

2001

The Influence of an Active Postvention on the Length of Time Elapsed Before Survivors of Suicide Seek Treatment.

Frank Ray Campbell

Louisiana State University and Agricultural & Mechanical College

Follow this and additional works at: https://digitalcommons.lsu.edu/gradschool_disstheses

Recommended Citation

Campbell, Frank Ray, "The Influence of an Active Postvention on the Length of Time Elapsed Before Survivors of Suicide Seek Treatment." (2001). *LSU Historical Dissertations and Theses*. 397.
https://digitalcommons.lsu.edu/gradschool_disstheses/397

This Dissertation is brought to you for free and open access by the Graduate School at LSU Digital Commons. It has been accepted for inclusion in LSU Historical Dissertations and Theses by an authorized administrator of LSU Digital Commons. For more information, please contact gradetd@lsu.edu.

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

**ProQuest Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600**

UMI[®]

**THE INFLUENCE OF AN ACTIVE
POSTVENTION ON THE LENGTH OF TIME
ELAPSED BEFORE SURVIVORS OF
SUICIDE SEEK TREATMENT**

A Dissertation

**Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
In partial fulfillment of the
requirements for the degree of
Doctor of Philosophy**

in

The School of Social Work

**by
Frank R. Campbell
B.S., Louisiana State University, 1972
M.S.W., Louisiana State University, 1988
December 2001**

UMI Number: 3042613

UMI[®]

UMI Microform 3042613

Copyright 2002 by ProQuest Information and Learning Company.

All rights reserved. This microform edition is protected against
unauthorized copying under Title 17, United States Code.

ProQuest Information and Learning Company
300 North Zeeb Road
P.O. Box 1346
Ann Arbor, MI 48106-1346

DEDICATION

This dissertation is dedicated to the memory of three men. Roger J. Tierney, Ph.D. from Canada was instrumental until the very end of his life in making a difference in the global rate of suicide. Stanley Abadie, Ph.D. from Louisiana lived his life above the petty concerns of those who could not see the vision that he had for Allied Health in this state. Michael Kelleher, M.D. from the Republic of Ireland stood on a distant shore and responded to the suicides in his country with the care and concern to which all physicians should aspire. These men were taken too soon by cancer and each leaves behind a legacy of change because they lived. Their support and friendship during their lives has been priceless and they remain an inspiration to me still in the work I hope to accomplish before I join them.

ACKNOWLEDGEMENTS

I wish to thank my wife Cheryl for her support, help, and patience in tolerating a grumpy non-traditional student and my daughters Barrett and London for believing in me and accepting that their father was in school through most of their developmental stages. For supporting me through the many challenges of graduate school, I thank my colleagues Taryn, Peggy, Jimmy. For being my installation of hope, my thanks to Dr. Nancy Hart. My sincere thanks to my Ph. D. committee members Dr. Margo Abadie, Dr. Barry Daste, Dr. John McIntosh, Dr. Kenneth Millar, and of course, my mentor and committee chair Dr. Brij Mohan. Special thanks to Dr. Stacia Haynie, representative of the Dean of the Graduate School, and to Dr. Michael Burnett for being an incredible resource for dissertation preparation. Thanks to Carol Anding for helping me resurrect data from computers and to the Killer Bees for their unconditional support, encouragement, and confidence in me as a person. I also want to express my thanks to the board of directors, staff, and volunteers of The Baton Rouge Crisis Intervention Center and, of course, the survivors and LOSS Team members who give so much to help others who are experiencing the pain and confusion that is suicide.

TABLE OF CONTENTS

DEDICATION.....	ii
ACKNOWLEDGEMENTS.....	iii
LIST OF TABLES.....	v
ABSTRACT.....	vi
INTRODUCTION.....	1
Statement of the Problem.....	14
Objectives.....	18
Definition of Terms	19
REVIEW OF THE LITERATURE.....	22
METHODOLOGY	43
Purpose of the Study.....	44
Population and Sample.....	45
Instrumentation and Data Collection.....	46
Data Analysis.....	47
FINDINGS.....	49
Objective One.....	49
Objective Two.....	53
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	
Summary.....	58
Conclusions and Recommendations.....	62
REFERENCES.....	66
APPENDIX: Suicide Survivor Intake Form.....	71
VITA.....	75

LIST OF TABLES

1. Survivor reactions to suicide.....	26
2. Age of survivors by group and age category.....	50
3. Relationship to the deceased.....	51
4. Elapsed time from death to assessment.....	53
5. Crosstabulation for RELGEN and APM.....	55
6. t-Test for AGE and APM or No-APM	56

ABSTRACT

Those who are significantly impacted by the death of someone to suicide are known as survivors of suicide. This study examined two groups of suicide survivors, one group received an active postvention model (APM), and the other group received no active postvention model. The study utilized both t-test and chi-square to compare the groups based on key demographic characteristics. The study compared model of postvention (active versus passive) for the time elapsed between the suicide and the survivors seeking treatment.

The two groups studied were survivors who sought treatment at a well established metropolitan crisis intervention center in the southern United States between January 1, 1999, and December 31, 2000. The experimental group received an active postvention and the control group was survivors who came to the center but did not receive an active postvention. The demographic information was obtained from the assessment forms completed by crisis center representatives conducting interviews with members of both groups of survivors. The study used data taken from the records of 126 subjects, experimental group (n=50) and control group (n=76). The 126 subjects represent the entire population of survivors of suicide seeking treatment at that particular crisis center during the two-year period (1999-2000) of examination. The research examined the impact that postvention services (an organized team response to the bereaved following

suicide) had as an influence on the length of time elapsed before survivors of suicide sought treatment.

The significant impact suicide can have on survivors has been discussed and reviewed in the literature (McIntosh, 1993), however little is known about the impact of postvention services when delivered to survivors in a timely manner. The postvention responders were trained in crisis intervention, critical incidence stress debriefing, and in facilitating survivor grief recovery. Included in that group were both mental health workers and survivors of suicide. The members of the postvention team who are survivors of suicide had previously participated in the survivor resources that they suggested during each postvention. The research employed bivariate analysis in the research design with a longitudinal component.

INTRODUCTION

The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description - Dr. Kay Redfield-Jamison, *Night falls fast*

Individual experiences and the sum of societal experience help to decide how a culture or group will approach those who are suicidal or the survivors who are grieving a death by suicide. The French sociologist, Emile Durkheim published his book *Le Suicide* in 1897 as a comparative study of suicide in the postindustrial society (Durkheim, 1951). This groundbreaking work by Durkheim was critical to the exploration of theories about suicidal behavior. Of the many researchers who have followed in Durkheim's path, Edwin Shneidman may have been the most influential in American suicidology. His theories have been used throughout the world to help understand the concepts of suicide first discussed by Durkheim.

The global impact of suicide can be viewed from both an historic and cultural perspective. The temporal dimensions of past, present, and future have special meaning when considering the way society has responded to the death of someone to suicide. In written and scientific history a variety of explanations have been accepted over the centuries to help one accept or reject suicide as a method of dying. Societies have developed many conflicting attributes to describe the act of suicide including "cowardice, weakness, irresponsibility, escapism, sinfulness, independence, heroism, or some combination of these" (van Hooff, p.96, in Maris et al., 2000).

Examination of suicide from an historical as well as a cultural basis helps to clarify the impact of suicide by those who are bereaved by this human behavior. Thousands of years of blending, rejecting, and accepting new perspectives on suicide have influenced the many cultures that make up our international community. From the widow in India who commits "suttee" by throwing herself on her husband's funeral pyre, to the 17th century Japanese code of "Bushido" suicide, examples of suicide as an appropriate societal response can be discovered (Bongar, 1991). Litman noted that "either God or man is responsible for each death (i.e., homicide, suicide); and if it was God's responsibility, nothing more is needed to be done, but if a human was to blame, then there must be a punishment for the guilty" (Bongar, 1991 pp. 2-3). This need to blame someone when God is not responsible has contributed to the rumors of motives as well as the shame assigned to the survivors. As the ability to migrate and assimilate into new cultures evolved, the cultural value of blaming or approving of a death by suicide, as well as the acceptance of suicide as a response to problems, came with those who resettled in new areas of the world. In addition to the many cultural influences regarding suicide there have been contributions by medical science, economics, religious groups, governments, mental health professionals, and researchers. In addition, poets and philosophers have been instrumental in creating cultural values about suicide. The accumulation of views on suicide has greatly impacted the general knowledge base that creates the myths and facts each culture and

generation has accepted and passed on to their heirs. The primary methods of suicide have evolved over the centuries (e.g., firearms instead of swords). Although technology and accessibility have greatly influenced the methods chosen, the ability to communicate the complex nature of self-murder to those who had a close emotional tie to the deceased as well as to the innocent bystander has also been influenced. Data collected by the World Health Organization (WHO) clarified that the global impact of suicide has reached a critical juncture promoting action by the WHO to "substantially expand their investment in mental health" (WHO/OMS, 2000) issues. In 1999, the World Health Organization responded to their awareness of suicide as a global public health concern by launching a worldwide initiative for the prevention of suicide known as SUPRE (suicide prevention). Of importance to the recognition of survivors as individuals impacted by suicide and deserving of help in coping with the death by suicide is a resource made available by SUPRE on their web site. That survivor resource is an extensive 21 page booklet on developing survivors of suicide support groups to assist those who are left behind to deal with the aftermath of suicide.

The United States of America may be the most important environment to understand the impact of suicide and help for those survivors impacted by suicide. Although the methods of suicide chosen by the various cultures living in the United States may differ from methods chosen by members of those cultures within their country of origin, within each culture suicide rates seem to reflect the country of origin (Lester, 1997). Because of

the diverse multicultural aspects of the citizenry available for study and a suicide rate that is close to the average global rate of suicide, America is well suited as a site for investigation into these issues.

The study of Suicidology began in the United States in the late 1950s, with the majority of work focused on the descriptive variables that could be identified from death certificate investigations (Farberow, 2000). Recent biochemistry advances in medical research have led to insights on how imbalances in brain chemistry can impact human behavior and contribute to suicidal behavior. In addition to the understanding of how brain chemistry works, new anti-depressant medications have shown a significant impact on depression, anxiety and other mental disorders. In spite of these advances in the treatment of mental illness, the rate of suicide in the United States had remained fairly stable for the past four decades at around 12 per 100,000 until the 1990s demonstrated a steady decline which predicts a ratio just over 10 per 100,000 by 2000. For the first time in the history of the United States, the Surgeon General's office developed a National Strategy for Suicide Prevention (*National Strategy for Suicide Prevention: goals and objectives for action*, Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service, 2001). It recognized the need for suicide prevention, intervention, and help for the survivors dealing with the suicide of a loved one. The first Congressional resolution to acknowledge that suicide is a problem in the United States (Reid, 1997) came about through the efforts of survivors of suicide speaking out about their loss and society's traditional

response to suicide. Senator Harry Reid from Nevada addressed the United States Senate on May 6, 1997 and told of growing up without his father because his dad had killed himself. Senator Reid's Senate Resolution 84, co-sponsored by the Senators from Louisiana, passed without opposition and led to the establishment of a National Suicide Prevention Center in Nevada. Millions of dollars for research have been made available and implementation of prevention programs that demonstrate effectiveness has begun. The same survivor efforts, which opened the eyes and hearts of our Congress, captured the interest of Dr. David Satcher, the United States Surgeon General. Within a few years, Dr. Satcher has used his authority along with other interested non-profit organizations, physicians, researchers, clinicians, advocates, and survivors to develop a strategy to address the suicide rate and aftermath of suicide in this country. The *National Strategy for Suicide Prevention: Goals and Objectives for Action* (NSSP) is a blueprint to use in achieving the goals outlined in the Nation's public health agenda, *Healthy People 2010*. One of the key elements in the framework of the NSSP is to "Reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends." The efforts to date have focused on the prevention of suicidal behavior from a public health strategy and while prevention is the primary objective, the relief for families is also stated in this approach.

The significance of a national strategy may be best understood in the context of similar efforts on the part of the Surgeon General's office. The

ability to impact breast cancer, colon cancer, and heart disease are only a few of the measurable changes in health care that have resulted from the public awareness campaigns that a public health approach to well-being can accomplish. The knowledge today about the risks of smoking are in large part a result of the Surgeon General's Warning on each package of cigarettes sold in this country. The efforts to reduce death from HIV/AIDS have been a quantifiable success when compared to efforts to reduce suicide. In 1988 there were many more AIDS related deaths in this country than deaths by suicide. More recently (1998), there were twice as many deaths to suicide than from HIV/AIDS.

In 1998, the national rate of suicide was 11.3 deaths per 100,000 which accounted for over 30,000 recorded suicides, becoming the 8th overall cause of death (McIntosh, 1999). Death by suicide exceeded deaths by homicide by more than 50 percent in 1998, homicide ranked 13th overall in causes of death. Therefore, suicide is a serious public health problem. Until the declines noted in the 1990s the rate of suicide in the United States had remained remarkably constant since the 1940s (CDC, 1995). Even with under reporting, the average number of suicides each year generates one death every 17 minutes. All suicides have one common side effect; they produce survivors (those who are significantly impacted by suicide as the cause of death). Included in the impact on survivors is their own increased risk for suicide (Cain, 1972).

Although males tend to have higher rates and ratios of completed suicide than women (18.6 for men and 4.4 for women or 4.1 male completion for each female completion) it is important to note that women report higher ratios of suicide attempts (3 female attempts for 1 male attempt). It has been estimated that five million living Americans have attempted to kill themselves (McIntosh, 1999).

Although demographic variables do not insulate or guarantee protection for any group from attempt or completion of suicide, there are some groups within the total population that are deemed to be at higher risk of suicidal behavior and death by suicide. In 1998, as in the past years, white males have reported the highest rate of suicide (20.3 per 100,000) when compared to all other groups by color and gender. In comparison to the 12.4 rate of suicide for whites in America, those classified as nonwhites have a rate of 6.2 per 100,000 with blacks having the lowest rate when viewed by race of 5.7 per 100,000. Americans age 65 and older reported a rate of 16.9, which is significantly higher than the rate of 11.1 for youth (ages 15-24). However this suicide rate of 11.1 places suicide as the third leading cause of death for youth, preceded by accidents and homicide (McIntosh, 1999).

Stereotypes about which age group is at higher risk to die from suicide have been generated by media coverage of research findings and misinformation about the overall impact of suicide on society. Some of the confusion came from reporting the actual suicide rate changes that have occurred over the past thirty years for youth, without reporting the impact of

suicide for other age groups as well. The emphasis on prevention of youth suicide is a reflection of the societal value for youth and a societal response to the unacceptability of youth suicide. Because of the potential for prevention of the top three causes of death for young people (accidents, homicide, and suicide) as well as the increase in youth suicides over the past thirty years, a great deal of media attention on youth suicide has been generated. Only a minimum of reporting on the risk of suicide in people over 65 can be identified in the media coverage on suicide in most communities. The myth that youth are the high-risk age group may be an outcome of other assumptions surrounding suicide generated by misinformation and social biases.

The tendency to identify in our own minds a typical suicidal personality (aided by movies and television) may contribute to the difficulty for someone at risk to be recognized as being at risk by family and friends. Efforts to educate the public regarding the facts on suicide, including which groups are the high-risk groups, could also focus attention away from the reality that all groups are at risk for suicidal behavior and that we are all vulnerable to becoming survivors.

The stigma associated with considering suicide is ancient and active within American culture (e.g., Colt, 1987). Society tends to polarize around the subject of suicide and this is reflected in the fact that some see suicide as the ultimate demonstration of courage and others consider suicide to be the lowest form of cowardice. While most will watch with apprehension as police

attempt to help someone safely from a high ledge or bridge railing, there are some that will encourage the person at risk to jump. The ambivalence that is consistent with suicidal behavior (both wanting to live and wanting to die) appears to reflect American society's ambivalence about suicide.

In the reporting of death by suicide there is evidence and concern that some of the deaths are inaccurately reported as accidental or unknown. This is probably a result of pressure from family or community as well as limited information about the psychological status of the deceased. Suicide has more potential to be under reported than other causes of death because of many factors including; time lapse between method and death, difficulty in developing adequate forensic information, antiquated local restrictions, and cultural biases.

This under reporting, in addition to creating inaccurate death statistics for suicide, may contribute to the confusion that survivors experience in the aftermath of the death. Despite efforts to reduce overall suicide rates in the United States, little has been done to address the specific needs of survivors of suicide. Edwin S. Shneidman (McIntosh, 1996) has estimated that each suicide intimately affects at least six other people. Using this formula and calculating the number of potential survivors from suicides from 1974 to 1998, the number of suicide survivors could be as high as 4.4 million. This would mean that as many as 1 in 62 Americans could meet the definition of suicide survivor (McIntosh, 1998). With the high number of potential survivors in the United States and the elevated risk of suicide among

survivors, it is important to examine the methods of referral currently in place. Presently, the number of survivors wanting services remains unclear because the primary referral systems for survivor services are unstructured and vary widely by community. The number of survivor groups and survivor sensitive clinicians in existence in the United States indicates a poverty of resources for survivors and a flawed entry system for those services.

In a survey mailed to the 350 programs listed in the American Association of Suicidology Directory, Rubey and McIntosh (1995) found that of the 141 groups who responded, they had been meeting for an average of 8.6 years. The meetings averaged ten people attending and varied in frequency from weekly to once a month. Some groups were time-limited and met for eight to ten weeks, while the majority were open-ended, allowing survivors to come for as long as they wished. The group leadership also varied from peer to professional facilitator and some used a combination of both. Significant is the fact that the majority of referrals to the support groups came from doctors (N=131), hospitals (N=107) and churches (N=102). A person who completes suicide is most often pronounced dead at the scene, and the opportunity to speak to doctors and hospital staff is bypassed, thereby eliminating the primary referral sources identified by McIntosh and Rubey. Other referral sources mentioned in the study were mental health agencies, crisis intervention services or therapists, and community resource guides (N=13), media (N=11), police and other officials such as coroners (N=7), funeral directors and mortuaries (N=4), and the public library (N=2).

When reviewing the sources of referrals made to service providers, it is clear that persons with the greatest access to survivors at the time of death (police, coroners, and funeral directors) are among the least credited for referring.

In 1998, Louisiana had a suicide rate of 11.0 per 100,000 (480 suicides) and was ranked number 35 in rate of suicide in the United States, resulting in a rate close to that of the national average (11.0 for Louisiana compared to 11.3 for the United States). Resources for survivors of suicide in Louisiana are limited to metropolitan areas with populations over 400,000. There were 528 deaths by suicide reported in Louisiana in 1997, which placed the state ranking at 26th with a rate of 12.1 compared to the national average of 11.4 for that same year. Until 1998 Louisiana had remained consistently above the national average and has remained 8th in the United States in the ranking of suicides by firearms. The resources for residents of the state of Louisiana are currently limited to two communities with only one of the two having a formal organizational approach, providing 24-hour availability of services to survivors of suicide.

Rather than challenge a system that has consistently under-utilized the opportunity to make referrals for survivor services, it is the intent of this research proposal to compare a more structured and achievable method for providing survivor services and referrals at the time of death. The method studied is known as "postvention," a term coined by Shneidman (1971) to describe "appropriate and helpful acts that come after a dire event." The

term postvention has been used primarily within the field of suicidology and is currently seen as those efforts intended to reduce the aftermath of a death by suicide for those impacted by that death. It was Shneidman's contention that "the largest public health problem is neither the prevention of suicide nor the management of suicide attempts, but the alleviation of the effects of stress in the survivors whose lives are forever altered" (Shneidman, 1973).

The provision of services during a postvention at the time of death (Active Postvention Model) directly addresses the public health concern articulated by Shneidman in 1973. By providing services in an active model of postvention (APM), the ability to identify all potential survivors (not just the immediate family members present) is greatly increased and the ability to make referrals is enhanced. This research compared the time between the suicide and coming for assessment for treatment between two groups of survivors; one group having received an Active Model of Postvention from the LOSS Team (an active postvention program) and the other group made up of those who did not (passive model) receive an APM. This study sought to determine if the elapsed time between death and seeking treatment could be reduced by an active model of postvention used to assist survivors of suicide instead of the more traditional passive model of referral.

Baton Rouge, Louisiana, located in East Baton Rouge Parish (county), has an established survivors program that began in 1981 with ongoing support from a 24-hour crisis intervention center. The center has a positive relationship with the local coroner and the center receives survivor referrals

from all areas of the state. Because of the wealth of existing resources for survivors, the relationship with the coroner, the access to survivors and the 24-hour access for services, this site is well suited to study the problems addressed in this research. In addition to the resources stated, the crisis intervention center in this parish provides an active model of postvention, which began in 1998.

The active model of postvention (APM) is known as the Local Outreach to Survivors of Suicide or LOSS program (LOSS Team), and is staffed by a team of responders to the scenes of suicides in East Baton Rouge Parish (county). The LOSS Team is made up of staff members of the crisis center and volunteer survivors who have had additional training in responding to the scenes of suicide. Each team member completes a Beck depression inventory (BDI), a Beck Anxiety Inventory (BAI), and a Hayes-Jackson Bereavement survey each 60 days. Ongoing research into the long range impact of providing this service is in progress and expected to evaluate the first three years of operation in the spring of 2002. The LOSS Team is a unique concept and different in several significant ways to other outreach services for survivors of suicide. First of all, the LOSS Team goes to the scenes of suicides and begins helping the survivors as close to the time of death or notification as possible. Secondly, the LOSS Team depends heavily on the trained survivors to be the primary resources at the scene. Finally, this active model of postvention at the scene of the suicide provides support services and referrals to all those identified as potential survivors of suicide.

This response team is an addition to the traditional first responders, such as police, emergency medical personnel, coroner, and crime scene investigators. The more traditional first responders cautiously accepted the LOSS Team responders in the beginning and after a few months began to inquire with the coroner's staff if the LOSS Team had been notified to come to the scene. The more traditional first responders have a specific objective to accomplish at the scenes of suicides and simultaneously are concerned for the survivors who are experiencing extreme emotional distress. The LOSS Team can provide comfort, explain the protocols used to investigate the scene, give information on organ donation resources (when appropriate), and answer questions that arise as a result of the many other responders at the scene. If survivors at the scene wish to see the deceased, the LOSS Team members can facilitate a viewing of the body before it is removed for autopsy. This choice (to view the body or not) is important for survivors to make. The lack of choice on viewing creates something on which they can focus (not getting to see the deceased) that distracts them from their initial shock and grief. This lost opportunity of viewing the body is about the choice to see the body and not that seeing the body is itself the helpful component. By having the choice to view the body, the survivor can avoid being angry with the first responders.

Statement of the Problem

Survivors of suicide represent a large portion of the population and are often recognized by mental health professionals as a high-risk group for

future suicidal behavior. However, stigma and societal norms regarding suicide create barriers for survivors that could increase their future risk of death by suicide and such barriers might reduce survivors reaching out to others. Until recently, traditional attempts to reach survivors have been passive in their approach to helping survivors and, most occurred weeks past the death. Compounding the problem, access to survivor services remains restricted to largely urban settings of the United States where the more formal support services are located. Survivors within a family also present different levels of grief response, which vary in intensity by a variety of factors. Society assumes that immediate family members are the most significantly impacted, however, the emotional and psychological connection (good or bad) of a particular relationship to the decedent may be a greater predictor of complicated bereavement (grief that will require support beyond traditional resources) than any particular familial relationship (Campbell, 2000). By providing services as close to the time of death as possible, the ability to identify all potential survivors is greatly increased. The opportunity for survivors to receive information deemed helpful by other survivors also has potential for relieving stress incurred by survivors. Although family members are often confronted with the same issues that other causes of death present, the tendency towards secrecy about the suicide is unique to this cause of death. The decision to tell some people the death was a suicide and not others results in cognitive confusion and the reinforcement of guilt and shame at a time when the survivor is experiencing shock and trauma.

Stigma is associated with many problems in our society and suicide carries a remarkable level of stigmatization for survivors. The stigma resulting from shame and secrecy generates many complex clinical issues for survivors. The increase in hyper vigilance and the commensurate reduction in trust create relationship problems both within and outside of the family. Suicide survivors report increased maladaptive coping, decreased sleep, and reduced activities of daily living. The preoccupation with a foreshortened future and with suicidal ideation is adequately described in this excerpt from Kurt Vonnegut, Jr.'s *God Bless You, Mr. Rosewater*:

Sons of suicides seldom do well. Characteristically, they find life lacking a certain zing. They tend to feel more rootless than most, even in a notoriously rootless nation. They are squeamishly incurious about the past and numbly certain about the future to this grisly extent: they suspect that they, too, will probably kill themselves.

This syndrome was surely Fred's and to it he added twitches, aversions and listlessnesses special to his own case. He had heard the shot that killed his father, had seen his father with a big piece of his head blown away, with the manuscript of the family history in his lap. Fred had the manuscript, which he had never read, which he never wanted to read. It was on top of the jelly cupboard in the cellar of Fred's home. That was where he kept the rat poison, too.

The ability to normalize the grief experience can be accomplished more effectively if survivor services are available during the initial shock period of notification of a death by suicide. During this period of time the survivors are aware of the need for guidance and support. Caregivers who are knowledgeable about the complications of this grief process develop a unique rapport with survivors, thus facilitating support during the first critical phase of the surviving process. The problems that are associated with

survivors may be mitigated by early intervention with the impacted population.

Rather than challenge a system that has consistently under-utilized the opportunity to make referrals for postvention services, it is the intent of this research to determine if a more structured and achievable method for providing postvention services can improve follow through on referrals using an active postvention model (APM). The problem of access to resources for survivors has been facilitated by an inadequate referral system that breaks down for those who experience a loss to suicide. The informal and non-inclusive nature of referrals leaves a large segment of the population without awareness of what help is available and by the time services are connected, many disturbing consequences may have already occurred. The active postvention model (APM) may normalize the grief process after suicide, identify more at-risk survivors, and reduce contagion through referral to survivor sensitive services.

The problems associated with suicide are many and long lasting and create a legacy for the survivor that is dangerous and painful. The ability to begin to study the impact of an active postvention model which is referring survivors for help closer to the time of death may provide the insight necessary to develop an array of services and a referral system that increases access for all survivors. The accomplishment of such a study is dependent on access to survivors at the time of death. Resolution of this primary barrier is achieved by the LOSS Team's ability to be at the scene

and make referrals at the time of death to the local crisis center's survivor of suicide program.

Objectives

The primary purpose of this study was to determine the influence of an active model of postvention on the length of time taken for a suicide survivor to seek treatment. Certain key demographic characteristics were important to consider due to speculations in the literature about which survivor relationships seek treatment and in what stage of life they are more likely to do so (Farberow, 1993). Race and gender will add to the limited body of knowledge within the survivor population as well. Specific objectives included:

- 1. to describe the survivors of suicide (N=126) who received an assessment for treatment in East Baton Rouge Parish, Louisiana between January 1, 1999 and December 31, 2000. The survivors described were divided into two groups, one group being the survivors who received an active postvention model (N=50) and the other group not having received an active postvention model (N=76). The two groups will be described based on the following demographic characteristics:**
 - a. age**
 - b. race**
 - c. gender**
 - d. relationship to the deceased**

- e. elapsed time from death to assessment
- 2. to compare suicide survivors (N=126) in East Baton Rouge Parish, Louisiana who received an assessment for treatment between January 1, 1999 and December 31, 2000. The two groups, one group received an active postvention model (N=50) and one group did not receive an active postvention model (N=76), were compared using the following demographic characteristics:
 - a. age
 - b. race
 - c. gender
 - d. relationship to the deceased
 - e. elapsed time from death to assessment

Definition of Terms

- **Active postvention Model (APM)**- This is a concept where responders who are prepared to assist the newly bereaved go to the scene of a suicide and begin to work with the survivors as close to the time of death as possible.
- **Attempt**- An act of self-harm with the purpose of dying by suicide.
- **Completed suicide**- This term is used in place of "committed suicide" to reduce the stigma and be consistent with terms in Suicidology i.e. Completed is the opposite of attempted (a term often used to describe suicidal behavior not resulting in death). This term is more accurate and

avoids the criminalization of suicide created when using "committed" to describe someone who took their own life.

- **Crisis Intervention**- The act of intervening on someone in a self-defined crisis. This can be by family, friend, community, or agency. The goal is to avoid the crisis resulting in self-harm.
- **Para-suicidal behavior**- Behavior that could result in suicide or accidental suicide and is more manipulative in its intent.
- **Passive postvention**- This is the more traditional method of delivery. This requires the survivors learn of the services and seek them by contacting the resources and requesting assistance in dealing with the aftermath of suicide.
- **Postvention**- Providing care for those impacted by a suicide regardless of familial relationship to the deceased. Postvention is delivered to the survivors in an organized fashion by trained responders in an active or passive approach.
- **Suicide**- The intentional taking of one's own life.
- **Suicidology**- The study of suicide, suicidal behavior, and those who are impacted by the death (survivors).
- **Survivor**- Those who are significantly impacted by the death of someone to suicide. This term is not limited to next of kin, and can include strangers who witness or discover the body, including first responders.
- **Thanatology**- The study of death and dying.

- **Survivors of Suicide Support Group**- These groups vary in operation (formal and informal), size, organizational affiliation, leadership, and duration. They can be open or closed and may have from two to over one hundred attending. Most meet on a regular basis and have peer and professional leadership involved. The purpose of most is to assist those who have lost someone to suicide to recover from the death.

•

REVIEW OF THE LITERATURE

In other words, the fear of death must be present behind all our normal functioning, in order for the organism to be armed toward self-preservation. But the fear of death cannot be present constantly in one's mental functioning, else the organism could not function - Ernest Becker, *Denial of Death*

Ernest Becker's Pulitzer prize winning work *The Denial of Death* developed a convincing argument that man is born with a fear of death and spends life in pursuit of heroism in order to cope with this growing fear at the core of mankind's being. The conquest of death can be seen in rituals as far back as our archeological discoveries can take our knowledge of ancient civilizations (Farberow, 1975). Mayan kings were chosen by their ability to stay alive while priests were opening their veins and draining blood until the royal prospects were able to hallucinate and communicate with the world of the ancestors. If they were able to survive this ritual then they were indeed worthy of the royal rewards due a king; if they died, they were presumed to have been rejected by the spirit world and taken away by death. Over the centuries many examples were described to help us understand how each culture has dealt with death. The process of grief and mourning is reflected in the attitudes and values that have been mankind's history of coping with the reality of death. Through many theorists, Thanatology (the study of death) has advanced the observation that grief occurs in observable stages or phases (Attig, 1996) and that we pass through them in some expectable order. Contributions from Bowlby, Engle, Parkes, and Kübler-Ross have

suggested from three to six distinct phases that are experienced by the bereaved (Attig, 1996). The ability to describe the process does produce the awareness that grief is normal with features that can and do impact individuals, families, communities, and all cultures. However, describing the grief process creates an expectation that those who are processing the loss in a manner that fits the more generalized values of the culture or the described stages or phases are "doing it right" and those who are grieving differently are engaged in some pathological process. The global impact of grief, like the impact of suicide, may vary in how and in what ways an individual will experience the aftermath of death. The research data on bereavement have primarily been in the form of interviews. Shackleton (1984), Lindemann (1944), Marris (1958), and Parkes (1964, 1972) were among the first to collect information about bereavement directly from the bereaved. Lindemann (1944) interviewed over 100 survivors of people who were killed either in the Coconut Grove fire or in the holocaust. Lindemann's study identified and recognized the acute grief reaction associated with survivors. The acute grief reactions were characterized by "anxiety, depression, guilt, anger, hostility, intrusive thoughts and images of the deceased and somatic complaints" (pg.143). Marris (1958) interviewed 72 widows two years after the death of the suicide of their spouses to investigate the long-term effects of bereavement. Marris found that the lower the income, the greater the number of symptoms associated with bereavement. Although Lindemann and Marris did not use control groups or

empirical measures in their work, they were able to contribute information about the impact of sudden and traumatic death to the body of knowledge on grief and survivors of suicide.

Parkes (1972) pioneered combining the interviews of widows and widowers with a control group of married couples matched for age. He found that the widows and widowers reported more anxiety and depression at thirteen months after their losses when comparing the control group versus the experimental group. Parkes also reported that those bereaved were three times more likely to have been hospitalized within the year following the death. Clayton (1974) did a similar study with widowers but matched the control group by age, income, and voting district; she concluded that the bereaved experienced more depression at thirteen months after the loss than did the control group. The criticism of the interview approach stems from the lack of structured interview instruments and from the variance of interview styles between different researchers.

Support or lack of support for the grief that is natural for each person will also impact the recovery processes that the bereaved is experiencing. Loss can be compounded if those who are mourning a death as a group cannot accept the many different ways that individuals within that group respond to death. In the last 35 years, observations about survivors of suicide and about what can help in the processing of that cause of death have come from personal stories, research, and new approaches to Critical Incidence Stress Debriefing. Over the past few decades, concepts and terms

such as postvention and debriefing have been developed. These concepts, when applied to cases involving other causes of death, may reduce trauma, especially the long-term trauma associated with sudden and unexpected death. Natural disasters (i.e., earthquakes, hurricanes, tornadoes, floods) and man-made disasters (Oklahoma City, Columbine, World Trade Center, and bombings of several American installations abroad) have shocked the public into accepting that these profound grief experiences qualify for a systematic approach to normalizing the abnormal features than can occur for some in the grief process. Some early postvention efforts were a result of large-scale disasters such as the Coconut Grove fire in Boston in November of 1941. The development of crisis theory has been greatly advanced from knowledge gained as a result of treating combat veterans and disaster victims closer to the time of exposure. The utilization of Critical Incident Stress debriefing developed by Mitchell in the 1990s has become an acceptable model for first responders in most communities in the United States. Fire Departments have adopted the principals of critical incidence stress debriefing and made the debriefing process a mandatory protocol for a response where a death occurred. Because survivors are in desperate need of "psychological first aid" (Kilman, 1984), the opportunity to provide postvention can have a therapeutic quality important to both sudden death and suicide.

The literature is somewhat limited in the area of postvention as it applies to suicide survivors, however there are postvention studies that are

relevant to the purpose of this study. The opportunity to perform a social intervention that could relieve the debilitating effects of suicide for survivors is a significant and appropriate undertaking. Postvention provides prevention possibilities for the survivors by normalizing the more pathological aspects of survivor grief. Survivor reactions to suicide have complicated manifestations and consequences (Hauser, 1983). Table 1 indicates the disorganization and debilitation that survivors may experience in their normal reactions to this abnormal cause of death. Psychological and behavioral manifestations result in suicide ideation and suicide attempts for survivors as consequences of their loss (see Table 1).

Table 1
Survivor Reactions to Suicide

<u>Manifestations</u>	<u>Consequences</u>
I. <i>Physical</i>	
Increased organic and psychosomatic complaints and symptoms	Visits to physicians
II. <i>Psychological</i>	
A. <i>Affective</i>	
Relief	Fuels guilt, self-blame, anger
Anger/Hostility	Scapegoating, triangling with family or therapist, lawsuits
Sadness/Depression	Increased suicide risk
B. <i>Cognitive</i>	
Shock/Disbelief	Fuels Denial, fear of "going crazy"
Guilt/Self reproach	Obsessive reviewing for acts of omission/commission
Denial	Myth-making about murder/accidents
One-way communication:	Search for meaning, explanation
"I choose not to live with you"	Anger toward the deceased
Shame/Secrecy associated	Closed-off
	Table 1 continues

<u>Manifestations</u>	<u>Consequences</u>
with stigma	communications
Emotional cut-offs	Geographic moves
Fear of "going crazy"	Avoidance of therapy as further stigma associated with sickness
Identification with deceased	Suicidal construct as means of coping, personal solution
<i>C. Behavioral</i>	
Loss of patterns of conduct	Accident proneness, suicide attempts
 <i>III. Psychosocial</i>	
Absence of social role for survivors, stigma	Truncated, pathological mourning secondary to

(Prepared by Frank A. Jones, Jr., M.D. *Suicide and Its Aftermath*, p.68.)

Cain (1972) found that survivors are at nine times the risk of the general population to repeat the act of suicide. Although this increased risk for suicide should produce great concern for survivors and communities, studies are missing from the literature which indicate if any change occurs in future risk for survivors who receive postvention support following the death. Communities, by providing postvention for survivors, could potentially play a vital role in increasing our knowledge. Research regarding community postvention models could help clarify if potential risk reduction for survivors of suicide can be achieved. Brent, Perper, and Mortiz (1993) reported on a survey of consecutive adolescent suicide victims in western Pennsylvania, which combined geographically matched, unexposed controls living in communities similar to those in which the suicides occurred. Great care was taken in all aspects of the study to match the siblings for age and number or

types of life events (excluding the sibling suicide). They found an excessive rate of depression: "there is a seven-fold increase in the incidence of major depression in siblings over community controls and similar excess of depressive disorders in the mothers of victims over the mothers of controls" (Brent et al., 1993).

Brent's previous study on acquaintances exposed to suicide (Brent et al., 1992) showed a similar excessive rate of depressions compared to controls: "this may be because friends and acquaintances of suicide victims are just as psychiatrically vulnerable as siblings." This finding further suggests the value of postvention in the schools as a method of identifying the at-risk students following a suicide and reducing the contagion effect that can occur. Farberow (1993) suggests that it may be the survivors stage in life (child, adolescent, adult, or older adult) that facilitates complicated bereavement issues including an increased risk of suicide for the survivors. McIntosh and Milne's (1986) research with college students indicated that the suicide survivors more often felt like killing themselves, reported more shame, believed they could have prevented the death, and believed someone (other than the deceased) was to blame for the suicide. Although these studies of college and adolescent students underscores the inability to limit survivor status to family and magnifies the importance of early intervention for the college age, empirical studies of risk for suicide ideation following a death for all stages of life are missing from the literature. A holistic and community wide approach to survivors would benefit from Dr.

Edwin Shneidman's suggestion that "postvention is prevention for the next generation" (in Cain, 1972) and that " a benign community ought routinely to provide postventive mental health care for the survivor-victims of suicidal deaths" (p. x). By allowing survivors to reconstruct some of the aspects of their involvement with the deceased (through the postvention process), they can confront some of their own faulty thinking in regard to their role in the suicide. They can experience psychological resuscitation (Resnik, 1969,1972), beginning a process of rehabilitation that will lead to a recovery from the loss.

Many of the articles on survivors of suicide address a segment of the overall population defined as survivors and provide insight into the unique characteristics of the various reported demographic categories. Although these studies and observations clarify the risk and identify concerns for helping survivors, the most beneficial approach to a safe resolution of the suicide for the survivors is unclear. The approach that is most helpful can vary by age, stage of life, relationship (kinship or emotional connection) to the deceased, elapsed time since death, and social support for seeking help for those who require additional resources. The more consistent positive outcomes that have been reported seem to indicate that group support was beneficial to the majority of those seeking help.

Although treatment of survivors and identifying survivors risk for suicide was the focus of the early literature on survivors of suicide, several unique approaches were identified for special sub-group populations of

survivors. In addition to information about treatment results, other characteristics unique to survivors began to emerge from the body of work based on case histories. Cain's book *Survivors of Suicide*, (1972) reported the case history by Lindemann, Vaughan, and McGinnis (pp. 70-92), of a four-year-old boy and his mother. The postvention of the family took place several years after the suicide and subsequent to telling some of the truth about the father's death, not however disclosing that it was a suicide. The son was told that his father died in a car accident when, in actuality, he died in his car from carbon monoxide poisoning. The child presented with psychomotor manifestations and behaviors that irritated the mother because they were similar to those of the dead father and husband. The descriptions of hyper vigilance by the mother and denial about the grief that she experienced were validating and consistent with what has become basic knowledge regarding survivors.

Jackab and Howard (1969) described the use of art therapy for the treatment of school phobia by a 12-year-old girl who witnessed a suicide and was subsequently hospitalized. By using the child's ability to express herself through her art, the screams that she held within her were vented and she was able to return to school. Much of the early literature is concerned with children who have experienced the suicide of a parent (Wallerstein, 1972; Whitis, 1972; Augenbraun & Neuringer, 1972). Schuyler (1973) reported on the treatment of a family following the suicide of a 16-year-old boy. The treatment involved various family members and, at eighteen months into the

therapy, the mother remained unengaged and symptomatic. Schuler points out the value of working closer to the time of death as a means of increasing rapport and intervening on the hazards of survivorhood. Junghardt (1977) suggested that intervention with survivors would be most beneficial if made within 24-hours of the suicide. Dunne states (1987, p.199): "although no other data supports an optimal time, a safe generalization would be to say the sooner the better after it is evident that the survivor is in a protracted struggle to deal with the event."

Attempts to shorten the time between death and support began in the mid-seventies in the United States. Doyle (1975) developed a model for helping survivors by training volunteers who would provide support, in person or by telephone, to individuals or families seeking help. The availability ranged from a few weeks to several months, and in 1977, services for children were added. Rogers et al. (1982) used nonprofessional volunteers to conduct a series of eight-session in-home focused discussions; following this, the survivors were invited to regularly attend a bi-weekly support group. The follow-up studies of those who participated showed a significant decline in symptoms at six weeks following the intervention; Rogers was also careful to caution that it is difficult to attribute the changes solely to the intervention design.

Hatton and Valente (1981) studied a group of bereaved parents who met ten times over a 14 week period. All of the parents (ranging in age from early thirties to late fifties) had experienced the death of a child (ranging in

age from 15 to 30 years) to suicide, and the time elapsed since death ranged from three weeks to seven years. The overall evaluation of the group after three months was that it was effective in reducing the acute symptoms of depression; and members of the group reported improvement in concentration and were less anxious in their presentation. Saffer (1986) reported the benefits of reducing guilt for a group of adolescents following a peer suicide. The three group sessions were structured, provided information, and focused on reducing their feelings of responsibility for not preventing the suicide. Kovarsky (1989) compared the parents who had experienced the death of children due to accidents with parents who had experienced the death of children to suicide. Kovarsky reported increased guilt and a tendency to blame themselves, other family members, and physicians for parents whose children died as a result of suicide. Miles and Demi (1991) found guilt followed by loneliness as the most difficult aspect of suicide survivors' grief as compared to subjects in the study whose loss came from accident or chronic illness (they listed loneliness as number one). This sense of being alone even when the other parent of the child is an active participant in the marriage and the grief process was of importance in understanding the need to have someone else understand exactly how the survivor is feeling.

The literature on death and dying corroborates the impact that death has on marriage following the loss of a child (Attig, 1996). What is less clear is the impact on marriage if the child dies as a result of suicide when

compared to a death by other causes. It is currently unknown if seeking support by one spouse (when the other does not “want or need” the same level of support) does not generate a new level of stress on the marriage. Those who attend support groups will often credit the experience as “having saved their life” (Campbell, 2000); empirical studies are lacking that examine bereavement for those who do not participate in survivor support groups. Self-reports and books written by survivors have been convincing in their support of attending a survivors of suicide support group meeting. What is unclear is how the groups compare to each other with so many different models from which to choose (Rubey & McIntosh, 1995). The concept of wanting to be with others who are going through the same experience is what began the support group movement. Survivors of Suicide Support groups began to spring up in the United States in the late 1970s and early eighties. These are independent support groups with leadership that varies from professional to peer or a combination of both peer and professional. The groups often satisfy the need to be with other survivors of suicide who gather for support to deal with the aftermath of suicide.

When someone dies by suicide the survivors are in a personal and emotional crisis, the resolution of that crisis will include many aspects of coping with any crisis. The literature on crisis intervention and crisis theory suggest the benefits of intervening on individuals in distress is basic: “virtually any intervention aimed at assisting people in managing life crises has been viewed as important since it might prevent psychopathology of

some sort later on," (Caplan, 1964 in Slaikeu, 1990). Crisis intervention is a response that is secondary prevention because the critical life event has already occurred (Caplan, 1964 in Slaikeu, 1990). However the fact that crisis intervention is secondary prevention does not indicate it is unimportant; it gains in value the closer it can be provided to the precipitating event. "With regard to the optimum time of intervention, it is our belief that increasing emphasis will have to be placed upon attempts to intervene during the period of turmoil that is so characteristic of transition states" (Tyhurst, 1958, in Slaikeu, 1990 p.163). Because the hope is that a person in crisis is in a position of change, the choices of danger and opportunity exist for that individual or group to have a positive or negative outcome. Danish argued:

In striving to achieve stability during crises, the coping process itself can result in the achievement of a qualitatively different "stability." Thus, contrary to the view that crises are destructive, we contend that they may initiate a restructuring process toward further growth. If crises can result in either negative or positive outcomes, the goal of intervention is not to prevent crises, but rather to enhance or enrich individuals' abilities to deal constructively with these events (Danish, 1977, in Slaikeu, 1990, p.11)

"A crisis is a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem solving, and by the potential for a radically positive or negative outcome" (Slaikeu, 1990 p.15). This definition describes the environment in which survivors of suicide are thrown without the awareness that positive results can possibly come out of the process of coping with the suicide. The irony is that the individual who has

died by suicide is assumed to have resolved a personal crisis through the negative outcome of the suicidal act. Even if the suicidal act was seen as positive at the time of death for the deceased, that choice becomes the precipitating event for those left behind, thus facilitating a crisis for the survivors. It is the legacy of additional suicidal behavior by the survivors that postvention seeks to interrupt by providing resources that can support the survivors and facilitate a more positive coping response.

Survivor grief has manifestations that are unique to suicide and bring additional burdens on the survivors. In his chapter on bereavement after suicide (*Suicidology: Essays in Honor of Edwin Shneidman*, 1993), Dr. Norman Farberow, a pioneer in the field of suicidology, has cited the following concerns among survivors of all ages and all kinds of kinship:

- (1). the search for "why"
- (2). increased and irrational guilt
- (3). stigma
- (4). identification with the suicide, or modeling
- (5). lack of trust
- (6). anger

This is not an exhaustive list and it may not be true that all survivors will experience each of these following their loss. However, it is important to note that this list includes complex cognitive and emotional concerns.

Survivors may face all of the concerns simultaneously and struggle to attend to the activities of daily living such as sleeping, eating, exercise, going to

work, or attending school. When components of coping, such as activities of daily living are compromised, the possibility of a state of crisis occurring for the survivors of a suicide is increased.

The majority of survivors are unaware of the risk factors that are emerging for them in the process of coping with the suicide of a loved one. Dunne (1987) likened the symptoms in children who are survivors to children diagnosed as having Post Traumatic Stress Disorder (PTSD). Dunne lists the following Post Traumatic Stress Disorder (PTSD) symptoms associated with children who are also suicide survivors: cognitive-perceptual difficulties, foreshortened sense of future, collapse of developmental accomplishments, dreams and/or nightmares, and contagion. Other features of survivorhood include flashbacks of painful memories, preoccupation with death, reversal to either extremes of behavior, excessive clinging, fearfulness or the ability to seemingly grow up overnight and become a parent to the remaining parent (Dunne, in Farberow (1993), p. 340). Many times the children of suicide are battling all of the feelings listed by Dunne and the feelings precipitated by well-meaning suggestions of individuals who do not realize the impact of their words. Society can exacerbate the grief process after suicide resulting in emotional abuse of the survivors. In an example where sexual abuse of a minor was a precipitating event for the suicide of her father, a police officer at the scene offered what he considered to be a well-meaning suggestion to the daughter and spouse of the deceased:

"He doesn't deserve your tears, what he did is unforgivable and now he has finally paid the price for what he did to his little girl.

Now you two dry your eyes and forget him, he took the coward's way out and died rather than face the court for what he did." This police officer's statement was the mother and child's first encounter with society's norm that grief, in that case, would be undeserved and inappropriate, thus leading to confusion about the survivors' rights to grieve and what was appropriate grief. Society's need for cause/effect reasoning leads to faulty conclusions for why a suicide occurred. Such reduction of a complex behavior oversimplifies the issues and fails to console or support the survivors, thus adding to the sense of isolation. (Campbell, 2000)

This officer became the voice of society to the family following suicide and the message taken by the survivors was confusing and discrediting of how they were feeling. The challenge for anyone who is dealing with the loss of someone to suicide is to feel and talk about his or her feelings in a safe and supportive environment. When the process of open and honest grief is subverted by the discomfort of others, the survivor bears the burden for a very long time. The complications that occur within the culture, community, and family because of suicide are captured in the case history of Colleen in Attig's book *How we Grieve, Relearning the World*:

A single woman, Sheila, twenty-eight, kills herself, writes no suicide note, and leaves family and friends with the mystery of her motivation. Her parents, Colleen and Jack, divorced when she was a teenager. Although Sheila lived with her mother, she became seriously estranged from her before escaping to college in a distant state. Hesitant reconciliation began only about a year before Sheila's suicide. Sheila's survivors search their souls for the means of understanding the tragic action, and each struggles to reconcile a love for her with hatred for what she has done. Most are uncomfortably silent about Sheila and her death. The sudden and unexpected disruption in their lives embarrasses some who are bothered by the social stigma of suicide, prompts others to resent the apparent selfishness of the act, and tempts still others to pretend that the death was accidental. Colleen alone pursues greater understanding of Sheila's life and death by seeking out the friends who knew her in her last years. As she does so, she struggles to understand and forgive herself. She is especially torn by her belief

that suicide is an unforgivable sin, and she seeks greater understanding and consolation in prayer. (Attig, 1996, p.6)

The case of Colleen is full of the complex issues that each survivor faces. The search for why is the most common beginning place even when the deceased has had a history of depression and suicide attempts. Two additional issues for survivors at the time of death are whether their loved one suffered at the time of their death and concerns about after-life. These concerns begin at the time of notification and may never be reconciled for some survivors. The coroner or physician can be of help by reassuring them, whenever possible, that their loved one did not suffer.

Clergy can be of great value by reassuring the family that the church sees suicide as a response to an illness and that old sanctions have been replaced by new insights into suicide and depression. Most survivors are reluctant to ask doctors or clergy for fear they will not be reassured. The complications of trying to piece together this puzzle of "why" without all the pieces is a difficult and painful process and survivors may seek help from friends of the deceased as Colleen did, or from mental health professionals.

Many survivors report not getting the help they sought from mental health professionals. They may find professional resistance to comment on why grief following suicide seems so different from other losses to death they may have experienced. Although many mental health professionals have been involved in the facilitation of suicide survivor support groups or in their treatment through individual counseling, some report professional ineptness

in helping survivors. Lack of understanding about the dynamics of suicidal behavior, survivor bereavement, and a lack of understanding of how to help such a challenging population contribute to hesitancy by professionals to work with survivors of suicide. Dunne (1987) outlines several reasons why survivors have been "ignored" by the mental health profession, including the suggestion that suicide "represents a confrontation with personal and professional limits in individuals and in the profession." Although many reasons for caregiver ambivalence toward survivors of suicide can be considered, it may be beyond the scope of traditional measures of study. Szasz (1986) suggested "a completed suicide represents both personal and professional failure." It is because of the opportunities for countertransference responses by professionals as well as projection by survivors that professionals who do choose to work with survivors be very clear on their limits. This includes their limitations on intervening with complicated bereavement and the limits of survivors to have intervened in the suicidal behavior of the deceased or on their own suicidal ideation.

The reluctance of mental health professionals to approach survivors and the growing use of para-professionals to staff crisis lines in the United States has generated a way for survivors to be involved in suicide prevention in a significant way. The crisis line or hot line movement began in the late sixties and early seventies in the United States. This volunteer approach to providing assistance in a crisis provided a logical place for survivors to volunteer and learn more about the evolving fields of suicidology and crisis

intervention. Those who have had that benefit best tell the benefit of assistance from another survivor at the time of death:

40 year old daughter of her 77 year old father who hung himself July 1999: I can not express how much help the Loss Team and all of the wonderful people who have been there for us since my father's suicide a few weeks ago. They were and are a wonderful source of support the day of the incident and were at our house within fifteen minutes of the call letting us know we were not alone and they were there for us, 24-hours a day. This meant more to us as survivors than anything else.

Mother of 33-year-old son, gunshot to the head: In May of 2000 my phone rang and I was told my 33-year-old son had shot and killed himself. I cannot describe my feelings and the trauma I experienced at that time. I suppose it was mostly shock and confusion on top of the incredible pain. By the time I arrived at the scene, about half an hour later, there were already two people from the LOSS Team there. I don't know what our family would have done without their help. They gave us information about the resources available to help us and came to our home later that afternoon. We went to counseling and started attending the group meetings on Tuesday evenings. There we have learned how to cope with our crisis and the feelings from suicide that are different from other deaths. I can attest to that because I lost another son, who died of bone cancer in 1978. Although the two deaths are equally painful, the suicide leaves survivors much more mentally and emotionally disabled than death from other causes. I cannot even imagine what the state of my mental health would be right now if it were not for the support and education we have received as a result of the LOSS Team and the referrals they gave us that day. We are learning to cope and know that grief is a very long and challenging process and that there are many others going through the same thing. When no one else can understand, we know where to get help. On behalf of my family I want to thank the volunteers and staff for being there for us and others, your work is saving countless numbers of survivors.

These are only samples of the letters of support that have been generated by the active postvention model in this research study. Social work research could be the key to helping the more than 180,000 new survivors each year in the United States to a safer and more comforting level of coping with their losses.

The review of the literature indicates that in spite of barriers placed before survivors by society, mental health professionals, and the majority of first responders to the scenes of suicides, survivors of suicide have found their voice. The “silent grief” described by Lucas and Seiden (1988) is becoming a loud and clear voice for prevention, intervention, and postvention. Survivors are changing our knowledge about suicide and altering the stereotypes that have been promoted on television, in movies, and by the media.

Through the inclusion of survivors in organizations like the American Association of Suicidology (AAS), Suicide Prevention Advocacy Network (SPAN), and the American Foundation for Suicide Prevention Foundation (AFSP), the issues and concerns of survivors have been brought to the attention of the American people. This awareness of survivor concerns has been accomplished in many ways and by several well-known celebrities and public figures such as Mariette Hartley, Joan Rivers, Art Linkletter, and Senator Harry Reid of Nevada. These public figures and many survivors, who are less well known, have been instrumental in increasing the awareness of needed resources for prevention, intervention and postvention. By having survivor volunteers participate in the Active Postvention Model (APM), the benefits of empathy, installation of hope, and normalcy can be provided and can potentially increase the rate of survivors seeking treatment, while reducing the time elapsed from death to getting help.

The LOSS Team is the most recent development in the effort to help survivors following a suicide. If this active postvention model can be shown to be effective in referring survivors for treatment closer to the time of death, it will be an important tool for social change.

METHODOLOGY

The Active Postvention Model studied utilizes a team (LOSS Team) of volunteers from and staff members of a crisis intervention center located in an urban setting and serving a parish wide (county) population of over 400,000 residents. The LOSS Team (Local Outreach to Survivors of Suicide) Program was implemented in 1998. Trained teams comprised of center staff and volunteers who are themselves survivors of suicide respond to calls to provide postvention services to family members following a completed suicide as close to the time of death notification as possible. The LOSS Team works closely with the East Baton Rouge Parish Coroner's Office which initiates calls for the team from the scene of the suicide (Annual Report of BRCIC, 2001).

The active postvention concept and model was proposed for consideration at the annual conference of the American Association of Suicidology in April of 1997 and later published in the AAS Journal *Suicide and Life-Threatening Behavior* (Campbell, 1997, volume 27, No. 4). The crisis center adopted the concept in the fall of 1997 and began training a team of eight volunteer survivors of suicide and four staff members. The initial 12 members of the program attended a survivor visitation training hosted by the LINK Counseling Center in Atlanta, Georgia. Additional extended skills training and monthly meetings were held to insure that all members of the team attained confidence as first responders. The program

was funded by a grant from a local foundation and in December, 1998 was activated by the local coroner. By the end of the second year (2000), the LOSS Team had responded to 57 suicide scenes.

The literature contains no evidence of a comprehensive study to determine the effects of an active postvention model on length of time between a suicide and the survivor seeking treatment. The LOSS Team is apparently the only program of its kind providing an active postvention approach in assisting suicide survivors at the time of death.

This chapter includes information regarding the data collection and data analysis of the study as well as information on population, sample, and instrumentation. The procedures described were used to achieve the purpose of the study.

Purpose of the Study

The primary purpose of this study was to determine the influence of an active model of postvention on the length of time taken for a suicide survivor to seek treatment. Survivors who have been visited by the LOSS Team (Active Postvention Model) and received an assessment for treatment were compared to survivors who sought treatment without having been visited (Passive Model of Postvention) by the LOSS Team. Specific objectives included:

1. to describe the survivors of suicide (N=126) who received an assessment for treatment in East Baton Rouge Parish, Louisiana between January 1, 1999 and December 31, 2000. The survivors

described were divided into two groups, one group being the survivors who received an active postvention model (N=50) and the other group not having received an active postvention model (N=76). The two groups will be described based on the following demographic characteristics:

- a. age
- b. race
- c. gender
- d. relationship to the deceased
- e. elapsed time from death to assessment

2. to compare suicide survivors (N=126) in East Baton Rouge Parish, Louisiana who received an assessment for treatment between January 1, 1999 and December 31, 2000. The two groups, one group received an active postvention model (N=50) and one group did not receive an active postvention model (N=76), were compared using the following demographic characteristics:

- a. age
- b. race
- c. gender
- d. relationship to the deceased
- e. elapsed time from death to assessment

Population and Sample

The target population is all survivors in the United States. For the purposes of this study, the accessible population was all of the survivors of

suicide who came to an urban crisis center for an assessment for treatment following a suicide. Each survivor received an assessment which lasted approximately two hours and had the option of receiving a copy of the assessment. Survivors were informed that although the center does use information from the forms for research, individual information is confidential.

The sample consisted of 100 percent of the survivors who came to the center for an assessment between January 1, 1999 and December 31, 2000 (N=126). The 126 survivors were seeking help as a result of the 83 individuals who took their life, some of the 83 had more than one relationship seeking treatment. This period was inclusive of the first 24 months of the LOSS Team's operation in the community. Two groups were identified. The first group (experimental N=50) was comprised of survivors of suicide who had received an active model of postvention by the center's LOSS Team at the time of death. The second group (control N=76) studied was the survivors of suicide who received an assessment for treatment during the same time period without having received an active model of postvention by the LOSS Team. The control group members either lived outside of the LOSS Team's response area or the suicide occurred prior to January 1999.

Instrumentation and Data Collection

The researcher secured permission from the crisis center's research ethics committee in order to be able to explore the survivor files and collect the target data from the records generated during the period of the study. A

recording form was designed by the researcher to collect the identified target variables for the two groups under study. The variables recorded included:

- age
- race
- gender
- relationship to the deceased
- elapsed time from death to assessment

The variables were recorded by the researcher directly from the assessment interview forms originally completed by crisis center personnel. When variable information was unclear or missing from the reviewed files, the staff person who completed the original assessment form was asked to clarify. If the staff member was unable to clarify or provide the variable information they were asked to contact the survivor directly to secure the information.

Data Analysis

The data analysis procedures used were consistent with descriptive statistics and enabled the properties of the sample observations to be summarized. The descriptive statistics better described and compared the two groups studied on the selected demographic variables and determined their measures of association. By following the guidelines for social theory research this study indicated the strength of the epistemic relationship between the Independent variable of receiving an active postvention and the dependent variable of elapsed time between death and assessment. The variables selected were coded and entered into the system file based on

having the properties of a nominal, interval, or ordinal variable. The significance level of .05 was chosen for this study.

To accomplish objective one, the use of descriptive statistics was employed to describe the nominal variables of gender, race, and relationship to the deceased for both groups. Because of the characteristics of nominal data, analysis of those variables was restricted to the use of frequencies and percentages within the qualifying categories. The variables of age and elapsed time from death to assessment were measured as interval data using means and standard deviations to describe those variables.

To accomplish objective two, the members of the group having received the Active Postvention Model (experimental group) were compared to the data developed for the group not having received the Active Postvention Model (control group). A *t* test was used to compare variables measured on an interval or higher level. The nonparametric test that was used to determine if the variables are independent at the variable treatment level was the Chi-square test.

FINDINGS

The findings of the research discussed in this chapter are organized by the objectives of the study. The similarities of the two groups in regard to age, race, gender, relationship to the deceased, and the time elapsed from death to treatment will be the focus of this chapter.

Objective One

Objective one was to describe the survivors in this study based on the two groups identified. The experimental group (N=50) received an active postvention model and the control group (N=76) did not receive an active postvention model. Both groups were studied based on specific demographic characteristics. The variable data described for the two groups came from files kept on all survivors (N=126) who sought treatment from January 1, 1999 through December 31, 2000 from the Baton Rouge Crisis Intervention Center, Inc. The demographic characteristic of age was reported for those receiving an active postvention (APM) and those not receiving an active postvention (NO-APM) in two ways. First the age of the survivors as recorded on the intake form was entered into the database, resulting in a "reported age" for each survivor.

The reported age for the 126 cases under study ranged from 14 to 85 years of age. For the experimental group (N=50), an age range from 18 years to 61 years of age was reported. A range of 14 to 85 years of age was reported for the control group (N=76). In an effort to further identify the

similarities of the two groups, the data for each were collapsed into age categories (see Table 2).

Table 2
Age of survivors by group and age category

Age **	Experimental (APM*)	Control (No-APM)
<30	8 (16%)	27 (35%)
30-44	21 (42%)	19 (25%)
45-54	14 (28%)	19 (25%)
55+	7 (14%)	11 (15%)
Total	50 (100%)	76 (100%)

Note: Experimental Mean=40.620, SD=12.123 , Control mean=38.974, SD=15.373

* Active Postvention Model

**Self reported age

In describing the two groups on the variable race, it was found that of the 126 survivor cases under study, only three of the cases were African-American and the rest (123) were Caucasian. There were no other race categories reported. Of the 50 cases who received an active postvention (APM), two (4%) were African-American and 48 (96%) were Caucasian. In reviewing the passive model (NO-APM), only one survivor (1.3%) was African-American from the 76 in that group and 75 (98.3%) were Caucasian.

Examination of data collected in this study reveals that on the characteristic gender the majority of survivors seeking treatment were women. Men made up 35.7% (N=45) of the 126 cases reviewed and women were 64.3% (N=81) of the total. In the two groups, men were 35.5% (N=27) of the group not receiving an active postvention (control) and women

represented 64.5% (N=49). In the group that received an active postvention (experimental), men made up 36% (N=18) and women represented 64% (N=32).

The number of survivors within the control (NO-APM) group and the experimental group (APM) by each of the distinct relationships were identified in this study (see Table 3).

Table 3
Relationship to the deceased

Relationship	Total Cases	Control	Experimental
Wife	19 (15%)	10 (13.0%)	9 (18%)
Mother	19 (15%)	11 (14.5%)	8 (16%)
Sister	13 (10%)	11 (14.5%)	2 (4%)
Brother	10 (8%)	5 (6.5%)	5 (10%)
Father	9 (7%)	2 (2.7%)	7 (14%)
Daughter	9 (7%)	6 (7.9%)	3 (6%)
Friend	9 (7%)	6 (7.9%)	3 (6%)
Husband	6 (5%)	5 (6.5%)	1 (2%)
Son	6 (5%)	6 (7.9%)	None
Girlfriend	6 (5%)	2 (2.7%)	4 (8%)
Uncle	3 (2.5%)	2 (2.7%)	1 (2%)
Son in law	3 (2.5%)	1 (1.3%)	2 (4%)
Stepfather	2 (1.5%)	2 (2.7%)	None
Brother in law	2 (1.5%)	2 (2.7%)	None
Aunt	1 (.8%)	1 (1.3%)	None
Niece	1 (.8%)	None	1 (2%)
Grandson	1 (.8%)	1 (1.3%)	None
Daughter in law	1 (.8%)	1 (1.3%)	None
Boyfriend	1 (.8%)	None	1 (2%)
Sister in law	1 (.8%)	None	1 (2%)
Stepdaughter	1 (.8%)	1 (1.3%)	None
Stepmother	1 (.8%)	None	1 (2%)
Cousin	1 (.8%)	1 (1.3%)	None
Engaged	1 (.8%)	None	1 (2%)
Total	126 (100%)	76 (100%)	50 (100%)

Note: Twenty-four specific relationships to the deceased were recorded

The data on "relationships to the deceased" were taken from the assessment document recorded from the perspective of the survivor. This allows the specific relationship to be discerned. For example, to record the survivor as the spouse of the deceased would not reveal the gender or role the spouse provided in the relationship. So careful attention was given to record the survivor as either wife or husband to the deceased instead of spouse, when that was the specific relationship reported. Three relationships from the 126 cases were coded without regard to gender as: friend (9), cousin (1), and engaged (1). From the 126 cases that were entered into the database, 24 distinct relationships were identified as having sought treatment. In Table 3 when one of the 24 relationships were not represented in a group the value of "none" was used to indicate that relationship was not represented. In the experimental group a total of 16 relationships were reported and 19 were reported in the control group. The top nine relationships in percent of total were family of origin relationships with wife and mother each representing 15% of the total (N=126) population studied. Sister (10%) and brother (8%) were followed by father, daughter, and friend each representing 7% of the total. It was noted that friend was represented in the total with the same frequency as father and daughter of the deceased.

The variable of "elapsed time from death to assessment" was measured in days from the date of death to assessment. The 76 members of the control group had an elapsed time from death to assessment that ranged from 3 to 16,026 days with a mean of 1263.4 (SD=3253.9 days). This wide

range is due to several survivors (9) who began to deal with the suicide of someone many years after the death. The 50 members of the experimental (APM) group had an elapsed time from death to assessment that ranged from 2 to 261 days with a mean of 37.7 (SD = 61.2 days). When the nine members of the control group considered to be extreme outliers on elapsed time were removed from the calculation of this variable, the control (adjusted) group (NO-APM) had a mean of 222.2 days (SD = 240.7 days). The more conservative control group is represented as control adjusted (N=67) in the study (see Table 4).

Table 4
Elapsed time from death to assessment

Group	N	Mean	Std. Deviation
Control	76	1263.4	3253.9
Control Adjusted	67	222.2	240.7
Experimental	50	37.7	61.2

Note: *nine study participants were eliminated from comparative analysis as Extreme outliers (death was more than three years prior to assessment)

Objective Two

The second objective of this study was to compare the survivors who received an active postvention (experimental group) with those who did not receive an active postvention (control), on selected demographic characteristics. The two groups were compared on age, race, gender, relationship to the deceased, and elapsed time from death to assessment.

The variables of age and elapsed time from death to assessment met the criteria for interval data and were compared using the *t* test procedure. The variables of race, relationship to the deceased, and gender were reviewed using the Chi-square.

For the purposes of the parametric and nonparametric testing, the control group used was the adjusted population (N=67) which removed the nine members who were treated as outliers for this portion of the study.

The Chi-square test of independence was utilized to determine if the variable race was independent of the variable postvention method (active vs. passive). The calculated statistic ($\chi^2(1)=.721, p=0.40$) indicated that the variables were independent.

When the variable relationship to the deceased was examined for its independence of the variable postvention method (active vs. passive), the 24 categories of relationship to the deceased caused the computation of the χ^2 statistic to be infeasible. The number of empty cells in the analysis would have created spurious results from the test. Therefore the variable was recoded into a variable called gender of the survivor. This new variable had three categories: male survivor, female survivor, and non-gender specific relationship (e.g., friend). When this variable was examined for independence with postvention method (active vs. passive) the resulting statistic ($\chi^2(2)=.352, p=.838$) indicated that the variables were independent. The frequencies and percentages of group members in the relationship to the

deceased by gender variable with the postvention method variable (APM or NO-APM) are summarized in Table 5.

Table 5
Crosstabulation for RELGEN and APM

RELGEN	Did not receive APM	Did receive APM	Total
Female – Count	40	29	69
% within APM	59.7%	58.0%	59.0%
% of Total	34.2%	24.8%	59.0%
Male – Count	20	17	37
% within APM	29.9%	34.0%	31.6%
% of Total	17.1%	14.5%	31.6%
*Other-Count	7	4	11
% within APM	10.4%	8.0%	9.4%
% of Total	6.0%	3.4%	9.4%
Total –Count	67	50	117
% within APM	100.0%	100.0%	100.0%
% of Total	57.3%	42.7%	100.0%

* Other indicates a relationship not defined by gender (i.e., cousin)
($\chi^2(2)=.352$, $p=.838$)

Examination of the independence of the variable gender of the survivor and postvention method was accomplished using the chi-square test of independence. The calculated statistic ($\chi^2(1)=.279$, $p=.597$) indicated that the variables gender and postvention method were independent.

The *t* test was used to study the continuous variables of age for the control group (N=67), the experimental group (N=50), and elapsed time from death to assessment. Age was the reported age of the survivors given and recorded during the assessment interview. Results of the *t* test statistic ($t(115) = .49, p = .63$) indicated the variables of age and method of postvention were independent (see Table 6). The age of the control had a mean of 39.3 years of age (SD=15.6) and the experimental group had a mean of 40.6 years of age (SD=12.1).

Table 6
***t* test for AGE and APM or No-APM**

	N	Mean	Std. Deviation	Std. Error Mean
AGE- No-APM	67	39.313	15.6624	1.9135
AGE- APM	50	40.620	12.1233	1.7145
CAGE-No-APM	59	39.7517	14.32522	1.86498
Cage APM	44	40.5511	12.44768	1.87656

t test ($t(115) = .49, p = .63$) age is independent of method of postvention

Another aspect of the study's objective two was to compare the elapsed time from suicide to the assessment for treatment by the postvention method (active vs. pasive). This was using the independent *t* test procedure. In addition, the nine individuals who had elapsed times of more than three years from the date of death were excluded from the analysis as extreme outliers. When the statistic was computed, the results revealed that the group who received the active postvention method ($M = 37.73, SD = 61.20$) had

a significantly shorter elapsed time from death to assessment than the group who received the passive postvention method ($M=222.2$, $SD=240.66$) ($t(115)=5.288$, $p<.001$).

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The primary purpose of this study was to determine the influence of an active postvention model (APM) on the length of time taken for a suicide survivor to seek treatment. Survivors who received an active postvention and survivors who did not were described and compared in an effort to determine if the influence of an active postvention had any significant impact. The survivor data that were used in this study came from the assessment forms completed by a local crisis center on each survivor seeking treatment from January 1, 1999 through December 31, 2000.

Objective one was to describe the two groups of survivors, those who did receive an active postvention (APM) and those who did not (NO-APM), on the characteristics of age, race, gender, relationship to the deceased, and elapsed time from death to assessment.

Objective two was to compare the two survivor groups by the characteristics of age, race, gender, relationship to the deceased, and elapsed time from death to assessment.

There were 126 survivors of suicide assessed by the local crisis intervention center. All 126 cases were entered into the database and reviewed for the purposes of this study. The cases were all assessed within the time period of January 1, 1999 to December 31, 2000.

The primary instrument used in this study was a recording form developed by the researcher to gather the variable data relevant for the

investigation from the assessment document maintained by the crisis intervention center (see Appendix). This document allowed the orderly recording of the variables to be studied directly from the assessment documents. Each case was coded to protect the confidentiality of the survivors of suicide represented. The cases were coded as having received an active postvention or not based on the referral information recorded on the actual assessment document.

The total number of survivors who were assessed was 126 with 50 having received an active postvention (APM) and 76 not receiving an active postvention (NO-APM). The 126 survivors studied ranged in age from 14 to 85 years. There were more females (N=81) in the study than men (N=45) and within the control (N=76) group (NO-APM) there were 49 women and 27 men. In the experimental (N=50) group (APM) there were 32 women and 18 men. Caucasians made up 97.6% (123) and African-Americans made up the remaining 2.4% (3) during the assessment period being studied. The small number of African-Americans represented in the variable "race" suggests that although receiving an active postvention doubled the number of African-Americans coming for an assessment the numbers were too low to make any scientific statements about the probability that race and receiving an active postvention are related or not. With African-Americans having been 21% of the suicides in the geographic area served by the LOSS Team it would seem barriers do exist for a more diverse representation among survivors of suicide. One potential remedy would be to have African-

American representation among the members of the LOSS Team, group members in leadership roles, or consider providing suicide survivor groups in African-American churches.

The variable “relationship to the deceased” was very descriptive of the survivors who sought treatment. Because women made up 64% of the 126 cases of survivors represented in the study, a larger number of female specific relationships were identified. Relationships such as: wife (N=19), mother (N=19), daughter (N=9), sister (N=13), stepmother (N=1), girlfriend (N=6), aunt (N=1), niece (N=1), daughter in law (N=1), sister in law (N=1), and stepdaughter (N=1) were found to have been reported in either the control or experimental and not in both. Men were represented in the following relationships: husband (N=6), father (N=9), son (N=6), brother (N=10), stepfather (N=2), boyfriend (N=1), uncle (N=3), grandson (N=1), son in law (N=3), and brother in law (N=2). In the control group a total of 19 of the 24 relationships identified were reported and in the experimental a total of 16 of the 24 were found. A crosstabulation of the computed variable of “RELGEN” was entered to determine if a relationship existed between gender specific relationships and receiving an active or passive model of postvention. The Pearson Chi-square for “REIGEN” was .352, which indicated the variable was not related to whether the survivor received an active postvention or not. There were three non-gender specific relationships identified: cousin (N=1), engaged (N=1), and friend (N=9). Friend was the only non-gender specific relationship to be found in both the control and

experimental groups. Although the relationship of friend is often overlooked as significant the number of survivors reporting to be the friend of the deceased was in the top ten relationships seeking treatment. A total of 11 relationships were found to occur in both groups. This is perhaps significant in how the literature and society have viewed those who have lost someone to suicide. The accepted and often used ratio of six survivors for each suicide may be valid for measuring the total number of individuals impacted by suicide, however it does not adequately describe the variety of relationships that are impacted by each death. The variety of survivors, based on relationship, who sought treatment during the two years of this study encourage a broader view of the various relationships that are impacted by suicide and seek treatment. The variables of relationship and receiving an active postvention or not was found to be independent of each other. The ability to predict which relationship will seek treatment based on type of postvention received could not be concluded from the data. The importance of recognizing that survivor is more appropriately defined as someone significantly impacted by the suicide is crucial in assessing the impact based on loss of relationship or closeness to the deceased and not on relationship by societal standards.

The variable of "elapsed time from death to assessment" was shown to have been significantly related to having received an active model of postvention (APM) when compared to not having received an active model of postvention (NO-APM). The experimental group (APM) had a *t* test

significance value of $<.001$, which exceeded the required value of $.05$ set for the study. There were nine cases in the control (NO-APM) group which biased the data in favor of the experimental (APM) group. When all 126 cases were left in the study the mean for the total group was 777.04 days with a range from 2 days to 16,026.34 days. The control group was reduced by the nine cases dropping the mean to 222.2 days from death to assessment for the remaining 67 cases. The experimental group ($n=50$) remained highly significant ($<.001$) with a mean of 37.7 days from death until assessment.

Conclusions and Recommendations

Based on the findings of this study, the following conclusions and recommendations were drawn by the researcher.

1. The survivors of suicide who sought treatment had a wide range of ages. This conclusion is based on the range of ages in the study. In the 126 cases reviewed the ages ranged from 14 to 85 years of age. Within the experimental group the range went from 18 to 61 and in the control group ages ranged from 14 to 85. This allows exploration of the concept put forth by Farberow suggesting that survivor grief could be impacted by the stage of life the survivor is in at the time of the death. Further testing of this concept could be a consideration for future research.
2. The majority (63.5%) of survivors seeking assessment was female and female specific roles accounted for 59% of the two groups.

Although men are three times more likely than women to die from suicide the relationships that seek treatment are less skewed than the ratio of suicide by gender. Women have traditionally been seen in our society as the gender to seek help and grieve more openly. The fact that so many males (35.7%) have sought treatment for having lost someone to suicide suggests that this cause of death profoundly impacts both men and women.

3. The majority of survivors seeking treatment were Caucasian (97.6%) with African-Americans being the only other race represented with only three (2.4%) of the cases in the study.

The percentage of suicide in the geographic area served by the LOSS Team (active model of postvention) during the two years studied indicated that 21% of the deaths that occurred were African-Americans. The smaller percentage of African-Americans represented by the survivors who sought treatment (n = 2.4%) could be a reflection of cultural barriers toward seeking help with such a stigmatizing cause of death. The fact that two of the three African-American survivors were in the experimental group (APM) suggests that the active postvention model is more likely to generate an assessment than the passive model. This would be an important variable to study from a qualitative as well as a quantitative approach.

4. The variable "relationship to the deceased" indicates 24 specific relationships were represented in those seeking treatment following a suicide.

The 83 suicides that generated the 126 survivor assessments in this study indicated that more than one person per suicide seeks treatment. How that survivor is connected to the deceased may include the quality of emotional closeness (like friendship) as well as familial connections. The ratio of six survivors to each suicide has been used to calculate the magnitude of impact suicide has on the overall society for many years. This calculation also suggests concern for how large a population is at risk in the future as a result of being a survivor. However, there has not been a study to examine the impact suicide has on specific relationships or if seeking treatment reduces the future risk that is assumed for all survivors in the literature. Because the literature does not distinguish between survivors who receive help or seek treatment and those who do not the knowledge of mitigating the risk concern remains an unknown. This study has accumulated a list of 24 relationships that sought treatment for the impact of a death to suicide. This researcher recommends that future research follow up on survivors who seek treatment, attend support groups, and complete instruments designed to calculate the course and intensity of grief as well as other mental health adjustment measures. If seeking treatment is determined to be helpful in reducing future risk of suicide as well as improving coping, then the specific relationships seeking treatment could be studied to indicate what was most helpful in their decision to seek help.

5. The influence of an active model of postvention is statistically significant in reducing the elapsed time from death to assessment.

The results of the t test on the two groups studied indicated a highly significant ($p < .001$) difference, with those receiving an active postvention (APM) coming sooner for treatment than those receiving a passive model of postvention. This finding is essential in helping to persuade communities, government, and survivor sensitive agencies to provide postvention services to survivors at the time of death. The impact of reducing the delay by 185 days is very important when the literature supports the concept of sooner is better. The impact of compromised activities of daily living for the survivors extending an additional six months does not support the passive model being accepted as a standard of care in this country.

By developing programs like the LOSS Team in a variety of jurisdictions research could indicate on a larger scale the positive impact that an active postvention model (APM) could have in the lives of survivors with more diverse cultural backgrounds as well as those who reflect the demographic characteristics of the two groups in this study.

Survivors of suicide have been ignored for too long and left to suffer needlessly without the usual support or grieving opportunities afforded survivors of other modes of death. The existence and proliferation of support groups are positive and important reasons for those bereaved. Encouraging and facilitating attendance are keys to recovery. Active postvention holds the promise of hastening entry into these invaluable resources where grieving can occur right away and avoid the delay that has been the passive model's legacy to survivors.

REFERENCES

Augenbraun, B., & Neuringer, C. (1972). Helping survivors with the impact of a suicide. In A.C. Cain (Ed.), *Survivors of suicide* (pp. 178-185). Springfield, IL: Charles C. Thomas.

Barrett, C.J., & Schneweis, K.M. (1980/1981). An empirical search for the stages of widowhood, *Omega*, 11(2), 97-104.

Beck, A.T., & Steer, R.A. (1987). *Beck Depression Inventory: Manual*. New York: The Psychological Corporation, Harcourt Brace Jovanovich, Inc.

Bland, D., "The Experiences of Suicide Survivors: An Independent Reading Study", Louisiana State University, Baton Rouge, LA. July 1994.

Bootsin, R.R., & Accocella, J.R. (1988). *Abnormal Psychology: fifth edition current perspectives*. New York: Random House.

Bongar, B. (1991). *The Suicidal Patient: Clinical and legal standards of care*. Washington, D.C.: American Psychological Association.

Bowlby, J. (1969). *Attachment and loss*, New York: Basic Books.

Brent, D. A., Preper, J., Mortiz, G., Allman, C., Friend, A., Schweers, J., Roth, C., Balach, L., & Harrington, K. (1992). Psychiatric effects of exposure to suicide among the friends and acquaintances of adolescent suicide victims. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 629-640.

Brent, D.A., Perper, J.A. & Moritz, G. (1993). Psychiatric impact of the loss of an adolescent sibling to suicide. *Journal of Affective Disorders*, 28, 249-256.

Cain, A.C. & Fast, I. (1972). The Legacy of suicide: observations on the pathogenic impact of suicide upon marital partners. In A.C. Cain (Ed.), *Survivors of suicide*. Springfield, IL: Charles C. Thomas.

Cain, A.C. (Ed.). (1972). *Survivors of suicide*. Springfield, IL: Charles C. Thomas.

Campbell, F.R. (1997). Changing the Legacy of Suicide, *Suicide and Life-Threatening Behavior*, 27 (4).

Campbell, F.R. (2000). Suicide: An American form of Abuse. *New Global Development: Journal of International and Comparative Social Welfare*, XVI: 1-3, 88-93.

Campbell, F.R. & Lester, D. (1996). The temporal distribution of suicides in Baton Rouge, *Perceptual and Motor Skills*, 83 (14).

Clayton, P. J. (1974). Mortality and morbidity in the first year of widowhood. *Archives of General Psychiatry*, 30,747-750.

Cook, A., & Dworkin, D. (1992). *Helping the bereaved: Therapeutic interventions for children, adolescents, and adults*. New York: Basic Books.

Doyle, P. (1975). The anniversary interview in grief counseling for the survivors of suicide [Abstract]. In B.S. Comstock & R. Maris (Eds.), *Proceedings* (8th annual meeting of the American Association of Suicidology, St. Louis). Houston, TX: American Association of Suicidology.

Doyle, P. (1977). Grief counseling for children. In B.L. Danto & A. H. Kutscher (Eds.), *Suicide and bereavement* (pp. 211-221). New York: Smith & Haas.

Dunne, E.J., Dunne-Maxim K., & McIntosh, J.L. (Eds.). (1987). *Suicide and its aftermath: Understanding and counseling the survivors*. New York: W.W. Norton.

Durkheim,E. (1951). *Suicide*. (J.A. Spaulding & G. Simpson, Trans.). Glencoe IL: The Free Press. (Original published in 1897 as *Le Suicide*).

Faschingbauer, T.R., Devaul, R.A., & Zisook, S. (1977). Development of the Texas inventory of grief. *American Journal of Psychiatry*, 134, 696-698.

Grossman,J., Pizzelo,L., Pennington, J., & Uit den Bogard, B. (1993). Longitudinal Bereavement in Child Survivors of Paternal Suicide [Abstract]. In D. Lester (Ed.), *Suicide ,93 Proceedings* (26th Annual Conference, American Association of Suicidology, San Francisco). Denver, Co.: American Association of Suicidology.

Hatton, C.L., & Valente, S.M. (1981). Bereavement group for parents who suffered a suicidal loss of a child. *Suicide and Life-Threatening Behavior*, 11, 141-150.

Hauser,M.J. (1983). Bereavement outcomes for widows. *Journal of Psychosocial Nursing and Mental Health Services*, 21(9), 22-31.

Hayes, D.N. (1993). The Development of an inventory to measure bereavement (Doctoral dissertation, Louisiana State University, 1994). *UMI Dissertation Services*, No.3058.

Hudson, W.W. (1981). Development and use of indexes and scales. In R.M. Grinnell (Ed.), *Social Work Research and Evaluation*. Itasca, IL.: F.E. Peacock, 130-155.

Jakab, I., & Howard, M.C. (1969). Art therapy with a 12-year-old girl who witnessed suicide and developed school phobia. *Psychotherapy and Psychosomatics*, 17, 309-324.

Junghardt, D. Z. (1977). Survivors of suicide: A program in postvention. In C.L. Hatton, S.M. Valente, & A. Rink (Eds.), *Suicide: Assessment and intervention* (pp. 124-132). New York: Appleton-Century-Crofts.

Kachur, S.P., Potter, L.B., James, S.P., & Powell, K.E., *Suicide in the United States, 1980-1992*. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 1995. Violence Surveillance Summary Series, No.1.

Kliman, A.S. (1984). Crisis: Psychological first aid for recovery and growth. In N. Linzer (Ed.), *Suicide: The will to live vs. The will to die* (pp. 171-186). New York: Human Sciences Press.

Kovarsky, R.S. (1989). Loneliness and disturbed grief: A comparison of parents who lost a child to suicide or accidental death. *Archives of Psychiatric Nursing*, 3, 86-96.

Kubler-Ross, E. (1969). *On death and dying*. New York: Macmillan.

Lester, D. Research methods for suicidologist. *Proceedings of the Pavese Society*, 1995, 6, 1-33.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American journal of Psychiatry*, 101, 141-149.

Lindemann, E., Vaughn, W.T., Jr., & McGinnis, M (1972). Preventive intervention in a four-year-old child whose father committed suicide. In A.C. Cain (Ed.), *Survivors of suicide* (pp. 70-92). Springfield, IL: Charles C. Thomas.

Lukas, C. & Seiden, H.M. *Silent Grief: Living in the Wake of Suicide*. New York: Charles Scribner's Sons, 1987.

Maris, R.W., Berman, A.L., & Silverman, M.M. *Comprehensive Textbook of Suicidology*. New York: Guilford Publications, 2000.

Marris, P. (1958). *Widows and their families*. London: Routledge and Kegan.

Mitchell, A., & Constantino, R. E. (1993). Nursing Postvention for Widows and Widowers who survive the suicide of a spouse [Abstract]. In D. Lester (Ed.), *Suicide 93 Proceedings* (26th Annual Conference, American Association of Suicidology, San Francisco). Denver, Co.: American Association of Suicidology.

McIntosh, J.L., & Milne, K.L., "Survivors reactions: Suicide vs. other causes." Paper presented at the annual meeting of the American Association of suicidology, Atlanta, GA., April 1986.

McIntosh, J.L. (1999). *USA Suicide: 1998 official final data* [Mimeograph]. South Bend, IN.

McIntosh, J.L. (1993). Control group studies of suicide survivors: a review and critique. *Suicide and Life-Threatening Behavior*, 23(2), 146-161.

Miles, M.S. & Demi, A.S. (1991). A comparison of guilt in bereaved parents whose children died by suicide, accident, or chronic disease. *Omega*, 24, 203-215.

Parkes, C.M. (1964). Recent bereavement as a cause for mental illness. *British Journal of Psychiatry*, 110, 198-204.

Parkes, C. M. (1972). *Bereavement: Studies of grief in adult life*. New York: International Universities Press.

Redfield Jamison, K. (1999). *Night falls fast: Understanding suicide*. NY:Knopf.

Reid, H. Senator. (1997). Congressional Record for House Resolution 84, *Proceedings and Debates of the 105th Congress*, First Session, Vol. 143-No. 57. Washington, D.C., Tuesday, May 6, 1997.

Resnik, H.L. P. (1970) Center comments. *Bulletin of Suicidology*, No. 6, pp.2-4.

Resnik, H.L.P. (1972). Psychological resynthesis: A clinical approach to the survivors of a death by suicide. In A.C. Cain (Ed.), *Survivors of suicide* (pp. 167-177), Springfield, IL: Charles C. Thomas.

Rogers, J., Sheldon, A., Barwick, C., Letofsky, K., & Lancee, W. (1982). Help for families of suicide: Survivors Support Program. *Canadian Journal of Psychiatry*, 27, 444-449.

Rubey, C.T., & McIntosh, J.L., "Suicide Survivors Groups: Results of a Survey", paper presented at the annual meeting of the American Association of Suicidology, Phoenix, AZ., May 1995.

Saffer, J.B. (1986). Group therapy with friends of an adolescent suicide. *Adolescence*, 21, 743-745.

Shackleton, C. H. (1984). The psychology of grief: A Review. *Advanced Behavior Research and Therapy*, 6, 153-205.

Szasz, T. (1986). The case against suicide prevention. *American Psychologist*, 41, 806-812.

Schuyler, D. (1973). Counseling suicide survivors: Issues and answers. *Omega*, 4, 313-321.

Shneidman, E.S. (1972). Foreword. In A.C. Cain (Ed.), *Survivors of suicide* (pp.ix-xi). Springfield, IL: Charles C. Thomas.

Shneidman, E.S. (1973). *Deaths of man*. New York: Quadrangle Books.

Toynbee, A. (1969). *Man's concern with death*. San Francisco: Jossey-Bass.

Vonnegut, K., Jr. (1970). *God bless you, Mr. Rosewater*. New York: Dell.

Wallerstein, R.S. (1972). Reconstruction and mastery in the transference psychosis. In A.C. Cain (Ed.), *Survivors of suicide* (pp. 242-255). Springfield, IL: Charles C. Thomas.

Whitis, P.R. (1972). The legacy of a child suicide. In A.C. Cain (Ed.), *Survivors of suicide* (pp. 155-166). Springfield IL: Charles C. Thomas.

Zisook, S. (Ed.). (1987). *Biopsychosocial aspects of bereavement*. Washington, DC: American Psychiatric Press.

APPENDIX

Suicide Survivor Intake Form Baton Rouge Crisis Intervention Center, Inc.

Counselor _____ Date _____ Time(begin & end) _____ am/pm

Referred by _____

General Information About Survivor

Survivor's Name _____ Race/Ethnicity _____

Address _____ Phone _____ (Home)
_____ (Work)

Parish _____

Date of Birth _____ Age _____ Gender _____ Living Situation _____

Marital Status _____ Marriage History _____

Religion _____ active/passive Religious counselor _____

Occupation _____ How long? _____

Currently working/student: yes / no Number of hours/week _____

Information About the Deceased

NAME _____ Age _____ Gender _____

Marital Status _____ Marital History _____ Occupation _____

Religion _____ active/passive Race/Ethnicity _____

Date of Death _____ Method _____ (HL,ML,LL)

Who found deceased _____

Survivor's relationship to deceased _____

Nature of relationship with deceased: good / ambivalent / bad

Counseling History _____

Medications _____

Problem Areas _____

Any prior suicidal behavior? _____

Death certified by coroner as _____ / currently unknown

Suicide Note: yes/no What did it say? _____

Other Survivor Losses to Death (family, friends, pets):

<u>Name/Relationship</u>	<u>Cause of Death</u>	<u>Date</u>	<u>Survivor's age at time</u>
--------------------------	-----------------------	-------------	-------------------------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

History of Abuse: None / Physical / Emotional / Sexual _____

What is survivor telling him/herself to explain why the suicide happened?

Specific Information About Survivor

Survivor counseling history (Hospitalization / Therapy / Other / None)

Therapist _____ Dates from _____ to _____

_____ Dates from _____ to _____

Is survivor currently taking any medication? yes / no

What medication? _____ What for? _____

Significant Others:

<u>Name/Relation</u>	<u>Age</u>	<u>Nature of Relationship</u>
----------------------	------------	-------------------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there other members of the family or friends who may need grief assistance?
yes / no _____

Page 2

Community Response

How did the police react? Emergency Service Providers? (Not present _____)

How did survivor's family react? _____

How did survivor's friends react? Church members? _____

Who will (did) support survivor in his/her grief period? _____

Survivor's Daily Activities / Coping

How many meals does survivor eat each day? _____ When are they eaten? _____ How is this different from before the death? _____

How much and when does survivor exercise? _____

How is this different from before the death? _____

How much does survivor sleep at night? _____ Day? _____

How is this different from before the death? _____

(Digital clock) _____

Does survivor have any: flashbacks / traumatic daydreams / images / dreams about the deceased? _____

Describe _____

Survivor's description of ability to concentrate in comparison to before the death?

Is bibliotherapy appropriate at this time (No Time to Say Good-bye) yes / no

Is survivor afraid of losing control?

All the time _____ Some of the time _____ Seldom _____ Never _____

Does survivor like him/herself? yes / no How has this changed since the suicide? _____

Of the following feelings, which, if any, does the survivor experience the most / least:

anger _____ guilt _____

happiness _____ relief _____

sadness _____ scared _____

How is this different since the suicide? _____

What was survivor's reason for coming to our program now? _____

Counselor Notes

Any prior suicidal behavior? yes / no Describe _____

Current ideation / behavior plan _____

Treatment Plan _____

Group Agreement Contract signed and in file? yes / no

Page 4

VITA

Frank Campbell was born in Baton Rouge and became a Social Worker after retiring from a management position with an international retailer. He has served as Executive Director of the Baton Rouge Crisis Intervention Center since 1989 and has worked with survivors of suicide since 1986, participating in over six hundred weekly support group sessions. Campbell developed the Active Postvention Model (APM) as a result of the many cases where survivors could have benefited from help at the time of death and did not know of the resources that existed in the community. The LOSS Team program he developed for the Baton Rouge Crisis Intervention Center inc. is now being considered by other communities in the United States and other countries as well. Campbell served as President of the American Association of Suicidology and is a past recipient of the State Social Worker of the Year award from the Louisiana Chapter of the National Association of Social Work. Campbell and his wife, Cheryl were honored in 2001 as co-recipients of the Roger J. Tierney Ph.D. award for service by the American Association of Suicidology. Campbell hopes to continue his work with survivors of suicide and develop effective models of postvention, through social work research, that can be implemented on a global basis in an effort to reduce the negative impact on the legacy of suicide for survivors.

DOCTORAL EXAMINATION AND DISSERTATION REPORT

Candidate: Frank R. Campbell

Major Field: Social Work

Title of Dissertation: The Influence of an Active Postvention on the Length of Time Elapsed Before Survivors of Suicide Seek Treatment

Approved:

Brij Mohan

Major Professor and Chairman

J. M. Perkins

Dean of the Graduate School

EXAMINING COMMITTEE:

Sam Tate

Margo M. Abadie

John McIntosh

Kenneth J. Miller

Steven F. Haynie

Date of Examination:

October 20, 2001