Suicidal thoughts and behavior can also be connected to trauma, a significant loss, isolation from friends and family, or feelings of rejection, hopelessness, and despair (Young, 2012). Women attempt suicide three times the rate of men, however, men die by suicide four times the rate of women. Lesbian, gay, and bisexual identifying youth attempt suicide four times the rate of straight youth and 40% of transgender adults reported having made a suicide attempt, with over 90% making the attempt before turning 25 years old (James, 2015). Veterans comprise 22.2% of suicide deaths. The suicide rate among American Indian/Alaska Natives ages 15-24 is 1.5 times the national average and the states of Montana, Wyoming, Utah, New Mexico, and Alaska have the highest suicide rate above the national rate of 12.93 per 100,000 people (AFSP, 2016).

Historical Perspectives

The deep historical roots of suicide continue to play a role in current perceptions of suicide on an individual and societal level, specifically in regard to the pervasive stigma surrounding this topic. Suicide has been seen as a legal, religious, philosophical, moral, political, economic, and health related issue; and it has been referenced in literature, plays, film, and music. There have been a multitude of perceptions and beliefs, mostly negative, on suicide dating back to the Classical Greek Era when suicide was represented in work by Plato and Aristotle (Cholbi, 2016). Over time, suicide has been understood as both a sin and a punishable, unjust act, while at other points in history, such as in Classical Rome, as a glorified and respected act

(Minois, 2001). Minois (2001) highlighted how views on suicide began to change as early as the 1500s as writers and philosophers wrote more openly about this topic, noting that Shakespeare wrote many tragedies, with 52 suicides occurring in his plays. During the Renaissance ages, the understanding of suicide became more complex with the rise of philosophers such as Rene Descartes

and Jean-Jacques Rousseau (Cholbi, 2016). Rousseau proclaimed that suicide is caused by society rather than the individual (Cholbi, 2016).

Historically, the family members of those who died by suicide were subjected to punishment, judgment, stigma, and social isolation. In a Review of the Literature by Cvinar (2005), the author discusses how in the past, family members were denied access to their loved ones in order to have a ceremony for closure when the death was a suicide. In addition, the family members were looked down upon or ostracized, receiving little or no support from their community due to the nature of the death. In the late 18th century, suicide deaths were commonly disguised as physical health issues which was considered more socially acceptable and decreased punishment of the surviving family members (Cvinar, 2005). In the late 19th century, there began to be more formal supports in place for survivors of suicide, particularly to help with the stigma the family members faced; however, suicide continued to be largely misunderstood.

At the turn of the 20th century, the psychological, social, and physical aspects contributing to suicide were more widely acknowledged (Cvinar, 2005). Psychological and philosophical theories, from those such as Freud and Durkheim, shifted focus from sin and crime to the individual, the subconscious, and to the role society had on the individual (Toynbee 1968). In the latter part of the 20th century, Edwin Schniedman, a clinical psychologist in the United States and one of the pioneers of 'suicidology,' began to study suicide and uncover the importance of also focusing research on the loved ones left behind. Edwin Schniedman is often referred to as 'the father of suicidology' and is known for being the founder of the American Association of Suicidology as well as his many publications on suicide (Pompili, 2008). Around the 1970's, 'postvention' emerged in the United States (Andriessen, 2014). Postvention is defined as "activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behavior" (Andriessen, 2009).

Changes in the understanding of suicide took place over a long stretch of time, and now as awareness on suicide prevention is growing, survivors of suicide loss are also gaining attention. This population is increasingly understood as needing specific support in coping with their loss (Cvinar, 2005). Despite the advancements towards understanding and responding to survivors of suicide, the social stigma remains and can strongly impact the response from the community and access to resources.

Debates in the Research

The literature on survivors of suicide loss reveals three issues among researchers. First, there are inconsistent definitions for the commonly used term 'survivor of suicide.' Second, the number of survivors of suicide remains undetermined with much of the research pointing to estimations. Third, there is some debate on if and how bereavement for survivors of suicide differs from bereavement of a non-suicide death.

Ali (2014) pointed out discrepancies and disagreement among researchers in how they define key terms in the suicide literature. 'Survivor of suicide' is used in the literature to indicate a person who has lost a family member to suicide, however, the term has been commonly confused to mean a person who has attempted suicide for those unfamiliar with the meaning. One common definition for 'survivor of suicide' in recent literature is "a person who has lost a significant other or loved one by suicide, and whose life is changed because of that loss" (Andriessen, 2009). Jordan (2011) proposed a definition that pertains to individuals who had close psychological involvement with the deceased, stating this criterion has been found to be a "predictor of grief and intensity of grief" (Jordan, 2011). This definition of 'suicide survivor' is "someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length after exposure to the suicide of another person." Measuring if and how a person's life has changed because of the loss poses a challenge and therefore this definition can easily be left up to different or vague

interpretations. As Berman (2011) highlights in his study, "for purposes of public health messaging and postvention programming, achieving greater specificity and sensitivity in the terminology used to denote survivors of suicide is both a desirable and yet-to-be-achieved goal." For the purpose of this research, we will utilize the definition proposed by Jordan (2011). The term will include any individual who self-identifies as having 'close psychological involvement' with the deceased in order for the research to be more inclusive of the wide range of meaningful relationships people can experience.

The number of survivors of suicide loss in the United States remains unknown, partly due to a lack of a consistent definition in the research. It was estimated by Schneidman (1969) that for every suicide there are at least 6 survivors who are left behind. More recent research estimates there are between 10-14 survivors for every suicide who are significantly impacted (Andriessen, 2011). A study by Crosby (2002) found there to be 450,000 new survivors of suicide every year in the United States, and according to Young (2012), approximately 85% of people in the United States will know someone personally who has died by suicide. It is of important note that the number of survivors for each suicide death can have considerable variation. Factors such as the decedent's age, types of relationships, and frequency of contact with others are necessary to consider when estimating the number of people who identify as a survivor of suicide (Berman, 2011).

There has also been a debate in the literature about whether or not the bereavement process for survivors of suicide is unique compared to those bereaved through other types of death. While some studies suggest that the suicide bereavement process is very similar to the experience following a non-suicide death, there is currently literature to support that suicide bereavement is unique (Cvinar, 2005). According to Gall (2014), the research suggests that although there are many similarities to the reactions to death of those bereaved by natural causes, suicide bereavement is qualitatively unique. Provini (2000), in an empirical study on adults mourning suicide, discussed how

the bereavement experience for this population has been shown to be particularly stressful by both clinical observation and empirical study.

Suicide Bereavement

The aftermath of a loved one's suicide can be overwhelmingly painful and might be one of the most arduous challenges an individual is forced to face (Pompili, 2008). According to, Andriessen (2014), a number of factors affect the experience of suicide bereavement and the related grief. These factors can include: quality of the survivor-victim relationship, the concepts of vulnerable families and transgenerational loss, kinship relationship, closeness of relationship, gender, age and developmental perspective of survivor, cognitive coping styles, and expectation and preparedness of death. While grief and bereavement are unique to each individual, there are some commonalities for those coping with a suicide death. The nature of suicide deaths is frequently violent and traumatic which, in any type of death, increases the potential for complicated grief in those left behind (Young, 2012). This is compounded for many survivors of suicide loss with the stigma often associated with mental illness and suicide (Scocco, 2016).

Those bereaved by suicide may struggle more with making meaning of the loss, questioning the reasoning, self-blaming and experiencing feelings of shame, guilt, responsibility, anger, rejection and perceived abandonment (Young, 2012). Survivors of suicide might also struggle with gruesome images, thoughts, or preoccupation with reminders of their loved one or the death if they were present at the time of the suicide or immediately after. Survivors of suicide have a higher risk of developing complicated grief which can interfere with functioning. This population can suffer from symptoms of Post-Traumatic Stress Disorder such as increased anxiety, depressed mood, withdrawal, hyperarousal, numbness, and difficulty with eating and sleeping (Young, 2012). Survivors of suicide are at an increased risk for their own suicidal ideation and have a higher rate of suicide attempts (Crosby, 2002). A study by De Leo and Heller (2008) that examined datasets found

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that exposure to the suicide of a non-family member, such as someone at the workplace, can also have strong negative effects on individuals, particularly those under 18 years old. Contrary to the assumptions that all suicide survivors are bereaved, the completed suicide may bring relief to some suicide survivors, resulting in complex and conflicting emotions contributing to a different bereavement process (Ali, 2014).

Family systems can also be impacted by a suicide loss. There is evidence of increased levels of psychopathology in family members, greater distance in family relationships, and more dysfunctional family patterns including communication difficulties, disruption of role functioning, conflicts regarding coping, and destabilization of family coalitions and intergenerational boundaries (Kaslow, 2004). Families may engage in blaming or may avoid talking about the suicide due to intensity of their grief (Stroebe, 2001). The suicide loss, however, may also lead to more open communication and family members growing closer to each other.

Research is lacking on the stigmatization survivors of suicide encounter, however, there is some indication that the stigma surrounding suicide can serve as a barrier to receiving support for this population. In Cvinar's (2005) review of the literature, she found survivors of suicide to be at an increased risk of psychological problems and were more likely to distance themselves from forms of support including social relationships and mental health providers in an effort to not identify with the suicide and any stigma attached to suicide (Ali, 2014). Adults who experience suicide bereavement may also feel isolated due to members of their social networks seeming unable to truly empathize with them (Moore, 1995). A person's ability to cope is significantly influenced by their social and environmental contexts (Gaffney, 2010). Unsupportive environments such as those with higher levels of stigma or few resources for survivors of suicide, may lead to a person enduring longer-term emotional distress such as depression and anxiety (Gaffney, 2010).

Support for Survivors of Suicide Loss

The grief process can be unique for survivors of suicide, demanding a unique response from their surrounding community, first responders, mental health professionals, and society. Cerel (2008), emphasizes the importance of postvention work with this population stating, "postvention is prevention when it comes to survivors of suicide" because of the possibility for negative psychological and physical health consequences for survivors of suicide. There has been an increase in recognition of the need for research and attention on postvention services including the formation of 'Task Force Postvention' by the International Association for Suicide Prevention (Gaffney, 2010). Common forms of support or steps taken to cope by survivors of suicide that have been researched include support groups, advocacy work, and raising awareness on suicide prevention. This can include participation on National Survivors of Suicide day, survivor outreach programs, support group facilitator training programs, and Out of Darkness community walk (Haprel, 2011).

First Responders. Immediately following a suicide, some survivors will be in contact with professionals in the roles of police officers, paramedics, the coroner's office, funeral directors, and early support workers. The quality of these initial interactions can have an impact on their individual grief process (Davis, 2004). Survivors of suicide have voiced in past studies the importance of being contacted early on in the process about forms of support and how to access support, rather than having to take on this task themselves (Dyregrov, 2002). Survivors of suicide often report difficulty in reaching out for support while dealing with the physical and psychological difficulties associated with complicated grief. There can be an additional barrier to connecting with services for the survivors located in a rural area (McKinnon, 2014). A study in Baton Rouge, Louisiana explored the role of a local outreach service for family members at the time of the suicide. The study found that people who had initial contact with the outreach team presented for treatment sooner and were more likely to attend support groups compared to

people who did not receive the outreach service (Cerel, 2008). In one study, the researchers found that while survivors commonly had initial contact with professionals, these contacts were often shortterm and did not provide enough support to survivors who believed they would benefit from long-term professional support (Dyregrov, 2002).

McKinnon (2014) conducted in-depth interviews with 14 survivors of suicide from both rural and metropolitan areas. The research participants ranged in ages 26-75 and all but two participants were women. The interviews explored the supports they utilized during their bereavement journey, what they found helpful, and the needs that remained unmet. Research participants identified a range of inconsistent experiences with first responders during the immediate aftermath. Some participants described negative and frustrating interactions with first responders who "lacked compassion and respect for what they were feeling" or who did not communicate effectively or timely. On the other hand, some participants reported positive interactions with first responders who they found to be understanding and supportive. Participants also found receiving information about services to be potentially helpful although the information received was often out of date or irrelevant to their needs. The limitations to this study include that participants were self-selected and had been or were currently connected to formal support. The participants were mostly women and did not represent culturally diverse backgrounds.

On-Going Supports. On-going supports for survivors of suicide could include support groups, individual therapy, rituals, traditions, forms of artistic expression, religion or spirituality, or any other activity, person, community, or belief that the survivor of suicide loss can engage in or with throughout their bereavement process. The current literature about on-going supports for this population is extremely limited.

Support groups for survivors of suicide is the most studied form of support and the most available form of support for survivors of suicide (Cerel, 2013). The research indicates that support

groups for suicide survivors are widely used; however, there is a lack of empirical evidence regarding their efficacy (Cerel, 2009). About half of the participants in McKinnon's (2014) study felt strongly against utilizing support groups as they found the idea of listening to other stories of suicide and retelling their own to be more harmful than helpful. Other participants who attended support groups described the experience as unproductive and were provided with little with or no new skills for coping. This response seemed to be particularly in response to peer support groups. The aspects of support groups that survivors of suicide have found helpful include, companionship, mutual understanding, a sense of belonging, validation, and hope (McKinnon, 2014). The survivors of suicide most frequently voice the need for trained professionals to facilitate support groups or intervene clinically in order for them to be more helpful in dealing with their grief and psychological symptoms (Provini, 2000).

Individual therapy is another ongoing support that can commonly be suggested to survivors of suicide due to the symptoms associated with suicide bereavement and complicated grief. The effectiveness of individual therapy as an intervention for survivors of suicide loss has not been widely studied. Hawton (2003) found that clinical interventions could play a beneficial role in the healing process and be associated with a decrease of mental health related symptoms such as depression and anxiety. In 2012, an empirical study examined suicide loss survivors' experiences with individual therapy through an online survey in the United States and Australia. The study found that while participants were mostly satisfied with their experience, clinicians "might need training in the specifics of how suicide grief is different and how to treat loss survivors, particularly around issues of trauma" (Sanford 2016). This study emphasizes a need to improve training for mental health professionals regarding how to provide adequate support for survivors of suicide. Additionally, this study found greater benefits from therapy for individuals who began utilizing this form of support within the first three months after the death.

In a qualitative study, Gall (2014) presented the following table on "Two Perspectives on Best Practices for Postvention with Suicide Bereavement". This table outlines the needs of survivors of suicide loss in six categories from the perspective of bereaved individuals and mental health workers based on interviews. The categories include grief experience, coping, interpersonal domain, struggle for meaning, self-reflection, and moving forward (Gall, 2014).

TABLE 1
Two Perspectives on Best Practices for Postvention With Suicide Bereavement

Suicide Bereavement Experience	Bereaved Individual	Mental Health Workers
Grief experience	• Talking is critical • Experience the "pain" of the loss • Vent emotions • Seek informal (support group) and/or formal (counseling) support	• Be open • Be honest • Listen empathically • Move at the bereaved person's pace • Acknowledge, normalize, validate emotions • Provide education • Stabilize from shock
Coping	• Adopt an adaptive attitude • Take control • Remain engaged • Reframe the suicide • Attend to self-care • Monitor negative coping • Gather information on suicide	• Assess coping • Evaluate negative coping and provide alternatives • Model coping strategies • Support a sense of control
Interpersonal domain	• Reject stigmatization • Recognize tendency to withdraw • Identify trusted others • Reach out for support • Monitor/manage expectations for others	• Help identify, build, access support • Involve supports as needed
Struggle for meaning	• Understand that suicide challenges beliefs • Explore the "why" as needed • Find a "good enough" understanding • Know when to "let go"	• Meaning is central • Attend to the unique needs of each person in the search for meaning • "Hold their pain" • Recognize "stuckness" • Create empathy for the loved one • Understand that suicide was the choice of the loved one
Self-reflection	• Work on self-awareness • Understand the loved one and his/her decision • Celebrate the loved one • Put suicide into a larger perspective • Recognize positive changes in self and relationships • Recognize personal strength • Take care of "old pains" that may surface	• Facilitate the person's reflections • Be open to discuss the loved one's life • Focus on resources • Provide hope
Moving forward	• Relinquish guilt • Accept that it was the loved one's decision to suicide • Accept the loved one with compassion • Accept the need to live with the suicide • Engage in self-reassurance • Move on with life • Recognize that the loved one will always be a part of self	• Challenge the guilt • Reinforce "it was not your fault" • Focus on a reengagement with life • Find a "new normal" in life

Family therapy for survivors of suicide is a potential ongoing form of support. The research on this intervention is limited. Kaslow (2004) suggests "family postvention requires a sophisticated therapeutic balance of attending to family units as wholes, as well as to the individual members within the system" with attention to the survivor's sociocultural identities. The chapter outlines recommendations for clinicians providing family therapy for survivors of suicide. The

recommendations include completing a specific assessment for each family member and the family as a whole, including family structure and family experience with loss and grief, the creation of a suicide story, healing rituals, and psycho-education based on relevant research (Kaslow, 2004).

Barriers to Resources. Survivors of suicide loss often face barriers to receiving mental health services and accessing resources that could help them cope with their loss. Stigma and geographic location are common barriers to accessing resources for survivors of suicide. Despite the lack of specificity regarding the number of survivors of suicide, one study found that while 72% of survivors expressed a need for professional help, only 47% received it (Provini, 2000). Even if individuals are able to access the available resources such as support groups or individual therapy, it may be difficult to find postvention activities that meet the needs of culturally diverse groups. Many support groups or therapy rely on western based grief theories and grief models, such as the stages of grief model, that can be linear and limiting as it attempts to predetermine the experience of grief for an individual (Ali, 2014). It is important to provide survivors of suicide with ways of accessing multiple types of support in order to meet individual needs and coping styles (Jordan, 2011).

Research Limitations

The research examining the impact of suicide on family members and partners appears to be limited, as the majority of literature focuses on suicide prevention, intervention for suicidal individuals, and general bereavement (Gaffney, 2010). A number of mitigating factors have prevented further research within this area. Challenges in the research of suicide and postvention activities include the many complex ethical dilemmas faced by researchers (Mishara, 2005), as well as an inconsistent definition of 'survivor of suicide,' small and unrepresentative samples, and pervasive stigma. McIntosh (1993), critiqued the empirical studies of suicide survivors and found that research limitations included small sample sizes and that study participants were primarily white and

female. Most of the studies have been quantitative in nature and many studies have recruited from suicide support groups, limiting the research to only represent the experiences of individuals who have access to postvention activities and might be more likely to engage (Ali, 2014).

There remains a gap in the literature around other forms of support and forms of support utilized by communities of non-white and non-female survivors of suicide. "Little has been done to design or implement postvention services for people who may be reluctant to reach out for help because they do not have the economic wherewithal or the sense of trust in the health care system to access services. In the United States, this could include African Americans, Hispanics, and other minority and immigrant populations" (Jordan, 2011). It is important to explore the role of religion, spirituality, artistic expressions of grief, meaning making activities, cultural rituals, and the role of community and family support for survivors of suicide.

Summary

This chapter consisted of six sections, reviewing the literature related to death by suicide, the impact of a suicide death on the survivors, and forms of support available to survivors of suicide loss. Suicide is currently one of the top ten leading deaths in the United States and is connected to a mental health or substance use disorder 90% of the time. The exact number of survivors of suicide is not known, but it is estimated that up to 85% of the population knows someone who has died by suicide. Historically, suicide and mental illness has been surrounded by significant stigma which has, and still does, impact the family members left behind. Survivors of suicide can experience grief, complicated grief, PTSD symptoms, and increased risk for suicidal ideation and suicide attempts. The research on forms of support for survivors of suicide is limited, focusing on support groups and individual therapy. These forms of support have not been very well researched in terms of effectiveness and can often be difficult to access due to stigma, geographic location, and for marginalized populations. Additionally, these forms of support may be geared towards westernized beliefs and do not provide

culturally appropriate interventions for diverse groups of people. The current literature on suicide and

survivors of suicide is limited due to ethical challenges, limited

sample sizes, and lack of diversity among research participants.

CHAPTER III

Methodology

This study was an exploratory investigation into forms of support for survivors of suicide. The purpose of this study was to highlight the experiences of individuals who have lost a loved one to suicide at least one year ago. This study asked survivors of suicide about forms of support that were available to them and that they used. The study also explored what survivors of suicide believe might be done differently to improve the supports provided in the future. The study was qualitative in nature. Semi-structured interviews with both open and close ended questions were used to gather narrative data from the participants (Appendix A). Authenticity of the data was increased by focusing on how the participants perceive their experiences (Engel, 2016).

Sample

Participants in this study were individuals who self-identify as a 'survivor of suicide loss' defined as, "someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length after exposure to the suicide of another person." Participants were at least 18 years old and at least one year had passed since the suicide. Participants were required to read, write, and speak English in order to complete the consent form and engage in the semi-structured interview. The researcher strived to include individuals of various gender, racial, and ethnic identities. Individuals interested in participating in this study were asked to complete the pre-screening questionnaire (Appendix B). Participants who answered 'yes' to all of the following questions were informed that they qualified to participate in the study.

1. Can you read, write, and speak English?

2. Are you at least 18 years old?
3. Has at least one year passed since the suicide of your loved one?

4. Are you ok with talking about this topic?

5. Are you willing to participate in an interview about forms of support related to your loss?

A total of 13 research participants were interviewed for this study.

Recruitment

Prior to recruitment of research participants, the study protocol was reviewed and approved by the Smith College School for Social Work Human Subjects Review (HSR) Committee. A non-probability, purposive and snowball sampling technique was used to recruit research participants. The researcher first contacted the facilitator of a support group for survivors of suicide in the San Francisco Bay Area requesting that the recruitment letter be sent out to potential research participants (Appendix C). The researcher also contacted the leader of a local meetup group with the recruitment letter. The recruitment letter was emailed to past and current colleagues with the request to be passed on to appropriate individuals based on the inclusion criteria. All potential research participants received recruitment material that provided information relating to the research topic, inclusion criteria, participation requirements, and the researcher's contact information. Potential research participants were asked to contact the researcher using email or telephone to complete a verbal pre-screening process in which the researcher confirmed their eligibility. The researcher and each participant then arranged a date and mutually convenient private or semi-private location for the personal interview. If the research participant was unable or unwilling to meet in-person, a Skype or phone interview time was arranged. At the time of the interview, research participants were asked to read and sign the Informed Consent Form (Appendix D) before data collection. In the case of a Skype or phone interview, the Informed Consent Form was sent by email prior to the interview time, signed by the participant, and returned electronically.

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Ethics and Safeguards

Anonymity of research participants was not possible due to the nature of the personal semi-structured interviews. Research participants' participation in this study was kept confidential as the researcher is the only person aware of each participant's identity. The following steps were taken to maintain confidentiality. Each participant was assigned a code number, which was placed on all materials and identifying information was removed from interview transcripts. Consent letters are kept in a secure location separate from notes and transcripts. The audio recording digital files were password protected, only accessible by the researcher. The researcher disguised any possible identifying information in the use of participants' quotations in this thesis. Recordings will be permanently deleted from the recording device after the mandated three years. All research materials including recordings, transcriptions, analyses, and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

The consent form outlined the purpose of this research study along with the risks and benefits of participation for each participant. Possible risk to research participants included feeling discomfort or distress from thinking about and talking about forms of support related to the loss of a loved one to suicide. The researcher asked each participant if they felt ok talking about this topic and confirmed they were willing to participate in an interview on this topic prior to beginning the interview. Participants were reminded they could stop participation in this study at any time. Participants were asked to identify some level of support following the interview, such as meeting with a friend, therapist, or other form of support. Participants were provided with a list of resources including hotline numbers, online resources, local support groups, and

counseling referrals (Appendix E). If participants were not in the San Francisco Bay Area, the researcher created a location specific-list for the participant prior to the interview.

It is possible that participation in this study provided participants an opportunity for reflection and insight regarding forms of support following their loss of a loved one to suicide. Participation in this study allows the voices of the participating survivors of suicide loss to be highlighted in the research on survivors of suicide loss. Conducting this study provided the researcher with information on individual experiences of survivors of suicide loss receiving support. The completion of this Thesis Project will fulfill one requirement for my masters of social work graduate degree. The information collected from this study could be used by clinical social workers when working directly or indirectly with survivors of suicide. This study could help to inform subsequent studies on forms of support for survivors of suicide.

Data Collection

Qualitative data was collected through 30-70 minute semi-structured interviews with each research participant. The length of each interview varied based on the length of answers each participant provided. The interviews took place at various location which were decided upon between the researcher and each participant. The interview locations were mutually convenient places where the participant felt comfortable talking about this topic. Interview locations included both private and public locations. The researcher and participant found a semi-private space for the interview when meeting in a public location. Interviews conducted via Skype video calls and audio calls were conducted at the researcher's home on a secure network for participants unable or unwilling to meet for an in-person interview in the San Francisco Bay Area. Eight participants were interviewed in person. Participants who were not interviewed in person were interviewed via Skype video call or audio call based on the individual participant's comfort level and accessibility. Three participants were interviewed using audio connection only

and three participants were interviewed using Skype video call. All but two participants were located in the San Francisco Bay Area.

Each interview was audio-recorded using Mac OS X QuickTime Player on the researcher's laptop. The interviews were conversational in style, including both open and close ended questions. The first few minutes of the interview was spent reviewing the informed consent form, answering any questions about the study, and reminding the participants that they could refuse to answer any questions and that they had the right to withdraw from this research study at any time during or after the interview before April 1, 2017. Then participants were asked basic demographic information including, race, ethnicity, gender, age, relationship to loved one lost to suicide and the time passed since the suicide. The researcher used a list of interview questions to guide the interview as needed (Appendix A). The interview question guide was reviewed and the questions were pre-tested using an individual familiar with this topic prior to data collection. Each interview was saved as a separate file on the researcher's computer. All interviews were transcribed by the researcher and identifiable information was removed to ensure confidentiality.

Data Analysis

The researcher transcribed the complete audio recordings containing narrative data following the interview. Each transcript was printed and read in detail multiple times. The data coding was manually analyzed, observing both similarities and differences in response. The transcripts were grouped in relation to each interview question and then placed into categories based on the occurrence of emerging themes, phrases, and words. The researcher used a general inductive approach to research analysis to condense the data into summary format and to identify thematic links within the data (Thomas, 2006). Categories emerged directly from the interview questions. Outlier responses were categorized appropriately. All categories were refined and

participant quotations were used to illustrate the categories. Categories included access to resources, participant experiences with various forms of support, responses from others, and recommendations for improving support for survivors of suicide loss. All quotes were presented anonymously, keeping participants' identity confidential.

Chapter IV

Findings

The purpose of this study was to identify forms of support available to and utilized by survivors of suicide, to identify barriers to receiving support, and to gather suggestions and/or critiques regarding survivors' experiences with the supports they received. This chapter documents the findings from thirteen semi-structured interviews with individuals who experienced the loss of a loved one to suicide at least one year before the time of the interview. Interview questions were designed to highlight the voices and individual perspectives of these survivors. Interviews began with demographic information about the participants, followed by how participants accessed resources, and the various forms of support they utilized including: support groups, individual therapy, community responses, family, religion and spirituality. Participants were also asked for their recommendations on how to better support survivors of suicide. Due to the nature of semi-structured interviews, follow-up questions were asked that were not included in the pre-planned question topics. This data was included if the emerging theme pertained directly to the research topic. This chapter is organized as follow:

1. Demographic Data
2. Accessing Resources
3. Support Groups
4. Individual Therapy
5. Community Response
6. Family
7. Religion and Spirituality
8. Artistic Expression
9. Giving Back
10. Acknowledging
11. Self-Care
12. Education
13. First Responders
14. Recommendations to Better Support Survivors of Suicide Loss 15. A List of Resource Recommendations from the Participants **Demographic Data**

Data on the following characteristics of participants were collected: age, race/ethnicity, geographic location, relationship to loved one lost to suicide, and time passed since the suicide. A majority of participants identified as female (n=11) and two participants identified as male. Ten participants (76.9%) identified as white or Caucasian. One participant identified as black, one as Native American, and one as Asian. At the time of the interview, 11 participants were located in the San Francisco Bay Area, one in the state of Virginia, and one in the state of Maryland. Participants ranged in age from 25-82 years old. Nine participants (69.2%) were over the age of 45 years old and only one participant was below the age of 30 years old. Relationships to loved ones lost to suicide included: "ex-husband" (n=1), "husband" (n=1), "wife" (n=1), "friend" or "close friend" (n=2), "son" (n=2), "brother" (n=3), and "father" (n=3). Time passed since the loss to suicide ranged from 32 years to one year and one month. Most participants (n=10) lost their loved one between two and four years ago.

Accessing Resources

All 13 participants identified utilizing at least one form of support (informal or formal) to cope with the loss of their loved one to suicide. Most participants reported limited support from first responders, community members, and social workers in regard to being connected to resources immediately following the suicide. Participants were asked about the different ways in which they accessed resources, some participants accessed resources in more than one way. Each of the following percentages is out of the 13 total participants. Seven participants (53.8%) reported using a google search to research what types of supports were out there. Three participants (23.1%) were contacted by a friend, who was also a social worker or therapist, who provided at least one resource suggestion. Three participants (23.1%) utilized work or school benefits, searched programs for mental health providers, or were given information by a

coworker. Three participants (23.1%) continued with or returned to a therapist they had met with previously. One participant sought support from their church. One participant received resources from their loved one's therapist and utilized their insurance. One participant was contacted by a friend who also identified as a survivor of suicide loss. The majority of participants reported finding resources on their own and were unaware what resources were available to them. One participant felt that their health professional didn't know of resources and she has since been sharing resources with them.

Two participants (15.4%) reflected on how previous exposure to mental health services in their personal life made it easier for them to access and connect to resources following their loss.

> I think I was really active in pursuing help but a lot of my friends weren't as active. I've been around the mental health world for several years so I knew how to navigate it more. A number of my friends didn't know how to get access to those resources and I think also the cost is prohibitive for a lot of people to see a counselor.

One participant who chose to not share the cause of death with others in their community responded to a question about others helping them access resources.

> Who would help if you're not talking about it? If you're not talking about how he died then you're not going to get support.

One participant commented on how their geographic location impacted accessibility to resources.

> I think the access to support and the access to finding some group that is free of the stigma and that has developed a more mature opinion on grieving is a lot harder to find in a smaller place.

Support Groups

Support groups were identified as a widely used and helpful form of support with only three participants (23.1%) expressing little or no interest in utilizing support groups. The participants who did not utilize support groups noted that individual therapy, AA recovery meetings, friends and family, staying busy, and not wanting to talk about the loss were some

reasons for not seeking a support group. Among the 10 participants who attended a support group for their loss to suicide, several themes emerged in discussing the use of support groups including helpfulness, group structure, group leader credentials, connection to other survivors of suicide loss, and suggestions or critiques of their support group experience.

      Helpfulness. Nine out of 10 participants (90%) reported that attending a support group was to some degree "helpful." Responses included: *"somewhat helpful," "helpful," "very helpful," "excellent and helpful," "incredibly helpful," "immensely helpful,"* and one participant who attended several groups stated, "*the support groups- there are none that have been unhelpful*." Two participants shared about their positive experience of attending a support group.

> I didn't know anyone who had lost someone to suicide. I didn't really have anyone necessarily to talk about it with. I did a weekly group support and found that incredibly helpful. That opened the door to learning more about what's available, the healing process and emotions you might go through. I think realizing whatever you're experiencing, whatever you're feeling is OK for you to feel and there's no clear line to your process and you're going to feel all sorts of things. I think being able to speak out loud and share very personal feelings and emotions with people who are also just doing the same, it definitely provides a sense of, a different sense of, I don't want to say community but I can trust these people, even though we are complete strangers we can be really open and honest and raw with no judgements; it was a really safe place. That was huge for me.

> What I liked about the group is that they were asking questions. They wanted to create space for you to engage in conversation, talk about things that you may have a hard time talking about with other people or not know how to approach talking about it with other people. It made a difference just being able to know that I can be provided that space and that opportunity to talk because I felt that I wanted to talk about it and didn't know how to go about doing that with people.

One participant expressed gaining insights and information about suicide from attending the support group but did not identify it as being supportive for them overall. One reason the group was not helpful was due to a lack of people in the group who shared the same type of relationship with their loved one.

Group Structure. Nine out of the 10 participants who attended a support group reflected on the structure of the group. All of the participants who attended one or more support group attended at least one group specifically for survivors of suicide loss. Three of the 10 participants (30%) also attended one or more support group that was not specific to suicide. Below, three participants explain the group structure and how it was helpful.

> The group started off by reading a list of rules, partially explaining why we were all there and the confidentiality rules. This was kind of a ritual in itself. We would then go briefly around the circle, each person would say their name, explain who they had lost, when they had lost them, and how they had lost them. This group particularly liked to actually say how they died, not just suicide, but the specifics of the suicide, to kind of help people cope with what actually happened I guess. We would check-in about how we did the past week and we had a chance to bring up a specific topic or question we wanted to discuss, for example, how do I tell my kids about this.

> It was 10 weeks. It was a small group of people and everyone had a somewhat recent loss of a person very close to them. Actually, most people in the group it was a family member. Each session was themed which I found to be really helpful. It was volunteer led I believe and the coordinators were great. It was a peer sharing group and everyone just kind of talked about their experience and then shared their responses to the themes each week. There were also drop-ins you could do.

> It was harder than I anticipated. I thought I would go and feel comfortable immediately but it was definitely hard to share with total strangers at first. In the end, it was really helpful. I think having structure was helpful in feeling not so alone, normalizing it in a way, getting more comfortable talking about it.

All participants who attended both open and closed groups reported a preference for closed groups. Open groups allow individuals to join the group at any time while closed groups do not. When discussing how support groups were structured, several participants spoke about the role of the group facilitator and how the facilitator's experience and style impacted the overall group experience.

> The facilitators had a very clear set of rules that were aimed at making people feel comfortable and open and ensuring that everyone that was there wanted to be there and so there were no guest supporters in the room that were just kind of listening to everyone else but not contributing.

One participant who attended multiple support groups compared two experiences and described

how the group structure and facilitation was influential in her overall experience.

> I was in a survivors of suicide loss support group which had four to five people in it. The demographics were very different from me. Everyone was pretty much over 50 and almost all of them had lost a child a long time ago. I wasn't able to relate as much to the demographics and also the group was run a little bit awkwardly. It wasn't run by a psychologist that knew how to run the group so there was a lot of weird moments where people felt uncomfortable that were not really addressed in a way that I would have addressed them knowing what I know now I guess… Then I found a really good support group here that I was in for about three months. That group had much more diverse demographics and diverse types of suicide losses. There were more concrete rules, you weren't allowed to have anyone with a couple, confidentiality rules were spelled out very clearly and we all had to read them in the circle before we started which made everyone pretty comfortable. The group was very well organized. It was run by two people who were trained psychologists who had both lost someone to suicide and decided to start the group because of that. It was really a much better group and I found that group to be really helpful for the few months I decided to be a part of it.

Connection to other Survivors of Suicide Loss. Nine out of the 10 participants (90%)

who attended a support group highlighted the benefits of connecting to other survivors of suicide

loss. There was an emphasis in participant responses about the specificity of this type of death

that is difficult or impossible to understand for those who have not personally experienced it.

Two participants describe this below.

> I think you can get tremendous comfort from talking to other people who have been through this because it's so unique and people can really help each other. The group, I don't see them regularly, every couple of months or so they will get together for dinner, it's not all doom and gloom and tears; we can laugh and we can have a lot of fun together and that's important. You can feel the pain and have the pain but there are still these moments of life and joy and laughter and humor. That's really important or else why get out of bed in the morning? It's hard, it's really hard.

> The best part of it was being with other people who had been affected by this. That just completely got what it was, what it felt like. Of course it's different for everybody but it's such a different kind of death that I think unless you have been touched by it, you don't truly understand how it feels. I think just being with other people, I felt a real sense of connection and closeness.

Individual Therapy

Ten participants (76.9%) utilized individual therapy at some point following their loss. Three of these 10 participants worked with an individual therapist they had previously been connected with. When asked to describe their experience with their individual therapist one participant expressed a positive experience.

> I think it was mostly that I had an existing relationship with her and felt very safe with her so talking about the suicide was easier because she knew my life pretty well.

Another participant who had been connected to their therapist for about 7 years shared the benefits of working with their therapist.

> I saw her three or four times after he died because she had all the history and the back story; she had even met him once. It was really helpful that she had all the family history. I wanted to continue seeing her because I knew her so well and felt so comfortable and safe. She knew a lot about grief. She could remind me of things that I had forgotten about from the past and situations where there was a lot of chaos and a lot of kind of frightening stuff, she could remind me of things and give me some perspective.

The existing relationship with a therapist seemed to benefit participants who returned to or continued with their individual therapist, however, one participant expressed a desire to have worked with a new therapist who specialized in grief or suicide loss.

Seven participants sought out a new individual therapist following their loss. One participant ultimately chose to not follow through with individual therapy.

> It's interesting, I did call, I did make an appointment and I didn't go. I just, every time I talk about it, I cry and I didn't want to cry anymore. I don't know if I would have benefitted if I had actually gone to that appointment. I don't know if anything helps you get over it but I don't know because I haven't tried it. It doesn't feel it's for me because I just can't imagine what they are going to offer me. I don't know what you can offer someone. I'm coping, I'm managing, it's not like I'm not coping so I don't know.

Participants who met with a new therapist (46.2%) had a range of positive and negative experiences.

I went, I liked her, I liked talking about it with her. She helped me work it out. I think one thing she helped me with is that feeling that I messed up, I should have been able to prevent it, I could have changed things. She helped me see how unlikely and how unhelpful that is. Where it comes from, most of my life being able to accomplish what I set out my mind to accomplish, being powerful. I don't think I'm all powerful but that's perhaps misguided that I have the power to prevent things from happening. That's helpful but when that's done I still have a dead son.

Every time that I think I've done my healing in regard to this, I find that there's just more layers to it. I'm in a much better place than I was five years ago and I can say that I'm happy and doing well but I think I'm always uncovering different ways that his death or even before his death has impacted me as a person and the things I struggle with or what I want to work on myself. Definitely a lot of individual therapy.

One participant who experienced their loss when they were a child, sought therapy almost ten years after the loss and they reported that they currently see a therapist.

The suicide is not front and center in the therapy but it's something that does come up just because my family of origin, it's still an issue in my family of origin. You would think 30 years later it wouldn't be but it is.

Two participants discussed negative experiences with the individual therapist they met with to cope with the loss of their loved one.

The first person that I talked to, I really felt uncomfortable with. I was pretty mad about it. She clearly had no clue about anything related to suicide. For her, what was going to happen in therapy was I needed to accept that my dad made this choice and that it was a good choice and things like that. I felt, you know, I can't. I don't see it that way. I didn't feel what she was going to provide me was going to help me in any way. I kind of hate the word 'accept'. Maybe you do eventually accept it in some capacity. I prefer the term 'coming to terms' with it because it's not something you can accept, really. After having dug a little deeper into the literature on suicide, I see it much more as him having lost his battle to depression and this is what happened, that's what that can look like. It's much more a tragic consequence of a disease that is very misunderstood and this is one of the possible outcomes of that. For me, there's no accepting because you can't accept the things that happen, the way I think the medical community handled his case, and him even arriving to that point if you do consider it as a choice, it's not an acceptable thing. I had a lot of issues with the whole accepting and loving the fact that he took his own life. No. I think that's one of the unfortunate things about suicide, it is so misunderstood. I don't know if in this therapist's case it was necessarily stigma but I think not knowing. I think it was just ignorance really. While it may be fine to accept somebody has cancer, the violent act of suicide is something, it's just not the same.

30

I saw two people about this. The first therapist that I was going to, I kind of had a bad experience with her. I saw her for probably six months. When I would talk about my father she would often use the words, something very similar to "what your father did was very selfish" I think maybe she had well intentions but I think it is not a very appropriate thing to say. I almost felt defensive for my father because I don't know what he was going through, what he was dealing with, what he was thinking and neither does she. I don't think it's fair to say what he did was selfish because we don't know the mind state and how bad it was and what he felt. Honestly, I think I felt more compassion and sadness for my father. I haven't really felt angry with him necessarily. So, to have someone tell me your father was selfish, just I think was hard and not the approach that I needed. It didn't really add anything to my healing process. I didn't feel she was sensitive to the topic and really understood or knew how to deal with that. She didn't have any experience with suicide survivors so I think perhaps it's just she had never come across something like this, I'm not sure how much suicide specific training there is when people go to be psychologists and therapists. That therapist didn't work out.

One participant reported that they met with two separate individual therapists for two months each but found that this form of support was not for them.

Community Response

Participants were asked about the response from community members including friends, acquaintances, and strangers. A large part of community response was filtered through the lens of the stigma the topic of suicide holds. This section includes a subsection on experiences with stigma. One participant did not expect the response she received after opening up about being a survivor of suicide loss.

I was surprised too that after I started talking about his death, there were a lot of people that I knew that if they hadn't experienced it themselves, knew multiple people who had been impacted. It was like wow, it's this whole silent society. We are just walking through life, not talking about it. Something that has clearly impacted a lot of people in a lot of different ways.

Two participants expressed gratitude for their community.

I remember walking on the street and three of these acquaintances came up to me and they asked if there was anything they could do for me. I said they could help me decorate for the memorial service. I found a lot of strength through my community. They came

together and just gave their time and their effort. I did not feel alone in that respect. I was so grateful they did that for me. It was like a gift.

There's something to feeling that you're a member of a community. That is, to me, a warm enveloping protective shell. I think the communities are a way of just being held in society and knowing that it's there, the collective might not be what the person particularly wants but to know it's there.

Two participants had common experiences of feeling that they were burdening others by sharing about the suicide death.

I do feel when I've talked to other people, to a stranger on the street or in an AA meeting, sometimes I just won't mention that because not wanting to make the other person uncomfortable which then makes me uncomfortable. In the first year or so when people ask how you are, people just want to hear 'fine' or 'good' or 'OK'. Seems like they don't want to hear it.

What use to happen when I was younger, I would tell people and they would be like "Oh my gosh, that's so terrible," "I feel so bad for you," or "oh my gosh! That's so awful!" Then I would feel bad for telling them. It was almost like it was hard for them to digest. And I was like yeah, I know. I almost felt like it would've been better if I hadn't told them or told them a lie or something like that. Now, I'm much more kind of straightforward about it.

Three participants reflected on people offering support but either not following through due to falling out of contact or waiting for the survivor of suicide to reach out for the support.

The things people have said to me over the time. In these groups, you could probably have two whole days just devoted to stupid things people say, even though I know they mean to be helpful. Also, I feel like people have avoided me since then. People say, "if there's anything I can do let me know" and then you don't hear from them for like three years and that seems to be pretty common.

One participant shared about specific comments that were particularly unhelpful.

Things that people said like "it will get better with time," or "everything will be OK," "time heals all wounds." Those statements were extremely annoying because they don't address the present. They address some sort of arbitrary future in which you have put your life back together.

Experiences with Stigma. The research participants were asked directly about their experience with stigma. Six participants reported feeling directly impacted by stigma while

seven stated they did not directly experience stigma. Two of the seven participants who did not

directly experience stigma shared that they did not share that the death was a suicide death with

others outside of family which protected them and their loved one from the stigma. One

participant passionately explained his decision to not share about the suicide due to stigma.

> To protect her. She's my wife. There's such a stigma behind it. I don't want people talking about her like that. She fought so hard. She utilized programs, recovery houses. She tried so hard. People think she took the wrong way out, she could have been stronger. No. She was strong. Incredibly strong. To continue until the last gasp. That's a fucking strength. She fought long and hard. She deserves better respect than her name being associated with 'oh, she just gave up.' She didn't. For a long part of her life she was fighting this. There was just no other way. I'll protect her until the day I die. There's a stigma. People at groups would say, yeah, people know about this and they treat me differently. I'm like well, it's not really me I'm worried about. It's not about me. It's about protecting her. I just get upset like, oh this person won't understand, but I'm not letting them understand. But they don't have to know what happened and in the end, I don't need everyone to understand, just a core few.

Eleven participants identified the underlying stigma around suicide that exists in our society and

can have an indirect effect on people regardless if they felt directly stigmatized as a survivor of

suicide loss.

> The reality I guess is different than what's in my mind. The reality is people have been supportive. When you say someone died of suicide, that's what they concentrate on, at least in my mind, that's what they concentrate on. It took me probably a couple of years to open up at church other than the minister. It's probably been in the last year that I've opened up to coworkers. I got no negative feedback. At first, I didn't know what to expect for feedback. I didn't want his death to be the focus of his life, I just didn't want to talk about it. The suicide.

Three participants openly talked about stigma within themselves regarding the topic of suicide.

> Personally, before I experienced it myself, I was like well, you know, suicide can be a cop out. It's a lot easier to kill yourself and leave everyone else holding the bag. Now, I would say it's much more complicated than that.

One participant explained how the stigma was more directed towards her loved one and
specifically mentioned the stigma towards substance use and addiction.

I think I experienced more stigma towards her. I think that made me really angry, people looking down on her in a way or just seeing it as a negative thing she had done. Some people refer to it as 'people die by suicide', it's something that happens to people and it's not necessarily something in their control. I thought that shift in thinking was really interesting to counter the stigma. I think there is a lot less empathy when drugs are involved too.

Family

Twelve participants discussed the complex role family had as a form of support or a lack of support after the suicide death. Just as the individual experiences in this study represented a range of unique and specific experiences, the family interactions or lack of family interactions were meaningful in different ways for each family and each family member. This study included daughters, husbands, sisters, wives, and mothers. Each type of relationship is worthy of its own attention and research. One participant expressed a desire for family therapy and one participant shared about a negative attempt at family therapy with her mother. Six participants touched on how this loss has led to their family becoming closer or communicating more openly. Two participants referred to this change as a 'silver lining' while others found great comfort in focusing on the connection with the surviving family members. One mother stated for her it was best to take some space.

I think I needed to get away from the family as the matriarch. I don't think they had a chance to do their own grieving because they were worried about me and I needed to not have to think about who is thinking about anything.

One sibling talked about the need for research on the loss of a sibling.

I think in general, it's important for people to understand that siblings, the loss of a sibling is very significant. At least from my own personal experience, not knowing other siblings, not having talked in depth with other siblings who have lost people, to make the assumption that a parent's grief is more important or more significant or a spouse's. It would be nice for there to be some data on how siblings feel and why that relationship or why those relationships are important.

Another participant emphasized the importance of not comparing grief among different family roles and of eventually discussing this traumatic loss together.

> I think the biggest challenge was with my immediate family. For me, I realized everyone was in a different space and it was a shock. It was a violent death, everyone was sort of in their own reality and their own space. Ideally, it would have been nice to be able to express yourself without people getting upset and freaking out. I tried to work through that and understand that a little bit more with my therapist. I would have preferred if we could have talked about it as a family, in a rational manner, that clearly wasn't going to happen. It still hasn't happened to this day. It's not that his death was swept under the carpet, it's just that we aren't talking about the hard stuff… If there's something that I would tell people that is important it's 1. Not to see grief as a competition and 2. Really be able to talk about each other's losses at some point. Maybe not right after but being able to acknowledge that everyone has suffered a loss, being able to talk about it as a family unit is really important.

One participant remembered how the loss led to hurtful interactions.

> In my family, there was a lot of, I don't want to say cover up, but denial is a better word. It wasn't really something that was dealt with out in the open or honestly. I think there was a lot of difficulty with it and so, it wasn't dealt with in a constructive way. It was more sort of like people would be pointing fingers or blaming and shaming, not being productive about it.

Two participants called attention to the need for support for difficult relationships, providing a reminder that sometimes hard feelings exist for the person who dies by suicide which can further complicate grief.

> I think what I really struggled with was coming to terms with losing someone to suicide that I've had a very difficult relationship with. I think that adds another layer of complexity around it. I had a really hard time for a very long time being able to say aloud and feel OK without not feeling guilty about talking ill of someone who had died, to just say my father was not a good father. I think a lot of support is focused around the loss and the good memories, which is great, but I found it really hard to be in my position and say I lost this person, I'm feeling all of these feelings, but I'm also feeling all of these other feelings about who he was as a person. I felt alone in that. How do you go about dealing with that? Who do you go to talk about them?

Two participants acknowledged the differences among their family members and their ability to respect those differences.

> I didn't really find talking about it a whole lot of help. I really didn't talk much about it. Some of my family members don't talk about it at all and others are very involved in suicide prevention. It's different strokes for different folks.

> It was very challenging to decide what to do for holidays or things like that without triggering anyone, especially because we came at it from completely different perspectives.

School and Work

Participants who were in school or working at the time of their loss were asked to share about support they received or that was lacking. Six participants shared about their experience with their job or school. Four participants reported positive experiences in which their place of employment or education was extremely supportive and responded very well. For some, this included extra time off, approval to work from home, flowers and food, support at a suicide prevention walk, and even a paid flight home. A theme that emerged around experiences with work or school was the amount of time taken off to grieve. Two participants, both students, spoke specifically about the pressure they felt to move on not long after the death.

> I think not taking enough time off wasn't a good idea. I was in grad school and it was really stressful. I thought about dropping out for the quarter and then I didn't and I think maybe I should have done that. I think the reason the grieving was so much worse was that I just didn't take maybe a couple of weeks off and just really try to sit with it at the time. I think that's maybe the only thing I would have done differently. I didn't really bottle up or isolate myself, I was pretty communicative and I did talk to a lot of people about it. Maybe I would just try to have a lot more protection for myself in school and work and just been like I need time, you know, as where I talked to my professors about it a little but I don't think I asked for as much as I needed.

> The bereavement policy was not clear. I guess as a student, as a grad student particularly, how much time can you just stop working? You're not paid by the day, you don't have to report your hours. There wasn't really an expectation of whether or not I could take time off so I didn't take any time off except for two days to go to the funeral. I really probably could have used a month of not being there and not doing any work. So, the major lack of

communication and lack of policy and standard procedure was not helpful because I went into my default of just trying to please everyone else around me. I'm just going to get back to the work and I'm just going to pretend to be ok. Sort of. There's definitely a lot of societal pressure to be over it in two weeks which is completely unreasonable.

One participant moved due to the unsupportive environment in which information about their loss was shared with co-workers without their knowledge and the response from others was disheartening.

People would look at me and nobody brought it up. Other people wouldn't look at me or completely pretended nothing happened. There was zero acknowledgement and I actually ended up hearing people talking about me multiple times, it was never anything bad, but no one actually wanted to talk to me.

Religion and Spirituality

Participants were asked if and how religion and/or spiritualty played a role in their coping after their loss. Eleven participants reported religion or spirituality did play a role and two participants reported it did not play a role in their healing.

Religion played a role for five participants. One participant identified as Christian, one as Catholic, one as Jewish, and one attends a Unity Church. One participant reported not being religious but found visiting churches and praying helpful. Three of the five participants reported a negative experience of religion and two reported a neutral or positive experience.

I'm not religious. Religion did play somewhat of a role maybe in a lack of support because I know that a lot of people were afraid of the stigma that suicide has in Christianity as being something you go to hell for. So, there was a certain degree to which my parents, especially, were very unwilling to let me announce in any sort of way how he died. So, the only way people found out how he died was in individual personal one-on-one conversations with me. I didn't really get to advertise for support very much because I couldn't really announce what happened in any sort of public way or with any sort of broader scope. I think it was partially just out of fear of the stigma. It comes partly from our culture but also from the religious roots of our culture which to some degree claim that suicide is a sin. I think the more updated, more liberal religious groups don't promote that anymore but it definitely is there.

Spirituality played a role for six participants, all of which reported a positive or neutral experience.

> I don't go to a regular church but I believe there's a higher power above me and this is a lesson. Not that this had to happen to be a lesson but it's a lesson in attachment and detachment and how to detach from someone else's behavior and still love them. I've done shaman work and circles of the four directions and all of that's in my history but I never had to practice it as hard as I had to practice it this time.

> I'm not religious, I guess I have a spiritual dimension to my life and it did play somewhat of a role. I think I had a number of dreams and kind of visions, more or less, that were very powerful and had to do with her and made me feel like I was still connected to her in some way. That was helpful.

Two participants expressed some desire to have religion in their life following the loss of their loved one even though this was not part of their beliefs.

> I've been on the fence about what exactly I believe in. I think I struggled with not having faith at the time. I think I really needed it. I think it would have brought me some comfort to feel like I know he is still here with me, I know he is in a better place, but I didn't necessarily believe that or know what to believe and it definitely made it harder.

One participant shared about their cultural beliefs when asked about religion.

> I'm not religious but I have a way of life that I've kind of fallen away from. I'm Native American. I believe in a creator, there's a balance in nature and earth. There are ceremonies I participated in, strong ceremonies. We've been doing them for 100s of years. Not secretive but not anyone can go. Powerful. It's called *Wiping The Tears*, a ceremony you can have after a year of your loved ones passing. It's for community healing. It helps you to accept, to release their spirit. This is where I falter because I still use her name a lot, I speak her name, I think of her every day.

Artistic Expression

Seven participants (53.8%) reported utilizing artistic expression as a form of support. Participants described several forms of artistic expression including, writing, poetry, painting, photography, knitting, and music. Seven participants reported artistic expression was a form of support and six participants reported it was not. After sharing a beautiful poem written about the

loved one they lost to suicide, one participant shared a specific experience in which writing had

helped them.

> I may have written a lot about him but that was the one when I woke up in the middle of the night and I said, "I want you back," put it in the poem. I had this voice talking to me, like, this is what you do with this, this is how you handle this pain, you write, writing has always been cathartic for me, even as a child.

Two other participants shared how art and self-expression was used to support them after their

loss.

> Art is a visual interpretation of what you are feeling and thinking. I think for me, personally I didn't really feel like doing a lot of art even though I'm a pretty active artist, immediately after. I think about a year after or a little over a year, I started getting back into painting and my focus really was painting all of those residual feelings. I think there's this human desire to talk about the stuff that hurts us or pains us and that's part of the healing process. That's kind of how my art has helped me.

> I carry a camera everywhere I go. I take a lot of pictures. I take a lot of pictures of San Francisco, even the kid sitting on the sidewalk shooting heroin. I'll publish it and I don't know if that helps but he was a heroin addict. I don't necessarily like it but I think it affects people in a great way. I like to photograph it and make a record of it in an artistic way.

Giving Back

Six participants identified giving back as a form of support. This included raising

awareness or money for suicide prevention, volunteering on the suicide hotline, participating in

suicide prevention walks, participating in this and other research studies, facilitating support

groups, contributing to search engine effectiveness, and sharing their story on the air. One

participant shared their experience participating in the American Foundation for Suicide

Prevention Overnight Walk.

> I did the overnight walk with AFSP last year. That was really good. I basically walked 7 hours overnight with a thousand or so people. I had conversations with a bunch of different people while I was walking through San Francisco. That was a good opportunity to feel like I was doing something to help and also to feel like I wasn't totally alone. There were another thousand people there who had been through something

similar to what I had been through. It was just really nice to see all of these people coming together for the same cause and to see people talking so openly about it.

Three participants expressed the importance of giving back.

I feel much stronger in the situation than I did before. It hurts but it's not overwhelming. I care about other people getting support and participating in this conversation even though it's hard.

I think for me what feels good about giving back is I really deeply believe that if something would have been there, some connection, way of connecting, or easier way of connecting would have been there for my dad, it would have gotten him through that moment and that's usually what it is. It's usually just this moment. Certainly, you have been thinking about it for a while but it is a moment of impulsivity and if you can get people through that moment they can live another day and perhaps go on to never even, not necessarily not think about suicide again but never make another attempt in many respects. So, for me I think that a huge way of giving back is just what can I do to help more people get through this moment, whatever moment it is that they're struggling with. Maybe they'll wake up tomorrow and it will be a little bit different.

I think that being able to talk about it and participate in a study like this actually helps me feel like I'm contributing to being a part of the solution for this bigger problem. I want to make sure that I can get out there as much as I can and talk to other people and be supportive. I'm still struggling with the loss myself and still have a lot of difficult days but ultimately, I think that I'll only continue to find a way to contribute to fix things, the bigger problem which is really the issue of suicide itself which in many ways is grounded in our society's unwillingness to fully address negative feelings particularly mental health issues and our society's struggle with properly dealing with grief.

Acknowledging

Six participants specifically referenced how an acknowledgement of their loved one through celebration of their life, engaging with activities they enjoyed, rituals, totem poles, keeping their loved one's ashes and visual reminders have been forms of support for them.

When it happened a number of her close friends and I got together and held a memorial and a number of different rituals. It was really helpful to process things, just coming together obviously was a shock so, I think just being in proximity and everybody spending time close to each other was really important. We just shared a lot of memories and shared a lot of things we loved about her. I think it was nice to have them sort of jog my memory about things like music she liked, or authors that she liked. It kind of felt like I was reliving her again through them and that was helpful and I think seeing everyone process it in their own way was really helpful. You know, to see the full range

of emotions that came along with that and letting people express all the different things they were feeling and kind of talking it out as a community made it feel more real I guess. It made it seem less, I don't know, other worldly or something... We shared a lot of photographs, she was an amazing artist and fashion designer so we ended up kind of collecting some of the things she had made and doing a sort of show at her memorial. I really decided that I wanted his memorial service, not to focus on just suicide, or just on alcoholism, or he was bipolar too, but I didn't want to pretend that stuff wasn't there. It was a real balance of celebrating who he was when he was his best self and also acknowledging these issues that he had and the reality of it, that so many people have.

One participant contacted the researcher after the interview to add that they have recently begun doing activities that their loved one enjoyed and that they also enjoy. The participant shared this helps them feel closer to their loved one sharing the following statement.

I know this can be painful for some people, and while I feel nostalgic that I can't share it with him, doing it brings me immense joy.

Self-Care

Eight participants expressed how their personal self-care has been an important form of support. Six participants mentioned their own personal struggles with mental health. Self-care activities included taking psychiatric medications, being physically active, getting out of the house, connecting with others, being around animals, and moving away from an unhealthy environment.

Being active physically, very helpful for me to feel good. Getting out of the house, not isolating. It's sort of like, it's almost like homework, one more thing I have to add to my day, like flossing. Get together with someone for coffee, get out into the world. Getting out of the house is great. Going back to work but not too soon. And being able to say things like "I'm taking next Monday off because it's my son's birthday" or "it's the anniversary of his death" which is really hard.

Education

Nine participants talked about how learning more about mental health, suicide, and grief was a helpful part of their own healing process. This included research, books, taking classes, attending workshops, and watching Ted talks.

What I learned is with loss, it's not a linear thing, that stages of grief don't always fall in the same progression, just that notion that it's not this linear process, that it can take longer than six months, and on some level, it's always with you, it doesn't just disappear and so then you can know it's not just me but that this process takes a long time.

First Responders

Two participants reported an interest in talking with the medical examiner to know details about their loved one's death. One of these participants felt a strong need to see her son's body and reported that the experience was healing.

Recommendations to Better Support Survivors of Suicide Loss

Participants were asked specifically about recommendations for better supporting survivors of suicide. A majority of participants spoke to the lack of awareness of suicide in our society. Participants experienced this in their interactions with others, while accessing resources, on social media, and in forms of entertainment.

I think for me, the thing I struggle with the most is the lack of education. I really feel in a lot of ways, indirectly, a lack of caring from the community. When you say you have been touched by this directly people will change their responses but the general consensus is we don't care about this issue. It's a non-issue in a lot of ways. I think that's something that's difficult about trying to raise awareness. It's just getting or trying to get that message to more people.

I think I was just really struck by everyone's inability to know how to cope and the total lack of cultural awareness or tools, even in people twice my age. I found that when I tried to talk to most people about it, you know when it wasn't in a specific grief context, in general people don't have a common language or understanding about how to even really talk about it and that bothered me. It was a really disturbing experience, I think I was just as disturbed by people's response to it as I was by the actual suicide. Not knowing how to talk about it but also just kind of brushing it aside or talking about it in a way like it was inevitable. I think people want to distance themselves from it as much as possible and not really think about their relationship to it.

I think there's that, it's just, to me, it's this constant struggle with watching TV or whatever, it's just like, when you watch these cop movies or whatever and I love a good detective story but when they're like this person couldn't have killed themselves because they didn't leave a note and it's like that actually rarely happens, very rarely happens. It just kind of perpetuating these really big myths about suicide that I know I carried myself

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and don't help, they're just not helpful to people. It's not going to help anyone that's struggling, it's not going to help them respond better to survivors.

I think growing up, you hear about it or maybe see on TV or in movies but until you've lost someone, it's hard to describe. It's a topic that people are aware of but its not a topic that people necessarily want to talk about. I will say that since losing my father to suicide, I'm way more hyperaware about suicide references. They make it lighthearted and I view it in a very different way.

Some participants shared insights they have developed around this experience that could be

helpful for others to be aware of.

Not everybody can help during a mourning process. Not everybody can help. The one thing I learned is that to grieve means that I have loved. So, when I'm grieving it's just a form of loving because I would not grieve that which I did not love…Grieving is like a virtue, it means that I have loved. Before I saw grieving as sorrow, sorrow, sorrow but then I was able to get to have this sorrow but to flip it over and see that you have sorrow because you loved somebody. That seems to be comforting to me when I grieve.

I guess the whole grief thing can just hit you when you're not expecting it. I started tearing up and it was like this wave that comes over you and you feel like it's going to pull you under and you have to tell yourself that it's not.

I've always known that mental health is a very important topic but I think having lost someone to suicide has just made me more passionate about the fact that we as a society need to view mental illness the same way that we view physical illness and that we need to be giving more resources, more attention to mental illness, it needs to be more accessible and more affordable for people. It's made me very much aware of the lack of resources that we have and the kind of stigma we have and the kind of judgements we make about people who struggle with this every day.

I would say it's not really helpful when people kind of use guilt. I think after something like this people feel a lot of guilt. Different people feel guilty on different levels for different things. My parents were going through a divorce. At a time, I sort of blamed my mother because I felt like if she wasn't divorcing my dad then maybe he wouldn't have killed himself. That sense of guilt I placed on her was not very helpful but it's probably a natural reaction that you need somebody to blame. I would say try not to guilt people. Instead of projecting hurt feelings on other people, try to deal with the feelings themselves.

I think people make their own path through it. It's not right or wrong, normal or abnormal, it's just what they do, their process, it's what makes human beings, we're all so

much alike and we're all somewhat unique. It's that kind of stuff that makes us unique. I try not to tell people how they should feel or how I should have felt.

While other participants provided specific recommendations or issues they wanted to shine light on.

> Talking about it, taking away that mystery, that secretiveness, that stigma. That is really important.

> I think there needs to be a community based effort to provide more support, not just for suicide survivors, but for people who are really struggling with mental health and don't have support. I think if she had community based support it wouldn't have happened. I don't appreciate people talking about it as if it is inevitable. Even though it is hard to carry, I feel we are responsible for each other. Yeah, I think people if people aren't around mental illness or suicide, I think it's easy to just not think about it, there's an alienation that happens for people. I think somehow trying to get more resources from the government, or if they aren't going to provide them then I think just figuring out how to self-organize to support people with mental health problems is really important.

> I'd be curious to know what their input was if there were more men in the support groups. Is there a macho thing that I missed out on? Or I'll hunker down, I'll get through this? There might have been two guys there but if there was another, that might have made it a little more helpful, at least more than two. We all learn from each other and people's input and hearing their input.

> My basic list is that when something bad happens to another person you should acknowledge it and then you should show that you care and then you should do something to help.

> I don't know, I just felt really angry that there wasn't a better conversation about the pharmaceutical industry or her therapist wasn't held accountable and I've really struggled with what to do about that.

> I think some sort of training for manager and bosses and people who have anyone else working under them would be really beneficial for this kind of loss because their response pretty much ruined my entire experience there and I was miserable for the entire year.

> I think it's really good for people to know that there are free resources available to them. I would also say that if there's any way to reach people who are minors, kids, anyone under 18 that would be really good because they are probably affected by it too. Maybe through their schools, school counselors, or school therapists, or social workers. I think it would have been better if I had been encouraged to see the school counselor on a regular basis, someone should have encouraged me.

I would have loved for my friends to ask the questions, to not just say "Hey! I'm here if you need me" because I think that can be very hard for someone, especially if you're not outgoing. It can be very hard to say "Yeah, actually I do need you". Instead, ask questions that provide a dialogue. Whether that's "What have you been feeling?", "What have you been experiencing in your day to day?", I think just asking questions. I love the love and support but at a time like this, I think it's not enough.

I guess just talk about it as much as they can, try to work with grief in multiple ways. Art can really help with grief. Just be gentle with yourself. I was surprised by how long it took me to integrate it or deal with it and maybe not having some expectation that you're going to be over it in 6 months. I think just around a year is when I started feeling better about it, or not better but accepted it and realized it was real. I think the main thing I've struggled with is how its affected my life more broadly in terms of pessimism and cynicism. I don't know how to turn that into advice. Try to be mindful of not letting it bleed into other areas of your life or trying to have more boundaries around it. Maybe that's impossible, I'm not really sure, I haven't figured out how to not let it really affect other areas of my life. How I view my life, it's really changed my perspective in a lot way, I wish I had more support around it I guess.

Resource Recommendations

Some participants named specific resources that were helpful for them. Below is a list of these resources that others can access although some resources are only accessible in a specific location. They include places, activities, and reading materials.

1. Death Dinners

    It wasn't focused as a grief ritual because it wasn't as personal. It was just general topics about death. I really appreciated she was holding a space like that for people and it didn't cost money, it was just community driven. It can be found online.

2. Sacred Grove Grief Retreat on Bainbridge Island near Seattle

3. Kara Organization in the San Francisco Bay Area

4. The Compassionate Friends Non-Profit Organization for Grief – Offers more than 660 meeting locations around the United States and they also offer international support in Australia, Belgium, Canada, France, Germany, The Netherlands, Philippines, South Africa, Switzerland, and United Kingdom.

5. Institute on Aging Grief Group in the San Francisco Bay Area

6. Hospice by the Bay in the San Francisco Bay Area

7. San Francisco Suicide Prevention

8. *After Suicide Loss: Coping with Your Grief* by: Robert Baugher & John. R. Jordan. Another
9. *SOS: A Handbook for Survivors of Suicide* by: Jeffery Jackson

10. Work by the author: James Hollis

11. Poetry by: Gregory Orr

12. Facebook support groups for survivors of suicide

13. Sheryl Sandberg article on Husband's death although not about a suicide death

Summary

The findings from 13 semi-structured interviews with survivors of suicide loss regarding forms of support were presented in this chapter. The findings suggest there is still a significant need for increased awareness and education about responding to and supporting people impacted by a suicide loss. The interviews revealed specific challenges and recommendations the 13 research participants faced in their experiences accessing and engaging with forms of support for their grief and bereavement process. The following chapter will discuss key findings in the context of the literature and will offer interpretations of the findings. The strengths and limitations of this study and implications of these findings for both social work and future research will be addressed.

CHAPTER V

Discussion

The objective of this qualitative study was to explore forms of support available to and utilized by survivors of suicide, and to find out how survivors of suicide would like to be better

supported. While many of the forms of support participants discussed were also found in the literature, additional forms of support, as well as, in-depth and personal narratives were given throughout the interview process that further illustrated the various needs of this population. The interviews emphasized how coping with such a profound loss can be a unique experience for each individual; and there can be significant similarity, indicating that survivors of suicide are not alone in their grief. This chapter will discuss the key findings presented in the previous chapter and describe the relationship between the study results and previous research. This chapter also presents the study's limitations, suggestions for future research, and implications for clinical social work.

Key Findings

This section explores the results of this study in the context of the existing literature on survivors of suicide loss. Due to the exploratory nature of this study and the wide range of supports discussed with research participants, this section will not discuss all of the data generated by this study. The information will be discussed in the following order: Formal Supports, Informal Supports, Challenges, and Recommendations.

Formal Supports. The formal supports discussed in this study included support groups, individual therapy, family therapy, and first responders. The results of this study showed that the majority of participants utilized support groups, with a preference for the closed group structure geared specifically towards survivors of suicide loss rather than general grief. This finding was in accordance with several studies indicating that support groups are commonly used by survivors of suicide and are reported to be helpful, although the effectiveness of this form of support has not been sufficiently researched (Cerel, 2008).

Most participants in this study identified that a connection with other survivors of suicide loss was one benefit of attending a support group, emphasizing the uniqueness of this type of

loss. This finding reflects Feigelman's (2008) study in which he applied Shulman's mutual aid theory to suicide survivor support groups to show how the use of groups can help people gain support through what he calls the "All-in-the-Same Boat" Phenomenon.

> From the very beginning of the meeting a clear linkage of common experience is established. Thus, in the suicide survivor support group, people find they are not alone. The shock, isolation, stigma, and confusion impacting on every part of one's life – from the inability to perform simple daily routines to the loss of one's total belief system—all is shared (Feigelman, 2008, p. 292).

Participants who attended at least one support group found the experience to be at least 'somewhat helpful', however, there were some aspects of support groups that could be improved. Several participants called for an increase in support groups in general and an increase in support groups for specific types of survivors of suicide. Participants requested relationship-specific support groups due to the ways in which the type of relationship with the decedent can have an impact on their grief. Specific types of support groups could also help survivors of suicide better relate to one another. One male participant, who represented a minority among the participants, questioned the apparent gender discrepancy among members of the support group he attended. His voice highlights the need for a shift in societal norms and attitudes toward being more accepting and encouraging of males participating in and receiving forms of emotional support. This issue has been prevalent throughout previous research on survivors of suicide as studies have included mainly female participants. This discrepancy could be an indication of how gender plays a role in a person's comfort level to reach out for support after experiencing a loss to suicide.

The participants who located a new individual therapist had experiences ranging from very positive to very negative. This finding possibly points to different levels of professional training for mental health providers on working with survivors of suicide and on the nature of

grief and bereavement for this type of loss. Sanford (2016) found that some individual therapists were not aware of and therefore, not properly assessing for and treating PTSD symptoms in survivors of suicide. Assessment, diagnosis, and appropriate treatment of PTSD symptoms were associated with satisfaction levels with individual therapy among the survivors. Sanford's study highlighted the need for therapist to be well informed of all the nuances of grief connected to a suicide death.

> "In addition to the traumatic aspects of suicide bereavement, therapists must develop knowledge of unique reactions experienced by loss survivors…Therapists need to be attentive to the emotions commonly experienced by loss survivors to adequately address those reactions. In the multivariate model, the significant predictors of perceived benefit of therapy were the statement endorsements concerning the therapist and therapy experience, suggesting that therapist who responded to the unique aspects of suicide grief were perceived to be more beneficial" (Sanford, 2016, p. 556).

Few participants discussed interactions with first responders and none of the participants reported being given resources by a first responder. This is an area that warrants increased attention.

Informal Supports. The informal supports discussed in this study included responses from the community, family, work and school, religion and spirituality, artistic expression, giving back, acknowledging, and education. There has been insufficient research on the use of informal supports for survivors of suicide. Findings from this study suggest that survivors of suicide could benefit from education on issues of mental health, grief and bereavement, and the importance of self-care in coping with their loss.

About 70% of participants identified that gaining education on mental health, suicide, and grief was a positive form of support for them after their loss. This finding could speak to the larger need for education on these topics to help people begin to understand to deal with these issues. Additionally, personal self-care including attention to survivors' own mental health

through individual therapy, psychiatric medication, physical activity, and pushing against the

urge to isolate was helpful in terms of coping with the loss for more than half of the participants.

Self-care, particularly in regard to the survivors' own mental health is crucial in addressing the

increased risk for suicidal behavior in this population. The results of this study show that more

participants found support through spirituality than religion. Only two participants identified

church or religion as a positive form of support. This finding could possibly be due to the

historical stigma and association with sin that Christianity has held for suicide.

      Challenges. Participants in the study spoke to several challenges they faced regarding

forms of support for their loss. Some of these challenges included accessing resources,

stigmatization, and specific circumstances that were unaddressed by the forms of support

available to them. While a surprising number of participants reported not being directly impacted

by stigma, the majority of participants referenced the underlying stigma associated with suicide

and more generally, with mental health, that impacted them. Stigma is frequently discussed in

the literature on suicide and survivors of suicide.

> "When reviewed, there is a predominant theme that the bereavement of suicide survivors
> is a panoply of emotional responses driven by both internal and societal influence. One
> theme that recurs in many studies is that stigma has a profound effect on survivors and
> that stigma is attached uniquely to suicide death." (Cvinar, 2005, pg 20).

The lack of direct stigmatization for participants in this study could be due to the fact that

11 of the 13 participants were located in the San Francisco Bay Area, a relatively liberal area of

the country where the community may be less stigmatizing than more conservative areas. Three

participants shared how the fear of stigma and anticipation of negative responses from others led

them to not share about the cause of death with others outside of their own family, at least until

some time had passed since the loss. Two of these participants were not located in the San

Francisco Bay Area and one of the participants was male-identified. This finding could speak to

the perceived openness, understanding, and supportiveness in specific geographic locations and for particular identities in regard to suicide loss.

The findings from this study also indicate that the amount of time the survivors were allowed or expected to take off of school or work was an issue warranting further attention. There seems to be very different bereavement policies among employers that impact survivors' ability to travel, be with family and friends, and grieve without pressure from work immediately following the loss. It is also important to consider individuals who are employed at work places that do not offer benefits and bereavement policies and who are not financially able to take time off from work without adding to the stress and burden on the individual and their family. Two participants who were attending graduate school programs at the time of their loss spoke to the lack of a clear bereavement policy and the pressure they experienced to fully reengage with their school work in a short amount of time.

These issues shed light on the issue of bereavement policies and the pressure put on individuals to swiftly return to be a contributing member of the work force. It begs the question of who determines the rights of the bereaved and the length of time needed to fully grieve before being an effective member of the work force? Bereavement policies tend to only address the time immediately following a loss and disregard the on-going nature of grief. There could be more attention on how work places and educational institutions can offer support that better aligns with the nature of grief.

Recommendations. The majority of participants offered recommendations on how they would have liked to be better supported. Participants overwhelmingly called for an increase in awareness and education on suicide, needs of survivors of suicide, and response to grief in our society. Jordan (2011) also called for this change and his message is worth repeating six years later.

All of the goals previously set forth must be embedded within the context of a continuing change in societal attitudes toward suicide, and by extension, toward those who have lost a loved one to suicide. Suicide, its cause and its impact, must become an acceptable topic of public discussion in media; in the church, synagogue, temple, or mosque; and in the schools—indeed, in all the institutions of our nation. Suicide must literally stop being an unspeakable event, and suicide survivors must move from being inappropriately stigmatized within their communities to being recognized for what they are: people grieving after the death of a loved one to a complex "perfect storm" of contributing factors. That storm typically includes deep psychological pain, hopelessness, overwhelming life problems, psychiatric disorder, and feelings of isolation from and burdensomeness to others. This change in perceptions has definitely begun around the world. In the next, decade, we hope to see it progress rapidly toward a new social response of compassion, acceptance, and effective long-term support for survivors of suicide loss. When this happens, then we truly will be able to lay claim to the late Edwin Shneidman's profound observation that postvention after suicide is prevention for the next generation" (Jordan, 2011, P. 531).

The study participants also provided specific resource recommendations for other survivors of suicide including grief groups, retreats, online resources, books, and poetry. The resources suggested by participants included ways to cope for both those who find talking about the loss to be helpful and those who do not. Specific resource recommendations may not be helpful for all survivors of suicide but there is a need to compile a list of potential resources that is easily accessible.

Study Limitations

There are several limitations to these data and the interpretations offered. The first limitation was the sample used in this study. When setting out to begin this research project, it was the researcher's intention to reach populations that are underrepresented in the current literature on survivors of suicide. Previous studies have included participants who were recruited through support groups, leading to a sample of predominately white and predominately female participants who by default had accessed and connected to resources. Due to time restraints of this project, 10 of the 13 participants for this study were recruited through local support groups.

This recruitment method led to a small sample that reflected the most commonly represented population in the literature—white females which contributed to issues of generalizability and a lack of attention on diverse groups of people. Many of the participants were able to access support for their loss and most had connected with other survivors of suicide at the time of the study. By consenting to participation in this study, participants indicated a willingness to speak about this topic, with only one participant reporting that 'talking' was not helpful. This indicates the current study was unable to reach survivors of suicide loss who have a more difficult time reaching out to others and speaking with others about their experience. Another limitation to the sample was the inconsistency of experiences among participants. All but one participant experienced their loss as an adult, participants represented different types of relationships to their loved one, participants had endured their loss for a different amount of time, and they were in different places with their grief.

The second limitation was the exploratory nature of the study. Data collection was done through semi-structured interviews that varied in method of contact, length, and follow-up questions. Interviews were conducted in-person, via Skype video call, or audio-only call depending on geographic location and the participants' individual comfort level. This impacted the researcher's level of connection with each participant. While all participants were asked the same questions, the conversational nature of the interviews allowed for a range of follow-up questions and discussions on additional forms of support, challenges, and experiences. Additionally, participants responded to questions with a varying degree of detail which effected the length of each interview.

The third limitation was the author's personal bias in designing, conducting, and analyzing the data of this study. The semi-structured interview questions and follow-up questions participants were asked were coming from the perspective of a white female who is a student in a

MSW program. While the intention was to reach underrepresented populations, and explore less researched forms of support, the recruitment methods, study design, and interview guide was influenced by her sociocultural identities and bias that talking about this topic is healthy and necessary on an individual and societal level. This is not true for all individuals, including some represented in this study.

Implications for Clinical Social Work

The likely underestimated number of survivors of suicide and the possibility for psychological suffering, complicated grief, and increased risk for suicidal thoughts and behaviors for those bereaved by suicide demands the attention of clinical social workers and clinical social work programs in the United States. There is a need for more education and training on suicide bereavement including symptoms of PTSD, available resources, and development of programs to initiate contact with survivors of suicide. One possible way to address this need could be for agencies and MSW programs to partner and deliver staff training around working with survivors of suicide.

It is recommended that future research on this topic strives to recruit a more diverse and representative sample. This study covered several important forms of support, barriers to accessing resources, and challenges within the forms of support that could each be studied more in-depth on their own. Further research on specific types of survivors of suicide, resources for men, representation of suicide in media and entertainment, and supports for culturally diverse populations is needed.

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Appendix A

Interview Guide

I will begin the interview by thanking the participant for their time and willingness to share some of their experiences with me. The interview will be semi-structured. The following questions are meant as a way to prompt the participant as the interview moves along.

-Tell me about your experience receiving support, please.

-Have you felt supported in coping with your loss?

-Was there anything or anyone in particular that was helpful for you?

-Was there anything or anyone in particular that was unhelpful to you?

-What role does your culture play in your bereavement/ healing process?

  • What are your religious or spiritual beliefs?

  • How did they play a role in your bereavement process?

-Tell me about the forms of support you utilized following the suicide of your loved one -Did you receive professional mental health services? - Please tell me about this experience   - How did you access these services?

        -Had you accessed mental health services prior to your loss?

-Were you informed of any support groups?

-Have you attended any support groups?

-How did your community respond?

-Were there any forms of support or services offered to you that you chose not to utilize? Why?

-What would you like to be different in terms of support for survivors of suicide?

- What concerns would you like to give voice to?

-What do others need to know about the experiences of survivors of suicide?

-What general advice might you have for other survivors going through the bereavement process?

Appendix B

Pre-screening Script

1. Can you read, write, and speak English?

2. Are you at least 18 years old?

3. Has at least one year passed since the suicide of your loved one?

4. Are you ok with talking about this topic?

5. Are you willing to participate in an interview about forms of support related to your loss?

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix C

Recruitment Letter

Dear interested research participants,

I am writing to let you know about an opportunity to participate in a research study about forms of support for individuals who have lost a loved one to suicide. The hope of this study is to highlight the voices of individuals who have endured this type of loss and highlight what has worked and what needs remain unaddressed. This study is being conducted by Nicole Dietze at Smith College School for Social Work as part of her Masters in Social Work.

This study will ask individuals who are at least 18 years old and who have lost a loved one to suicide at least one year ago to engage in 30-45 minute long conversational interviews about the forms of supports utilized or not utilized while coping with the loss of your loved one. The researcher will not ask directly about your loss and will provide resources following the interview in the case you experience any emotional distress. Please also be aware that, even if you are eligible, your participation in this or any research study is completely voluntary.

Please contact Nicole Dietze at xxx-xxx-xxxx or ndietze@smith.edu with any questions or if interested in participating.

Thank you very much for your time,
Nicole Dietze

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix D

Informed Consent

SMITH COLLEGE

2016-2017
Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA

....

Title of Study: The voices of Survivors of Suicide: A qualitative approach to the experiences of survivors of suicide
Investigator(s): Nicole Dietze: ndietze@smith.edu

....

Introduction
• You are being asked to be in a research study of forms of support for survivors of suicide.
• You were selected as a possible participant because you have experienced the loss of a loved one to suicide and at least one year has passed since your loss. You are at least 18 years old and you can read, write, and speak English. You are ok with talking about this topic and you are willing to participate in an interview about forms of support related to your loss. You will be unable to participate if the suicide of your loved one happened less than a year ago, you are under 18 years old, you are unable to read, write, and speak in English, or if you are not ok with talking about this topic.

- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
- The purpose of this study is to highlight the experiences of individuals who have a loved one who committed suicide. This study will be exploring forms of support available to and utilized by this population following the suicide, as well as, exploring what individuals believe needs to be done differently in order to improve the supports provided in the future.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures
- If you agree to be in this study and you are ok with talking about this topic, you will be asked to do the following things:
- Read and sign this consent form. (5 minutes)
- Engage in audio-recorded semi-structured interview with researcher in person or via skype. (3045 minutes)

Risks/Discomforts of Being in this Study
- The study has the following risks. First, the risk to feel discomfort or distress from thinking about and talking about forms of support for the loss of your loved one to suicide. You will receive a list of local resources including support groups, hotline phone numbers, and counseling services.

Benefits of Being in the Study
- The benefits of participation are: Reflection and insight regarding forms of support following the loss of a loved one to suicide. Participation in this study will also provide the opportunity for your voice to be highlighted in the research on survivors of suicide.
- The benefits to social work/society are: The information collected from this study could be used by clinical social workers when working directly or indirectly with survivors of suicide. This study could also inform subsequent studies on forms of support for survivors of suicide.

Confidentiality
- Your participation will be kept confidential. The researcher will be the only person aware of your participation. Consent letters will be kept separate from notes and transcripts. Each participant will be assigned a code number, which will be placed on all materials. The audio recording digital files will be password protected, only accessible by the researcher and a potential transcriber who will sign a confidentiality agreement. Recordings will be permanently deleted from recording device after the mandated three years.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift
- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

• The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If this is an interview and you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 1, 2017. After that date, your information will be part of the thesis.

Right to Ask Questions and Report Concerns

• You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Nicole Dietze at ndietze@smith.edu or by telephone at xxx-xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

• Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

………………………………………………………………………………………..

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

………………………………………………………………………………..

[if using audio or video recording, use next section for signatures:]

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be recorded:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix E

Resource List

Hotlines:

National Suicide Prevention Lifeline - Available 24 hours every day

Call 1-800-273-8255

Lifeline Crisis Chat: http://chat.suicidepreventionlifeline.org/GetHelp/LifelineChat.aspx

Suicide Survivor Support Groups:

San Francisco: contact: Tayler Lim at taylerl@sfsuicide.org or call 415/288-7113 East
Bay: Crisis Support Services of Alameda County: 510-420-2460

Counseling Resources:

San Francisco Counseling Center

1801 Bush Street

Suite 215

San Francisco, CA 94109 415.440.0500
http://www.sfcounselingcenter.com/

Golden Gate Integral Counseling Center
507 Polk Street, Suite 450
San Francisco, CA 94102
Phone: 415.561.0230
Email: goldengateicc@ciis.edu

Online Resources:

http://www.crisissupport.org/resources/suicide-loss-survivors/