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Survivors of Individuals Who Completed Suicide: The Influence of Time Since the Loss

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SURVIVORS OF INDIVIDUALS WHO COMPLETED SUICIDE: THE
INFLUENCE OF TIME SINCE THE LOSS

A Thesis

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
Master of Social Work

in

The School of Social Work

by
Alexis M. Rabalais
B.S., Louisiana State University, 2012
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Abstract

This cross sectional study explores associations between elapsed time since the loss and outcomes of prominent feelings and self-regard among 187 help-seeking survivors bereaved by suicide. Chi-square tests were conducted to examine the aforementioned relationships. In examining suicide survivors' most prominent feelings over time, this study found mixed results in early bereavement. This study showed that at 25 to 59 months elapsed time since the loss both scared and happiness were significant for suicide survivors. No significance was found before 25 to 59 months, suggesting a change in suicide survivors' prominent feelings following two years elapsed time since the loss. In later bereavement (i.e., 5+ years), suicide survivors' chosen most prominent feeling of happiness was significant. The aforementioned results could be suggesting that following two years elapsed time since the loss, this sample of survivors bereaved by suicide experienced a change in their grief experience.

Chapter 1

Introduction

The purpose of this cross-sectional study is to examine the relationship between the elapsed time since the loss of the help-seeking survivors of suicide (SOS) and one or more of the following outcomes: the SOS' most prominent feeling and/or self-regard. According to the American Associations of Suicidology (AAS, 2014), SOS can refer to *suicide loss survivors* and *suicide attempt survivors*. Suicide attempt survivors are individuals that have survived a suicide attempt through intervention of the survivor or others (Crosby et al., 2011; AAS, 2014). Suicide loss survivors are family and friends who are *intimately* (e.g., immediate family, best friend, etc.) affected by the loss of a loved one that completed suicide (AAS, 2014; Berman, 2011; McIntosh & Drapeau, 2015). This thesis focuses on suicide loss survivors (AAS, 2014).

Centers for Disease Control and Prevention (CDC, 2015) reported that 41,149 individuals in the United States (U.S.) completed suicide in 2013. CDC (2015) also reported that Caucasian males 85 and older in the U.S. had 940 suicides and the highest crude rate (54.94) of suicide for the year 2013. With an estimation of six survivors of suicide (SOS) for every one completed suicide, there were 248,800 new SOS in 2013. Furthermore, counting from 1989 through 2013, there are approximately 4.95 million SOS currently living in the U.S. The target population of this thesis is help-seeking adult *survivor(s) of suicide* (SOS), individuals surviving a loved one who died by suicide (AAS, 2014).

According to U.S. Public Health Service (1999), losing a loved one to suicide increases the SOS' risk for suicide. Due to the stigma that still exists with the topic of suicide, SOS have found talking to another SOS or support groups for survivors bereaved by suicide to be the most for grief support (McMenamy, Jordan, & Mitchell, 2008). The following paper will discuss

previous literature on suicide involving definitions of suicide and suicidal behavior and the scope of suicide in the U.S. Then, the U.S. suicide statistics will be broken down by the following characteristics: gender and race, age group, suicide risk factors, and methods of suicide.

Next, SOS, the target population, was explicated through preceding literature. This portion of the thesis involved SOS definitions, statistics, and further explication of the population via research samples. The conceptualization of outcomes followed the explanation of SOS, which included the SOS' most prominent feeling in association with the suicide loss and self-regard. Conceptualization of the independent variable, elapsed time since the loss, was then presented. Next, the theoretical frameworks were explained. Each framework was then applied to this study's outcomes (the SOS' most prominent feeling and self-regard). The literature review ends with a summary of the theoretical foundation. A review of literature regarding suicide, the population of interest, conceptualization of primary dependent and independent variables, and the theoretical frameworks will now be presented below.

Chapter 2

Review of the Literature

Crosby, Ortega, and Melanson (2011) described a *completed suicide* as an individual's intentional, self-infliction of injury that results in death. Kazdin (2000) defined a completed suicide as a self-execution, which in many suicide cases is the outcome of *depression* or another *mental illness*. A *suicide attempt* is an act of self-inflicted harm, where the determined goal is death, but the behavior leaves the individual alive (uninjured or injured; Crosby et al., 2011). The American Psychiatric Association (2013) conceptualized a suicide attempt as a series of behaviors that are self-instituted and anticipated to end the individual's life, when the series of behaviors begin. As stated above the focus of this thesis is *survivor(s) of suicide loss* (SOS). The following terms will be referring to individual's experiencing suicide loss: SOS, *suicide survivor(s)*, or *person(s) bereaved by suicide(s)* (AAS, 2014; Cerel, Maple, Aldrich, & Venne, 2013). Before the topic of SOS is explicated, further knowledge of suicide in the United States (U.S.) will be presented.

U.S. Suicide Statistics

Gender and race. The Centers for Disease Control and Prevention (CDC, 2015), which is the repository of the most recent suicide statistics, reported in 2013 there were 41,149 suicides in the U.S, which was 1.6% of the nation's deaths. These figures represented a crude rate of 13.0 per 100,000 individuals (McIntosh & Drapeau, 2015). All rates in this thesis are *crude rates per 100,000* individuals. *Crude rates* are the number of deaths in a specific group (e.g., the number of male suicides) divided by the group's population, and multiplied by 100,000 (CDC, 2015). All CDC (2015) and McIntosh and Drapeau (2015) data reported in this literature review are characteristic of the U.S. in 2013. To illustrate gender differences in suicide, males experienced 32,005 suicides, a rate of 20.2, and accounted for 77.9% of the suicides (CDC, 2015). Whereas

females completed 9,094 suicides for a rate of 5.7, and these accounted for 21.1% of all suicides (CDC, 2015). This showed that 3.5 males died by suicide for every one female death by suicide (CDC, 2015). McIntosh and Drapeau's (2015) report for 2013 stated in America there were 3 female attempts for every male attempt. Overall the trend illustrates that males completed suicide more frequently than females (CDC, 2015; Denney, 2010; Grove, 1972).

Also, the CDC (2015) reported suicides by race for the year 2013, which included the following:

- Asian and Pacific Islanders: 1,121 individuals, 2.7% of suicides, and a rate of 6.02;
- Black: 2,353 individuals, 5.7% of suicides, and a rate of 5.38;
- Caucasians: 37,154 individuals, 90.3% of suicides, and rate of 14.9; and
- Native Americans: 521 individuals, 1.3% of suicides, and rate a rate 11.69.

Looking across races, Caucasians have a higher raw amount, percent, and rate of suicides (CDC, 2015). Furthermore, combining race and gender, Caucasian males are the most at risk for completing suicide (CDC, 2015). According to CDC (2015) Caucasian males experienced 28,943, suicides, a rate of 23.2, and accounted for 70.3% of the suicides.

Age group statistics. McIntosh and Drapeau's (2015) research on age demographics in 2013 found that suicide was the second leading cause of death for the *young* population, ages 15-24, comprising 17.1 % of the nation's deaths and at a rate of 11.1. In 2013, the young age group made up 13.9% of the total U.S. population and accounted for 11.9% of the nation's suicides (McIntosh & Drapeau, 2015). Furthermore, McIntosh and Drapeau reported that the young age group included 100-200 suicide attempts for every one completed suicide. Also, the report explained the *middle-aged* group, ages 45-64, accounted for 26.3% of the population in 2013, but accounted for 38.3% of the suicides (McIntosh & Drapeau, 2015). McIntosh and Drapeau stated

that the *old* population, as defined by 65 years of age and older, in 2013 was 14.1% of the U.S. population, but accounted for 17.5% of the nation's suicides. Furthermore, McIntosh and Drapeau reported in 2013 the old population had four suicide attempts for every one completed suicide (McIntosh & Drapeau, 2015). The CDC (2015) report for 2013 showed the largest number of suicides (4, 610) and the highest rate (20.44) for individuals ages 50-54.

Consistent with the CDC's (2015) age group data for both sexes, females had the largest rate (10.11) and the amount of deaths (1,162) at ages 50-54 (CDC, 2015). The largest rate of suicide (48.49) for males was for the 85 years and older age group (CDC, 2015). This age group experienced 990 individuals, the second smallest number of deaths across all age groups (CDC, 2015). The age group with the smallest number of suicides (249) was the 10-14 years of age group. Research statistics (CDC, 2015; McIntosh & Drapeau, 2015) indicated that suicide rates increased with age among the elderly. Older adult age group rates as follows: 65- 69 (14.69), 70-74 (15.54), 75-79 (15.73), 80-84 (18.93), and 85 and older (18.56; CDC, 2015). When the age groups were examined separately for males and females, however, older adult suicide rates increased with age for males but decreased with age for females (CDC, 2015).

The CDC (2015) examined the 2013 rates by sex, race, and age group, and patterns were found for *adolescents* (11-21), *young adults* (22-34), *middle adults* (35-64), *older adults* (65-84), and the *oldest adults* (85 and older; Ashford & Lecroy, 2013; CDC, 2015). Native American males had the highest rates for individuals categorized as adolescents (19.73) with 84 individuals included and young adults (29.89), which included 143 individuals (CDC, 2015). Furthermore, the CDC reported that Caucasian males had the highest rates of suicide for individuals categorized as follows: middle adults (31.44), older adults (31.92), and the oldest adults (52.89). Overall, research has consistently presented the highest suicide rates for Caucasian males 85

years of age and older including 940 completed suicides for a rate of 54.94 (Ashford & Lecroy, 2013; CDC, 2015).

Suicide risk factors. Several researchers (e.g., Denney, 2010; Grove, 1972; U.S. Public Health Service, 1999) explained that a completed suicide occurs due to a lack of social connectedness. Consistently, Denney (2010) reported that an individual's living situation comes into play when examining demographic patterns of completed suicides. Denney's research sample consisted of 825,462 adults, with 1,166 suicides completed from 1986-2002. This research demonstrated that for every level of social connectedness added to an individual's life, there was a decrease in suicide risk (Denney, 2010). Individuals who lived in married households with zero children had a 34% decrease in suicide risk, compared to individuals living alone (Denney, 2010). Furthermore, individuals married with children had a 51% decrease in comparison to individuals living alone (Denney, 2010). Other adult living situations with a decrease in suicide risk compared to single individuals living alone included nonmarried individuals living with kin (24%) and nonmarried individuals living with children (16%; Denney, 2010). Furthermore, two adults living together who were unrelated were at an increased suicide risk, but the risk decreased with every additional individual added to the household (Denney, 2010).

Previous researchers (Denney, Rogers, Krueger, & Wadsworth, 2009; Gove, 1972; Smith, James, Mercy, & Conn; 1988) have agreed that less socially connected individuals (e.g., divorced, separated, and widowed) were more at risk for suicide in comparison to married individuals. According to Denney et al. (2009), controlling for size of the family, social status, and economic status lowered the risk for divorced, never-married, and widowed females, resulting in marital status concepts being insignificant to female suicide. Furthermore, when the

same concepts were controlled for in males, suicide risk decreased, but not enough to determine marital status concepts insignificant to risk for suicide (Denney et al., 2009).

Researchers (Denney et al. 2009; Gove, 1972) both agreed that becoming widowed held the highest risk factor for males. For example, Denney et al. (2009) reported widowed males encompassed a 60% increase in suicide risk, and Grove (1972) reported that the *Durkheim coefficient of preservation* (i.e., widowed suicide rate divided by married suicide rate) was the largest amongst widowed males, 4.356. Also, Denney et al. (2009) reported a 39% increase in suicide risk for divorced or separated individuals and a 22% increase for never married individuals. Denny et al. found that the amount of family members a person lived with decreased an individual's risk for suicide. Further for every individual added to the family, there was a 15% decrease in suicide risk (Denney et al., 2009). Another factor that increased an individual's risk for suicide was employment status (Denny et al., 2009). According to Denney et al., individuals who were unemployed had a 70% increase in suicide risk compared to employed individuals. Denny et al. also explained that higher incomes lowered the risk for males, but this was not the case for females. Furthermore, Denney et al. found that higher income was insignificant for females.

The U.S. Public Health Service (1999), identified obstacles to obtaining mental health resources a risk for suicide, and this appears to be dependent on where the individual resides. Researchers (Fiske, Gatz, & Hannell, 2005; Holzer, Goldsmith, & Ciarlo, 2000; Searles, Valley, Hedegaard, & Betz, 2014) have continually found that rural areas include a deficit of mental health resources. Suicide rates are higher in rural areas in comparison to urban areas (Fiske et al., 2005; Searles et al., 2014; Singh & Siahpush, 2002). The amount of accessibility to resources,

more specifically, can be connected to higher risk levels for individuals residing in certain states or regions (McIntosh & Drapeau, 2015; U.S. Public Health Service, 1999).

McIntosh and Drapeau (2015) ranked the states of America by suicide rates. McIntosh and Drapeau reported the states with the highest suicide rates in 2013, which included the following: Montana (23.9), Alaska (19.8), Wyoming (22.1), and New Mexico (20.2). McIntosh (2015) further reported the states with the highest suicide rates of young (15-24) and elderly (65+). The states with the highest rates of elderly suicides included the following: Wyoming (30.5), Nevada (29.9), and Idaho (25.5; McIntosh, 2015). McIntosh reported the states with the highest rates of young suicides involved the following: Alaska (38.2), North Dakota (30.4), and South Dakota (29.6). Other geographical data, which involved suicide rates, included breaking down the U.S. into regional areas (McIntosh & Drapeau, 2015). Overall, researchers (Barkan, Rocque, & Houle, 2013; McIntosh & Drapeau, 2015) established that the western region was characterized by the highest suicide rates. McIntosh and Drapeau (2015) reported the regional rates of suicide as follows: West (14.1), South (13.4), Midwest (13.2), and Northeast (10.4).

Suicide methods. McAndrews and Garrison's (2007) research which studied methods of suicide based on gender reported the following methods: shooting, hanging, overdose (legal drugs), overdose (illegal drugs), jumping in front of a moving vehicle, jumping off of a bridge, cutting wrists, use of poison, drowning, crashing one's vehicle on purpose. A CDC (2015) report for 2013 presented suicide methods by the number of individuals, percent of suicides, and suicide rate, which comprised the following:

- cutting or piercing: 783 individuals, 1.9% of suicides, and rate of 0.25;
- drowning: 397 individuals, 0.9% of suicides, and rate of 0.13;
- falling: 976 individuals, 2.4% of suicide, and rate of 0.31;

- firearms: 21,175 individuals, 51.5% of suicides, and rate of 6.70;
- immolation: 173 individuals, 0.4% of suicides, and rate of 0.05;
- poisoning: 6,637 individuals, 16.1% of suicides, and rate of 2.10;
- suffocation: 10,062 individuals, 24.5% of suicides, and rate of 3.18; and
- transportation related: 191 individuals, 0.5% of suicides, and rate of 0.06.

The presented rates of suicide showed that the most frequently used methods of suicide were firearms, suffocation, and poisoning (CDC, 2015). The CDC found that most often males use firearms (rate of 11.7) and females use poisoning to complete suicide (rate of 1.97). In the following section, the main focus of this thesis, survivors of suicide (SOS) will be explicated.

Explication of Survivors of Suicide

According to U.S. Public Health Service (1999), SOS were an at-risk population for suicide and often experience *suicide ideation*. Suicide ideation means an individual is having thoughts of suicide (Public Health Service, 1999). An individual who completes suicide was often referred to as the *deceased* or *decedent* (Berman, 2011; Cerel et al. 2013). The major demographic characteristics discussed above for suicide victims are useful in determining the SOS who are at higher risk (e.g., older adult Caucasian males; Ashford & Lecroy, 2013). Cerel, Fristad, Weller, and Weller (2000) found that children and adolescent survivors of parent suicides are more at risk of experiencing mental health problems in comparison to *other violent deaths* (e.g., homicide). Moreover, Cerel et al. (2000) found that children and adolescent survivors, who lose a parent to suicide experience more psychopathology over time than parents who lose a child to suicide.

All numbers of survivors bereaved by suicide in this literature review are estimations because the subsequent data provides only a formula for calculating SOS (McIntosh & Drapeau,

2015). According to McIntosh and Drapeau (2015), one completed suicide approximately affects a minimum of six people. Although, the number of individuals affected by the suicide could increase or decrease depending on perceived nature of the relationship (Cerel et al., 2013). Individuals who were distantly connected to a decedent emotionally can become very vulnerable (e.g, children and adolescents; Cerel et al., 2000). Furthermore, adding setting of the suicide, plus a vulnerable population to the equation could cause the number of SOS to increase greatly (e.g., a completed suicide at an elementary school; Celotta, 1995). McIntosh and Drapeau reported 825,832 completed suicides from 1989 throughout 2013, which converts to at least 4.95 million SOS in the U.S. Additionally, about 246,800 SOS resulted from the 41,149 completed suicides in 2013, which means 1 in every 64 Americans were affected by a completed suicide (McIntosh & Drapeau, 2015). McIntosh and Drapeau reported that a suicide occurred every 12.8 minutes; therefore, on average, 6 more survivors every 12.8 minutes (McIntosh & Drapeau, 2015).

Furthermore, research samples will be used to explicate the SOS population. Cerel et al. (2013) conducted a random telephone survey in 2007 in Kentucky to identify SOS demographics. The study concluded that identification, as a SOS was defined by an individual's perceived closeness rather than the relationship type and demographics (Cerel et al., 2013). Cerel et al.'s study involved 61 SOS respondents, which included the following demographics: gender (23% male), race (90% white), rural or urban status (44% rural), education (47% high school or lower), and income level (68% \$50,000 a year or less). Also, the study looked at the following relationships between the SOS and the deceased individual: acquaintance, aunt, brother, brother-in-law, classmate, client, cousin, coworker, ex-partner, family friend, family other, father, father-in-law, friend, grandfather, husband, mother-in-law, neighbor, nephew, niece, other, sister, son-in-law, stepfather, stepsister, student, and uncle (Cerel et al., 2013).

The SOS' that 100% identified as a SOS included the following relationship with the deceased: brother, classmate, father-in-law, husband, mother-in-law, niece, sister, son-in-law, and stepsister (Cerel et al., 2013). The other survivor relationship types varied in percent of the sample identifying as a SOS were as follows: Brother-in-law (75%), cousin (66.7%), ex-partner (66.7%), nephew (66.7%), family other (57%), friend (51.1%), grandfather (50%), other (50%), coworker (40%), family friend (28.6%), uncle (28.5%), and neighbor (25%; Cere et al., 2013). The relationships with zero percent SOS identification included the following the following: aunt (1.7), client (0.8), father (0.8), and student (0.8; Cerel et al., 2013). In this study, mother was not an identified relationship with the deceased (Cere et al., 2013).

Cerel and Campbell (2008) performed a study on adult suicide survivors (18-89) requesting mental health services from 1999 to 2005 in Louisiana. The study involved 356 SOS with the following (Cerel & Campbell, 2008) demographics:

- females represented 254 individuals and 71.3% of the survivors;
- males encompassed 102 individuals and 28.7% of the survivors;
- Blacks comprised 8 individuals and 2.2% of the survivors; and
- Whites included 348 individuals and 97.8% of the survivors.

Another study by Mitchell, Kim, Prigerson, and Mortimer-Stephens (2004) examined the probability of *complicated grief* manifesting in suicide survivors who were closely or distantly related to the deceased. Complicated grief is also known as *Prolonged Grief Disorder (PGD)*, *Persistent Complex Bereavement*, or *Traumatic Bereavement* (i.e., bereaved by homicide or suicide; APA, 2013). Prigerson et al. (1995) defined complicated grief as a group of symptoms that result during bereavement of and in reaction to a death. Prigerson et al. reported the following symptoms of complicated grief: intrinsic feelings, distressing feelings, and four or

more trauma-related symptoms continuous in nature (e.g., purposeless, detachment, excessive anger, and avoiding reminders of the deceased). Mitchell et al.'s (2004) study reported that SOS were overall at a higher risk for developing complicated grief, for example, 43.3% of their 60 SOS sample developed complicated grief. Mitchell et al. reported that approximately 60 to 80% of the *closely related* (e.g., spouses, parents, children, and siblings) developed complicated grief compared to about 14% to 29% of the *distantly related* survivors (e.g., coworkers, friends, in-laws, or nephews/nieces).

Mitchell et al. (2004) listed the demographic statistics of their sample of 60 SOS comprised of the following:

- gender involved 43 females, 72% of the sample and 17 males, 28% of the sample;
- living situation involved 95% lived with a spouse, partner, children, or other relative;
- marital status comprised 55% married survivors and 20% widowed survivors;
- mean age, was 43.3 years and the range was 18-78 years;
- race included 100% Caucasian survivors; and
- religion involved 67% Catholic survivors and 23% Protestant survivors.

Also, Mitchell et al. reported the categories of the SOS' relationships with the deceased. The sample encompassed the following survivor-deceased relationships: 0 aunts or uncles, 1 niece/nephew 1.7%, 5 children 8.3%, 6 parents 10.0%, 7 siblings 11.7%, 9 spouses 15%, 14 friends or coworkers 23.3%, and 18 in-laws, 30% of the sample (Mitchell et al., 2004). The majority of the studies involving SOS that were found involved Whites; relatively less is known about the SOS experience among Blacks and other ethnic minorities (Sharpe, Joe, & Taylor, 2012)

Studies (Barnes 2006; Sharpe et al., 2012) have associated the lack of research on Black SOS with the traditionally high levels of stigmatization of suicide in Black communities. Sharpe et al. (2012) found that culturally Blacks seek help through church or spiritual resources. Also, Sharpe et al. reported that due to the stigma of suicide in the Black community, Black SOS found survivor resources unhelpful. Since the population of focus has been identified and explicated, it is time to conceptualize some characteristics of SOS, which are the outcomes of this study.

Conceptualization of Outcomes

The SOS' most prominent feeling. *Most Prominent feeling* is the main emotion expressed or made aware of by the survivor in regards to the deceased or the deceased's completed suicide. Extensive research has been completed on the feelings that arise following a loss by suicide. Cerel, Fristad, Weller, and Weller (1999) compared a sample of 26 children and adolescents bereaved by parental suicide and 332 children bereaved by other causes of parent death over a two-year period following the death, beginning at one month. Cerel et al. (1999) found that SOS were more likely than other survivors to experience the following prominent feelings encompassing the death: anger, anxiety, and shame.

Barrett and Scott (1990) compared 14 spousal suicide survivors' grief reactions to other spouses bereaved by unexpected *accidental deaths* (e.g., vehicle accidents), *unanticipated natural death* (15, e.g., heart attack), or *expected natural death* (13, e.g., terminal illness). Barrett and Scott looked at the mean scores on the Grief Experience Questionnaire (GEQ) to determine the level of survivor grief reactions. It is important to note that survivors completed this questionnaire an average of two to four years after the loss (Barrett & Scott, 1990). Barrett and Scott recorded the survivors' reaction scores on the GEQ, which included the following feelings for each survivor group:

- accident: 14.87 guilt, 9.20 rejection, 10.07 responsible, and 10.27 shame;
- expected: natural: 12.23 guilt, 7.46 rejection, 6.69 responsible, and 8.23 shame;
- suicide: 16.50 guilt, 15.79 rejection, 14.50 responsible, and 13.07 shame; and
- unanticipated natural: 14.60 guilt, 8.67 rejection, 9.73 responsible, and 7.87 shame.

Barrett and Scott found that SOS experienced the following four groups of feelings: normal grief (anger and guilt), non-naturally bereavement (shame and abandoned), sudden death bereavement (responsibility and self-blame), and suicide or trauma-related bereavement (embarrassed and rejected). According to the study findings, SOS experienced guilt, rejection, responsibility, and shame more frequently than other survivors (Barrett & Scott, 1990). Barrett and Scott (1990) reported that SOS grief was unique in nature compared to survivors bereaved by other losses.

Another study by Reed and Greenwald (1991) analyzed the current grief experience of 85 SOS and 96 accident survivors about 280 days after the death. Similar to Barrett and Scott (1990), Reed and Greenwald (1991) found that SOS experienced more guilt, rejection, and shame in comparison to survivors of accidental deaths. The SOS reported less shock and emotional distress about the death in comparison to survivors of accidental death. Reed and Greenwald noted that 79% of the SOS reported receiving suggestive *behavioral clues of suicide* (e.g., suicide attempt) from the deceased. Reed and Greenwald reported that this fact might explain the lack of shock and emotional distress experienced by SOS. From qualitative questions administered to the SOS, Reed and Greenwald gathered that while part of the SOS sample experienced devastation from the loss, some SOS felt relieved problems encountered while the deceased was alive (e.g., domestic violence, drug addiction, mental illness, etc.). Furthermore, Lester (2005) described two suicide cases where co-workers reported feeling happy and relieved following the suicide due to past interpersonal problems with the decedent. Lester explained that

the prominent feeling of happiness associated with suicide is seldom discussed and as a result SOS may feel guilty for feeling happy.

The SOS' self-regard. *Self-regard* refers to an individual's negative or positive view about themselves, for example, an individual's self-like, self-love, self-dislike, self-hate, etc. (Maltsberger, 1997). Little research was found on the topic of survivors bereaved by suicide and an inherent positive or negative self-regard. Reed (1993) found that SOS were more likely to receive *expressive support* (e.g., receiving validation of feelings) in comparison to survivors bereaved by accidents. Furthermore, Reed found that expressive support increased self-esteem. The research found that self-esteem was the strongest predictor of grief symptom intensity (Reed, 1993). Reed reported no significance difference between the SOS' and the accident survivors' grief. Demi and Howell (1991) reported qualitative responses for two SOS, which were coded as low in self-esteem. For example, a male SOS reported feeling low self-worth in response to a parental suicide, which reflected a lack of connection with women (Demi & Howell, 1991). Therefore, their research suggested that low self-esteem was a mediator between surviving a parent's suicide and social connectedness later in life (Demi & Howell, 1991).

Conceptualization of the Independent Variable

Elapsed time since the loss in this thesis refers to the difference in time between the survivor seeking support services and the suicide loss (Cerel & Campbell, 2008). McMenemy, Jordan, & Mitchell, 2008; Provini and Everett (2008) reported that SOS utilized a variety of support resources following the loss of a loved one. The research showed that the time in which survivors seek support varies (Campbell, Cataldie, McIntosh, & Millet, 2004; Cerel & Campbell, 2008). Feigelman, Jordan, McIntosh, and Feigelman (2012a) presented the term *newly bereaved* as fewer than two years after the suicide. Feigelman, Jordan, McIntosh, and Feigelman (2012b)

presented *early bereavement* or *shorter-term bereavement* as less than five years after a loss by suicide. Feigelman, Jordan, McIntosh, and Feigelman (2012c) defined *Longer-term bereavement* as five or more years the loss by suicide. All studies involving Feigelman, Jordan, McIntosh, and Feigelman (2012a-2012i) in this thesis, utilized a sample of 462 SOS parents and 46 parents who lost a child to drug overdose and attempted to reach out to support services. The sample encompassed 258 survivors in shorter-term bereavement and 204 survivors in longer-term bereavement (Feigelman et al., 2012d). Feigelman et al. (2012c) presented that the elapsed time since the loss among study participants ranged from 29 days to 27 years. Out of 24 follow-ups occurring within their sample, Feigelman et al. (2012a) noted that about 33.3% of the survivors were newly bereaved, but the majority of survivors were in longer-term bereavement.

Time elapsed in seeking services appears to vary with type of resources available. Cerel and Campbell (2008) tested the ability of an *Active Postvention Model* (APM) to decrease the time since loss for SOS (Campbell et al., 2004). APM is the delivery of emotional support, SOS support group information, and other community resources to survivors shortly after the loss by other survivors or crisis professionals (Cerel & Campbell, 2008). In contrast, a *Passive Postvention Model* (PPM) is a service model that empowers survivors to search for needed resources (e.g., support services and groups and other community resources) on their own by eliminating the direct delivery of support and resources (Cerel & Campbell, 2008).

Campbell et al. (2004) found that APM has shown to decrease the time in which SOS seek support from an SOS support group. When the PPM was utilized, the average time survivors sought support over a 4-year period was more than 880 days. In the cases where the APM was implemented, survivors reached out for support over a four-year period an average of 39 days (Campbell et al., 2004). Cerel and Campbell (2008) found that SOS that received the

APM reached out for support services at range of 2 to 532 days. Survivors that received the PPM had a time range of 3 to 883 days (Cerel & Campbell, 2008). Cerel and Campbell also found that survivors who received APM were more likely to attend a SOS support group (104/150) 69.3% compared to those who did not (122/206) 59.0%. Furthermore, Cerel and Campbell determined that the implementation of an APM resulted in less elapsed time between the suicide and SOS seeking support.

Also, Provini and Everett (2000) contacted 144 adult SOS to assess bereavement concerns, support needs, and help-seeking behavior at about 5 months or at a mean of 145 days. They reported that 33% of the survivors contacted had never obtained help and were not looking to receive help for the suicide loss (Provini and Everett, 2000). Another study by Feigelman et al. (2012e) compared 292 parent survivors that attended one of two in-person suicide support groups to 104 survivors using an Internet support group. Feigelman et al. (2012e) found that the Internet support group consisted of more recent bereaved parents of suicide compared to the in-person suicide support group (mean time since the loss: 4.1 year vs. 6.1 years). Feigelman et al. (2012e) reported that this could be due to the finding that Internet support group SOS had more grief difficulties compared to in-person group SOS.

Limited research was found on how the timing in which SOS seek support is associated with the efficacy of support services. Feigelman et al. (2012a) presented qualitative research on 24 SOS that stopped attending SOS groups. One of the 24 SOS reported *retraumatization* as the reason for leaving the SOS support group (Feigelman et al., 2012a). Jennings (n.d.) defined retraumatization as an environmental interaction that resembles the experienced trauma and results in reoccurring feelings, which were experienced at the time of the trauma. According to

Duckworth and Follette (2012), retraumatization has been referred to in the following two ways: reoccurring traumatic events or distress resulting from restating a traumatic story.

The retraumatization case in Feigelman et al.'s (2012a) sample involved a survivor and her husband, who attended the support group at three weeks following the death by suicide of their daughter (Feigelman et al., 2012a). The women expressed that hearing other survivor' stories in the SOS group caused her to think about finding her daughter dead (Feigelman et al., 2012a). She also reported feeling a large amount of distress due to hearing other survivor' stories (Feigelman et al., 2012a). Whether the husband experienced the same reaction was not stated (Feigelman et al., 2012a). Feigelman et al. (2012a) described retraumatization as a rare occurrence for SOS. Feigelman et al. (2012a) further explained that without bravery to participate and a strong intact ego, retraumatization could occur in newly bereaved survivors. Timing seems to be important, when working with SOS due to the possibility of retraumatization. Feigelman et al. (2012a) suggested that facilitators provide extra support before, during, and after group meetings to newly bereaved SOS to prevent retraumatization.

Cerel et al. (2009) presented the results of a SOS group leader survey. The survey asked SOS group leaders to answer questions related to SOS group effectiveness and group practices on a 4-point rating scale (Cerel et al., 2009). Higher scale numbers were associated with either a positive opinion or high agreement with the statement (Cerel et al., 2009). Leaders presented positive opinions about SOS group effectiveness for the following: helping survivors with large amounts of distress in the beginning months as well as one or more years following the suicide (Cerel et al., 2009). Group leaders more often disagreed with the following statements: SOS should not attend group sooner than six months after the suicide loss, and re-traumatization can occur by frequently sharing one's story (Cerel et al., 2009). When the statement: attendance

immediately following the suicide loss is best was presented, the mean score was neutral (Cerel et al., 2009).

Theoretical Frameworks

Passage of time framework. Feigelman et al.'s (2012a-2012i) cross-sectional studies on parent SOS established trends in the bereavement process typically experienced by SOS. The *passage of time* was a significant factor throughout this research (Feigelman et al., 2012a-2012i). This thesis will incorporate the passage of time framework as discussed in Feigelman et al.'s (2012a-2012i), wherein it was found that in the first year following the suicide loss, SOS experienced a decrease in *personal growth* and an increase in *mental health problems*. After the first year, Feigelman et al. (2012d) observed an increase in personal growth and a decrease in mental health problems. Personal growth was assessed by the Hogan Grief Reaction Checklist (HGRC; Hogan, Greenwald, & Schmidt, 2001). This measurement tool asked SOS to rate the following experiences in the last two weeks: amount of care for others, amount of forgiveness the individual feels, amount of compassion for others, betterment of their outlook on life, betterment of self, feeling stronger because of grief, and wellness of coping (Hogan, Greenwald, & Schmidt, 2001). The following rating scale topics determined the amount of mental health problems in Feigelman et al.'s (2012f) framework: health, depression, and life satisfaction.

Feigelman et al. (2012c) found that parents between the first and second year following the loss were characterized by an increase in *grief difficulties*. The scales used in Feigelman et al.'s (2012f) framework to determine grief difficulties included the following: brief Grief Experience Questionnaire (brief GEQ), Complicated Grief scale, and the Impact of Events Scale (IES). The brief GEQ scale was a 5-point response format ranging from *almost never* to *always*

experience the reaction in the past 2 months (Feigelman et al., 2012g). Feigelman et al.'s (2012g) Brief GEQ included 16 items covering the following types of grief reactions types:

- behavioral: attempting suicide or self-harming;
- emotional: feelings of abandonment, embarrassment, guilt, and rejection;
- psychological: an obsession with the question why, thinking you or someone else is to blame, and thoughts of suicide;
- somatic: fainting or symptoms associated with fainting.

Furthermore, Feigelman et al. (2012c) found that SOS experienced an increase in negative impactation (e.g., continuously visualizing the death) and steady complicated grief symptoms between one and two years following the death by suicide. The IES utilized in Feigelman et al.'s (2012g) research had a 4-point response format ranging from *not at all* to *often*. The scale assessed the SOS for symptoms PTSD occurring in past 30 days. The complicated grief scale included 12 items, regarding the SOS' emotional responses and psychological stress in the past month (Feigelman et al., 2012g). These items varied in response format and the items were altered to fit parent SOS (Feigelman et al., 2012g).

Feigelman et al. (2012c) presented the probable time period of severe grief symptom decline to exist between three to five years following a loss by suicide. In other words after five years since the loss, the SOS seemed to be characterized by a slower decline in grief difficulties (Feigelman et al., 2012c). Feigelman et al. (2012d) explained that SOS tended to visit mental health professionals more rapidly during early bereavement, when the probability of personal growth was lower. According to Feigelman et al. (2012b), during early bereavement, SOS gained support from both mental health professional and supports groups more frequently than solely support groups, solely mental health professionals, or no outside help On the other hand, in the

later bereavement period (i.e., 5 years or more), Feigelman et al. (2012d, 2012h) found that as time continued to progress, SOS experienced reduction in mental health difficulties and increase in personal growth, resulting in a reduced need for support. Feigelman et al. (2012d) noted that SOS contributing to support groups were associated with personal growth in later bereavement, but not early bereavement. Now that the passage of time framework has been expounded, the thesis outcomes will be explicated in connection with the framework (Feigelman et al., 2012a-2012i).

Application of framework to the most prominent feeling of SOS. Feigelman et al. (2012c) found that grief difficulties (e.g., emotional difficulties) peaked during the second year of bereavement. Therefore, a postulation can be made that newly bereaved SOS most often experience undesirable feelings, prominently in association with the suicide loss. As found in the literature (e.g., American Foundation for Suicide Prevention, n.d.; Reed & Greenwalk, 1991), undesirable feelings following a suicide loss may include the following: alone, anger, guilt, rejection, sadness, scared, and shame. Feigelman et al. (2012c) reported that following the two-year mark; the grief difficulties of SOS began to decline. Therefore, one may assume that SOS will begin to experience undesirable less prominently after two years. Following Feigelman et al.'s (2012b, 2012c, 2012h) framework, which establishes the greatest decline between years 3 and 5, one may presume that during early bereavement SOS will continue to experience undesirable feelings less prominently with the suicide loss. Furthermore, SOS will also experience a decline in the prominence of undesirable feelings in the later bereavement period (i.e. 5 or more years) due to higher levels of personal growth (Feigelman et al., 2012d).

Application of framework to the self-regard of SOS. Feigelman et al. (2012d) observed SOS experiencing a decrease in personal growth within the first year following the

loss. Also, Feigelman et al. (2012c) wrote about the benefits of SOS group attendance for SOS, where he presented that the group experience allows SOS to increase self-esteem. This was an insinuation that help-seeking SOS have a low self-esteem (Feigelman et al., 2012c). Therefore, it can be assumed that first-year help-seeking SOS have an inherent negative self-regard.

Following the passage of time framework (Feigelman, 2012d), a supposition can be suggested, which involves the following: as personal growth increases after the first year, SOS can expect self-regard to increase.

Durkheim's theory of anomie. The concept, *anomie*, was first mentioned in Durkheim's (1933) work with *The Division of Labor in Society*, where he associated lack of society rules with a state of chaos or anomie. Durkheim (1958 [1897]) linked suicide to anomie. Durkheim (1958 [1897]) defined anomie as a state of crisis, having a lack of control, lack of connectedness to others (e.g., social isolation), and disturbance in equilibrium.

One could propose that losing a loved one to suicide puts the individual in an anomic state due to the following: the complete loss in connection with another person, the inability to control a loved one's suicidal behavior(s), and the inability to reconnect with the decedent. Feigelman et al. (2012i) reported on a response item involving a 4-point response format, ranging from *a great deal* to *not at all/none*. The item assessed the SOS' and parent survivors of child overdoses' perception of the amount of control they had over their life. The majority (71.5%) of the 529 respondents, who were surviving one child, reported less than a great deal of control. Therefore it appears that on some level SOS experience a loss of control in their life, which is a factor in determining anomie (Durkheim, 1958 [1897]; Feigelman et al., 2012i). Furthermore, researchers have reported that SOS could feel completely disconnected from others following the loss, due to a lack of empathetic responding from others (e.g., relative or friends;

Feigelman et al., 2012h; Neimeyer, & Jordon, 2002). The aforementioned research further connected losses of SOS to the concept of anomie.

SOS could experience a longer period of grief difficulties due to the anomic (loss of control and loss of connectedness) aspect and potential trauma involved in a suicide loss (Durkheim, 1958 [1897]; Feigelman et al., 2012b). Feigelman et al. (2012b) reported that among all surviving parents, who lost a child no more than three years ago 41% reported *fair* or *poor* physical health and 65% reported fair or poor mental health within the past year. In contrast, survivors losing a child more than 3 years ago involved the following self-reports for the past year: 30% reported fair or poor physical health and 34% fair or poor mental health (Feigelman et al., 2012b). Furthermore in later bereavement survivors' self-reports of depressive symptoms included the following: about 63% (94/149) at 5 to 9.99 years and about 41% (38/94) at 10 or more years (Feigelman et al., 2012h). Therefore, researchers have observed the anomic crisis of a suicide loss prolonging grief difficulties for SOS (Feigelman et al., 2012b, 2012h).

Theoretical foundation summary. Feigelman et al.'s (2012c) framework, which determined time as the most significant factor in determining grief difficulties of parental SOS, was derived from Ott, Lueger, and Prigerson's (2007) findings of bereavement over time. Ott et al. (2007) utilized a sample of older adults bereaved by chronic illness or sudden death, involving only one loss by suicide. Ott et al. found that as time progressed, the majority of survivors experienced a decrease in bereavement difficulties (e.g. depression symptoms, spousal dependency, and grief symptomology). Both studies (Feigelman et al., 2012a-2012i; Ott et al., 2007) utilized specific populations experiencing bereavement. The presented research attempted to apply the passage of time framework to a variety of suicide survivors seeking help from a SOS support group. Durkheim's (1958 [1897]) theory of anomie presented that individuals who

completed suicide were in a state of anomie prior to their death. This brings us to SOS, who as a result could also experience a state of anomie.

Research Questions and Hypotheses

Time elapsed since the loss influences the SOS' sense of self and help-seeking behaviors associated with a change in survivors' self-regard. Based on the purpose statement, literature review, and theoretical foundation previously discussed, the following research questions were formulated:

- **R₁**. Does elapsed time since the suicide loss influence the SOS' selected most prominent feeling?
- **R₂**. Does elapsed time since the loss influence the SOS' self-regard?

From the research questions, the following hypotheses were formulated:

- **H₁**. Elapsed time since the suicide loss will influence the SOS' selected most prominent feeling. Earlier in bereavement, a SOS will select anger, guilt, or fear and later in bereavement a SOS will select sadness. Furthermore, elapsed time since the loss will have no influence on the selected prominent feelings of happiness or relief.
- **H₂**. Elapsed time since the loss will influence the SOS' self-regard.

Chapter 3

Methodology

Design and Sampling

This study was a cross-sectional study that utilized cross-sectional secondary data (Rubin & Babbie, 2013). The study's population of interest was SOS, seeking support from a SOS group at a crisis center in the southern U.S. region. In order to gain access to the SOS data, permission was requested from the director of the agency and the clinical director over the SOS support group program at the crisis center. Then, the clinical director of the crisis center wrote a letter of permission, which was sent to the Louisiana State University International Review Board (IRB). Following permission received from IRB to implement the study, the researcher obtained the data. The SOS data were collected from the crisis center's intake assessment, which determined whether the survivor was appropriate for the SOS support group. Data from all of the assessments were de-identified to ensure confidentiality.

Measures

The demographic information obtained was considered non-parametric in measurement level. To obtain the SOS' age, the assessment solicited which age group best represented the number of years the respondent had been alive. The responses included 1) 18-24, 2) 25-34, 3) 35-44, 4) 45-54, 5) 55-64, 6) 65+. This response type was considered non-parametric. The SOS' ethnicity/race was solicited by the assessment. This response type was non-parametric. The assessment responses involved the following: 1) African American, 2) Asian, 3) Caucasian, 4) Hispanic, 5) multiracial, 6) other. The assessment inquired about the SOS' gender. The responses were 1) male, 2) female, 3) other. The response type was non-parametric. The SOS' living situation was solicited by the assessment. The assessment responses were 1) alone, 2) with 1 other person, 3) with 2 people, 4) with 3 people, 5) with 4 or more people. Therefore, the

response type was non-parametric. The SOS' marital/relationship status was solicited by the assessment. The responses included the following: 1) single, 2) married, 3) separated, 4) divorced, 5) widowed, 6) cohabitating, 7) noncohabitating. This response type was non-parametric. The assessment also solicited the SOS' relation to the deceased. The responses were 1) child, 2) grandchild, 3) grandparent, 4) sibling, 5) spouse, 6) friend, 7) other. This response type was non-parametric.

Furthermore, the assessment asked whether the respondent was affiliated with a religion. The responses involved the following: 1) Catholic, 2) Protestant, 3) other Christian, 4) Jewish, 5) other, 6) none. This response type was non-parametric. The assessment inquired about the SOS' involvement in the religion by soliciting how the respondent characterized their religious participation. The responses included 1) active, 2) passive. Therefore, the response type was non-parametric. To gather the SOS' working status and student status the assessment solicited whether the respondent was working and attending school. The assessment responses for these questions were 1) yes, 2) no. These response types were considered non-parametric in measurement level.

The independent variable, elapsed time since the loss, was acquired through two assessment questions. First, the assessor noted the date of the assessment on the intake assessment form. Next, the date of the suicide loss was solicited from the respondent. To obtain the amount of time that had passed since the loss, the researcher calculated the difference between the date of the SOS' assessment and the SOS' date of the loss. The question on the assessment was parametric. The data were later categorized, which transformed the data into an ordinal variable. After the independent variable's measures were explicated, the presentation of the dependent variable's measures began.

To obtain the SOS' most prominent feeling, the assessment solicited the respondents' current most intense feeling. The assessment responses included the following feelings: 1) anger, 2) happiness, 3) sadness, 4) guilt, 5) relief, 6) scared, 7) other. This response type was non-parametric in level of measurement.

To determine the SOS' self-regard, the assessment inquired whether the SOS embodied self-like. The response selection included the following: 1) yes, 2) sometimes, 3) no. This response type was measured on the non-parametric level.

Data Analysis

The descriptive statistics in the study were reported with frequencies and percentages. The following demographic statistics were reported using frequencies and percentages: age, employment/student status, gender, living situation, marital/relationship status, race/ethnicity, religion, and religious involvement. The following non-demographic statistics were presented with frequencies and percentages: elapsed time since the loss, most prominent feeling, and self-regard.

The following research questions/hypotheses were analyzed using a chi-square test: R_1/H_1 and R_2/H_2 . The level of significance threshold (p -value) for the chi-square test was .05.

Chapter 4 Results

Sample Characteristics

As mentioned above, the descriptive statistics are non-parametric variables and are reported by frequencies and percentages. The overall sample size of this study was 187 SOS. The date of assessment ranged from 2008 to 2015. Almost one-fourth of the sample identified as 45-54 years of age ($n = 45$, 24.2%). The sample was predominately female ($n = 137$, 73.3%) and Caucasian ($n = 172$, 92.0%). The majority of the sample was married ($n = 64$, 34.4%) and living with 1 other person ($n = 69$, 32.7%). SOS mainly had a parental relation to the deceased ($n = 44$, 24.3%). Over half of the SOS reported their religious status as other Christian ($n = 92$, 51.7%). Also, the vast majority of SOS had active participation in religion ($n = 90$, 72.6%). Furthermore, the majority of the sample was working ($n = 117$, 64.3%) and was not of student status ($n = 169$, 92.3%). Table 1 presents the demographic information for this study in detail.

Table 1. Descriptive statistics of demographic information ($N=187$)

Variable	Valid %	n
<i>Age</i>		
18-24	10.8	20
25-34	19.4	36
35-44	17.7	33
45-54	24.2	45
55-64	17.7	33
65+	10.2	19
<i>Gender</i>		
Female	73.3	137
Male	26.2	49
Other	0.5	1

(Table 1 continued)

Variable	Valid %	n
<i>Ethnicity/Race</i>		
African American	5.4	10
Asian	0.5	1
Caucasian	93.0	172
Multiracial	0.5	1
Other	0.5	1
<i>Living Situation</i>		
Alone	32.7	56
With 1 other person	40.4	69
With 2 people	17.5	30
With 3 people	7.0	12
With 4 or more people	2.3	4
<i>Marital/Relationship Status</i>		
Single	23.7	44
Married	34.4	64
Separated	0.5	1
Divorced	15.6	29
Widowed	20.4	38
Cohabiting	3.8	7
Noncohabiting	1.6	3
<i>Relation to the deceased</i>		
Child	17.1	31
Grandchild	0.6	1
Grandparent	2.2	4
Parent	24.3	44
Sibling	16.0	29
Spouse	20.4	37
Friend	7.7	14
Other	11.6	21
<i>Religious Status</i>		
Catholic	34.8	62
Protestant	0.6	1
Other Christian	51.7	92
Jewish	0.6	1
Other	5.1	9
None	7.3	13

(Table 1 continued)

Variable		Valid %	n
<i>Student</i>	Yes	7.7	14
	No	92.3	169
<i>Working</i>	Yes	64.3	117
	No	35.7	65

Descriptive Statistics of Primary Variables

The overwhelming majority of SOS chose sadness (n = 100, 53.8%) as their most prominent feeling since the loss. On the other hand, happiness (n = 5, 2.7%) was scarcely chosen by SOS as their most prominent feeling. For the self-regard of SOS, survivors most frequently reported yes (n = 155, 84.2%) to the assessor asking whether or not the SOS liked himself/herself. For this sample, No (n = 9, 4.9%) was the least reported response to the aforementioned question. Elapsed time since the loss was recorded in months. The average number of months between the date of the death and date of the intake assessment was 7 (mean = 7.3, SD = 24.13). This variable was transformed from parametric to non-parametric due to previous research (Farberow et al., 1992; Gilewski, Farerow, Gallagher, & Thompson, 1991; Feigelman et al., 2012b-2012h).

Following the methodology of Fareberow et al. (1992) and Gileweski et al. (1991), the researcher formed the following groups: 0-2 months and 3-12 months elapsed time since the loss. Following the methodology of Feigelman et al. (2012b-2012h), the researcher formed the remaining elapsed time since the loss groups: 13-24 months, 25-59 months, and 60 months or more. SOS most frequently had an elapsed time since the loss of 0-2 months (n = 129, 70.5%).

The least reported elapsed time since the loss was 60 or more months (n = 4, 2.2%). Table 2 presents the complete primary variable details for this study.

Table 2. Descriptive statistics of primary variables (N=187)

Variable	Valid%	n	Mean (SD)
<i>SOS' Most Prominent Feeling</i>			
Anger	17.2	32	
Guilt	12.4	23	
Happiness	2.7	5	
Relief	4.3	8	
Sadness	53.8	100	
Scared	6.5	12	
Other	3.2	6	
<i>SOS' Self-regard</i>			
Yes	84.2	155	
Sometimes	10.9	20	
No	4.9	9	
<i>Grouped Elapsed Time Since the Loss</i>			
0-2 Months	70.5	129	
3-12 Months	16.4	30	
13-24 Months	6.6	12	
25-59 Months	4.4	8	
60+ Months	2.2	4	
<i>Elapsed Time Since the Loss</i>			7.3(24.13)

Testing the Research Questions/Hypotheses

For this study, all variables involved were non-parametric. Therefore, the testing was conducted via chi-square test. The chi-square test for R_1/H_1 was significant: $\chi^2 = 40.305, p < .05$. Thus, elapsed time since the loss is significantly related to the SOS' most prominent feeling. A post-hoc analysis test was run to determine the specific group(s) that is/are significantly related to the SOS' most prominent feeling. During the 25-59 months time group, the sample was significantly more likely to be happy (z-score = 3.9). For 25-59 months, the sample was also

significantly likely to report being scared as the prominent feeling (z-score = 2.3). Furthermore, for the 60+ months (i.e., 5+ years) time group, the sample was significantly likely to feel happiness most prominently (z-score = 2.8). The chi-square test for R_2/H_2 was not significant: $\chi^2 = 9.824, p = .278$. In other words, there was no relationship between elapsed time since the loss and the self-regard of SOS.

Chapter 5 Discussion

Summary of Results

This cross-sectional study found one of two hypotheses to be significant. The first hypothesis stated, elapsed time since the suicide loss will influence the SOS' selected most prominent feeling. Furthermore the first hypothesis stated the following: earlier in bereavement, a SOS will select anger, guilt, or fear/scared; later in bereavement a SOS will select sadness; and elapsed time since the loss will have no influence on the selected prominent feelings of happiness or relief. This study found that during 25-59 months elapsed time since the loss, SOS significantly experienced the prominent feeling of fear (i.e., feeling scared). This was consistent with the researcher's projected findings (R₁/H₁). Also, this was consistent with Feigelman et al.'s (2012h) findings regarding a peak of grief difficulties in early bereavement (<= 4.9 years). This could be explained by *other specified trauma- and stressor-related disorder* with reason of *adjustment-like disorders* (APA, 2013). When this type of disorder is due to an experienced trauma (e.g., finding the deceased by suicide), the symptoms of grief are delayed by over three months following the death (APA, 2013).

As previously mentioned in this study, Durkheim (1958 [1897]) presented that the deceased are in an anomic straight before completing suicide. The researcher suggested that SOS might experience the same anomic state following the loss by suicide (Durkheim, 1958 [1897]). Furthermore, the SOS' most prominent feeling of fear in early bereavement suggests that SOS were in an anomic state following the loss (Durkheim, 1958 [1897]). No other findings from this study pointed to the SOS experiencing an anomic state.

For hypothesis one, the researcher expected anger and guilt would be significant at some point in early bereavement, but this projection was not accurate. This study showed no

significance in the SOS' most prominent feeling in the following grouped time periods since the loss: 0-2 months, 3-12 months, and 13-24 months. Feigelman et al. (2012c) reported an increase in the SOS' grief difficulties between 12 and 24 months following the loss. Gilewski et al. (1991) reported that mildly depressed spousal SOS had the highest levels of depression one month after the loss, which significantly decreased by 6 months. Feigelman et al. (2012c) and Gilewski et al.'s (1991) findings were not consistent with this study's results.

The researcher expected happiness to be an insignificant prominent feeling at all points in time for SOS. This study found happiness to be significant at both, 25-59 months and 60+ months. Therefore, this study is consistent with the finding in thanatology, the passage of time framework (Feigelman et al., 2012e, 2012i). The passage of time frameworks reported that grief difficulties begin to decline following two years since the loss (i.e., at 25 months; Feigelman et al., 2012e, 2012i).

The second hypothesis stated, elapsed time since the loss will influence the SOS' self-regard. This study found no significant relationship between elapsed time since the loss and the self-regard of SOS. The researcher projected that the SOS' self-regard would follow a similar trend reported by Feigelman et al. (2012c) regarding grief difficulties. Feigelman et al. (2012c) reported a peak of grief difficulties at two years directly followed by a decline of the SOS' grief difficulties. This study's results concerning the self-regard of SOS are in opposition to Feigelman et al.'s (2012c) trend of grief difficulties previously mentioned and the researcher's projected findings (R_2/H_2). Now that this study's findings have been explained, the implications to social work will be presented.

Implications to Social Work

The results of this study contradicted many aspects of what the researcher expected for R_1/H_1 and all aspects of R_2/H_2 . This study adds to the research on elapsed time since the loss of SOS by examining two variables, the SOS' most prominent feeling and self-regard. The researcher accurately expected the prominent feeling of fear to be significant in early bereavement. More specifically, this feeling was significant during 25-59 months elapsed time since the loss. This could be a delayed reaction to trauma (i.e., other specified trauma and stressor-related disorder). Therefore, current and prospective professionals in the field of social work should receive education on the wide range of grief responses to traumatic loss.

The researcher expected elapsed time since the loss to have no influence on the selected prominent feelings of happiness, which was significant for two groups, 25-59 and 60+ months. This suggests that SOS clients are more resilient than professionals (e.g., Murphy, 2000) have previously concluded. The findings regarding expected prominent feeling of happiness from this study can assist social work professionals in educating future social workers on the importance of empowering clients to work through their grief. The finding present that SOS can gain happiness over an extended period of time. Therefore, current and future social workers can instill hope in clients by using individual, group, and/or family counseling.

As previously mentioned, elapsed time had no influence on the SOS' self-regard. Although the researcher thought the self-regard of SOS would follow a similar trend to the SOS' grief difficulties presented by Feigelman et al. (2012c), this information proposes further implication to social work. These findings may suggest that a social work professional can assess the SOS' grief experience at any point following the suicide loss. In other words, since time is irrelevant in this self-regard study, no harm to the SOS' inherent self-worth is likely to occur by

the assessment of grief experience. During the SOS' intake assessments for this thesis (face-to-face interviews), SOS were not only asked questions regarding their grief experience, they were solicited to tell their story of survival. Allowing the SOS to tell their story builds rapport between the social worker and client (Hoff, 2001). This technique sends the message to the client that they are in a safe space to talk openly about their survivor experience (Hoff, 2001). Social work educators, administrators, practitioners, and related professionals can use this technique when working with SOS to build trust between the professional and client (Hoff, 2001).

As previously mentioned, the SOS' most prominent feeling variable followed a similar trend to Feigelman et al.'s (2012c) trend of grief difficulties. This study found a significant level of happiness reported by SOS after two years since the loss. This information presents another way to determine the SOS' level of grief difficulty. Additionally, this information will help social workers and other similar professionals determine adequate referrals for clients based on their grief severity. Unlike other research on SOS (e.g., Feigelman et al., 2012a-2012i), this study utilized a wide range of survivor relations to the deceased. Therefore, this study's data may be applied to a wide range of SOS.

Policy Implications

Since the intake assessments utilized for this thesis were used to determine whether or not a SOS would benefit from participation in a SOS support group, the below policy implications were proposed. When assessing SOS for group, the Inventory of Complicated Grief (ICG) should be useful to determine the SOS' prolonged trauma symptoms in relation to the suicide loss (Mitchell, Kim, Prigerson, & Mortimer, 2005). The ICG is a 19-item scale that measures symptoms of complicated grief. The scale has a 4-point response format ranging from *never* to *always* (Prigerson et al., 1995). Prigerson et al. (1995) reported the Cronbach's coefficient alpha

of .94. The complicated grief scale can help prevent retraumatization via group attendance by identifying SOS with complicated grief and referring them to individual therapy.

Also, Orden et al. (2010) presented two psychological states that predict suicide behavior (e.g., suicide attempt or completed suicide), perceived loneliness and feeling like a burden to others. According to Orden et al., the feeling of hopelessness reinforces the aforementioned states. Therefore, the researcher proposes that lonely and hopelessness be added to the possible choices of the SOS' most prominent feeling during the intake assessment. This will further help the assessor determine suicide risk of the SOS.

Limitations

There were some limitations of this study worth mentioning. First, this study was based on cross-sectional data involving different SOS at varying points in their bereavement.

Therefore, influential links between elapsed time since the loss and the SOS' most prominent feeling, as well as the SOS' self-regard should be made with careful thought. Future research should focus on longitudinal designs to determine the SOS' grief experience over time. Second, the SOS' most prominent feeling and self-regard were each based off of a single assessment question. Thus, caution should be taken in generalization from this study's results. Future research should gather data from multiple questions regarding the SOS' most prominent feeling and self-regard.

Third for this study, the first communicated feeling to practitioners and clinicians was recorded as the most prominently feeling. Through experience completing SOS intake assessments and reviewing the data, the researcher noticed that SOS often responded by naming several feelings at one time. Additionally, the researcher noticed that SOS often reported sadness first and then reported more complex feelings (e.g., guilt). Luterek, Orsillo, and Marx (2005)

reported that people in general have difficulty communicating how they are feeling. Luterek et al. (2005) reported that the difficulty of self-reporting feelings increased for those who have experienced some sort of trauma (Luterek et al., 2005). Robinson and Clore (2002) reported that individuals associate certain feelings with specific situations. This could explain why over half of the SOS reported their most prominent feeling as sadness (e.g., associating death and sadness). To address this issue, future research should examine the first two reported feelings and/or reflectively solicit the survivor to choose between the first two feelings reported.

Conclusion

The purpose of this cross-sectional study was to determine the relationship between the elapsed time since the loss of help-seeking SOS and their most prominent feeling and/or self-regard. Despite limitations, the results of the cross-sectional study on SOS provided various applications for the following individuals: those bereaved by suicide; suicide bereavement educators, administrators, and practitioners; and more generally, all professionals practicing directly with clients. Among the most important findings of the study were the following: the SOS' most prominent feeling in long-term bereavement and in early bereavement, as well as the lack of association between elapsed time since the loss and the SOS' self-regard. Moreover, clinical utilization of this data can be implemented during the following: intake assessment design, emotion-focused support, determination of mental health severity, and referral decision-making.

Results of this cross-sectional study further stress the need for research on the self-regard of SOS. As previously mentioned in the literature review, little was found on the self-regard of SOS in general. Since previous research (e.g., Feigelman et al., 2012a-2012i) has labeled newly bereaved as less than two years elapsed time, the researcher suggests combining the first two

time groups (0-1 month and 2-12 months) in repetition of this study. A priority in research should be placed on longitudinal designs for SOS. This would help professionals gain an understanding of the SOS' grief experience. Finally, longitudinal studies would help professionals support SOS during a complex emotional experience.

References

- American Foundation for Suicide Prevention. (n.d.). *Survivors of suicide: Living with loss*. Retrieved from University of California Santa Cruz website <http://caps.ucsc.edu/pdf/survivors-of-suicide.pdf>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Ashford, J., & Lecroy, C. (2013). *Human behavior in the social environment* (5th ed.). Pacific-Grove, CA: Brooks/Cole.
- Barnes, D. (2006). The aftermath of suicide among African Americans. *Journal of Black Psychology*, 32(3), 335-348. doi:10.1177/0095798406290470
- Barrett, T., & Scott, T. (1990). Suicide bereavement and recovery patterns compared with nonsuicide bereavement patterns. *Suicide & Life-Threatening Behavior*, 20(1), 1- 15.
- Berman, A. L. (2011). Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide & Life-Threatening Behavior*, 41(1), 110-116.
- Campbell, F. R., Cataldie, L., McIntosh, J., & Millet, K. (2004). An active postvention program. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 25(1), 30-32. doi:10.1027/0227-5910.25.1.30
- Celotta, B. (1995). The aftermath of suicide: Postvention in a school setting. *Journal of Mental Health Counseling*, 17(4), 397.
- Centers for Disease Control and Prevention. (2013). Fatal injury reports, national and regional, 1999-2010. *Web-based injury statistics query and reporting systems (WISQARS)*. Atlanta, GA: Author. Retrieved from http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html
- Cerel, J., Maple, M., Aldrich, R., & van de Venne, J. (2013). Exposure to suicide and identification as survivor: Results from a random-digit dial survey. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 34(6), doi:10.1027/0227-5910/a000220
- Cerel, J., Padgett, J. H., Conwell, Y., & Reed, G. r. (2009). A call for research: The need to better understand the impact of support groups for suicide survivors. *Suicide & Life-Threatening Behavior*, 39(3), 269-281. doi:10.1521/suli.2009.39.3.269
- Cerel, J., & Campbell, F. (2008). Suicide survivors seeking mental health services: A preliminary examination of the role of an active postvention model. *Suicide & Life-Threatening Behavior*, 38(1), 30-34. doi:10.1521/suli.2008.38.1.30

- Cerel, J., Fristad, M. A., Weller, E. B., & Weller, R. A. (2000). Suicide-bereaved children and adolescents: II. Parental and family functioning. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(4), 437-444. doi:10.1097/00004583-200004000-00012
- Crosby, A., Ortega, L., & Melanson, C. (2011). *Self-directed violence surveillance: Uniform definitions and recommended data elements*. Retrieved from National Center for Injury Prevention and Control, Centers for Disease Control and Prevention website <http://www.cdc.gov/violenceprevention/suicide/definitions.html>
- Demi, A., & Howell, C. (1991). Hiding and healing: Resolving the suicide of a parent or sibling. *Archives of Psychiatric Nursing*, 5(6), 350-356.
- Denney, J. T. (2010). Family and household formations and suicide in the United States. *Journal of Marriage and Family*, 72(1), 202-213. doi:10.1111/j.1741-3737.2009.00692.x
- Denney, J. T., Rogers, R. G., Krueger, P. M., & Wadsworth, T. (2009). Adult suicide mortality in the United States: Marital status, family size, socioeconomic status, and differences by sex. *Social Science Quarterly (Wiley-Blackwell)*, 90(5), 1167-1185. doi:10.1111/j.1540-6237.2009.00652.x
- Duckworth, M. P., & Follette, V. M. (2012). Introduction. In M. P. Duckworth, V. M. Follette, M. P. Duckworth, V. M. Follette (Eds.), *Retraumatization: Assessment, treatment, and prevention* (pp. 1-8). New York, NY: Routledge/Taylor & Francis Group.
- Farberow, N. L., Gallagher, T. D., Gilewski, M., Gallagher, D., Gilewski, M., & Thompson, L. (1992). The role of social supports in the bereavement process of surviving spouses of suicide and natural deaths. *Suicide & Life-Threatening Behavior*, 22(1), 107-124.
- Feigelman, W., Jordan, J. R., McIntosh, J. L., & Feigelman, B. (2012a). Suicide survivor support groups: Comings and goings. In *Devastating losses: How parents cope with the death of a child to suicide or drugs* (pp.187-214). New York, NY: Springer Publishing Co.
- Feigelman, W., Jordan, J. R., McIntosh, J. L., & Feigelman, B. (2012b). Early years after the loss: Survivors get help and advance through their depths of despair. In *Devastating losses: How parents cope with the death of a child to suicide or drugs* (pp.125-246). New York, NY: Springer Publishing Co.
- Feigelman, W., Jordan, J. R., McIntosh, J. L., & Feigelman, B. (2012c). Differences in the suicide death circumstances and how they may affect a survivor's grief. In *Devastating losses: How parents cope with the death of a child to suicide or drugs* (pp. 81-96). New York, NY: Springer Publishing Co.

- Feigelman, W., Jordan, J. R., McIntosh, J. L., & Feigelman, B. (2012d). Person growth after a suicide loss: Is it associated with a survivor's mental health? In *Devastating losses: How parents cope with the death of a child to suicide or drugs* (pp. 215-230). New York, NY: Springer Publishing Co.
- Feigelman, W., Jordan, J. R., McIntosh, J. L., & Feigelman, B. (2012e). Internet support groups for suicide survivors: A new form of grief support. In *Devastating losses: How parents cope with the death of a child to suicide or drugs* (pp.231-254). New York, NY: Springer Publishing Co.
- Feigelman, W., Jordan, J. R., McIntosh, J. L., & Feigelman, B. (2012f). Theoretical issues guiding this study and how the data were collected. In *Devastating losses: How parents cope with the death of a child to suicide or drugs* (pp.15-38). New York, NY: Springer Publishing Co.
- Feigelman, W., Jordan, J. R., McIntosh, J. L., & Feigelman, B. (2012g). Suggestions for future research. In *Devastating losses: How parents cope with the death of a child to suicide or drugs* (pp. 295-334). New York, NY: Springer Publishing Co.
- Feigelman, W., Jordan, J. R., McIntosh, J. L., & Feigelman, B. (2012h). Later years after loss: Identifying the postvention needs. In *Devastating losses: How parents cope with the death of a child to suicide or drugs* (pp.147-186). New York, NY: Springer Publishing Co.
- Feigelman, W., Jordan, J. R., McIntosh, J. L., & Feigelman, B. (2012i). Grief overload: The impact of multiple losses, only-child loss, and multiple stressor events on bereaved parents. In *Devastating losses: How parents cope with the death of a child to suicide or drugs* (pp.97-214). New York, NY: Springer Publishing Co.
- Fiske, A., Garz, M., & Hannell, E. (2005). Rural suicide rates and availability of health care providers. *Journal of Community Psychology*, 33(5), 537-543. doi:10.1002/jcop.20069
- Gilewski, M. J., Farberow, N. L., Gallagher, D. E., & Thompson, L. W. (1991). Interaction of depression and bereavement on mental health in the elderly. *Psychology and Aging*, 6(1), 67-75. doi:10.1037/0882-7974.6.1.67
- Gove, W. R. (1972). Sex, marital status and suicide. *Journal of Health & Social Behavior*, 13(2), 204-213.
- Hoff, L. A. (2001). Part one the understanding and practice of crisis intervention. In *People in crisis: Clinical and public health perspectives*. San Francisco, CA: Jossey-Bass. Retrieved from eBook Collection (EBSCOhost)

- Holzer, C. E., III, Goldsmith, H. F., & Ciarlo, J. A. (2000). *The availability of health and mental health providers by population density*. [Letter to the field no. 11]. WICHE Project Archive, Boulder, CO. Retrieved from <http://www.wiche.edu/MentalHealth/Frontier/letter11.asp>
- Jennings, A. (n.d.). *Retraumatization*. Retrieved from www.theannainstitute.org/Retraumatization%20with%20chart.ppt
- Kazdin, A. E. (2000). *Encyclopedia of psychology: 8 volume set*. Washington, DC: Oxford University Press.
- Lester, D. (2005). On being happy that someone has committed suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 26(2), 95-96. doi:10.1027/0227-5910.26.2.95
- Maltsberger, J. T. (1997). Culture and ego-ideal in suicide: An adult case. *Suicide & Life-Threatening Behavior*, 27(1), 28-33.
- McAndrew, F. T., & Garrison, A. J. (2007). Beliefs about gender differences in methods and causes of suicide. *Archives of Suicide Research*, 11(3), 271-279. doi:10.1080/13811110701403940
- McIntosh, J. L., & Drapeau, C. W. (2015). *U.S.A. suicide 2013: Official final data*. Washington, DC: American Association of Suicidology. Retrieved from <http://www.suicidology.org/resources/facts-statistics>
- McMenamy, J. M., Jordan, J. R., & Mitchell, A. M. (2008). What do suicide survivors tell us they need? Results of a pilot study. *Suicide & Life-Threatening Behavior*, 38(4), 375-389.
- Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer, M. K. (2005). Complicated grief and suicidal ideation in adult survivors of suicide. *Suicide & Life-Threatening Behavior*, 35(5), 498-506.
- Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer-Stephens, M. (2004). Complicated grief in survivors of suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 25(1), 12-18. doi:10.1027/0227-5910.25.1.12
- Murphy, S. L., Xu, J., & Kochanek, K. D. (2013). Deaths: Final data for 2010. *National vital statistics reports*, 61(4), 1-117. Hyattsville, MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf
- Murphy, S. A. (2000). The use of research findings in bereavement programs: A case study. *Death Studies*, 24(7), 585-602. doi:10.1080/07481180050132794

- Neimeyer, R. A., & Jordan, J. R. (2002). Disenfranchisement as empathic failure: Grief therapy and the co-construction of meaning. In Doka, K. (Ed.), *Disenfranchised grief: New directions, challenges, and strategies for practice* (pp. 95–118). Champaign, IL: Research Press.
- Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. J. (2010). The interpersonal theory of suicide. *Psychological Review*, *117*(2), 575-600.
- Ott, C. H., Lueger, R. J., Kelber, S. T., & Prigerson, H. G. (2007). Spousal bereavement in older adults: Common, resilient, and chronic grief with defining characteristics. *Journal of Nervous and Mental Disease*, *195*(4), 332-341.
doi:10.1097/01.nmd.0000243890.93992.1e
- Prigerson, H. G., Maciejewski, P. K., Reynolds, C., Bierhals, A. J., Newsom, J. T., Fasiczka, A., Frank, E., Doman, J., & Miller, M. (1995). Inventory of Complicated Grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research*, *59*(1-2), 65-79.
doi:10.1016/0165-1781(95)02757-2
- Provini, C., & Everett, J. R. (2000). Adults mourning suicide: Self-reported concerns about bereavement, needs for assistance, and help-seeking behavior. *Death Studies*, *24*(1), 1.
- Reed, M. (1993). Sudden death and bereavement outcomes: The impact of resources on grief symptomatology and detachment. *Suicide & Life-Threatening Behavior*, *23*(3), 204-220.
- Reed, M. D., & Greenwald, J. Y. (1991). Survivor-victim status, attachment, and sudden death bereavement. *Suicide & Life-Threatening Behavior*, *21*(4), 385-401.
- Searles, V. B., Valley, M. A., Hedegaard, H., & Betz, M. E. (2014). Suicides in urban and rural counties in the United States, 2006–2008. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *35*(1), 18-26. doi:10.1027/0227-5910/a000224
- Sharpe, T. L., Joe, S., & Taylor, K. C. (2012). Suicide and homicide bereavement among African Americans: Implications for survivor research and practice. *Omega: Journal of Death & Dying*, *66*(2), 153-172.
- Singh, G. K., & Siahpush, M. (2002). Increasing rural-urban gradients in U.S. suicide mortality, 1970–1997. *American Journal of Public Health*, *92*(7), 1161–1167.
- Smith, J. C., Mercy, J. A., & Conn, J. M. (1988). Marital status and the risk of suicide. *American Journal of Public Health*, *78*(1), 78-80.
- U.S. Public Health Service. (1999). U.S. Department of Health and Human Services, Office of the Surgeon General. *The surgeon general's call to action to prevent suicide* (NNBBBH). Retrieved from <http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html>

Appendix

ACTION ON PROTOCOL APPROVAL REQUEST



Institutional Review Board
Dr. Dennis Landin, Chair
130 David Boyd Hall
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P: 225.578.8692
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TO: Scott Wilks
Social Work

FROM: Dennis Landin
Chair, Institutional Review Board

DATE: December 8, 2014

RE: IRB# 3576

TITLE: Survivors of Individuals Who Complete Suicide: The Impact of Time since the Loss

New Protocol/Modification/Continuation: New Protocol

Review type: Full ___ Expedited X **Review date:** 12/5/2014

Risk Factor: Minimal X Uncertain _____ Greater Than Minimal _____

Approved X **Disapproved** _____

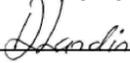
Approval Date: 12/5/2014 **Approval Expiration Date:** 12/4/2015

Re-review frequency: (annual unless otherwise stated)

Number of subjects approved: 200

LSU Proposal Number (if applicable): _____

Protocol Matches Scope of Work in Grant proposal: (if applicable) _____

By: Dennis Landin, Chairman 

**PRINCIPAL INVESTIGATOR: PLEASE READ THE FOLLOWING –
Continuing approval is CONDITIONAL on:**

1. Adherence to the approved protocol, familiarity with, and adherence to the ethical standards of the Belmont Report, and LSU's Assurance of Compliance with DHHS regulations for the protection of human subjects*
2. Prior approval of a change in protocol, including revision of the consent documents or an increase in the number of subjects over that approved.
3. Obtaining renewed approval (or submittal of a termination report), prior to the approval expiration date, upon request by the IRB office (irrespective of when the project actually begins); notification of project termination.
4. Retention of documentation of informed consent and study records for at least 3 years after the study ends.
5. Continuing attention to the physical and psychological well-being and informed consent of the individual participants, including notification of new information that might affect consent.
6. A prompt report to the IRB of any adverse event affecting a participant potentially arising from the study.
7. Notification of the IRB of a serious compliance failure.
8. SPECIAL NOTE:

**All investigators and support staff have access to copies of the Belmont Report, LSU's Assurance with DHHS, DHHS (45 CFR 46) and FDA regulations governing use of human subjects, and other relevant documents in print in this office or on our World Wide Web site at <http://www.lsu.edu/irb>*

Vita

Alexis Rabalais was raised in Baton Rouge, Louisiana. She attended Louisiana State University and in her junior at the university she began volunteering at a crisis center. She graduated in 2012 with a Bachelor of Science degree in Psychology. Her continuous time at the crisis center inspired her to apply to the School of Social Work at Louisiana State University. Following her acceptance into the School of Social Work, she was asked to intern at the crisis center. This internship was the start to her passion about suicide and those who have lost loved ones to suicide. She is a candidate for her master's degree in May, 2015 and plans to continue to work in the area of crisis intervention.