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Suicide Postvention:
How Can We Improve
Existing Models?

ABSTRACT

This study was undertaken to assess the effectiveness of suicide postvention

approaches used with suicide survivors, who are defined as the families, partners and

friends who have lost a loved one to suicide. The goal was to determine the experience of

postvention support for survivors through their own voice, and then to use the findings to

develop a proposal for a National Suicide Postvention Plan to better meet the stated needs

of this disenfranchised population.

Twelve male and female survivors from around Massachusetts were interviewed

using an open-ended question format to encourage the description of their own postvention

experience. The participants were all over eighteen years old at the time of the suicide and

had endured the loss at least one full year ago. The questions also elicited the participant's

perspective on what an ideal postvention plan would look like.

The findings of the research showed that more than half of the participants had no

postvention support available to them after the death. For those who did, group therapy

comprised of other survivors and led by a facilitator who is also survivor was reported as

being the most effective. The majority of the participants articulated the need for an active

outreach program as an ideal model, to help combat the isolation so prevalent among

survivors.

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A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
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CHAPTER I

INTRODUCTION

According to the American Foundation of Suicide Prevention, "every eighteen minutes someone in the US dies by suicide and every nineteen minutes someone is left to make sense of it" (Retrieved on September 26th, 2006 from, www.afsp.org/files/Surviving//resource_healing_guide.pdf). The Center for Disease Control and Prevention has recognized suicide as being a serious public health problem, taking the lives of more than 30, 000 Americans a year (Retrieved on June 24th, 2006, from www.mentalhealth.samhsa.gov/suicideprevention/costtonation.asp). However, inadequate attention has been given to the survivors of those suicides, and it has been estimated that there are about 28 different survivor relationships for every suicide, including the immediate and extended family, friends, and partners of survivors (Davis & Hinger, 2005).

The term "survivor" is understandably confusing, many who come across it believe that it refers to those individuals who have attempted suicide but failed. However, the term actually defines those individuals who have endured the loss of a loved one through the act of suicide. Indeed, the very fact that there are linguistic challenges in describing this population is indicative of the lack of awareness around the issue of suicide bereavement. It is a topic largely ignored by the general public and hence most of the archaic stigma associated with the issue of suicide has yet to be dismantled. While it is clear that multiple forces contribute to the decision of an individual to take his or her own life, it has been largely accepted that there is no single cause of suicide, and therefore blame of a targeted individual for the suicide, though it happens often, should

be avoided (Dunne & Dunne-maxim, 1987). Suicide as an existential reality is not yet part of mainstream thought or consciousness, and as a result we as a culture are challenged not just by the harmful terms used to describe the act itself such as "committed suicide", "killed self", or "off-ed self", but we also struggle with how best to treat the unique individuals whose lives are forever changed as a result of losing their loved ones through suicide.

From a demographic perspective, the incidence of suicide is higher among males than among females and while more women attempt suicide, more men complete the act. A large reason behind this is that men tend to select modes of death through more aggressive means than do women. For example, more men use firearms than women in the act, while women are more likely to use drugs or other more passive modes. In addition, whites have a much higher rate of suicide than nonwhites in the U.S. Suicide rates increase with age and following childhood, rates continue to increase throughout life into old age (over age 65), and the highest rates exist among the elderly (McIntosh, 1987; McIntosh & Santos, 1984).

The cause of suicide is still an area being explored. "Suicide is almost always complicated, resulting from a combination of painful suffering, desperate hopelessness, and underlying psychiatric illness" (Retrieved on September 26th, 2006, from www.afsp.org/files/Surviving//resource_healing_guide.pdf). Indeed, 90% of all people who die by suicide have a diagnosable psychiatric disorder at the time of their death (Retrieved on September 26th, 2006, from www.afsp.org/files/ Surviving//resources_healing_guide.pdf). It is becoming more widely accepted through findings in medical research that some major psychiatric disorders involve changes in

brain functioning that can severely alter the thinking, mood, and behavior of someone

suffering from the disorder. As a result, the environmental factors that are likely to trigger

a stress reaction in an individual with a predisposition to a psychiatric disorder, may

combine with the biological changes in the brain that the illness causes and lead the

individual to suicide (Retrieved on September 26th, 2006, from

www.afsp.org/files/Surviving//resources_healing_guide.pdf).

Survivors of suicide are prone to experiencing disenfranchised grief, defined as

"grief that is experienced when a loss cannot be openly acknowledged, socially sanctioned,

or publicly mourned" (Doka, 2002, p.160). Bereavement for survivors of suicide is

complicated for a number of reasons, perhaps the most damaging of which is the social

stigma ascribed to it. Survivors of suicide often experience a profound sense of guilt,

adding a dimension of shame that does not typically accompany natural death. This often

results in survivors being both negatively viewed by others as well as themselves, and can

lead to social isolation at the very time they most need support, causing the survivors to be

at a greater risk for further medical and psychological illnesses. According to a study

conducted by Health Canada in March 2003, "in general social isolation is associated with

poorer health" (Davis & Hinger, 2005, p. 17).

Postvention, a term coined by Shneidman (1971), is the support provided to

survivors of suicide and it refers to "those things done after the dire event has occurred; it

deals with the traumatic aftereffects" (Leenaars & Wenckstern, 1998, p. 364). Based on the

literature reviewed it appears as though research in the field of postvention has taken a

back seat to the work done on prevention. It is now time that postvention support becomes

a priority for the health of our nation. How can we improve upon already existing

approaches to postvention to better meet the needs of this disenfranchised population?

CHAPTER II

LITERATURE REVIEW

Suicide survivors are at a higher risk for complicated bereavement due to the traumatic nature of the death. "Clinical observations ...consistently confirm that the experience of surviving a loss to suicide is more difficult, more complicated and more intense" (Retrieved on September 26th, 2006, from, www.afsp.org/files/Surviving//resource_healing_guide.pdf). This fact directed the author's literature review in many ways. It led to a search for studies done in the field of suicide postvention with the hopes of gaining clarity on this "more complicated" and "more intense" loss. However, the author discovered that the field of suicide postvention is lacking in its relevant and contemporary research and little attention has been apparently devoted to research that focuses on the self-reported needs of survivors according to the following authors: Andriessen, 2004; Cvinar, 2005; Davis & Hinger, 2005; Dyregrov, 2002; Fine, 1997; Poussaint & Alexander, 2000. As a result the author was directed to other sources of information through references made in some of the studies I did find. These other sources of information were chapters and books authored by survivors themselves, written both for the general public as well as clinical audiences. It appears that these were written by survivors in an attempt to make meaning of their personal loss, but also to provide a perspective on an issue upon which as survivors they are themselves expert.

The literature identified several areas of concern facing this particular population. An exploration of the early history of suicide and its effects on survivors with respect to the clergy, the government, and the larger society, shed light on the current ways in which

suicide is viewed in our culture. Included in the literature is the difference apparent in bereavement found in suicide versus other forms of death. In addition, the recognition that survivors are less likely to seek out treatment and support due to stigma, calls for a community outreach program offering clinical intervention, as well as support for assistance with the practical, economic, and legal issues following the death since survivors may still be in shock. Another area identified was survivors' desire for support from their social network, in combination with professional help. Of note also is the dramatic effect suicide has on the family dynamic of the surviving family. An additional area of concern was the need for careful and sensitive handling by first-responders and the media. Finally, consideration is given to the dire need for the mental health care community to devise a way of reaching individuals from targeted populations, in order to address and support survivors. This need is particularly strong among the African American population where there are "formidable obstacles to the search for solutions to the problem of growing numbers of blacks who kill themselves" (Poussaint &Alexander, 2000, p.44).

Historical Perspective on Suicide

What follows is largely based on literature that addresses Western culture. "For thousands of years, survivors of suicide have suffered alone and in silence. In fact the best treatment they could hope for was to be left alone" (Colt, 1987, p.4). Suicide has historically been treated as a crime; the deceased were *convicted* of suicide. In the early 18th century, common practice for handling the suicide included the corpse being dragged through the streets attached to a horse and hanged head down in the town square, all in an effort to warn others against committing this crime. The *convicted*, would be stripped of

his title, his property, and his cattle. His possessions would be given over to the King

(Smolin & Guinan, 1993). Indeed, in fuedal England, suicide was deemed a crime because

of the person who suicided had "broken his or her bond of fealty to the crown" (Poussaint

& Alexander, 2000, p. 49).The survivors of the *convicted* would be left with nothing,

themselves stripped of all they had owned, including the family member who suicided,

gaining instead only a stigma that followed them where ever they went until they roamed

far enough away to find a safe place where no one knew of their loved one's "criminal act"

(Colt, 1997).

Across various cultures and centuries, the corpse might have been decapitated, or

buried outside of the city so as to protect the living from the *convict's* "harmful ghost".

Furthermore, it was often the survivors who were directly penalized and were treated as an

accessory to the "crime" (Colt, 1997). Indeed, in Europe during the medieval era, a widow

was made to surrender her property, or pay a fine to her in-laws for the shame that resulted

from her husband's "criminal act", leading to a sense of blame of the widow for the death.

Many of these practices in the early 18th century were in effect attempts at suicide

prevention, however, for the survivors the result of the shame caused by the stigma led to a

valiant effort on their part to disguise the true nature of the death. Notes left behind and

weapons used in the act were destroyed and a veil of secrecy around the death ensued. This

was done not simply to avoid confiscation of property and the like, but also to secure an

appropriate burial. Most suicides in early history were not allowed to be buried on

consecrated land and the church dealt with it as a sin.

Additionally, "Christianity, Judaism, and Islam have regarded suicide as a crime

against nature and God; life is sacred and what God gives, only God can take away"

(Poussaint & Alexander, 2000, p.49). Religious history has contributed to the caring of

suicide survivors by the clergy, which in the past was met with ambivalence on the part of

the survivor because of the stigma associated with suicide. There are at least three

foundations found in Judeo-Christian sacred scriptures upon which is built the notion that

suicide is "wrong". These include the concept mentioned above: that only God can take

away what he has given you. The fifth commandment, "thou shalt not kill" has been

interpreted to mean not just the killing of another human being but also the killing of

oneself. Finally, another pervasive belief which has contributed to the cultural fear of

suicide rests in the common belief that the individual represents the home of God's spirit,

and consequently, through taking one's own life, one also goes against God (Rubey &

Clark, 1997).

"The judgmental and unempathic responses of institutional religion to instances of

suicide was apparent and wide spread in the United States as recently as the late 1950's…"

(Rubey & Clark, 1997, p.152). This often kept survivors of suicide from being able to

benefit from the comfort and closure afforded through the rites and rituals of funerals,

which are now considered to be essential to healthy bereavement (Rubey & Clark, 1997).

In the Bible as well as in the Talmund, there are no specific laws against suicide. It

is noteworthy however, that the Bible does have four cases of suicide; Samson, Saul and

his armor bearer, and Ahithophel, the scoundrel (Posner, 1997). According to Jewish law,

only if the act is done with clear resolve and conducted by a person who is fully conscious

of his or her actions, without the limitations of mental distress, is it considered a suicide

(Posner, 1997). This law allowed individuals who took there own lives while in a state of

mental or emotional distress, to avoid being labeled a suicide. Some theorists even believe

that it can only be considered a suicide if the individual announces his or her intention first. This law, it seems, results in a greater leniency in the Jewish tradition for survivors to be afforded the right to mourning rituals. Indeed, rabbinic authorities "could and- always did, as they do today- permit full funeral rights for those unfortunates whom, out of kindness, they declared were not legal suicides" (Posner, 1997, p.161). However, while they permit full funeral rites, nearly all authorities agree that no elaborate eulogy should be given. Despite the fact that they believe suicide should be pardoned, the belief is that the victim should not be regarded as a role model or exemplary as might be insinuated through allowing a formal eulogy (Posner, 1997).

By the 19th century the stigma surrounding suicide continued however, the perspective shifted from the act being seen as a criminal offense instead to it being seen as the result of an illness. With this shift in perspective, survivors were no longer forced to give up their property and were even able to bury their loved ones within the walls of church grounds, but the new stigma carried with it its own scarlet letter: that of insanity. At the time, it was largely believed that insanity was passed on genetically. This concept received little accurate study during the early 19th century, but nonetheless, the implication to survivors themselves was that they were likely to be met with the same fate as their loved ones. Indeed, "the popular view of suicide as a social disgrace- fanned by the Victorian legacy of respectability and the emphasis on the family- brought a new kind of stigma" (Colt, 1997, p.13). The suicide tarnished the family's façade, and the disgrace felt by the family led many to rush through funeral services, cover up the true nature of the deaths, and instead transform them in to "accidents" thereby keeping the truth from children and other family members for years, if not forever. Still the stigma followed, and

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the echoes of blame from the society towards the survivors mirrored the concept of the suicide victim's ghost haunting the survivors, an early primitive idea that led to the corpse of a suicide being buried with his hand cut off and buried in another location so as to render the ghost harmless. The disgrace felt by the family reinforced the need to keep the truth secret and led survivors to suffer their grief alone, without support.

"In the traditional psychiatric model, the case was closed when the patient died" (Colt, 1997, p.14), and this fact led to survivors being left out of the mental health support system, even as late as the 20th century. Survivors often avoided seeking therapy as a result of the shame and fear of being blamed or seen themselves as insane or mentally ill. In addition, in the later 20th century, mental health professionals were and still are often seen by survivors as being distrustful or as having failed in protecting their loved ones from suicide. Consequently they are often seen as ineffectual by survivors (Colt, 1987; Appel & Wrobleski, 1987). As a result of the stigma, isolation is often the fate of the survivor and the consequences of such a fate include severe psychological disturbances.

A Different Bereavement

Mitchell, Dysart Gale, Garand, & Wesner, (2003) concluded in an article based on the synopsis of psychosocial outcomes of suicide survivor bereavement as revealed in the context of group intervention, that suicide is different from other forms of death and tends to stigmatize survivors, leading to negative mental health outcomes. In the opinion of the following writers, not necessarily substantiated by evidence but rather through anecdotal evidence, Leenaars and Wenckstern (1998) conclude that with respect to suicide, "there is almost no other death in our society for which there is a higher social (and often personal dynamic) stigma for the survivors" (p. 360). In dealing with suicide we are required to

confront two traumatic events simultaneously; the death and the question of why a loved one went through with the act. Carla Fine (1997) who wrote an autobiographical account of her own loss to suicide coupled with reflections gathered by other survivors explains that the stress caused by losing a loved one to suicide is considered catastrophic and is often compared to the experience of enduring the horror of a concentration camp. Suicide is different because the survivors cannot direct anger at anything but the act of suicide itself, there is no deadly disease to blame or murderer to punish except the violence of the person we love against him or her self. Indeed, in this case, the murderer and the victim are one and the survivor therefore grieves the very person who has taken the life of the one they love. This leads to unfinished business that may cause interference in the mourning process and delay healing. The path towards acceptance of this type of death results in the "gradual recognition that (the survivor) may never know what happened or why" (Fine, 1997, p.13).

Suicide appears to engender blame. The issue of blame can come from the perspective of hindsight taken by survivors, and contribute to the difficult nature of this type of bereavement. Blame may be targeted at the self or directed at others. In many circumstances as a result of the closeness of the survivors to the deceased it is they who are often left on the receiving end of the blame if they are not directing blame themselves. Blame is alluring to survivors because it allows for a possible explanation to a problem which for many has none apparent (Alexander, 1991). In addition, blame can be contagious within a family system; members may collude in their blame of another because it can help provide an answer to the question "why?" and because it can be a defense mechanism that absolves them personally of the guilt they may be feeling. Blame allows for a concrete

answer to a question that lacks a concrete foundation. Ultimately, blame can lead survivors down the overwhelming trail of painful memories preceding the act; the trail of "if onlys" that perhaps plagues survivors of suicide more than any other form of death.

On the other hand, "Sometimes the need to find an external locus of blame blankets a deeper sense of self-blame that is too frightening to acknowledge" (Alexander, 1991, p.9). This self-blame described alludes to yet another complicated aspect of the survivors' experience: guilt. Most of the research agrees that survivors experience guilt over what they may have done to contribute to the decision of their loved one (Alexander, 1991; Carlson, 1999; Cvinar, 2005; Colt, 1997; Davis & Hinger, 2005; Doka, 2002, Fielden, 2003; Fine, 1997; Glover, 1999; Jones, 1987, Robinson, 2001; Ross, 1997; Smolin & Guinan, 1993; Stillion, 1996).

Another difference with this type of death is that it is often associated with mental illness and many people erroneously fear that suicide will be passed on genetically or will plague all family members of the deceased. As indicated previously, and as noted by Dyregrov (2002), in his work on a quantitative study on local authorities in Norway as providers of help and survivors as recipients of help after the suicide of a young person, some cultures have even applied religious, legal or other sanctions against survivors of suicide. As mentioned, possible feelings of guilt, anger, shame, and distress are common reactions which can lead to serious problems in psychosocial functioning, existential crisis, and complicated grief. Survivors often face negative social outcomes as well due to a lack of social support and an inability to share their grief with others because of the stigma associated with suicide.

Based on conclusions from systemic research (Dyregrov, 2002, & Mitchell, et al., 2003) as well as autobiographical accounts and anecdotal evidence (Fine, 1997; Stillion, 1996) and literature and reviews (Clark, 2001 & Cvinar, 2005), survivors face dilemmas about whether or not to disclose the actual cause of death whether to hold a public funeral, how to answer the "why the loved one did it" question, and feelings of responsibility. In addition, survivors must choose whether to reveal the truth about the suicide to prove that they are not ashamed of the act, but this does not spare them from the reaction of others to the revelation. They may still be ostracized by society, blamed, questioned or become the focus of harmful gossip and assumptions about why they did not prevent the death or what they may have done to contribute to it. In speaking about survivors, Fine (1997) explains, "The taboo against suicide can often condemn us to a life sentence of silence" (p.71). In this silence there is a great risk for isolation and further complication in bereavement. While society is largely responsible for directing blame towards survivors, it is often the survivors themselves who are the most critical judges. The questions survivors tend to replay in their minds about what they could have done or not done to affect the outcome can be overwhelmingly devastating and lead to further complications in the bereavement process (Fine, 1997). Fine, a survivor herself continues, "…as we become more open about our experiences, the stigma of suicide will start to recede. By letting go of the secret of our loved ones death, we can begin to reclaim our memories of his or her life" (Fine, 1997, p.71).

Sometimes the decision to reveal the truth of the suicide gets complicated by the perspective of the survivors themselves. In the survivor's challenge to come to grips with nature of death, he or she may want or need to see the act in a different light. The survivor

may need to believe, for example, that the death occurring from a one car accident, deemed a suicide by the coroner, was unintentional. The fatal overdose may need to be seen as accidental, by a survivor. Confusion around the nature of the death can be complicated by the survivor's shock as well, and lead them in their desire to understand and makes sense of the death, to view the suicide through the lens of an accident. This can be seen as a coping mechanism on the part of the survivor.

This dynamic is not limited to the microcosm of individual families rather it can be seen within the culture at large in examples of celebrities who have successfully suicided. To this day, over 40 years since the death of Marilyn Monroe, the public is still divided in the belief over the true nature of her death. There exists many elaborate conspiracy theories that she was murdered in an attempt to cover up an affair she was having with the Kennedy brothers, or that her overdose was accidental. This division over the nature of her death mirrors something many survivors struggle with. How could such a beautiful, young, successful person, who seemed to have so much going for her, take her own life? This same divided reaction to understanding the nature of death can be seen in most celebrity suicides or suicides of public figures, such as in the case of Vincent Foster, the deputy White House Counsel for the Clinton Administration in 1993. In Foster's case, allegations of foul play prevailed despite numerous investigations by law enforcement that concluded his death was indeed a suicide.

Considering how the public at large is often challenged in accepting the act of suicide as the cause of death because of the fact that it leaves so many questions unanswered, it is easier to see why survivors struggle with admitting and accepting suicide

especially when it occurs in situations where depression or emotional struggle was masked by the person before the suicide.

In other forms of death, traditional funeral rites and rituals help the bereaved to find order and closure to an aspect of the death, however as Fine (1997) points out, "Although many religious leaders now regard people who kill themselves as having suffered from a mental illness and not having committed a mortal sin, the act of suicide itself is still universally condemned by most major religions" (p.49). Fine (1997) goes on to reinforce the need for the bereaved family to be handled with the utmost care and attention during the process of mourning because they are not the perpetrators of the act of suicide which in the past has been condemned, but rather they are the sufferers of the act of suicide and should be supported as such. Fine (1997) even goes on to recommend that recognition of the act of suicide at the religious ritual be openly addressed and recognized because the religious ritual can be a primary source for comfort in assisting the survivors. Indeed, "…the course of a suicide survivors mourning process can be profoundly affected by the degree of compassion and understanding extended by members of the clergy" (Fine, 1997, p. 51).

Schneidman described the unique experience of suicide for the survivors as follows, "I believe that the person who commits suicide puts his psychological skeleton in the survivor's emotional closet" (Schneidman, E., 1972, p. ix). In addition, there is possibility of family break down, and fear that it will happen to "them" as a result of the discoveries of the genetic inheritance of suicidality (Brent, Moritz, Bridge, Perper, Canobbio, 1996; Roy, Nielsen, Rylander, Sarchiapone, 2000).

Suicide acts as a catalyst in opening old wounds in the family dynamic (Fine, 1997), and this can lead to challenges in the way the various members of the family deal with the suicide. Some members of the family may need to see the suicide as an accident. They may need to be in denial of the act while others may need to be open about the details. There is a challenge when this dissonance arises within the fabric of the family unit. It may interfere in the individual's personal path to recovery if members of the family impose their own version of the story on to each other. Any death that is sudden can be especially shocking to the families left behind because of the lack of preparation for the death and the fact that the opportunity to say goodbye is forever gone. However, according to Fine (1997) more psychological distress is experienced by family members following death by suicide than death by natural causes because of the possibility of anger directed at the deceased and because of the feelings of guilt about not being able to prevent it. Survivors tend to move back and forth between the numerous stages of grief, however, "the most immediate response is shock, numbness and a sense of disbelief" (Fine, 1997, p.104).

One reason why conflict within the surviving family often results is that the death of one member requires that the family system itself be realigned. Immediately after the suicide the energy directed towards the deceased can be a strong pull to keeping the family connected but with time if the family has not undergone a realignment, conflict may result and estrangement can occur (Alexander, 1991). If differences existed within the family before the suicide, Alexander (1991) explains, "... in the aftermath of suicide, relationships that were already strained by conflict may be entirely ruptured" (p.60).

Postvention Services

First Responders

The handling of the suicide by first-responders was also indicated as being particularly important (Danto, 1987). "Reactions by first-responders, such as police, EMS, fire and medical examiner personnel, have lasting impact and can vastly influence the course of recovery" (Davis & Hinger, 2005, p.20). In their study of assessing the needs of survivors, Davis and Hinger (2005) found that survivors were able to recall specific details about reactions by first-responders. The research of Davis and Hinger was completed in two phases and included both focus groups and written questionnaires with participants who were members of immediate family of individuals deceased through suicide. Among the results of this study, the authors found that participants identified a number of experiences that were not helpful and which led to greater distress for the survivors. They identified these experiences as "inappropriate communication" and went on further to say, "The communication by first responders, specifically police officers was identified as being particularly traumatizing in a few cases" (Davis & Hinger, p.9, 2005). It is apparent that special care should be given to the manner in which initial response is delivered, so to avoid further traumatization of survivors.

Unfortunately it is apparent from the literature review done by Danto (1987), that both police officers as well as physicians who are among the first responders at the scene of the crime have little training on how to address the unique needs of survivors. Police officers must be particularly careful of their attitudes towards suicide. Because they are often left to work alone, they must be able to draw on their own intuition and inner resources in providing the most effective help. This can be achieved through effective

training which includes information about effects of suicide on survivors as well as the fundamentals of grief counseling and basic principals of grief and bereavement. Follow-up supervision should be provided for the officer and the physician who ends up providing counseling or advising, as is routinely done with mental health workers and volunteers but rarely with the first responders (Danto, 1987).

Another crucial aspect of suicide about which police officers should be educated is the possibility of violence and rage that may be expressed by the survivor and could be directed at the police officer or other members of the first response team. This anger may be a major inhibitor to communication with the survivor, thus further complicating an already challenging situation. It is crucial that the officer be patient and supportive despite the potential anger. An effective first response intervention by police would include sensitivity in pragmatic affairs such as, for example, in cleaning up a particularly gruesome crime scene, or recruiting neighbors or volunteers to assist with this should it be too overwhelming for the survivor.

Of particular importance is the routine procedure of treating the death as a homicide until all evidence is gathered to deem the death a suicide. Survivors are in shock and knowing that they are being questioned to rule out homicide of their loved one is an overwhelmingly difficult experience. A well trained officer would help the survivor to understand that the line of questioning is a matter of formality and it should be done with extra care and without blame or judgment. This should also be done when the police gather forensic evidence such as a firearm or knife. Being equipped with a list of referrals to support the survivor is very useful in helping the survivor to realize that indeed the officer is there to help and not condemn the survivor. Danto (1987) deduced through his own

review of the literature and in the recommendations for first responders that he wrote based on his research, that the physician who is called to the scene of the suicide can also be seen by the survivor as the first support system available. Danto (1987) suggests that the physician can be useful in setting up appropriate referrals for support such as mutual aid support groups or clinicians skilled in bereavement. In addition, Danto (1987) adds that some psycho-educational information about the unique grief and bereavement experience of survivors would be helpful for physicians to share with survivors to help normalize their feelings as they emerge, including the possibility of the emergence of anger directed at the deceased, something many survivors feel is inappropriate. Finally, Danto (1987) recommends that both police officers and medical personnel must be aware that they themselves are among a group of professionals who are at a high risk for suicide and so in addition to training to help survivors, police and physicians should also be provided with support for suicide prevention.

Campbell, Cataldie, McIntosh, & Millet (2004) noted that use of the active model of postvention in collaboration with the first-responders, has led to improvement in the atmosphere at the scene "to a more concerned and caring environment for the survivors" (p.31). This points to what Davis and Hinger (2005) suggest: there is a need for first-responders and all professionals who encounter survivors, to receive training and education about to how to better meet the needs of this unique population. In addition, improved coordination of services in the justice, health and social sectors would be useful in ensuring appropriate and helpful support at the scene of the suicide.

Peer Support

Peer support has been identified as being useful in providing practical and emotional support for survivors (Davis & Hinger, 2005; Fielden, 2003). In Davis & Hinger's 2005 study of assessing the needs of survivors, among the results found, "survivors identified informal support such as family, friends and neighbors as providing the most comfort in the crisis period after the death" (Davis & Hinger, p.7, 2005). They also found that support from peers who themselves were survivors and had been through the experience, was very helpful (Davis & Hinger, 2005). The authors also found that two weeks past the death informal support from "family and friends continued to provide the practical and emotional assistance needed by survivors" (Davis & Hinger , p.10, 2005). As found in the study cited above, Patton (1996) also considers that social network support is often considered the most appropriate postvention strategy. According to Clark (2001) who bases her conclusion on a review of the literature, many friends and neighbors "feel out of their depth and fail to support the bereaved families" (p.102). In addition, since the author has revealed that she is a survivor of suicide, it is both a result of personal experience as well as a conclusion based on the literature reviewed, that there is a need also for professional intervention. In addition to one on one counseling, psychotherapeutic group interventions were suggested as being particularly helpful for survivors, specifically because of the mutual aid afforded them through other survivors in the group (Andriessen, 2004; Mitchell, et al., 2003). Davis and Hinger (2005) revealed in their study that the participants "found support groups specific to suicide loss to be very helpful" (p.11). The authors explained that the shared experience of loss through suicide was important because

the participants experienced no judgment or stigma associated with their loss and felt that their grief was adequately validated (Davis & Hinger, 2005).

In a study conducted in 2003, group intervention focusing on narrative therapy with survivors, which is a therapeutic approach that focuses on the description and interpretation of patterns of communication, showed that peer support helped to shift participants' victimic themes to being more agentic over the course of the group, which led to an improved sense of agency in the grief process and an ultimate ability to move on from being the "helpless" victim of suicide (Mitchell, et al., 2003).

It is noted in an article evaluating the active postvention model done by Campbell et al., that postvention outreach programs which include survivor volunteers, is particularly useful because "an immediate and valuable bond is established between the newly bereaved and the para-professional survivor team member. This bond simultaneously provides the beginning of an honest conversation about grief after suicide and the installation of hope" (Campbell, et al., 2004, p. 30).

In a unique type of peer support, Davis & Hinger (2005) found in their study that a number of the female survivors themselves identified that finding ways to "give back" was viewed as particularly helpful in their healing process. Specifically, these female participants identified reaching out to newly bereaved survivors by becoming peer volunteers themselves was perceived as a means towards greater healing (Davis & Hinger, 2005).

Outreach Support

As mentioned earlier, survivors of suicide are more likely to socially withdraw at the very time that they most need support. Historically postvention services were provided

through a passive model wherein the survivors came upon the resources available to them indirectly and sometimes accidentally (Campbell, et al., 2004). "Survivors strongly want an early community outreach without having to take the first initiative" (Dyregrov, 2002, p. 661). In his qualitative study on survivors, Dyregrov (2002) highlights that survivors wished for ideal support as per recommendations by experts in the field but found that the local authorities lacked the organization to meet their needs and it is this issue which the author has found to be the most revealing of where the problem lies in our current postvention approaches. In addition, Davis & Hinger (2005) found in their study that experiences with Victim's Assistance, which is a community outreach program Calgary, Alberta where the study was conducted, were all positive with only one exception. In fact, the author will use this perceived weakness to guide her own suggestions for a postvention program.

A combination of factors contributes to the inability of survivors taking the first initiative in seeking help: exhaustion, loss of energy, shock, and the remaining societal stigma. In addition, Dyregrov's study (2002) and an article written on the evaluation of an active postvention program done by Campbell et al., (2004) found that survivors of suicide suggested that crisis intervention not only be initiated by the community, but that it be done often and over a significant period of time (over several months). This was suggested so that the survivor does not give up on the possibility of taking advantage of the help when they feel ready, and so that community support still exits long after the initial support of family and friends has waned (Dyregrov, 2002).

Role of the Media

The research indicated a dire need for the media to react appropriately in handling cases of suicide. Clark (2001) points out that careful attention by the media should be given to word choice such as "commit suicide", and other descriptive metaphors relating to the act because of the judicial and stigmatizing connotations associated. Many countries outside of the US now have media guidelines for reporting suicide (Clark, 2001). Indeed, simplistic or sensational portrayal of suicide or survivors should be avoided as it can be harmful to survivors and contribute to the pervasiveness of the stigma associated with suicide. In Belgium, for example, the Ministry of Health has distributed to all journalists recommendations about appropriate portrayal of suicide and survivors (Andriessen, 2004). In addition to the recommendations, the Ministry of Health uses positive reinforcement to encourage appropriate portrayal of suicide by granting a Media award once a year for outstanding adherence to sensitivity and responsibility in covering the issue (Andriessen, 2004)

Similarly, Leenaars and Wenckstern (1998) explain that, "Information about suicide in the form of publicity, especially that which tends to sensationalize or glamorize the suicide, should be avoided" (p. 380). The argument is made that part of an effective postvention approach should have a media liaison established on the postvention team. The liaison must have an understanding of postvention procedures and sensitivity to the subject so to effectively communicate with the media the actuarial details of the suicide, conveying the positive impacts of a postvention program, and ensuring that sensationalization is avoided because of the risk of the contagion effect of suicide among youths (Leenaars & Wenckstern, 1998).

In her evaluation of the effect of media on survivors based largely on anecdotal evidence Dunne- Maxim (1987), suggests that survivors find even the simple act of reporting suicide as the cause of death places them in the vulnerable position of feeling exposed to the public and this, she explains, is compounded because the media is unlikely to get the facts correct. The media can perpetuate the stigma associated with suicide by sensationalizing the notion that suicide only happens to "bad" families where dysfunction, drug use or abuse is prevalent. In addition, survivors themselves may use the media to express their anger. It has been used to place blame on others in such a way that those scapegoated cannot respond or defend themselves, and assumes a sense of truth because so many people are reached through the media. Headlines are often very harmful and can place heavy blame on some survivors who can then become targeted by other survivors who are surviving the same suicide death. For example a teen's parents might blame their daughter's suicide on her ex-boyfriend who cheated on her, thereby scapegoating the ex-boyfriend and directing the parents' anger towards him but aggravating the bereavement and guilt of the ex-boyfriend. These types of stories sell and newspapers often capitalize on this. In addition to Dunne-Maxim's work, Davis & Hinger (2005) also found that according to their participants the communication by the media actually contributed to a more complicated bereavement process, noting, " Survivors reported that the media sensationalized the deaths, did not report facts and caused trauma for the families and friends of the deceased" (Davis & Hinger, p.9, 2005).

Postvention Services for the African American Community

A review of the current literature indicates a significant lack of research on the impact of cultural, racial, and ethnic diversity on the experience of survivors. It is apparent

that further study of survivorship among African American, American Indian, Alaska Native, Hispanic, and Asian American populations, as well as the effect of economic status, religious or spiritual affiliation, sexual identity/ preference on the experience of survivors, is greatly needed and is crucial to the formulation of a successful postvention plan (Retrieved on September 11th, 2006, from www.afsp.org./index.cfm?fuseaction=home.viewpage&page_id=2D9DF73E-BB25-0). Of particular note is the drastic increase in suicides among the youths of the African American community and this begs for closer attention to be paid to current diagnostic models used to identify suicide risk, as these models are based on the dominant culture.

While there is a great need for further research across different races and ethnicities, the author has chosen to focus on the particular needs of African Americans. The reason for this choice is that the literature revealed an increase in suicide rates among African Americans. It called attention to the way in which mental health is regarded in the African American community as well as by those outside of the community; there appears to be a level of discomfort around the issue of Black mental health. It is the hope of the author that through illustrating this group some light may be shed on the needs of other subordinate groups.

Most of the information included in this section comes from a review of work done by Poussaint and Alexander (2000) who wrote a book based on the compilation of African American survivor stories, interviews, and analysis of data, and who are both survivors. According to their work, traditionally communal strength and individual self-preservation helped the African American population to endure. Now, however, self-destructive behavior has become all too common among the black youths of today and our nation's

health care system has failed to explore the reason and causes behind this behavior. For young African Americans, aged 15-24 suicide has become the third leading cause of death, behind homicides and accidents (Poussaint & Alexander, 2000). Overall the increase in black suicides is dramatic when compared to whites (Poussaint & Alexander, 2000; Willis, Coombs, Cockerham, & Frison, 2002). Some theories identified in the literature by Poussaint and Alexander (2000) about why this increase has occurred, were extracted by evaluation of the commonalities between cases of suicide victims. Some of these commonalities included contact with the criminal justice system, diagnosis of a mental illness, increased social and familial isolation, and poor clinical intervention for treatment of the diagnosed mental illness and drug abuse.

Important correlations have been drawn between the inadequacies of our nation's diagnostic models and mental health issues for African Americans. Indeed, most if not all of our nation's diagnostic criteria for mental illness, are based on the dominant culture, leaving out the unique concerns of our targeted populations. Without accurate diagnostic ability, mental health care practitioners are less likely to be able to look for and detect the warning signs of suicide. In addition, there has been an increase noted in the literature, of a systemic crisis within the African American community: that of self-destructive behavior, expressed in the high incidences of drug addiction, alcoholism, and crime (Poussaint & Alexander, 2000). It can be argued that this self-destructive behavior is greatly influenced by the cumulative effects of African American history on the present culture.

Indeed, the history reveals the blatant discrimination endured by the African American community from the medical establishment in the past. This likely led to distrust by the black community of the medical establishment and therefore a resistance to seek

medical help when needed. This distrust is arguably appropriate. For example, the "infamous case in which white government doctors directed syphilis experiments on unwitting black patients through the Tuskegee Institute during the 1930s and 1940s is but the best known example among many" (Poussaint & Alexander, 2000, p. 15). Racism continues to plague the African American community in ways of which, due to "white privilege", most whites today are unconscious. Poussaint and Alexander (2000) described the experience as Post Traumatic Slavery Syndrome; the cultural oppression that has led to many African Americans being overwhelmed physically and mentally with no resources available to them to bring themselves from out beneath the hold of the dominant culture. Indeed, Poussaint and Alexander (2000) explain that despite the increase in the rates of suicide among the black community, inadequate support has still prevailed. The systemic nature of oppression has led to less culturally sensitive clinicians to help navigate the territory. A consequence of this is that in the past, appropriate diagnosis of clinical depression among blacks has been ineffectual. Unfortunately, it seems that there exists a cultural collusion with the stereotype that blacks do not need mental health support.

It appears in the literature that African Americans are reticent to discuss the issue of suicide and mental illness and this tended in the past to be reinforced by the community itself. Poussaint and Alexander (2000) explain, "The fundamental challenge of identifying and addressing the causal factors of suicide lies in overcoming the recondite nature of the subject within the black community and the stigma attached to it, which is stubborn and strong" (p. 25).

The stigma referred to above is reinforced by the African American religious community. For example, Christian African Americans were taught in the past that taking

ones own life was a sin and could prevent entrance in to heaven (Poussaint & Alexander,

2000). In addition, the centuries of endured oppression has led to the idea that blacks are

resilient and capable of self-preservation despite cruelty. "Previous research suggests that

African-American cultural characteristics, like high levels of religiosity and collectivism,

served as protection against suicide (Willis, et al., 2002, p. 908). Suicide is the very

antithesis of pushing through the pain, being strong in the face of adversity and

overcoming the injustice of racism. Has the prevalent belief that blacks are supposed to be

stoic in the name of dignity, prevented blacks from admitting their own vulnerabilities and

seek help? Does this speak to the sense of hopelessness that has grown within the

community as a result of the high rates of poverty and the ensuing stress that such poverty

has on an individual? Poverty leads to long term exposure to endemic stressors which

increases vulnerability in individuals to mental and physical health problems, and poverty

is one possible reason for the increase in suicide among African Americans (Poussaint &

Alexander, 2000).In the black community, poverty is the result of the current high rates of

unemployment, the decline of unskilled labor in the job market, poor preparation at inferior

schools as well as an inability to attend college due to financial restraints, among other

reasons. Without higher education or employment, the likelihood of living above the

poverty level seems almost impossible for many blacks. Living under these circumstances

can lead to chronic despair, loss of hope and increased self-destructive behavior (Poussaint

& Alexander, 2000). Indeed, this reveals how African Americans are at an economic

disadvantage in having the means to buy themselves protection from suicide risk (Willis, et

al., 2002).

It has been widely accepted that social dislocation is one of the leading causes of suicide. Poussaint and Alexander (2000) agree that, "Undeniably black men in America have experienced a greater degree of several forms of social dislocation than most other groups" (p. 50). In addition, studies by Gibbs (1988) and Willis, et al. (2002) suggest that the recent breakdown of traditional African American community values of social and family cohesion, self-improvement and education, has led to a decrease in connectedness between one another and therefore a diminished sense of community in general which in earlier times may have been significant support in preventing suicide (Gibbs, 1988; Willis, et al., 2002).

The Center for Disease Control (1998) as well as studies by Gibbs (1997), Lester (1998) and Willis, et al. (2002) all suggest that the National Suicide Prevention Plan put in place by the Surgeon General in 1994 (Retrieved on June 24th, 2006, from www.mentalhealth.samhsa.gov/suicideprevention/costtonation.asp) is ineffectual with the African American community in successfully preventing suicide.

Summary

The history of suicide through the ages sheds lights upon the evolution of the stigma associated with suicide, and the difficulty that exists in removing the cultural scarlet letter its leaves upon survivors. There continues to be dire need for additional research in the field of suicide postvention. There are many challenges faced by this unique population and the research indicates that more widespread use of an active postvention model (APM) would greatly improve available assistance to survivors. There is a need to increase the contribution of survivors in the development of new intervention strategies and programs. Additional exploration of programs already in existence in other countries, which are

considerably more progressive in this area than the US, would be helpful. Based on the literature, it is apparent that a successful approach would be multi-tiered and would enlist a team to assist survivors. This type of intervention would involve the collaboration of many agencies and support networks so that the numerous factors involved in the complicated bereavement of suicide could be adequately addressed.

Further research into suicide postvention through the perspectives of survivors themselves would be one way to explore how we might add to the existing postvention programs, with the hope that a concrete and comprehensive model of intervention be developed to add to the Surgeon General's National Suicide Prevention Plan.

CHAPTER III

METHODOLOGY

There currently is no formalized national suicide postvention plan in existence here in the US. There is however, a national prevention plan in place. It is apparent in the research that a successful and effective prevention plan must have a postvention component given the correlation to increased suicidality among survivors. While many schools have postvention plans, adult survivors lack a concrete, comprehensive, community-based model to assist them in their bereavement. The researcher has explored the perceived effectiveness of the current postvention approaches for adult survivors, through the use of the voices of survivors themselves, to identify ways to improve how we treat this unique population.

Design

Using a qualitative, exploratory research design afforded the researcher the opportunity to integrate the voices of survivors themselves to help identify areas for improvement in the existing frameworks. The flexible methods the researcher used included narrative data from participants. The narratives were gathered through the use of in-depth, in person, tape recorded interviews, beginning with a primary trigger question. The researcher used a number of other predetermined interview questions to stimulate ongoing dialogue and to maintain consistency among all interviews and to maintain reliability. This led to validity of the instruments employed. All of the interviews were less than one hour in duration. The questions were open-ended to encourage survivors to

answer in their own voice and focused on their perception of the effectiveness of postvention approaches they received, what was available to them in the way of support, and how they were able to access this support if they did. The researcher tape recorded each session and the narratives were all transcribed immediately after each interview.

The method for sample selection was originally intended to be accomplished through recruitment letters to agencies in Massachusetts conducting suicide survivor groups, however, the researcher was successful in recruiting samples through a random snow ball method, wherein individuals in the community who knew of the researcher's interest, forwarded the researcher's contact information to survivors they knew. These survivors then made connections for the researcher to their family members in some cases, or other survivors they had met through support groups. The researcher was given the potential subject's telephone or email address and contact was initiated on the part of the researcher once the subject expressed interest in participating. At this point all subjects were forwarded a recruitment letter directly through email or postal mail, along with the informed consent.

It is noteworthy that the method of recruitment used by the researcher may have attracted relatively resilient participants who were at a stage in their bereavement that made them more readily open to discuss their process. Consequently the researcher acknowledges that this study does not adequately reflect those survivors who are more withdrawn and socially isolated due to their bereavement process.
The method used for completing data organization and data analysis was theme analysis. The researcher went through all transcribed interviews and found the common themes that emerged and compared the experiences of each subject to note the different or similar

experiences and what was considered by the subjects to be the most useful or least helpful postvention approaches. The final question to each subject was about how they would create the perfect suicide postvention plan and the researcher used content analysis to deduce the common reactions and also used their answers in creating a proposed National Suicide Postvention Plan.

Sample

As noted the sample was selected through random snow ball sampling, wherein individuals aware of the thesis question being studied informed suicide survivors they knew who then informed other survivors in their own family or ones they had met at support groups. After the potential subjects indicated their interest, the contact information was provided to the researcher and initial contact was made at that time, including providing the subject with the recruitment letter and informed consent.

The requirements of the researcher's recruitment process included the stipulation that all subjects had to be survivors of suicide: family, friends, or partners of individuals who had completed suicide. They all had to be at least 18 or older at the time of the suicide and at least 1 year had to have elapsed since the death.

There were a total of twelve subjects all of whom were from parts of Massachusetts with the majority coming from the Western part of the state: Northfield (2), Sudbury (3), Holyoke (1), Deerfield (1), Newburyport (1), Easthampton (1), Leeds (1), Amherst (1), and Northampton (1). The selection from a variety of different areas across the state was purposive and meant to provide diversity in the subjects recruited. The researcher intended to include a variety of races in the study, to compare the differences or similarities experienced between minority and dominant cultures. However, despite the effort to select

from many different areas across the state, zero minority subjects responded and so the study is flawed in that only the dominant culture is reflected in the research findings; all subjects were White. The researcher had a total of five other leads on subjects that came from areas outside of Western Massachusetts, however, these potential subjects declined participation after the initial telephone contact was made by the researcher. Other demographic information included: five of the subjects were male and seven were female. The socio-economic class was reflected as follows: four were working-class, two were middle-class and six were upper-class. Although it was not asked, it was the researcher's personal impression that all participants had at least an undergraduate college degree and that most also had a Master's Degree.

The ages of the subjects interviewed were 25, 28, 31, 35, 45, 47, 50, 52, 58, 59, 63, and 63. Two thirds of the participants reported themselves as being Christian (5 Catholic, 2 Christian and 1 Protestant). Three of the subjects called themselves Atheist and one defined herself as Eclectic. The relationship to the deceased included: brother (2), sister (1) daughter (2), father (1), mother (1), son (1), and friend (4). It is important to acknowledge that none of the subjects were partners, husbands or wives of the deceased, however, a third of the sample were friends of the deceased. The subjects of this group were aged 19, 33, 45 and 45 at the time of the death. Three of the sample had lost siblings and were aged 23 (a brother), 43 (a sister) and 44 (a brother) at the time. Two were parents of the deceased and were aged 53 and 54 at the time of the suicide. Two lost a mother and were both aged 29 at the time. One lost a father and was aged 20 at the time of the suicide. The deceased in the relationship of the sample used included five woman and seven men. Time elapsed since the suicide varied a great deal. For eight of the subjects it was between two

and five years and for four it varied from eighteen to twenty-seven years since the time of the death.

It occurred to the researcher that distance from the suicide may have been a factor in getting help. At least two of the participants lived in states other than the loved one who died so it is possible that the degree of support afforded them was limited as a result of this.

Ethics and Safeguards

The researcher recognizes the ethical challenges inherent in conducting research with this vulnerable population. There is a risk of triggering emotional pain while discussing the suicide of a loved one. The focus of the interviews was therefore centered on the survivors' experience of treatment received. However, questions about the relationship to the deceased (mother, father, etc) and the duration of time passed since the death were asked.

In the written consent, it was clearly stated that the researcher did not want to know any personal information about the deceased except for the aforementioned relationship information. This was done to respect the difficult nature of relaying such information on the part of the survivor. In doing so the researcher hoped that the perceived vulnerability of participating in this study was diminished. It was indicated to all participants that they could choose a pseudo-name to use for the study and that all names would be changed for the study in order to protect their confidentiality. In the consent form it was explained that all identifying information would be kept out of the research, and that all collected data would be stored in a locked container when not being used. Only the researcher has access

to the data and in so doing the researcher has been able to perfectly meet the federal regulations for data analysis and storage.

Data Collection

The researcher gathered narrative data through individual tape recorded interviews, using an interview guide of six open-ended questions, intended to encourage the survivors to answer in their own voice. This interview guide was created by the researcher based on similar approaches used in other studies, such as seen in work done by Fielden (2003). The structure and choice of the questions were intended to be open and flexible and elicit genuine non-triggering responses on the part of the survivors. The researcher intentionally aimed to keep the focus of the interviews on the experience of the survivor as he/she navigated through the grief process. Therefore the questions centered on the survivor and not on the deceased. The researcher used special care in creating a primary trigger question that was meant to be supportive and yet guiding, intended to evoke the felt experience of the postvention treatment received or not received, by the survivor. The interview guide was intended to demonstrate sensitivity on the part of the researcher towards the survivors given the vulnerability of this population and the risk inherent in discussing this subject matter. However, an attempt was made on the part of the researcher to ensure that the participants recognized that they themselves are the experts on the subject of suicide survivor's experience with postvention, and that through their personal insight, improvement in the field can be accomplished.

The primary trigger question is as follows:

You have told me that your (relation to deceased, ex: brother, mother, etc) completed suicide (time since death, ex; 2 years ago). In this interview, I would like you to tell me about the type of intervention and support that you received after the death. Talk as

openly and as freely as you want. It may help to begin with the support you received
immediately following the death, up until now. There are no right or wrong answers. You
may also discuss the support you did not receive but had wished you had, and what you
might like to see available to others going through the same difficulty. The most important
thing is that you begin with whatever feels most comfortable.

Additional predetermined questions used in the interview guide to maintain consistency

and stimulate ongoing conversation, are included in Appendix C.

The researcher kept all interviews to less than one hour in length in order to

maintain consistency among participants, and in an effort to ensure manageability of the

volume of narrative data collected. With the consent of the participants, all interviews were

taped recorded and stored in a locked and secure location, accessible only to the researcher,

as explained to the participants in the informed consent form. The researcher attempted to

enhance the rigor and trustworthiness of the data by transcribing the data immediately after

the interview so as to include any additional notes about non-verbal cues observed.

The researcher terminated the interviews by offering telephone contact information

should participants wish to clarify information in the narratives collected. No contact was

made by any of the subjects however, after the interview was completed. In addition, the

researcher offered to provide all participants with referrals of support services in their area

in the event that the interview process and narrative sharing triggered a difficult reaction,

however all subjects declined the offer.

Data Analysis

The researcher's intent was to gain insight into the felt experience of the survivors

of suicide through their own voice. Unique experience and authenticity was desired and

indeed the researcher maintained accuracy in the participant's subjective meanings in the

processes of data coding and summarizing results. The researcher successfully achieved

this using self-awareness to prevent the risk of bias on the part of the researcher (Drisko, 1997). This was accomplished through prolonged engagement with the data and extensive replaying of the recorded interviews, in order to ensure that no subtleties in tone, pitch, rate or pauses in speech were missed.

Coding of the data began with data reduction, through a review of the data (the transcribed interviews along with any additional notes taken as soon as it was completed). The goal of this initial step was to "cast the data in a new light and suggest an initial focus for the analysis" (Anastas, 1999, p. 418-419). The researcher then pulled out the common themes that emerged and formulated sections based on what was gathered. Since the voice of the survivors themselves is crucial to this study, the themes that emerged were not quantified but were instead categorized in an effort to maintain the participant's authentic voice. In this way the theme or idea that emerged from the data was considered the unit of analysis. An attempt was made to ensure that the theme was heuristic. Coding was done to assign a name to the themes that emerge, and the names were either named by the participants themselves or termed in vivo (Anastas, 1999). A thematic code was created using the following five elements: a label, a definition of what is contained in the theme, a description of how to recognize the theme occurring, a description of qualifications or exclusions to the identification of the theme, and examples to avoid potential confusion when searching for the theme.

Once the data analysis was completed, the researcher used the themes that emerged as well as information gathered through the literature review, to formulate a comprehensive active, community based postvention model.

CHAPTER IV

FINDINGS

The intention of this study was to use the voice of survivors themselves to uncover the most useful postvention treatment options given their felt needs and experience being a survivor. The researcher's intent was to then use the voice of the survivors to create a proposal for a National Suicide Postvention Program based on the findings of the study. It should be noted that all of the findings are based on the dominant culture and so specific racial and cultural groups are not reflected and that while subjects were chosen at random, the sexes were disproportionately reflected with five of the twelve subjects being male and seven being female.

Summary of Findings

The major findings were: seven of the twelve did not receive any postvention support after the suicide. Of the five who had some sort of postvention support, all had to seek out the postvention support on their own. Four of the five who received support used group therapy (Survivors of Suicide Support groups) combined with individual counseling, and one of the five used individual counseling only. The four who attended specialized support groups reported that in their opinion these were very effective in their healing process because they were led by survivors and the group members were all survivors. Of these five subjects who sought out and received postvention support, two of them also used psycho-pharmaceuticals (antidepressants) to help them through the initial pain. Three of

the five reported that the postvention support they sought was very expensive costing each of them 175$ for fifty minutes.

Of the seven subjects who did not receive any postvention support, three sought individual counseling many years after the suicide (at least five years after in all three cases) and two of those three also ended up in Suicide Survivor Support groups along with the individual counseling. The one subject of the three who did not attend a support group did begin taking an antidepressant along with individual counseling five years after the incident stating, "I had to because I was still messed up over it". None of the subjects received any follow up support after they terminated their treatment.

Ten of the twelve subjects reported feeling stigmatized by the suicide or felt the family was blamed for the death. All subjects explained that their ideal postvention support would include community outreach (especially from a trusted and familiar community member) and survivor led supports groups including groups with specific relationships being the focus, such as mothers who have lost their children to suicide. All subjects also indicated that referrals and lists of literature about surviving suicide should be provided to the family by funeral directors or first responders. Eleven of the twelve subjects expressed that peer support was what had been the most helpful at the time of the suicide, whether they sought postvention support or not.

One of the subjects reported that men and women grieve differently and he felt that as a result support groups should reflect this by being broken up between the sexes. One of the subjects also reported that the postvention support should always be provided by a survivor, whether as a group leader or independent clinician due to the sense of stigma felt by the survivors.

Experiences with Receiving Postvention Support

Five of the twelve members did actively seek out postvention support on their own. All of these subjects were immediate family of the deceased. These five participants included a mother, father, sister, and two daughters (of a mother who took her own life). Among the help received Suicide Survivor Support groups were revealed to be the most helpful. It is noteworthy however that all of the subjects who did seek out help had the education and social standing to know how to find the resources available in the community. All five fell in the upper or middle socio-economic class and based on the researcher's observations during the interviews, it was revealed that three had advanced degrees and two were actively engaged in pursuing their Master's Degree at the time of the death. They also had the financial means and health insurance coverage at the time to afford the specialized clinical help they sought to cover psycho-pharmaceuticals if they were used.

One female subject who lost a brother to suicide two years ago explained that she had just started graduate school in San Diego at the time of the incident. " I went back home for two weeks to Massachusetts, and then I was fortunate because out in San Diego there was Survivor's of Suicide Support groups offered in a variety of different locations…I forget how I even found out about them, I think my mom did it online since she knew I did not yet know anyone". She also explained that she sought out individual counseling as well, "I actually went to the group leader independent of the group for a little while too".

A mother who lost her son explained "Our friends worked very hard and they came up with names of resources. We ended up joining a group for Survivors of Suicide…Then

we went to a Suicide Survivor Conference at MIT. That did begin some very helpful

connections. It is then we saw a psychiatrist who was presenting, who I am very grateful

we found…I also found another support group too that we attended but it is out in

Littleton, which is a little far so we haven't gone to that one too often". When asked what

the most successful intervention was, she explained, "The psychiatrist…it was not that far

away. It was not affordable, however. It was expensive, 175$ for 50 min, but we just

basically said, it doesn't matter. We felt grateful we could afford it because we made it a

priority to try and cope and not let this take over our life and find some meaning".

A father who lost his son expressed, "We were just so overwhelmed with love, our

mailbox was chock full of cards and letters and notes, it was amazing". He added, "We had

friends who are doctors so they prescribed us some meds (valium) right up front…Then I

went to see my primary care physician and he prescribed some antidepressants". In

identifying the most helpful resource he had, he explained, "We found a great doctor

whose life's work is in suicide prevention and survivors. He turned out to be a God

send…he helped us to really understand what had happened and that it wasn't our

fault…He was just totally uplifting and because of him we are on the local board of the

American Foundation of Suicide Prevention". He added, "We had a great parish priest as

well. He was the 'Ying' to the doctor…those two people helped to get us through both

spiritually and mentally".

A female subject who lost her mother to suicide explained that while she had no

support offered to her, she sought out clinical intervention on her own and fortunately had

the health insurance to pay for it. "I had support from three or four close friends, one who

was a survivor…About a month afterwards, I went into therapy and I went to a social

worker. I went to her for therapy and then I went to a psychiatrist and was put on Effexor, which is an antidepressant, it was all for like a 10$ co-pay with my insurance".

Another female subject who lost her brother to suicide explained that she actively sought out support because she had gone through a twelve step program in the past and knew how helpful groups were for her. She actively researched support groups in her area and located a Survivors of Suicide group. "It meets twice a month and then I also found a grief writing group. I also decided it would be a good time to get back into individual therapy too". When asked if referrals were made to her or outreach done, she answered, "Um, no. I chalked that up to the fact that the suicide happened in Indiana and I was here in Massachusetts. I think I first went through the local hospital to see if they had resources, and that is how I found the writing group". In addition to this participant there was one other female subject who lived in another state at the time her mother suicided, however, both sought out support in their own state despite not having referrals. The issue of distance that emerged in this study made clear the need to develop a strategy that took this in to consideration when evaluating a referral list for survivors. An effort should be made to identify the deceased's closest family and friends who reside outside of the location of the suicide so that an adequate list of resources in their area could be sent to them.

Experiences with not Receiving Postvention Support

The seven subjects who did not receive any support after the suicide expressed how difficult it was for them to not have the support extended to them because they felt that given the nature of the death they were either too much in shock to seek it out on their own, or they were unaware that such specific and unique help was even available.

It is important to point out here that of the seven who did not receive postvention support all four of the subjects who were friends of the deceased fell in to this group. The findings of this study reinforce those found in the study conducted by Davis & Hinger (2005) mentioned in Chapter II (Literature Review): friends are at a particular risk for complicated bereavement because there appears to be little support available for this specific relationship. The researcher concluded therefore that friends should be included in all referral policies and efforts should be made to identify the closest friends of the deceased for this purpose through surviving family members or partners.

One subject who lost a friend to suicide explained, "…I think there was no intervention afterwards…If you wanted to go talk to the minister, I guess that was possible, but there wasn't anything for us. I wish that we would have had a chance to talk with our other friends more formally. I think there was informal communication but nothing set up to get us all together to talk about the situation". With respect to whether referrals were made, this subject answered, "Not really, but I think that the church was there to help us if we wanted to. It was assumed but never directly offered". Another subject who also lost a friend to suicide said "Well, I do not think we received any support, except that I talked with my husband". Again with respect to referrals being made, she answered "We know the husband of the victim well and we're not aware of any referrals made to him."

A male subject who lost his father to suicide explained "I was looking back and trying to think if there was anything available and I don't remember any …I buried my father's death big time with drugs and alcohol and my addiction really took off. As far as support groups go, back twenty-seven years ago, I do not know. Like I said before, maybe there wasn't any".

A female subject who lost a friend to suicide explained "I never had any kind of support from anyone, like my parents, you know they didn't know how to support me…. I was working in a school at the time that he (victim) had gone to and a lot of the teachers had had him in class, but they never were like, how are you doing? Are you doing ok?" When asked about referrals or services she might have heard about after the death, she answered "Um, there were no services. I had none available to me". She went on to note "But even in my profession working in a school system as a teacher, I wasn't given any support. I wasn't offered support, it was never, you know 'take some time off to deal with this'". Upon reflecting back on the lack of support she received after the death three years ago, this subject said, "You know at the time it didn't affect me until I went to social work school and realized what someone can offer you. I was like 'Oh my God, what kind of support are you guys giving? Zero!'

A male subject who lost a roommate/ friend and ice hockey teammate six years ago while in college explained, "There was a definite effort made by the school to make it known that support was available but they did not actively go out and approach kids to find out if they needed support…I felt that certain people definitely could have used …a hand on the shoulder and all they would have had to do was ask…Because what 18 year old boy wants the stigma of going to seek mental health counseling?" He went on to explain that, "…I wish there was a greater effort to reach out to people individually, you know?...How hard would it be to ask one guy, 'who is affected the most?'. I think if you sit back and wait for them to come to them, it doesn't happen".

Stigma Experienced

There were ten of the twelve subjects who indicated that they felt stigmatized by the suicide or that the family of the individual who completed suicide was blamed for the death. Two participants who lost a friend indicated that while they themselves did not feel stigmatized they felt that their friend's husband and family were stigmatized. In some cases this stigma was what kept the survivors from actively seeking help. In other cases, it was the stigma that complicated the grieving process for them.

One woman who lost her mother to suicide explained that "We called our minister from when we were kids and asked him if he would preside over the service for her and he refused". She went on to explain how the interaction which took place between herself and the minister over the phone left her "really vulnerable". "He was very cool on the phone, but I feel like that was sort of a punch. I think we were all a little shell shocked by it".

A female subject who lost her female friend to suicide expressed the fact that the stigma of suicide led to conspiracy theories among people in her community. "Her husband (the victim's) was accused by people in the community of murdering her. All of that was known by her kids and our kids in the community…Some of the ones accusing him were like 'Oh just confess!'". A male subject who lost his female friend mirrored this sentiment, "There was a lot of animosity towards the husband afterwards. It was really strong in the town…He eventually left the town."

A male who lost his father explained why he kept his feelings inside and did not share his despair even when asked by his best friend. "I am like, why didn't I just tell him? I do not know if it was shame, I did not feel at the time that it was shame or embarrassment, but maybe it was". Another male who lost his roommate and friend

explained why he did not seek help, "Because there is a huge stigma, especially as a male, as an athlete, as a young adult, you know, like you do not want to appear dependant on anything, especially when it comes to you know, being competent to handle things on your own. I knew I was not going if none of my teammates were going."

A young woman who lost her brother expressed the implications of stigma on her and her family. "I think that was something I was very sensitive to, not necessarily judging me but judging my brother. I remember someone at some point saying, 'Well was he sexually abused as a child or something?' It was a good friend of mine that said this, who was really bright, studied neuroscience in college! I was like 'NO'!" She went on to add, "So there is that stigma attached to it, if you are with other survivors, you feel like you understand what that person went through and you understand that so I think having peers in your healing is really important." Even thought this question itself was perhaps an effort to understand the suicide, the sister of the deceased experienced it as stigmatizing and judgmental. When asked what would be the most helpful in the way of postvention support, she explained, "In general, people's perceptions should be changed so people understand that this is something that can happen to anyone and that there is not necessarily always a reason".

A father who lost his son adds, "I do not know if it is the media or what but there is still a negativity to suicide and I do not think until it happens to you do you realize that there is a story behind a story". A female who lost her brother responded to a question about her ideal postvention program by saying, "Um, let's see, I wish I could imagine a clear postvention picture, but partly because everyone deals with grief differently and partly because there is still such taboo around suicide, I am finding it hard to do."

The Ideal Postvention Support

All of the subjects indicated that community outreach was the most effective way to make postvention support available given the stigma still attached to suicide. A woman who lost her mother said, "The ideal program would have to be an outreach program, something that was very popular like MADD (Mother Against drunk Driving). A brother who lost his sister said, "I think for somebody to reach out in the community would be extremely helpful". A male who lost his friend agreed, "Ideally you would send a person who could be at the scene to help the family." A woman who lost several friends to suicide within a three year period explained, "If I could change the (lack) of support I received, I would want some kind of intervention from the community, not an outsider but somebody that is a trusted member of the community. There must be a therapist in town that would be able to work with survivors…or who could be hired to work with first responders."

A young male who lost his teammate/ roommate felt that, "I wish they had like an emergency response type of crisis handling or interpersonal training…I feel like the priority at least momentarily has to shift to the living and those most affected because when it is over and done with, suicide isn't finite, it finishes for that person but it can last forever for the ones who go on living." He suggested that "Maybe a health insurance provider could send someone out automatically in the event of suicide, this person could come to your house and you could talk to them at no charge".

A woman who lost her brother said, "It definitely needs to be proactive in finding those resources and in a certain way that makes sense but it could probably be helpful if obviously the police department, or something provided a menu so they can say here is what is out there. I feel like I had a little more of that stuff in place because I was at an

academic institution where they can refer, and they have counseling centers". A woman who lost her son explains, "So the perfect program would involve outreach of some kind. You know frequent outreach maybe phone calls or you know, where groups are available, and then probably as someone is ready, contact with a clinician". The father of a son who suicided explained that the ideal postvention should focus on "community outreach, education and communication". A daughter who lost her mother expressed her opinion that, "A person should get in touch with the family, whether they are hired through the funeral home or whatever faith they may be, like through a synagogue or something. Maybe if places like that had someone they could call, like a crisis intervention thing. I just think it is really important that people have a really good support system". A sister who lost her brother expressed her disappointment over the handling of the suicide by the sheriff department when they questioned her brother's friend who found the body, in order to rule out murder. "I guess if the sheriff had called some crisis intervention people to be with my brother's friend, you know, I think that would have really helped".

Another theme that emerged in the responses about an ideal postvention program was that of specialized support groups led by survivors. The subjects articulated that being among peers would elicit understanding and acceptance simply knowing that they were among individuals who had gone through what they went through. Most of the subjects also felt that these groups would be even more effective if they were relationship centered and divided as such.

A daughter who lost her mother felt that, "It would have been great to have had a suicide group available, or if therapists in the area volunteered their time to run something like that…Especially for me because it was my mom, I felt like I had such a special

relationship with her that for me to be in a suicide group with just anybody who had lost a loved one to suicide would not have been enough. For me it would have to be women who lost their moms to suicide". A female who lost a friend felt that "A conversation group for survivors would have been great".

A man whose father suicided answered the question about an ideal postvention program saying, "I would say a couple of things would be needed. A group, where people had the same things happen, where like there was a breakout group in the meeting where you all go into one room if your father committed suicide, for example. A group where people are sharing their experience and somebody is running it who is a counselor but also a survivor, and then following up with the counselor so that suggestions could be made for individual counseling even if it is not with the person running the group." A sister who lost her brother felt that an ideal postvention program would include "a Suicide Survivors Support group led by people who have lost someone to suicide".

All of the subjects also explained that a system should be established wherein referrals can be made for specialized clinicians or groups as well as literature resources for psycho-education, by either funeral directors or first responders in an outreach effort.

A male subject who lost a friend to suicide suggested that "mental health agencies should have available counseling services, literature referrals, and organizations to refer people to". A woman who lost several friends to suicide felt that "funeral homes should offer families support through providing a referral service". In addition she felt that "The chiefs of the police, fire, and rescue, should bring in a clinician they get to know who they can use at the scene, and that they can establish a relationship with".

A mother who lost her son explained that "We did a lot of reading. That was another resource". She explained that "We got books from friends, a lot of friends got us books on suicide and grief, so providing a literature list or something would be helpful". A father said, "I think there is a need for more training, education, and outreach and that since, especially for young men, it is like the second or third largest cause of death…I think we should look at where we are putting money into mental health issues". He added that " I think funeral directors should understand the need for families and friends to have some sort of counseling for issues that can come up—that they (the funeral directors) can tell the family, 'Here is a list of psychiatrists or psychologists to call. I can't tell you who to call but maybe you want to try this one first'. That did not happen for us and I think it needs to be done".

CHAPTER V

DISCUSSION AND CONCLUSION

Expectations and Findings

The researcher expected to find that the current health care system in the US is inadequately prepared to deal with suicide postvention for adult survivors, and that complicated grief and bereavement due to this form of death, continues to be a challenge for survivors, leading to increased risk of psychological, and physiological health problems. The researcher also expected to find that most participants interviewed experienced no community outreach or active postvention treatment plans and that as a result, the participants would be more likely to be socially isolated, leading to little or no treatment intervention received which specifically addressed the bereavement process. The researcher expected to find that specific forms of postvention, such as group therapy versus individual therapy, would be identified as being most helpful. Another expected finding was that men and women prefer and seek different postvention treatment; men preferring individual work and women preferring group or peer support as offered by volunteer survivors, for example.

The findings, literature review and the researcher's personal expectations were congruent. There was no community outreach provided, and specialized group therapy such as Survivors of Suicide, especially relationship centered groups led by survivors, was reported as more valuable than individual counseling. An additional finding not considered by the researcher was indicated by one survivor: that men and woman grieve differently

and so should be afforded gender specific therapy groups. It also surfaced that peer support was highly valued and reported as being the most effective for all subjects including those who had no other form of support and no other intervention.

Limitations of Study

The study certainly has limitations. For one, the researcher was not interested in postvention plans in existence in schools for school aged survivors. These happen to be much more extensive and more thoroughly researched than those being used for adult survivors. The study was conducted with adult survivors within the US and by nature this limits perspectives from survivors of other countries and youth survivors. In addition, as noted, all subjects were part of the dominant culture so different races and ethnicities were not reflected in this study. Another limitation is that given the highly vulnerable population the researcher interviewed, participant availability was likely limited due to the greater likelihood of social isolation of this population. In addition, the stigma associated with suicide may have kept participants from volunteering out of shame. The secrecy factor around death by suicide may have caused participants to be hesitant to partake in a research study, and participants may have chosen not to participate because of the perceived possibility of re-traumatization through discussing the suicide with a stranger. It is probable that this fact contributed to why all subjects were recruited through a random snowball sampling as this approach likely attracted a more resilient subject group who may have worked through their issues of shame and stigma given that for most of the participants at least two to five years had elapsed since the death. In addition because none of the subjects were partners, husbands or wives of the deceased, it is unclear to the

researcher whether or not that specific relationship experiences greater challenges in the bereavement process.

The researcher and the study itself present issues of bias. The researcher's personal experience of being a survivor has led to a subjective opinion that the US is inadequately prepared to address the complicated bereavement of this form of death. As a result the study was set up to explore the effectiveness of postvention plans. In this way, the assumption can be made that the postvention models addressed in the study were ineffective, thereby potentially eliciting from the participants in their interviews all that did not work in their postvention treatment. A conscious attempt was made, therefore, to keep the researcher's subjective views out of the interview process, inviting instead a participant oriented approach wherein the participants told their story in their own voice. The researcher avoided the use of leading questions, reinforcing body language, or verbal responses to anything shared which may reflect the researcher's own bias. In addition, the primary trigger question was set up to avoid insinuating that the postvention plans are being studied for their effectiveness because they are ineffective. The researcher used caution in addressing the nature of the study when describing it to participants so not to insinuate that they are ineffective. Finally, the researcher used conscious self –awareness with respect to bias in the coding of the data, so to avoid not reporting findings that contradict the research hypothesis.

Implications

The findings of the study will likely have implications in the fields of suicidology and thanatology. It has been identified in the current literature that adequate suicide prevention necessitates an effective postvention model to reduce the risk of additional suicides caused by the complicated grief and bereavement experienced by survivors (Carter & Brooks, 1990; Clark, 2001; King, 2001; Leenaars & Wenckstern, 1998). By having an active community based, postvention model in place on a national level, the thanatophobic culture in which we live would be provided with an opportunity to openly address the issue of death and bereavement, thereby normalizing an experience that the Western world tends to avoid and deny; the issue of death and dying. The outreach model, or an active postvention model (APM), should be one that assists not only with emotional support as close to the death as possible, but also can provide educational resources about suicide, practical assistance with post-suicide protocols, such as funeral arrangements, and assistance in navigating the legal matters that ensue (Campbell, et al., 2004). The outreach model should also take into consideration the finding revealed in the study that friends of the deceased were the least likely to receive postvention support or referrals and address this issue head on. Such a program would be multi-tiered and could even provide help to the family of the deceased in notifying other family members of the death. Using the data collected the researcher formulated a suggestion for a comprehensive active postvention model, which is described at the end of this chapter.

Need for Prevention

Because suicide is generally a death that survivors are unprepared for, it often results in shock. The nature of death is also frequently violent in nature, causing the

survivors to be more prone to severe anxiety, nightmares, intrusive memories and other symptoms of post-traumatic stress disorder (Hauser, 1987; Poussaint & Alexander, 2000).The aforementioned societal stigma leads to social isolation. In addition, impaired psychosocial functioning has also been directly linked to the isolation of survivors of sudden and traumatic loss (Dyregrov, 2002; McIntosh, 1987; Poussaint & Alexander, 2000). This social isolation leads to chronically high levels of stress which have been linked to compromised neuroendocrine and psychological functioning, ultimately placing the survivors at greater risk for diseases (Brunner, 1997; Hauser, 1987; Rudestam, 1987). Substance abuse and even suicide in some cases can result, in what is known as the contagion effect of copying methods used in the initial "triggering" suicide. The contagion effect is particularly prevalent in adolescents who appear to be the most reactive to deaths by suicide, likely because they are prone to engage in modeling behavior at this developmental stage (Carter & Brooks, 1990; Clark, 2001; Dunne-Maxim, Dunne & Hauser, 1987; King, 2001; Lamb & Dunne-Maxim, 1987; Leenaars & Wenckstern, 1998). Effective suicide postvention for survivors for use in communities is therefore, a preventative necessity.

All of the subjects interviewed articulated the importance of support groups and the effectiveness of peer support. The researcher believes this reflects the survivors' wish to be accepted and understood given their felt experience of shame and given the tendency towards social isolation. As was reflected in the literature, historically treatment of survivors strongly reinforced the feelings of shame. Today, fortunately, there is a shift in the way in which survivors of suicide are being supported, however, there is much more work still needed to lift them out of the restrictive trauma of centuries of stigma. While

survivors are now free to keep their possessions and their property after a suicide, they are still denied life insurance benefits if the suicide occurs within two years of purchasing the policy (Colt, 1997). It is therefore apparent that while the stigma has considerably lightened, its brand still seers the skin of survivors deep enough to mark them apart from the grief and bereavement caused by other forms of death. This sentiment was certainly reflected in the experience of the subjects interviewed.

Issues of Race and Culture

The fact that all of the subjects of this study were of the dominant culture is a major limitation in this research. Originally the intent of the researcher was to explore the postvention approaches available in the US by including subjects from a number of different locations across the state of Massachusetts to ensure that a realistic variety of experiences was captured. The researcher did not receive any response from subjects of a different race or ethnicity. It is unclear whether this reflects a different cultural approach to suicide postvention in non-dominant cultures, or whether it reflects poor cultural awareness on the part of the research in the way in which subjects were recruited, indicating that perhaps non-dominant cultures are less open about suicide and therefore not attracted to this method of recruitment. It is also possible that the snowball sampling used simply drew from a dominant cultural network despite efforts to recruit samples from various parts of the state to avoid this. One thing that emerged as a result of this limitation, however, is that more culturally sensitive interventions need to be developed in the field of postvention. Only five of the twelve subjects actively sought out and received postvention support. This reflects that the needs of survivors are not being met by the approaches the researcher studied. The researcher feels that because we are barely meeting the needs of

the dominant culture, it is likely that we have fallen very short of meeting the needs of other cultures.

The literature reviewed indicated that the African American men are at a very high risk for suicide. The researcher wonders whether the US as a whole is unprepared to address survivors' needs with cultural competency. The researcher feels it is therefore necessary to research the risk factors associated specifically with African Americans, such as how racism impacts mental health and how this correlates with increased suicide risk (Clark, Anderson, Clark, & Williams, 1999; Poussaint & Alexander, 2000; Willis, et al., 2002).

While important findings were revealed by the study, the researcher feels that the proposed National Suicide Postvention Plan that follows colludes with the status quo and reflects, as stated, only the dominant culture's voice in its creation. The researcher feels therefore that there is a need to conduct this same study with only members of non-dominant cultures and then combine the findings to revamp the proposed program so that it is made more culturally sensitive. With this disclaimer in place, the program that follows was created with the intent of more fully meeting the needs of survivors' by incorporating the voice of the subjects interviewed.

Proposed National Suicide Postvention Plan

This proposed plan is multi-tiered and team based. It involves a collaboration of many agencies and support networks. Ideally, the researcher would like to see this service funded by the government under the National Suicide Prevention Plan and the AFSP and available to survivors free of charge. However, it seems more likely that it be a service covered by the health insurance of the survivors, with no co-payment charged. Each major

city in the US would begin with one postvention team. This team would be modeled after the Hospice model of care, which enlists an entire team to assist each family. Upon first response to a potential suicide by EMS, Firefighters, or Police, the Postvention Team would be called in and at least one member of the team would arrive at the scene with the first responders. This first representative of the team would introduce the team concept to the survivors and explain the various roles each team member holds. The team representative would stay with the survivors through the death pronouncement, body removal, and investigation should one be conducted. Contact information for the team, including a twenty-four hour crisis line telephone number would be given to the survivors. It would be indicated that the other team members would contact the survivors and make their respective initial visits within twenty-four hours of the death, at a time that is convenient for the survivors. By meeting with the survivors the team would identify other survivors, and pay special attention to friends as well as family of the deceased that may live outside of the area where the suicide occurred and contact those distant survivors to provide a list of referrals for support in their area as well as connect them with the closest National Postvention Team in their area.

The team would include a social worker who would also serve as a case manager, one to two trained survivor volunteers to provide peer support (they must be at least two years beyond their own loss and have undergone an extensive thirty hour training held twice a year by the Postvention Team in the Spring and in the Fall), and a physician or nurse practitioner, available to address the physical and medical issues of survivors which may arise, including prescriptions for sedatives or sleeping pills should these be necessary, and to monitor blood pressure, etc., as well as to instruct and assist survivors with self-care

during this traumatic time when so often this gets neglected, potentially further

complicating grief.

The social worker/ case manager would distribute literature to survivors, to which

they can refer during their healing process, such as *Surviving a Suicide Loss: A Resource*

and Healing Guide, a booklet put out by the American Foundation for Suicide Prevention.

Assessment about bereavement risk could be done by the social worker at the time of or

shortly after the incident. The social worker would also make an assessment at the same

time about how long the team should expect to be involved with the case and provide

service, with full team support for the first week and then more limited aid such as weekly

volunteer support and weekly or bi-weekly support from the social worker, eventually

establishing a once a month visit with the social worker (depending on assessed

bereavement risk). This more limited support would continue for thirteen months after the

death so to aid the survivors through the one year anniversary mark. The social worker

could also make referrals for emotional and psychological support to clinicians affiliated

with the team who specialize in traumatic loss and suicide postvention. In addition,

referrals would also be made to Survivors of Suicide Support groups in the area. The social

worker would also offer to assist with the pragmatic aspects of the post suicide protocol,

such as funeral arrangements by connecting the survivors to local funeral directors, etc., as

well as introduce the trained survivor volunteers to the family.

The volunteer's role would include offering to simply be a companion to the

survivor, helping with meals, offering to make calls to friends and family about the death,

holding the survivors hand as he/she writes the obituary, or even cleaning out the

deceased's things from the home. The volunteers would be available to the survivors for

shifts up to three hours at a time five days a week if needed for the first one to two weeks

(if assessed by the social worker as being a serious bereavement risk), and then to a more

limited schedule for the rest of the thirteen months the survivor is on service with the

postvention team.

All civic professionals would be trained in the unique approach to postvention

support as part of their specific job training, using a manual released by the Colorado

Office of Suicide Prevention, in 1996, *Suicide First Response: A Training Manual for

Professionals Who Respond to Suicides*. They would also be taught about sensitivity in

communicating with the media and the importance of the impact of their words and their

handling of investigative questions.

Each year on National Survivors of Suicide Day (created by U. S. senate

resolution, through the efforts of Sen. Harry Reid of Nevada), the American Foundation

for Suicide Prevention, links simultaneous survivor conferences through a broadcast via

satellite and the web. The National Postvention Plan this researcher is proposing, would

sponsor a media award on this day as part of the simultaneous conferences broadcast

through satellite or the web. It would be given to the reporter, journalist, or editor who

most sensitively portrays suicide, thereby serving to discourage sensationalized or

simplistic portrayal that can be very harmful to survivors. On the Saturday before National

Survivors of Suicide Day, every major city would simultaneously hold a 5K road race

(similar to the Susan G. Komen Race for the Cure), with all proceeds funding postvention

support and for services provided by the Postvention Team. The proceeds would also be

used to fund research to further study this public health problem from a culturally

competent perspective. The nationally held 5K races would serve to raise public awareness

of the problem and would allow the public to be involved in supporting survivors, ultimately desensitizing the discomfort around the issue of suicide. A different approach is however possible. A working alliance between survivors and the media can be accomplished through using survivors to help in the fight for suicide prevention as well as desensitization of the stigma of suicide in relaying the true nature of death thereby providing courage for other survivors to come out of the closet (Dunne-Maxim, 1987). In this same vain, celebrities who are survivors can be encouraged to help in the efforts to desensitize the stigma through bring awareness to the issue.

Effective guidelines for media coverage can be established to help in the desensitization efforts. Suicide has many factors present, including psychological, cultural, sociological, interpersonal, interpsychic and philosophical, and therefore it is very important to consider the appropriate angle to take in media coverage. Some angles can actually be useful in the healing process, such as entirely avoiding a blaming stance for example. What is needed is not a censoring by the media but rather a sensitization of the reporters about the unique vulnerabilities of survivors. An ideal way this might be accomplished is through the establishment of an alliance between reporters and clinicians working in the field of postvention who can be used as consults to ensure effective and sensitive news coverage (Dunne-Maxim, 1987).

Recruiting celebrities willing to promote the National Postvention events through the media would be very useful in spreading public awareness and inspiring support for the cause. The proposed plan also calls for an interactive website where survivors can chat with each other and have their feelings normalized, perhaps directly through the American Foundation for Suicide Prevention website.

This multi-tiered approach is consistent with the foundations of social work which is to address the biopsychosocial needs of the client, and so this holistic approach would foster greater respect for the victims of this tragic form of loss, and provide them instead with dignity and right to a life free of stigma and judgment.

A benefit to such a multi-tiered approach is that it provides an opportunity for survivors to move through their bereavement by making meaning of their own loss. They can extend their support to others who have lost loved ones to suicide. Indeed this proposed plan offers a number of possible avenues for survivors to get involved and potentially become an integral part of another person's healing. Survivors could go through the volunteer training and join their city's Postvention Team or could volunteer in other ways as well, such as working at the various events on National Suicide Postvention Day, or simply spreading awareness about the unique difficulties facing suicide survivors.

Because the findings of the study indicated the value of active outreach and peer support, this proposed National Suicide Postvention Plan would focus on meeting the needs of survivors in this way. This plan also provides an opportunity to survivors to find some meaning in their personal life for the tragedy experienced, despite perhaps never understanding why their loved one took their own life. It promotes a societal reaction to suicide that is supportive and this would allow survivors to navigate the complicated bereavement without the weight of stigma holding them down. In turn this would assist survivors to make meaning of their loss and channel their grief in a productive and potentially uplifting way through helping other survivors once they feel ready.

References

Appel, Y., & Wrobleski, A. (1987). Self-help and support groups: Mutual aid for survivors. In E. Dunne, J. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling the Survivors* (p.215-233). New York: W.W. Norton & Company.

Alexander, V. (1991). *In the Wake of Suicide: Stories of the People Left Behind.* San Francisco: Jossey-Bass Publishers.

Anastas, J. (1999). *Research Design for Social Work and the Human Services (2ⁿᵈ ed.).* New York: Columbia University Press.

Andriessen, K. (2004). How to increase suicide survivor support? Experiences from the national survivor program in Flanders- Belgium. Retrieved 06/06/06, from www.scholar.google.com.

Brent, D. A., Moritz, G., Bridge, J., Perper, J. A., Canobbio, R. (1996). The impact of adolescent suicide on siblings and parents: A longitudinal follow-up. *Suicide and Life Threatening Behavior, 26,* 253-259.

Brunner, E. (1997) Socioeconomic determinants of health: Stress and the biology of inequality. *British Medical Journal, 314,* 1472-1481.

Campbell, F. R., Cataldie, L., McIntosh, J., Millet, K. (2004). An active postvention program. *Crisis, 25,* 30-32.

Carlson, T. (1999). *Suicide Survivors' Handbook.* Duluth: Benline Press.

Carter, B. F. & Frank, Brooks, A. (1990). Suicide postvention: crisis or opportunity? *School Counselor, 37,* 378-390.

Center for Disease Control. (1998). *Suicide Among Black Youths- United States*, 1980-1995. Atlanta: US Department of Health and Human Services.

Clark, R., Anderson, N., Clark, V., & Williams, D. (1999). Racism as a stressor for African-Americans: A biopsychosocial model. *American Psychologist*, *54*, 805-816.

Colt, G. H. (1987). The history of the suicide survivor: The mark of Cain. In E .Dunne, J. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling the Survivors* (pp.3-18). New York: W.W. Norton & Company.

Cvinar, J. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care, 41,* 14-21.

Davis, C., & Hinger, B. (2005). Assessing the needs of survivors of suicide. Alberta: Calgary Health Region.

Danto, B. (1987). Recommendations for police officers and physicians. In E Dunne, J. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling the Survivor* (pp.163-170). New York: W.W Norton & Company.

Document of the U. S. Public Health Service, "The Surgeon General's call to action to prevent suicide, 1999". In *Historic documents of 1999.* Washington: CQ Press. Retrieved June 24th, 2006 from CQ Electronic Library, CQ Public Affairs Collection, http://library.cqpress.com/cqpac/hsdc99-0000038585. Document ID:hsdc99-0000038585.

Doka, K. (2002). Disenfranchised grief. In K. Doka (Ed.), *Living with Grief: Loss in Later Life* (pp.159-168). Washington: The Hospice Foundation of America.

Drisko, J. (1997) Strengthening qualitative studies and reports: Standards to promote academic integrity. *Journal of Social Work Education, 33,* 185-197.

Dunne, E. & Dunne-Maxim, K. (1987) Preface. In E, Dunne, J. McIntosh, K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling the Survivor* (pp. xi-xix). New York: W.W. Norton & Company.

Dunne-Maxim, K., Dunne, E., & Hauser, M. (1987).When children are suicide survivors. In E. Dunne, J. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling the Survivor* (pp. 234-244). New York: W.W Norton & Company.

Dyregrov, K. (2002) Assistance from local authorities versus survivor's needs for support after suicide, *Death Studies, 26,* 647-668.

Fielden, J. (2003). Grief as a transformative experience: Weaving through the different lifeworlds after a loved one has completed suicide. *International Journal of Mental Health Nursing, 12*, 74-85.

Fine, C. (1997). *No Time to Say Goodbye*: *Surviving the Suicide of a Loved One*. New York: Broadway Books.

Gibbs, J. (1988). *Young, Black and Male in America: An Endangered Species.* Westport: Greenwood Press.

Gibbs, J. (1997). African- American suicide: A cultural paradox. *Suicide and Life-Threatening Behavior*, *27,* 68-79.

Glover, B. (1999).*The Empty Chair: The Journey of Grief After Suicide.* Oklahoma City: In-Sight Books.

Hauser, M. (1987). Special aspects of grief after suicide. In E. Dunne, J. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling Survivors* (pp. 57-70). New York: W.W. Norton & Company.

Jones, F. (1987). Therapists as survivors of client suicide. In E. Dunne, J. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling Survivors* (pp.126-141). New York: W.W Norton & Company.

King, K. (2001). Developing a comprehensive school suicide prevention program. *Journal of School Health, 71,* 132-137.

Lamb, F., & Dunne- Maxim, K. (1987) Postvention in schools; Policy and process. In E. Dunne, McIntosh, J., & K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling Survivors* (pp.245-260). New York: W.W Norton & Company.

Leenaars, A., & Wenckstern, S. (1998). Principals of postvention: Applications to suicide and trauma in schools. *Death Studies, 22,* 357-391.

Lester, D. (1998). *Suicide in African-Americans.* Commack: Nova Science.

McIntosh, J. (1987). Suicide as a mental health problem: Epidemiological aspects. In E. Dunne, J. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling Survivors* (pp. 19-30). New York: Norton & Company.

McIntosh, J., & Santos, J. (1984). Suicide counseling and intervention with racial/ethnic minorities. In C. Hatton & S. Valente (Eds.), *Suicide: Assessment and Intervention* (2nd ed.) (pp. 175-194). Norwalk: Appelton-Century-Crofts.

Mitchell, A., Dysart Gale, D., Garand, L., & Wesner, S. (2003). The use of narrative data to inform the psychotherapeutic group process with suicide survivors. *Issues in Mental Health Nursing, 24*, 91-106.

Patton, C.M. (1996). Evaluation of suicide postvention: Effects of postvention on suicide survivors. Dissertation. Dissertation Abstracts International, 56, 11b:6030.

Posner, D. (1987) Suicide and the Jewish tradition. In E. Dunne, J. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling the Survivors* (pp.159-162). New York: W.W. Norton & Company.

Poussaint, A., & Alexander, A. (2000). *Lay My Burden Down.* Boston: Beacon Press.

Robinson, R. (2001). *Survivors of Suicide.* Franklin Lakes: New Page Books.

Ross, E. (1997). *After Suicide: A Ray of Hope for Those Left Behind.* Cambridge: Da Capo Books.

Roy, A., Nielsen, D., Rylander, G., Sarchiapone, M. (2000). The genetics of suicidal behavior. In K. Hawton & K. Van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp.209-221). Chinchester: John Wiley & Sons, Ltd.

Rubey, C., &Clark, D. (1987) Suicide survivors and the clergy. In E. Dunne, J. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling the Survivors* (pp. 151-158). New York: W.W. Norton & Company.

Rudestam, K. (1987). Public perceptions of suicide survivors. In E. Dunne, J. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its Aftermath: Understanding and Counseling the Survivors* (pp. 31-44). New York: W.W. Norton & Company.

Shneidman, E. S. (1971). Prevention, intervention, and postvention of suicide. *Annuls of Internal Medicine, 75,* 453-458.

Shneidman, E. S. (1972). Foreword. In A. Cain (Ed.), *Survivors of Suicide.* Springfield: Charles C. Thomas.

Smolin, A., & Guinan, J. (1993) *Healing After the Suicide of a Loved One.* New York: Simon & Schuster.

Stillion, J. (1996) Survivors of suicide. In K. Doka (Ed.), *Living with grief after sudden loss*. (pp. 41-52). Washington: Taylor & Francis.

Suicide: Cost to the Nation. (n.d.) Retrieved June 24th, 2006, from http://www.mentalhealth.samha.gov/suicideprevention/costtonation.asp

Surviving a Suicide Loss: A resource and healing guide. (n.d.) Retrieved September 26th, 2006, from http://www.afsp.org/files/Surviving//resource_healing_guide.pdf

Survivor Research. (n.d.) Retrieved September 11th, 2006, from http://www.afsp.org/index.cfm?fuseaction=home.viewpage&page_id2D9DF73E-BB25-0

Willis, L., Coombs, D., Cockerham, W., & Frison, S. (2002). Ready to die: A postmodern interpretation of the increase of African-American adolescent male suicide. *Social Science & Medicine*, *55*, 907-920

APPENDIX A

Informed Consent Form

Dear Participant,

My name is Seana Carmean. I am a second year graduate student at Smith College pursuing a Master's Degree in Clinical Social Work. I am conducting a research study for my Master's thesis, on suicide postvention; the interventions and treatments provided to survivors of suicide. Survivors are described as those family members, partners, and friends who have survived the deceased. I am exploring the effectiveness of assistance available currently to individuals who have lost a loved one to suicide. I plan to use the experience of the survivors themselves to help inform and stimulate effective approaches to support. The data collected for my study will be used explicitly for my thesis project and will be published by Smith College School for Social Work. It is my great aspiration that this study be used ultimately to further research into the development of a national suicide postvention program.

The participant's involvement in the study will be in the form of an in-depth, in person interview, lasting approximately one hour. All participants must be 18 or older and be a survivor of suicide (survivors constitute any form of relationship to a loved one who completed suicide). No children or individuals who were under age 18 at the time of the suicide will be included. Because I acknowledge the extreme vulnerability inherent in being a survivor, the participant should be at least 2 years beyond the date of the suicide, to reduce potential difficulty in answering questions, and to protect survivor's grief experience. The questions will be open-ended to encourage survivors to answer in their own voice as the research is focused on the input of survivors themselves in improving postvention treatment. The interviews will begin with a primary trigger question and I will stimulate further dialogue through other predetermined questions to ensure a level of consistency in each interview. I will be tape recording sessions and then transcribing them into written form to use in my thesis.

In an effort to protect the vulnerability of survivors, my research is focused on the survivors' experience of postvention treatment, there is no need to reveal anything to me about your deceased loved one if you choose not to. For screening purposes, I need only to know the nature of the relationship, and the length of time passed since the death. Once the interview is completed, if you have something that you would like to add, you will be provided with my card to contact me should you need to.

It is important that you are aware of the possible risk of emotional difficulty in engaging in this process as it will likely bring up challenging and painful memories. If you feel incapable of tolerating this risk at this time in your bereavement process, I encourage you to abstain from the research study. It is crucial that you take care of yourself as a survivor. If you recognize that emotional discomfort may arise but you feel capable of tolerating it at this time, I encourage you to partake. I will provide you with a referral list of professionals in your area who might be able to assist you should you need this once the interview is completed.

Your involvement in this study will be incredibly valuable to the field of postvention treatment in Social Work. The most effective treatment for survivors can be established through survivors themselves and involvement in this study will give you an opportunity to voice your perspective on how to help this unique population. In addition, participation may provide you with the benefit of "telling your story", which can be therapeutic in itself.

All identifying information will be concealed and all names will be changed for use in my thesis. I encourage you to use a pseudo-name with me if that is more comfortable for you, or simply provide me with your first name. I will store all data collected in a locked container, and only I will have access to the narratives. These data will be kept securely locked in accordance with Federal guidelines for three years beyond the date of collection and will be appropriately destroyed after this time.

All participation in this study is voluntary and you can withdraw from the study at anytime should you experience intolerable emotional discomfort during the course of the interview, or leading up to the interview. Withdrawal can be done up to 3 hours before the agreed upon interview time, and can be done by leaving a message for me at 413-626-3231. In addition, should you complete the interview but then decide to withdraw your participation, this can be done up to March 15th, 2007.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

 X

APPENDIX B

Recruitment Letter

Date:

Dear   :

My name is Seana Carmean. I am a second year graduate student pursuing a Master's
Degree in Social work at the Smith College School for Social Work. I am currently
conducting research to be used for the requirements of the MSW Thesis. The research
study I am conducting is on suicide postvention, the intervention available to survivors of
suicide, defined as the family members, friends, or partners who have lost a loved one to
suicide.

This unique population is prone to complicated grief and bereavement due to the nature of
the death, leading to increased risk of poor mental, emotional, and physical health. Because
research in the field of suicide postvention has taken a back seat to the research on
prevention, there is a need to make this area of study a priority for the health of our nation.
The thesis project I am conducting will aim to identify some current models of suicide
postvention and explore their perceived effectiveness through the voice of the survivors
themselves.

The potential usefulness of the findings could have implications for nurses and social
workers working in the area of suicide bereavement. In addition, it is my hope that through
sharing their experience of postvention treatment, survivors will be afforded an
opportunity for potential healing and a possibility to gain new insights into their experience
of loss.

Using a qualitative, exploratory research design, I plan to use narrative data gathered
through in-depth, in person, tape recorded interviews, beginning with a primary question. I
will also have a number of other pre-determined questions to stimulate ongoing dialogue
and to maintain consistency among all interviews. I will attempt to keep all interviews to
approximately one hour in duration. The questions will be open-ended to encourage
survivors to answer in their own voice and will be focused on how they perceived the
effectiveness of the postvention approaches they received, what was available to them in
the way of support, and how they were able to access this support if they did.

Because I recognize the vulnerability of the population and the potential for
retraumatization through discussing the subject of suicide, all interviews will be centered
on questions about the survivors' experience and will be kept completely confidential. I
will change all names and identifying information in all data collected. For screening
purposes, however, I will ask about the nature of the relationship of the survivor to the

deceased (mother, father, etc), and about the duration of time passed since the loss occurred.

All participants must be 18 or older, and must have been at least 18 at the time of the death. They must all live within the state of MA, and have endured the loss at least one year ago. All participants must be English speaking due to my own language limitations as the researcher. At the interview, the participants will be provided with a list of resources for support including your agency.

I would greatly appreciate any help that you may be able to offer in the way of assisting me in recruiting participants for this study. If you could post the included flyer at your agency and also hand out the provided photocopies of this flyer at your next bereavement support group, I would be very grateful. The study I am conducting may help us to understand what survivors themselves identify as effective assistance. If you or anyone at the agency knows of participants who may fit the criteria mentioned above, please forward my email address and phone number to potential participants. I thank you in advance for your help and express my gratitude for your efforts to help me make a difference in the lives of individuals who have endured a difficult and complicated grief and bereavement.

Sincerely,

Seana Carmean
scarmean@smith.edu
413-626-3231

APPENDIX C

Interview Guide

Demographics:
This demographic section will be completed by me for the use of identifying subjects and coding data before the "Primary Trigger Question" is asked. I will indicate that all demographic questions are optional.

*Gender:
*Age:
*Relationship to deceased:
*Time elapsed since death:
*Race/ Ethnic Orientation:
*Spiritual, Religious, or Faith Affiliation:
*Were you(the participant) actively involved in mental health counseling or support at the time of the suicide? If yes, where and for how long?

Primary Trigger Question:

1) You have told me that your (relation to deceased, ex: brother, mother, etc) completed suicide (time since death, ex: 2 years ago). In this interview, I would like you to tell me about the type of intervention and support that you received after the death. Talk as openly and as freely as you want. It may help to begin with the support you received immediately following the death, up until now. There are no right or wrong answers. You may also discuss the support you did not receive but had wished you had, and what you might like to see available to others going through the same difficulty. The most important thing is that you begin with whatever feels the most comfortable.

Additional predetermined questions to maintain consistency in interviews and stimulate ongoing conversation:

2) Are you still seeking support? If so what kind of treatment?

3) What services were the most helpful and at what point were they offered? How did you get in touch with them? Did anyone refer you to these services, if so who?

4) How accessible was the support? How far away was it from your home and how easy was it to get to?

5) What services were not as helpful and why?

6) Did any of the services you received do follow up support after you stopped seeking treatment?

7) If you could create the perfect suicide postvention program, what are some things that you would absolutely want to be included, and are there some things you would want to be handled in a very specific manner, (such as reactions by first responders and funeral homes, etc)?

8) Is there anything else that you feel you want to add at this time?

▪▪▪

I will leave my card for all participants with instructions to call me if they remember something that they wanted to include once I have left.

APPENDIX D

Resources

E-mail Support Groups and Chat Groups:

www.afsp.org

www.angelfire.com/ga4/ffos/Suicide_Discussion_board.html

www.griefnet.org

www.grohol.com/helpme.htm

www.groww.org/Branches/sos.htm

www.healingthehurt.com

www.pbs.org/weblab/living

www.compassionatefriends.org

www.thegiftofkeith.org/info/main_navigation.html

www.samaritanshope.org

www.siblingsurvivors.com

www.suicidememorialwall.com

www.survivorsofsuicide.com

Websites for Suicide Prevention and Awareness:

www.familyaware.org

www.nami.org
This is the National Alliance on Mental Illness and is a resource for individuals at risk for suicide. It includes education on depression, how to manage stress, and how to live with grief.

APPENDIX E

Massachusetts Suicide Survivor Support Groups

Metro Boston:
Samaritans
141 Tremont St, 7th Floor Boston, MA 02111
617-534-2460
Crisis line: 617-247-0220; 817-870-4673
www.samaritanshope.org
Peer based leadership groups meeting twice a month free of charge in Metro Boston, Quincy, Medford, Worcester, and Framingham.

The Good Grief Program
Boston Medical Centre, 91 East Concord St. Boston, MA 02118
617-414-4005
Contact: Maria Trozzi
www.bmc.org/pediatrics
Support groups and bereavement for child survivors. Also provides crisis response to schools after suicide. Groups in Jamaica Plain and Hingham.

Metrowest:
Family Loss Project
Suicide Grief Support Group
26 Curve St, Sherborn, MA 01770
508-653-1609
Email:jjorddan50@aol.com
A series of 10 two-hour group sessions every other week for survivors. Fees based on insurance and sliding scale.

Southeast:
Samaritans of Fall River/ New Bedford
PO Box 1333, Westport, MA 02790
508-673-3777
508-673-5160
Toll free: 866-508-4357
Peer led groups for survivors, twice a month on first and third Wednesday, free of charge.

Northeast/Merrimack Valley
Samaritans of Merrimack Valley
A program of family Service, Inc.
430 North Canal St. Lawrence, MA 01840
978-688-0030
Crisis line: 1-866-912-4673
          978-688-6607

Support groups for survivors, meets second and fourth Tuesdays of month free of charge at 7:00 to 8:30 PM. Held at St. Michael's Church, 196 Main St. North Andover, MA

Cape Cod:
Compassionate Friends
Harwich Community Centre
Oak St. Harwich, MA
508-432-4287
Peer led groups for survivors, every second Wednesday of the month at 7:30 PM free of charge.

The Samaritans on Cape Cod & the Islands
65 Town Hall Square, Falmouth, MA 02541
Crisis line: 508-548-8900
Toll free: 800-893-9900
Crisis line operates 7 days a week to support bereaved survivors.

Western:
Forestiere Family Funeral Home
220 North Main St, East Longmeadow, MA 01028
Contact: Mary Pat Mcmahon
413-734-9139
Peer led groups for survivors of suicide, meeting twice a month on first and third Mondays from 6:45 to 9:00 PM. Free of charge.

HospiceCare in the Berkshires
369 South St, Pittsfield, MA 01201
413-443-2994
Various loss support groups available free of charge. One-on-one sessions also available.

The Garden: A centre for Grieving Children and Teens
286 Prospect St, Northampton, MA 01060
413-584-7086 ext. 124
Contact: Shelly Bathe Lenn   www.garden-cgc.org
Groups led by trained members, for children and families free of charge.

SMITH COLLEGE
School for
Social Work

Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

November 15, 2006

Seana Carmean
30 North Street
Belchertown, MA 01007

Dear Seana,

Thanks for returning the corrected Consent. We are now happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

I hope your recruitment efforts are successful. It will be interesting to see whether this population will be willing to revisit this painful time. They may well be interested, hopefully, in having a chance to have their say. Good luck.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Nel Wijnhoven, Research Advisor