

5-2013

Stigmatized Loss and Suicide

Ann Brosnan
St. Catherine University

Recommended Citation

Brosnan, Ann, "Stigmatized Loss and Suicide" (2013). *Master of Social Work Clinical Research Papers*. Paper 158.
http://sophia.stkate.edu/msw_papers/158

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact ejasch@stkate.edu.

Stigmatized Loss and Suicide

By

Ann Brosnan, B.A, B.S

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of
Master of Social Work

Committee Members
Richa Dhanju, Ph.D. (Chair)
Miriam Itzkowitz, MSW, LICSW
Dianna Diers, MA, LMFT

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis or nor a dissertation.

Abstract

Over the past ten years, suicide has increased at an alarming rate. A loss such as this leaves behind family members and friends who often have many unresolved questions and feelings. Suicide is often not discussed as openly as other types of loss and this can affect and limit the grieving process. A review of the literature indicates a higher incidence of complicated bereavement when compared to naturally occurring losses and difficulty in meaning making of the loss. This also includes a higher incidence of physical and mental health concerns. By studying what barriers, including stigma, affect the grieving process, those in the helping profession can help those individuals who have lost someone to suicide work through the grieving process and reduce the negative impact associated with it. The field of social work also has an obligation to educate the public on mental illness to reduce or eliminate negative stereotyping and encourage those who have been affected by it to seek help. Members of three suicide support groups in the Twin Cities were asked to complete a survey discussing perceptions regarding the loss of their loved ones. This included their perception and dominant feelings toward the person who died, perceptions of themselves and how others may perceive them, and how this may have affected their World View. Members were also given an opportunity to make suggestions to practitioners how they can help an individual who has lost someone to suicide. Results indicate those who lost someone to suicide did not perceive the person who died differently, but felt others may perceive them differently. Their World View was maintained as generally positive, with an increased realization of life's fragility and higher sense of spirituality. Implications for social work were also discussed in providing more education around mental health help as a means of reducing stigma.

Acknowledgements

I would like to take an opportunity to thank my committee members for their support and encouragement throughout my journey in completing this research project. This includes Richa Dhanju, (Chair), Miriam Itzkowitz, and Dianna Diers, all of whom provided a great deal of insight and patience with me from the beginning to the end this project.

I would also like to thank the facilitators and group members who took the time and effort to complete the survey. Their courage, insight, and genuineness helped me further gain an understanding of the impact their loss has had on their lives. This was not an easy thing to do and I thank them so very much and wish them healing through this difficult time in their lives.

I would also like to thank my family and friends for the mammoth amount of support and encouragement they offered to me throughout this project. I could not have done this without them and them for the insight, humor, and offering of a shoulder to lean on during this process. I hope I can in some way return the favor in the future.

Table of Contents

Abstract.....	3
Introduction.....	6
Literature Review.....	7
Stigmatized Loss with Suicide.....	10
Meaning Making.....	11
Common Feelings Shared by Survivors.....	12
Complicated Grief.....	14
Treatment/Interventions for Bereaved Individuals.....	16
Conceptual Framework.....	21
Methods.....	24
Research Design.....	24
Sample.....	25
Protection of Human Subjects.....	24
Instrument.....	26
Data Collection.....	26
Data Analysis.....	28
Strengths and Limitations.....	28
Findings.....	29
Relationship to Suicide.....	30
Relationship to Other.....	32
Relationship to Self and to the World.....	37
Discussion.....	40
Limitations and Recommendations for Future Research.....	42

Implications for Social Work.....	43
Conclusion.....	44
Appendix A.....	46
Appendix B.....	47
Appendix C.....	48
Appendix D.....	51
References.....	52

Introduction

Losing a loved one is a devastating event and the circumstances that surround the death substantially affect the way in which those close to the individual (“survivors”) grieve the loss and eventually move forward (Walsh & McGoldrick, 2004). Cultural standards often affect the experience of the bereavement process, including ways in which one behaves, thinks, and feels about the loss. When there are distinguishing factors surrounding the loss that do not meet socially approved categories, the grief one feels over the loss may come to feel unacknowledged or “disenfranchised”. Those deaths that do not meet socially approved categories may result in a form of social stigma to both the individual lost and surviving family and friends. Examples of socially unapproved causes of death include, but are not limited to, death by AIDS, loss of same-sex partners, abortion, homicide, and suicide. These social forces can keep family members from maneuvering through the grief process and getting significant support (Walsh & McGoldrick, 2004).

When stigma first originated, it was a means of marking slaves in order to acknowledge their position in social structure and to indicate their being of less value than others. Presently, this term is now associated as a social construct whereby a distinguishing ‘mark’ of social disgrace is attached to others in order to identify and devalue them. Stigma consists of two elements: the recognition of the differentiating “mark” and the resulting devaluation of the person. This can include a measure of labeling, stereotyping, setting apart, and discriminating (Link, & Phalen, 2001). A person that is stigmatized may come to understand early on whether or not their identity fits with family or community’s expectations and this contributes to their identity being shaped by how others view them. This prejudice can foster shame and keep a

person from acknowledging their authentic self (Boss, 2006). Stigma shares both a public and private component where people turn inward, which is termed self-stigma (Arboleda-Florez, 2002). According to Corrigan (2004), stigma serves as a cue to provoke stereotypes and is deeply discrediting to an individual. This appears to be a universal, cross-cultural phenomenon, however, varies in degree and quality (Yang, Kleinman, Link, Phelan, Lee, & Good, 2007).

Death by suicide is one type of loss that has elements that both do not meet socially acceptable factors and remains rarely discussed in our society. The purpose of this study is to assess the impact stigma has had on survivors of suicide and how this has affects the desire to seek treatment. Information will be gathered for this project through suicide support groups. Throughout this project I will explore variables associated with loss through suicide and how the grief process may be different than death by natural causes. In addition, ways in which the variable of stigma affects survivors of suicide and the environment in which they live will be explored. Implications for social work will also be studied, examining how therapists can gear specific interventions toward the healing process. The following research question will be examined: How does stigma affect the grief process?

Literature Review

At some point in time, every person will encounter some type of loss that is significantly felt. This includes non-death related loss (i.e. job, health, changing life goals, etc.) and loss through the death of a loved one. When this happens, people tend to grieve loss differently and the depth or intensity is often related to factors including the type of relationship one had with the individual and the manner in which a person died (Fowles, 1990). Some losses are more difficult to grieve, given the nature of the death and the culture in which we live. Our culture can

heavily influence the way we grieve, including the way we behave after the loss, how we come to think and feel about the loss and the manner in which it may be appropriate to grieve (Walsh & McGoldrick, 2004). Every society has rules or norms that shape the grieving process. When a loss occurs, these norms affect the way in which a person thinks and feels about it. This, in turn, affects how one grieves the loss (Bryant & Peck, 2009). The manner in which an individual died may greatly affect how those who cared for the individual will grieve and also affects the legacy of the person who passed. Those losses that are less socially sanctioned can also create an array of feelings for those that were close to the individual who died including, but not limited to, anxiety, defensiveness, guilt, shame, or a denial that the person died in a particular manner (Dunn & Morrish-Vidners, 1987). Stigma plays a fundamental part in the bereavement process and may partially influence an individual's well-being by determining emotional and behavioral responses to the death. When it comes to determining whether a loss is stigmatized, one must look at cultural bias, fear, stereotyping, and sometimes shame in the type of death. Stigmatized losses are generally not discussed as openly as other, non-stigmatized, types of death.

Feigelman, Gorman and Jordan (2009) identify that this stigmatization can be overt, with action taken against the survivor, or subtle. They note that subtle stigmatization is more common and often involves omitting an action (i.e. not attending to or acknowledging the needs of the survivor). It is a characteristic that tends to dishonor and discredit both the individual that is lost and those left behind. Suicide, in particular, is an unpredictable act without fixed norms as how to react to the individual who has died and to those grieving it (Walsh & McGoldrick, 2004).

As previously mentioned, suicide is one in a variety of losses that permeate our society today. In the United States, the highest rates occur among elderly aged 65 and over. Rates among

middle-aged Americans have jumped significantly in the past decade, with suicide among Americans aged 35-64 rising by nearly 30 percent from 1999-2010. It is the third leading cause of death in young people between the ages of 15-24 and the ninth leading cause of death in the United States overall (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004). According to the Centers for Disease Control, more people die by suicide than die in car accidents. It is estimated that more than 30,000 people die each year by suicide. For each person lost, at least six people are closely connected to the person and are significantly affected by the death (Walsh & McGoldrick, 2004). While this is a tremendously high number of people lost to suicide each year, researchers have found this has been vastly underreported (Parker-Pope, 2013). This leaves behind many more to grieve their loss. Given the nature and stigmatization of suicide, there are many people who will utilize poor coping strategies. Poor coping strategies may include not talking about the loss, an increase in using addictive substances including drugs and alcohol, or engaging in increasingly risky behavior. As a result, this affects not only the bereaved individual, but family members, friends, and others who wish to provide support.

Death by suicide has been prevalent since the earliest documented times in history. During the Greco Roman and Far Eastern world of the Middle Ages, survivors were denied the bodies of the deceased and the dead were mutilated to prevent the unleashing of wandering spirits (Cvinar, 2005; Feigelman et al., 2009). The deceased were also denied burial in church cemeteries. Survivors were denied not only closure with the deceased, but also confiscation of their property. Families were often ostracized and often did not receive any financial or emotional support from the community. Thankfully, a shift occurred during the 19th century when an effort to prevent a family's isolation from society began. In the 20th century, suicide

finally began to be looked at through the lens of physical, psychological, and social concerns (Cvinar, 2005).

Gender differences are pervasive throughout the research on suicide. Males tend to use more violent and aggressive resources (i.e. guns) and have a higher rate of completed suicide. This differs from females who tend to use less lethal means (i.e. pills) and engage more in self-harm behaviors (Hawton, 2000; Parker-Pope, 2013).

Suicide goes against the nature of self-preservation, is often violent in nature, and can leave a great deal of unanswered questions to those that survive this type of loss. Due to the nature of suicide, reasons for an individual's purposeful death can only be speculated. It can be greatly misunderstood by those who are directly affected by it and those who may simply discuss it in passing. The high prevalence of this type of loss means that numerous people will be affected by suicide each year. Those who work in the healing profession, including the field of social work, would benefit greatly from developing an understanding of this type of loss and designing specific, individualized therapeutic interventions it. Social work holds a large responsibility to educate survivors and the general public to reduce stigma associated with this and other forms of loss to help survivors cope (Fowles, 1990).

Stigmatized Loss With Suicide and Aspects of Bereavement

Any type of loss is difficult by nature; however, there are various aspects of suicide that makes the process of bereavement both challenging and unique. Practitioners working with individuals who have suffered this type of loss may benefit from gaining an understanding as how suicide is different from other forms of loss (Worden, 2009). Jordan (2001) suggests there are thematic aspects of suicide that may be different than other types of grief. Although there are

numerous variables that may factor into an individual completing a suicide (i.e. mental illness, sudden physical/medical challenges, prolonged illness, etc.), there are unique themes that survivors face in the bereavement process.

Meaning Making

There are various ways in which suicide grief tends to manifest itself. One of the main concepts survivors of suicide attempt to understand is *why* it happened. American culture prides itself on logical reasoning, finding answers, getting things done quickly, competently, and by the most efficient means possible. Because this type of loss is self-inflicted, survivors are left to use speculation in attempting to make sense of the reasoning, although sense and logic are not something that can be formulated. This often contributes to the difficulty in trying to work through the grieving process and making sense of something that is almost impossible to comprehend. Compared to other forms of mourning, a great deal more time and energy is taken trying to understand the reason for the death and meaning behind it (Jordan, 2011). Begley & Quayle (2007) identify an “incremental examination” of events leading up to the death in an attempt to find understanding and reasoning behind the motivation. It is a complex process and often an attempt to match survivor’s prior beliefs about the deceased as to the cause of death and protect the survivor’s sense of self and responsibility for it. Due to the profound feelings of helplessness, powerlessness, and often responsibility, it is often difficult to find meaning or an explanation for the loss (Dunn and Morrish-Vidners, 1987). However, this is an important aspect in being able to work through the grief process and find a new place for the deceased person in the survivor’s life (Worden, 2009). When the finality of a loss is accepted and

embraced into the “working model” of the deceased, mourning is said to be occurring in a healthy manner (Shear & Mulhare, 2008).

Common Feelings Shared by Survivors

Grieving a loved one through both natural and more traumatic circumstances evokes a variety of feelings. Research identifies a common set of feelings survivors of suicide tend to have including higher levels of guilt, shame, blame, anger and a sense of responsibility for the death. This is often different from those grieving a naturally occurring death (Bryant & Peck, 2009). One of the dominant feelings associated with suicide survivors is shame, which is the internalized belief of responsibility for the loss. It is important to note the distinction between the feeling of guilt and shame in the reaction to this type of loss. According to Teyber and McClure (2011), guilt is feeling badly that something happened. This may correspond with feeling the need to be punished for the event (Worden, 2009). There is a sense of wanting to repair what happened or make apologies for what occurred. When a person experiences shame, one feels as though they *are* bad and essentially flawed as a person. It is an all-encompassing feeling about how one views the self. While experiencing shame, an individual may feel a desire to hide or isolate in order to avoid scrutiny from other people. The notion of wanting to make repairs is not present. This level of shame can grow to affect the level of interaction and communication survivors have within the family unit, as well as their discussing the loss with others. This is also significantly affected by reactions people have to the loss.

Blame is considered central to the grieving process with suicide and is typically an attempt to restore a sense of order to an event that is, by nature, without it. The blaming of others serves a psychological function for the bereaved individual in that it attempts to help the

individual gain a sense of control over the feelings of helplessness and powerlessness (Dunn & Morrish-Vidners, 1987).

Another theme surrounding survivors of suicide includes feeling an increased sense of rejection, abandonment, and isolation from others. Survivors often find that others are not able to understand or respond to their needs in a meaningful way and may stop seeking out support in an effort to protect themselves, as well as, not wishing to put others in uncomfortable positions (Dunn & Morrish-Vidners, 1987; Jordan , 2011). These individuals fear being judged negatively, even though others may simply want to offer support or compassion. As a result, survivors may withdraw or act in ways that discourage social support from others and increase the feelings of frustration and rejection from others. Interpersonal interaction and social support is often different and more problematic after a death by suicide when compared to other loss (Armour, 2006).

Jordan (2001) emphasizes the perception that those bereaved by suicide are more psychologically disturbed, less likable, more blameworthy, and more ashamed. There is also the perception these individuals have an increased need of professional mental health care and are likely to remain depressed for a longer period of time. Jordan (2001) and Cvinar (2005) highlight that there may be discrepancy between the perceptions survivors feel and how members of society actually view them. Often, those in the community may wish to support the bereaved individual, but are not sure how to do so, given the uncomfortable and traumatic nature of the loss. This tends to increase the level of isolation an individual or family may experience. The social stigma can only be reduced as survivors become more open about the experience (Jordan, 2011).

Complicated Grief

A death that was self-inflicted or violent in nature creates a different form of mourning behavior. Bereavement of this type is considered complicated (Armour, 2006) and often involves features of Post-Traumatic Stress Disorder, also known as ‘traumatic’ grief (Boss, 2006; Copping, 2011). When compared to natural death, reactions to this type of loss can have differing intensity and duration. This is often felt for a longer period of time and at higher intensity than non-stigmatized loss (Zhang, El-Jawahri; Prigerson, 2006). At times, the reaction to this type of death can later prove to be pathological, given the intensity of physical impact to survivor’s system. This type of extreme shock can bring physical and emotional reactions such as sleep disturbance, exaggerated startle behavior, phobic anxiety, intense shame, rage, horror, fear, and guilt. Mitchell et al. (2004), describe cases of complicated grief having higher rates of heart trouble, cancer, headaches, and flu-like symptoms. Adverse health outcomes experienced by individuals having long-term reactions to bereavement is now identified as complicated grief. Those who grieve violent deaths such as suicide are more likely to have this experience (Hawton, 2007; Zhang et al., 2006). This is separate from typical grief and other psychiatric disorders, such as depression and anxiety (Mitchell et al., 2004). Although people grieve in unique ways, there is differentiation between the "normal" grief process and complicated grief. Zhang et al. (2006) differentiated bereaved individuals with uncomplicated or “normal” grief as exhibiting limited signs of impairment after six months of loss. Other proposed criteria for complicated grief include intrusive and distressing core symptoms including yearning, longing, and searching for the deceased person (Johnson et al., 2009; Shear and Mulhare, 2008; Zhang et al., 2006). For complicated grief, individuals must also have four or more persistent symptoms of

traumatization. These include avoidance of reminders of the deceased, purposelessness, feelings of futility, difficulty imagining a life without the deceased, numbness, detachment, feeling stunned, dazed, shocked, feeling life is empty or meaningless, feeling a part of one's self has died, disbelief, and excessive anger or bitterness related to the death.

Another factor contributing to the development of complicated grief may depend upon an internal mechanism associated with one's ability to form bonds in early childhood. John Bowlby's Attachment theory describes this further with his three major theoretical assumptions. The first is that through the course of development, human bonds are intimate and biologically based. The formation and maintenance of human bonds are controlled by a feedback system within the human nervous system. The "cybernetic" system will operate efficiently only if the person builds mental working models of the self, of relationship partners, and of the interactional patterns between the two. The second is that early childhood experiences have powerful influence in later development. Finally, the third assumption is that humans can follow numerous different developmental pathways, with some being more compatible with healthy development (Forte, 2007). Throughout the lifespan, all persons have an inborn attachment/caregiving system that motivates us to seek out and maintain close relationships with others (Shear & Mulhare, 2008). For instance, in what Bowlby describes as a secure attachment, an individual grows to trust others, reaches out for care and assistance, and is able to bounce back from emotional distress (Forte, 2007). Adults experience attachments that change over time. The loss of an attachment can create intense emotions and produce permanent psychological changes as the bereaved person struggles to accept the finality of the loss (Shear & Mulhare, 2008).

Treatment/Interventions for Bereaved Individuals

When engaging an individual who has lost someone to suicide, it is important to remember that the nature of this loss is stigmatized or socially unspeakable (Worden, 2009). Individuals close to the individual who passed often have difficulty or do not wish to discuss the loss. In this case, it is important to make a distinction between how the survivor is feeling about the loss and how they are feeling about themselves. A person in this situation may often feel judged in a negative manner and withdraw or otherwise act in ways that inhibit social support efforts from others (Worden, 2009). Because of the traumatized symptoms that arise in a loss by suicide (and other stigmatized forms of loss) it is important for the therapist to understand that more time/sessions may be needed to work through these symptoms (Boss, 2006).

Having a complicated grief diagnosis could help the therapist gain more understanding of the individual's distress and formulate treatment interventions to reduce self-blame/ begin to externalize the blame, lower distress, and reduce isolation. In studies performed by Johnson et al (2009) 93.8% of those interviewed identified being relieved to know they had a recognizable problem. Often individuals are working through a high level of distress that is often misunderstood by others that one is "feeling sorry for one's self", which often leads to a higher degree of interpersonal stress and emotions not being expressed. If this can be identified and accepted as a diagnosis, it may reduce the likelihood of subsequent stigmatization, especially if treatment is effective in reducing the distress associated with severe grief. Suicide survivors are often working through a great deal of rejection, shame, and guilt for the person's self-inflicted action (Jordan, 2001).

For those suffering from complicated grief, it is recommended that specialized treatment be considered that includes identifying the nature of the relationship of the bereaved to the individual that has passed. Survivors with close relationships to the deceased, typically kinship relationships (i.e. spouse, parent, and offspring), may be more likely to develop dysfunctional coping and communication strategies. This includes such experiences as increased suicidal ideation of their own and it will be important to identify and manage the possible need for psychiatric care (Mitchell et al., 2004; Jordan, 2001). Zhang et al., (2006) suggest interventions that encourage the development of secure attachments to others and offer emotional re-engagement. These have been found to be absent when meeting the criteria for complicated grief. Because the level of attachment and kinship is directly associated with the development of complicated grief reactions, it would be important to take this into consideration in hopes of reducing the level of symptomology while increasing feelings of security and trust (Mitchell et al., 2004).

Involving the whole family in the recovery process is especially important for survivors of suicide. Other family members are at increased probability for additional suicides and it is important to consider the manner in which communication and emotional processing occurs or develops (Jordan, 2001). Active and passive suicidal ideation is common among suicide survivors who have not resolved factors relating to complicated grief. Passively, individuals may do this by engaging in risky behaviors and neglecting physical health needs in effort to accelerate the likelihood of death but avoid actively taking their own lives so as not to separate themselves permanently from loved ones (Shear and Mulhare, 2008).

Worden (2009) and Begley & Quayle (2007) emphasize the need for meaning making in working through grief reactions to this type of loss. Family members will often struggle in an attempt to make sense of the loss and it is vital to incorporate them in the intervention process as much as possible (Boss, 2006). This may be due in part with our Western culture's sense of personal responsibility, mastery, and control (Walsh & McGoldrick, 2004). Making sense of a loss of this nature does not occur in a linear fashion, however, is a vital part of recovery. The assumptions about benevolence, self-worth, and order in the world are shattered with the loss of the loved one. This can greatly restrict an individual's ability to find meaning in the loss. This also contributes to the bereaved questioning beliefs about life and finding a changed "world view" of life being what was once thought of as "predictable" and "fair" (Armour, 2006).

Boss (2006) also discusses the importance of meaning making in developing resiliency to cope with the loss. An individual may not understand the reasoning behind the loss, but can become more tolerant of the ambiguity behind it. The therapeutic goal should not be closure, but helping the person develop resiliency to adapt to the negative emotions (stress, anger, etc.) behind the ambiguity.

Survivors who have a limited understanding of suicide and contributing factors can access resources in the community to begin educating themselves. This assistance can come in the form of reading materials and being linked to a variety of mental health professionals. This can begin to put suicide in a larger perspective and help to reduce the stigma associated with it (Jordan, 2001).

Worden (2009) also discussed the need to reality test blame, guilt, the sense of abandonment, and correcting denial and distortions of the loss. Boss (2006) identified looking at

an individual's perceptions and subjective meanings in determining what the loss has meant to the person. In this regard, the client is then the source of "knowing" and this can be done in both an individual and group format. This can be assisted through the bereaved individual's participation in social support interventions to counteract many of these distortions in reality. Groups that focus specifically on suicide may assist an individual in reducing the sense of isolation and stigma. During these groups, individuals are allowed a chance to recognize and express emotions such as rage, anger, and frustration, and have them validated. A sense of trust in the community can be developed again and reactions to the loss can be normalized. This contributes to the increased feelings of competence and self-worth (Armour, 2006).

Conclusion

Social workers will have many things to take into consideration when working with survivors of suicide and other forms of stigmatized loss, including being able to identify factors of complicated bereavement and stigmatization associated with it. As discussed, stigmatization of loss greatly affects strategies used by individuals to cope. If not addressed, this has the potential to affect loved one's mental and physical health, in addition to interactions with others. It is important to consider the notion of death and how it is perceived in our culture. Western society is often focused on rationalization, control, and being able to solve problems quickly (Cvinar, 2005). Death is something that is typically avoided or not discussed on a regular basis in our society. This is more evident in regards to suicide. The aspects of isolation and loneliness experienced by many, either through traumatic or natural events, can be partially due to the cultural failure to understand death and the individuality of the bereavement process. The field of social work has a great deal to contribute in working with both. This includes work on a micro

level such as engaging with individuals in a therapeutic setting, in addition to addressing issues associated with direct family members. The field of social work can also contribute on a mezzo and macro level, working with community agencies in educating practitioners and the public on grief and loss to “normalize”, as much as possible, the death experience. This can also serve to reduce the sense of isolation survivors of any death may experience and create a greater environment of support. Working to reduce the stigmatization of suicide and other types of loss will affect individuals and families on a multi-generational level. This includes working to create a more cohesive family unit that utilizes open communication and expression. Given the high prevalence of suicide, and other types of stigmatized and complicated loss, social workers can have a key role in advocating for various services in becoming more prevalent and assisting communities in knowing that they are there. This adheres to many of the values within the social work Code of Ethics, such as social justice, dignity and self-worth of the person and importance of human relationships. Stigma can be greatly influential and judgmental in affecting how an individual may perceive one’s self. If left unaided or unchallenged, studies have shown that it can physically and mentally affect individuals, families, how one interacts within the community, and on a multi-generational level (Zhang et al., 2006).

It is important for the social worker to understand the dynamics of grief and loss when working with this specific group of individuals. There are many common experiences to suicide and yet each person reacts to them differently. The clinician working with survivors must look at the individual and family holistically, and allow each person to grieve autonomously. Considering the person-in-the-environment (PIE) is crucial in identifying various variables to

mourning and understanding that each person's situation is different. It is also important for social workers to have an understanding of how various cultures identify stigmatized loss.

As Walsh & McGoldrick (2004) identify, suicide has a history of being looked at differently in other cultures than in the United States. For example, suicide in Japan, China, and India, at different times in history, had means of restoring honor to a family, as is currently prevalent in many Middle Eastern countries. Suicide for this reason may be decreasing in other countries and the effect on families from these areas needs more research. Religious beliefs may also affect how a person reacts to suicide, as well as, how an individual may use it as a means of coping. In referencing the Quran in Muslim culture, for instance, Almeida posits that suicide is considered forbidden and is said to contribute to the "end of all mankind" (Walsh and McGoldrick, 2004, p.140). It is important for social workers to also understand and be accepting of the culture of grieving within a family system or "meeting the person where they are at". Although it is recommended to grieve in an open manner that encourages discussion and support, not all families grieve in this way and social workers will have to continue to utilize flexibility and creativity in meeting these needs.

Conceptual Framework

This research used the theoretical frameworks of both the attachment and ecological perspectives. These perspectives are important in identifying variables that affect the grieving process concerning both stigmatized and non-stigmatized losses. How a person reacts to the loss of a loved one is determined by a complex set of factors and is determined on an individual basis. Environmental factors associated with culture, norms, and perceived support within the person's environment, are just a few determinants. If these factors are not conducive to support,

an individual may not work through the grieving process, come to terms with the loss, find meaning and acceptance, and continue to feel “stuck” as though life cannot move forward. This is a common theme in what is now known as complicated grief. Part of what contributes to this type of grief is the increased length of time associated with moving forward after the death of a loved one. There are many factors that contribute to the development of this type of grief, however, research has often focused on the attachment styles of bereaved individuals and how this affects one’s ability, or lack thereof, to move forward from the loss.

Attachment theory posits the importance of positive early family experiences as being critical to human development. For survivors of suicide, one of the aspects contributing to complicated bereavement is the level of attachment to the person that has passed. If the attachment to the deceased person was strong and the survivor had not developed a strong sense of attachment (insecure attachment) to their own parental figures, there may be more likelihood to a longer length of time with bereavement (Forte, 2007). According to the psychodynamic perspective, grief is the socially shaped emotional response to the disruption in the relationship between the loved one lost and the self. Focus should be in helping the person develop a new self-concept and the feeling of belonging in relationships with others (Forte, 2007). This also relates to the concept of *meaning making*, which is a central tenant to the healing process of the bereaved person of suicide and stigmatized loss. Interventions assist the survivor in working through the circular stages of grief, identifying a new way of remembering and maintaining a relationship with the deceased, and helping the person move forward out of being “stuck”.

The Ecological perspective provides a dual focus of both the person and their environment and how there is unpredictability within the environment throughout one’s life

course. The focal system is both the identified person and the relevant aspects of the environment. Factors such as race, culture, ethnicity, etc. influence “transactions” within the environment and result in non-uniform, or individualized, pathways to human development. One assumption of this theory is that individuals interact with many environmental contexts over the lifespan and behavior evolves as it relates to the interactions within their environment. For survivors of suicide, environmental factors include (but not limited to) other extended family members, friends, colleagues, those with whom they interact in the community, and the varied societal view of suicide toward the person who died and those immediate family members of the deceased. This is significant in determining how one may develop coping strategies concerning the loss of a loved one. Stigma can play a factor in determining whether one may attempt to access community environmental supports. Bereaved individuals, as it relates to suicide, often turn toward isolation due to their not feeling anyone understands what they are going through, not wanting to make others uncomfortable, and often feeling judged by others (Forte, 2007). Stigma is very much associated with our culture and how we interact within it. In most societies, suicide goes against the cultural norm and much blame is often placed upon the survivors. This places a great deal of influence on how one personally reacts to the loss, as well as, how the survivor interacts within the environment.

Given the strengths associated with the theories in how people develop coping strategies on an individual basis associated with their form of attachment, this conceptual framework contributed to the development of the survey schedule. Another contributing context includes the environmental, or ecological, contexts associated with the norms of one’s culture and how this affects the grieving process.

Methods

Research Design

The research design for this study is exploratory and qualitative in nature. Surveys with survivors of suicide in a support group atmosphere looked to obtain perspectives associated with potential stigma of the suicide survivor, the deceased individual and perceived support from others after the loss. Survey questions looked to assess the impact suicide has made between the individual and their lost one, the survivor in relation to others, and the impact suicide has had on their view of the world.

Sampling

Purposive sampling was used to select a sample from the larger population of adult men and women who have lost a loved one specifically through suicide. This type of sample is when researchers use their special knowledge or expertise about some group to select subjects who will represent the population. Subjects are selected to ensure that certain types of individuals or persons displaying certain attributes are included in the study and are asked to respond to questionnaire material (Berg, 2009). The criterion to participate in this study included the individual being a participating member of a support group for adults that have lost someone through suicide. Support groups were located within the Twin Cities area and took place in non-clinical destinations (i.e. hospitals and clinics) and had at least one group facilitator. Permission was obtained from the group facilitator who discussed the survey with members to inquire interest in completing the survey. The surveys were left in an envelope for the facilitator prior to the group and administered before or after the group had its' session. Upon completion, the facilitator sealed the envelope and contact the researcher to pick up the completed surveys after

group had disseminated to ensure confidentiality. The sample size for this survey consisted of 25 individuals from 3 suicide support groups throughout the Twin Cities.

Sample

A total of 25 people from three different suicide support groups in the Twin Cities metro area completed a survey which consisted of 20 questions (with one question being optional). Two of the surveys were mailed to the facilitators of one group and picked up by this researcher after one support group had ended. Otherwise, all surveys were completed at the beginning of the support group under the guidance of the facilitator and a coordinated pick-up date was made between this researcher and group facilitators. The participants who completed the surveys were all members of a support group and had lost a loved one to suicide. The surveys were given to the various groups between February and March of 2013. Survey participants answered brief background information, following with four questions relating to the individuals Relationship to the Suicide, seven questions regarding Relationship to Others, and five questions associated to their Relationship to Self and the World. A theme was identified when two or more participants were in agreement or made similar statements to a particular question. Throughout this section, statements written by various participants were italicized to clarify results.

Protection of Human Subjects

Potential participants were provided information about the survey, including background information, procedures, risks, benefits, confidentiality, anonymity, and contact information of the researcher and research chair. Participants in the survey were provided with the research questions in advance before making a decision to participate. These participants were able to

withdraw from the study without penalty. A statement of consent was given to the potential participant to sign with agreement to take part in the study (see Appendix A). The data received was kept in a secure facility to ensure participant's confidentiality and all data stored on a computer was protected by a password. No identifying information about the participant and the support group in which they belong was used in the final paper or presentation. All surveys and any possible identifying information obtained will be destroyed on May 31, 2013. Each support group was given a pseudonym to maintain confidentiality.

Instrument

The survey consisted of nineteen questions (see Appendix C); four demographical or background questions, fourteen questions that examined key themes discussed in the conceptual framework and literature review, and one optional open question. Demographical information consisted of: age, gender, how long a survivor of suicide, and number of losses to suicide. Four questions asked the participant to identify their feelings regarding the loss of their loved one. Seven questions focused on identifying perception to their relationship with others. Three final questions focused on the individual's perception toward the relationship between one's self and the world. The final question allowed for individual reflection and was optional. Questions were reviewed by committee members to increase their validity.

Data Collection

The data for this study was generated through participant responses to a structured survey using Likert scale and open-ended questions. Survey questions were developed by the researcher, as well as through information obtained through questionnaire developed by Dunn and Morrish-Vidners, (1987). These questions were based on themes developed through the conceptual

frameworks and literature review associated with individual's own sense of loss, their sense of support and isolation through the grieving process, and how the individual experiences every-day relationships after losing a loved one to suicide.

Data collection will include the following steps:

1. The researcher and committee members developed a list of community suicide grief support groups in the Twin Cities area.
2. The researcher contacted each potential group facilitators to invite participation and introduce them to the study. Researcher provided them with a consent form and a list of the questions for the survey. One letter of consent was signed by the group facilitator identifying group members of that particular group have agreed to participate.
3. The researcher communicated and coordinated with the group facilitator a plan to drop off survey to be completed by group members over a 2-4 week timeframe and retrieve surveys in an envelope sealed by the facilitator after the support group has ended and members are not observed. The researcher made sure not to visit the facilitator at a time before or after the group's usual meeting time.
4. Information was analyzed and kept confidential in a locked file box at the residence of the researcher. On May 31, 2013, all surveys will be destroyed by the researcher.

Data Analysis

Content analysis was used to interpret data obtained through the survey material. According to Berg (2009), this form of analysis includes careful, detailed, and systematic examination and interpretation of a particular body of work to identify themes, patterns, and meanings. Material was sorted using open coding to identify similar themes, phrases, and meanings that are established.

Strengths and Limitations

Participants from four different support groups were asked to complete the survey. Initially four were scheduled to participate; however, one did not participate. Although 25 surveys were completed and a significant amount of data was collected from these responses, more surveys were hoped to be completed. Although it is hoped a diverse population of individuals will agree to complete the survey, it remains to be a smaller sampling and may not be an accurate representation of other demographic areas throughout the United States.

A limitation to this survey is that those completing the survey have, through their engagement in a support group, come to a point in their healing to seek outside support. Although it may be in varied degree, the individual in a support group appears to be open to engaging in a form of support outside the immediate family.

Results/Findings

Findings include results obtained from three of the four designated groups. One group could not be reached despite numerous contact attempts.

Findings

The purpose of this research project was to identify how stigma may affect an individual who has lost someone to suicide and determine variables affecting their seeking support. This study also attempted to gain insight into the feelings and perceptions associated toward the individual that died and the extent to which these feelings were expressed. In addition to this, the study looked at the person in their environment in exploring cultural/environmental attitudes toward suicide and how this may have influenced their wanting to speak to others about their loss. Finally, this study attempted to look at how the individual's loss has affected the perception of their relationship to the world, or "life view" and what recommendations can be made to social workers and helping professionals in helping those who have lost a loved one to suicide.

Background Information

Seventeen women and eight men ranging in ages 18-76 participated and completed surveys. Group members were also asked to identify the length of time since their loved one had passed. Responses ranged from three weeks to twenty one years and were divided into four categories: Those having lost someone between 1 week-3 months totaled 7 respondents. Those between 4 -12 months totaled 5 respondents. Those having lost someone 18 months-5 years totaled 9 respondent and 5 + years totaled 6 respondents. Six individuals also identified having lost more than one person to suicide.

Relationship To The Suicide

Research has discussed various feelings (i.e. anger, guilt, blame, acceptance, confusion, sadness) identified by those individuals that have lost someone to suicide. Participants in the survey were asked to recognize these feelings that may have arisen since their loss and identify those that were described as dominant

Dominant Feelings

Although most individuals identified more than one feeling in working through the grief process, the feelings respondents mostly identified with at this time were those of sadness (22 respondents) and confusion (14 respondents). Other feelings associated with their loss but not as prevalent include guilt, anger, acceptance, and relief. Two individuals identified feeling *other* emotions including their own increased anxiety and wondering “did I do enough?” Another identified a “heightened sense of empathy toward people that seem depressed”.

Expression of Feelings

Within this part of the survey, participants were then asked to rate how they managed their feelings through answering the question “Did you mostly keep these feelings to yourself or had you been able to express them to others?”. Most respondents identified being able to *occasionally* (15) and *often* (10) discuss their loss with others. This appears to have been impacted by the nature of the loss and their openness to discuss this with others. The following written responses by participants highlight this emerging theme:

“I would not have been as angry had it happened by a natural death. I wouldn’t be as angry and would be more able to accept the loss were it an accident or a disease.”

“I would be able to express and talk about it and not feel so guilty.”

“I would feel like I could relate to others and feel like other people understood my specific feelings.”

“I think it would be easier for others to understand.”

“I probably would have been more open about my feelings.”

“Other people don’t understand suicide. If there was an illness, I would have been cradled, comforted, and pitied. Now, no one knows how to act, so they just leave me alone by myself.”

“I think I would be more open to others and them to me.”

“Less stigma would lead to more openness on my part. I would let others in.”

Perceptions

Those participating in the survey were then asked to consider whether their perceptions of the person they lost to suicide changed given the nature of the death and if this was attributed to stigma by answering the question “Have your perceptions of the person you lost changed because of the suicide or do you feel they have changed? If so, do you attribute this to the stigma often associated with suicide?” Respondent’s perceptions of their loved ones did not appear to have changed; however, if any changed did occur, this was not influenced by stigma.

In the two identified cases of their perceptions having changed, this was attributed to the *frustration* that was experienced in that they did not realize the extent to how badly the individual had been feeling and that outside help had not been sought. Several participants looked at depression as an illness and having a sense of not understanding or realize the depth of the person's pain prior to their death, as illustrated in the following responses:

"I did not feel stigma. His death was the same as a 'normal' death."

"Same. I feel his death was a result of depression-a disease. I don't feel stigma."

"I feel the same either way. He was suffering and wanted relief-perhaps like cancer. Depression is an illness."

"Stigma, No. I'm really sorry I didn't know his pain."

"I feel the same amount of love for him. No stigma."

"Same, no change". "Don't attribute it to stigma, but didn't know he was suicidal."

"I love him as much as ever and can't be angry with him."

"I don't think differently of him, but more understand depression. It's an illness."

Relationship to Other

Participants were next asked to explore their perceptions of how others have responded to their loss by determining the level of support received after the loss. The majority of respondents

identified responses by others as having been *supportive* (18) or helpful with three identifying responses as not having been helpful. Four individuals did not reply to this question.

Relatedness and Feeling Heard

Dunn and Morrish-Vidners (1987); and Jordan (2011) discuss feelings of isolation, rejection, and abandonment from others after experiencing a loss by suicide. Survivors often discuss feeling as though other who have not experiences this type of loss have a limited ability to understand or respond to their needs in a meaningful way. This may increase the likelihood to seek out support in an attempt toward self-protection as well as not putting others in an uncomfortable position.

A theme that emerged with responses being helpful include feeling most understood by those individuals that had gone through *similar experiences* to them or hearing comments made by those that knew the individual who had died. This is found in the following comments:

“Finding a support group is the best because they understand me. There are people that have gone further down the road and hold your hand to help you get through it. There are also new ones that, sadly, you feel you can help them.”

“Only those who can relate a similar experience.”

“I have found some that have gone through similar experiences.”

“Personal comments about my brother if they knew him when he was alive.”

“People in the support group have understood and helped me understand mental illness.”

“When people tell me of their loss (suicide or other) and try to relate to my grief.”

Participants also identified responses as being helpful when they felt as though they were *being listened to*.

“Someone who really listens.”

“Someone who doesn’t judge.”

“Someone who doesn’t judge and tries to understand how hard it’s been.”

What four respondents expressed as *not* being helpful to them is when they were speaking with others and responded to in ways they felt were “cliché” or not feeling as though people were really listening to them. When this occurred, there was a tendency to *emotionally “shut down”*.

Feeling of Blame

According to the research, the sense of blame towards self and by others is a common feeling associated with the grieving process. Those individuals that have lost someone close to them by suicide often feel as though others are judging them negatively or the person often tends to feel a sense of blame for the loss. As a result of this perception, these individuals tend to isolate more and pull away from groups or individuals that would like to be supportive (Dunn and Morrish-Vidners, 1987). This was explored in the survey when participants were asked to answer Likert-scale questions “Have you felt a sense of blame by others?” And “Do you feel a sense of blame toward yourself?”

The majority of participants surveyed did *not* feel a sense of blame by *others* for their loss; however more appeared to most often feel a sense of blame toward *themselves* (16). Two individuals identified “always” feeling sense of blame toward themselves, adding additional comments of “I should have known” or “why didn’t I know”.

Respondents to the survey also predominantly identified *sometimes* (15) feeling as though others now saw them differently since the suicide of their loved one as indicated by the following responses:

“Others who have experienced a suicide death do see me more like them.”

“People talk about suicide in hushed voices-either that or not talking. How he died should not affect how my friends view me, but sometimes it does. Stigma.”

Societal Views of Suicide

As the research previously indicated, death that occurs by suicide is not typically discussed as openly as those by natural causes (Dunn & Morrish-Vidners, 1987). Perceptions of support group members were requested in attempting to further gain cultural/environmental attitudes of suicide and how this may have affected their grieving process. The question “*Would you say your situation could have been made more tolerable by changes in society?*” was asked to explore this further.

Understanding of Mental Illness. Most (16) of the participants identified that their situation could have been made more tolerable if changes in society occurred (attitudes, culture, etc.). A theme that emerged from participant response to this was a general feeling of our

culture's misunderstanding or ignorance of depression, suicide, and mental illness, as indicated by the following quotes:

"I believe people are ignorant of the causes and the fact it is not typically a 'choice.'

"20 years ago, people didn't understand depression as much as now. Felt it was a sign of weakness."

"Most people think it was a choice. They do not understand it was not a choice a mentally healthy person would have made."

"If people understood mental illness more, they would understand his brain got sick and broke and that you can die from depression."

"Perhaps more suicide awareness and prevention. People tend to whisper about suicide."

"There are so many casual references to killing oneself."

"Suicide scares people and they run away and hide from it."

"I think there have been changes in the past 20 years that would have alleviated my suffering."

"NAMI and SAVE have worked hard to create changes, but I think we have a long way to go."

Relationship to Self and The World

The final part of the survey involved three questions around how participants view the world after losing a person to suicide. The first question asked participants to identify via Likert-scale whether their loss had affected the way in which they view themselves. The majority of participants felt as though the experience of losing a loved one to suicide has changed the way they view themselves.

Changed Outlook on Life

A common theme that emerged from the responses to this question includes participant's more dominantly constructive outlook on life. An acknowledgement of life's fragility, redefining what is important, and a desire to help others was often described by others. Several respondents identified an appreciation for each day and being aware of other's feelings, as evidenced by the following quotes:

"Life is short. Some people take a lifetime to educate."

"I am now more tolerant and reserved of others. I don't see myself as right about so many things."

"A lot of things don't seem as important now."

"I wonder about doing things differently and reaching out to others."

"I am more accepting of other persons and their problems."

"I look at life in such a different way. I'm grateful for each day."

“I try to enjoy my world more. Life is precious.”

“This experience has changed my life in so many ways. Everything from how I appreciate each day I’m given to the people I know and the volunteer activities I spend time on.”

Life View

The experience of losing a loved one to suicide appears to affect or change the way in which an individual sees the world, or their “life view”. A theme that emerged similar to the responses to the previous question identified the *fragility of life* and three individuals identified a *stronger religious faith* after the experience.

“I have a much stronger Christian faith as a result.”

“Closer to God.”

“Life is precious and short. Pay attention to your family and friends.”

“The world is such a fragile place. Life and happiness are fleeting and uncertain.”

“You never know.”

“Look at what is and what isn’t important.”

Feeling Heard By Others

This survey was conducted to ask individuals who have experienced this type of loss to identify what has been helpful to them in working through the grieving process and what they feel are barriers to working through their grief. The final survey question asked participants to identify what the professionals can do to assist people who have lost someone to suicide. One theme that emerged from participants is the *importance of feeling heard* by those that are trying to help them and *not feeling judged* by them.

“Listen without judgment. Also, devise questions that will pull it out of people.”

“Listen to the strong and be sensitive to the weak.”

“Don’t judge or say a person will “get over it”. Realize it’s a complex process and on-going.”

“Be gentle.”

“Don’t always medicate. Compassion, listen, educate, pray, attentive treatment. It takes a long time!”

“Walking up Mt Everest with a backpack full of rocks. Hard. Shakes your world and sense of reliability in it. Sometimes you are waiting for the other shoe to drop in many other things.”

Comparing Loss To A Natural Death

Several respondents to the survey identified a desire to not have their loss compared to that of a death that occurs naturally and for those that do want to help people who have lost a

loved one by suicide to gain an understanding of the mental illness, the impact it has on a person's life and being able/willing to have a discussion about it. This is evident in the following responses:

“Equate depression/mental illness to other physical ailments (like cancer). It is not a choice!”

“I am a helping professional so I knew I needed to get my own help and to have boundaries with my patients.”

“Get more education about suicide.”

“Don't compare us to your loss of a parent or grandparent!”

“Find a group! Help them remember their loved one. Bring pictures to sessions. Help them know they are not alone.”

“There needs to be additional support for extended family members. It is difficult to get connected to other survivors.”

“I think suicide is the hardest to accept. There is no closure.”

“Help them acknowledge the person beyond the suicide. Don't shy away from suicide and acknowledge the loss this way.”

Discussion

This survey looked to examine various aspects of the grief cycle following the loss of a loved one to suicide. Dimensions of this survey included demographic information of those in the Twin Cities area and looked at relational aspects of the individual's feelings and perceptions toward the individual who died, feelings and perceptions an individual may have toward themselves and how others perceive them, and the impact suicide has on one's relationship to the world or "life view".

As previously indicated, there are many emotions that arise from grieving the loss of someone through both natural and other ways. As indicated by this survey, dominant feelings associated for those having lost someone to suicide appear to be sadness and confusion about the loss. Those participating in the support group often felt as though they were able to discuss their feelings with others most of the time. Talking to someone with similar experiences allowed for feeling more understood and an increased ability to open up about their loss. However, this may not be as apparent for those not involved in a support group and future study may look to see what factors led to those attending the group to initiate their participation in it.

Also, perceptions the person had toward the loved one predominantly did not change, although how they felt they were perceived by others appeared to be the most dominant. This contributed to the difficulty associated with seeking out help from others. Stigma did not appear to be a contributing factor in how the individual perceived their lost one, however, it did appear to affect how they felt they were perceived by others. This also contributed to the degree of openness to disclose with others who did not share experiences similar to their own.

Most individuals in the study did not identify with a negative view of the world or their relationship in it. For most, their life-view was impacted in a more spiritual manner and many found a stronger connection to faith, spirituality, or religion. Many acknowledged feeling the uncertainty and fragility of life while not taking day-to-day experiences for granted. There also appeared to be a value shift concerning the degree of importance placed toward things outside the relationship with one's family.

Limitations and Recommendations for Future Research

This research study was conducted through suicide support group member's completion of a survey. Originally, four support group facilitators had agreed to share this survey with support group members; however, despite numerous contact attempts, only three groups participated. This was a limitation in and of itself due to group members having already identified a need to seek out additional support. Members were actively participating in a support group in which they had similar experiences, were openly encouraged to express themselves, and received a high level of support from other group members. Finding a larger scope of individuals to either survey or complete in-depth interviews may also further contribute to gaining information. Additional study on suicide, stigma, and the implications on survivors may benefit by obtaining information from individuals not associated with a suicide support group and identifying barriers that inhibit seeking support.

Research may also look toward assessing if gender differences are associated with openness to seek out help and whether the amount of time after the loss impacts help-seeking. More information could be obtained through individual interviews of family members, in

addition to interviews with facilitators or therapists who work with those who have lost someone to suicide.

Implications for Social Work

This research is valuable to the field of social work in that it gives a small glimpse into how the loss of a loved one through suicide impacts the lives of family members or friends and how stigma may or may not affect those having lost someone. It is an attempt to give those individuals voice to some of the feelings associated with their loss and elicit factors that contribute to beginning the healing process. This also begins to identify those interventions that may be useful in working with those close to individuals whom have died by suicide. It is also useful in identifying what is not useful and can be avoided.

The implications of this research can be extended from the micro level to the mezzo, and macro levels, as well. For instance, a community with a greater understanding of depression and mental health in general will more likely be able to serve individuals and their families by providing resources and possibly having a higher likelihood of families willing to access them. It is hoped, as well, that mental health services would be expanded or more properly funded. On a macro level, it is hoped that education around mental health can influence how it is portrayed in our media and affect funding decisions on a stated and national level.

Although it has improved somewhat over the last twenty years, it appears there continues to be a lack of understanding around depression and mental illness in our culture. For someone who has lost someone to suicide, this appears to impact the ability to understand the depth of pain/difficulty endured by the individual. This also impacts the degree to which an individual

may feel understood by others if they have not shared a similar experience. This lack of understanding about mental illness that is felt may inhibit the ability to talk about their experience. Not being understood, and possibly feeling judged or blamed by others appear to be considerable barriers for individual's in seeking out help. An increased understanding of depression not being a choice and having more knowledge as to signs, symptoms and severity is needed.

Further research on the implications of unresolved grief (complicated bereavement) and the impact of this on subsequent losses, the impact on family dynamics, and medical/ health implications of unresolved grief would benefit from further study.

Conclusion

This research study identified several themes in beginning to understand the impact the loss of a loved one to suicide has on those close to them. Social work, through its' scope of practice, can assist in educating the public about mental illness, depression, and the prevalence of suicide. Taking into consideration the complexity of grieving this type of loss and understanding the impact it has on both survivors and society's perception will require further study. This research provides insight into important variables in working with those who have lost someone to suicide. This includes providing an environment for the person to feel safe, understood, and not judged. It is important for practitioners to listen intently and possibly reality test perceptions that may be held by survivors toward others. Also, facilitating suicide support groups where individuals can share and discuss with others experiences similar to others is of great benefit to them.

Those in the social work field (and helping profession) working with those who have suffered a stigmatized loss would benefit from continuing education on suicide, mental illness, and the impact it has on not only the person suffering from it, but for families that are trying to understand. Because losses of this type are often, but not always, associated with mental illness and are more complex in nature, it may be important for social work therapists not to compare this type of loss as similar to a naturally occurring death.

Because suicide appears to be on the rise and appears to be less discussed as openly as other types of loss, practitioners would be wise to pursue continued education to understand the grief process. This also includes the cultural aspects surrounding how our society views this and death in general. Ours is often a society of efficiency and getting things done quickly and this goes against the ambiguous and complicated nature of suicide. Understanding the complex and circular nature of grieving a loss of this type is important to normalize feelings and decrease the sense of isolation that is common for those trying to heal. This presents social workers with an opportunity to help those grieving suicide on a personal level. In addition, this field can, and has an obligation, to educate the community on mental illness and work to develop policy changes on a societal level to decrease the stigma associated with suicide and pass legislation to make mental health services more available to everyone.

Appendix A

To whom it may concern:

I am writing to acknowledge our group's support of Ann Brosnan's clinical research project: Stigmatized Loss and Suicide. I give Ann Brosnan permission to conduct research members of our suicide support group by inviting them to anonymously complete a survey prior to the start of our support group meeting. The group facilitator will notify group members of the survey and its' intended purpose prior to their scheduled meeting and Ann Brosnan will drop off surveys to the facilitator a day before the group is scheduled for purposes of maintaining membership confidentiality. At the beginning of the support group meeting, the facilitator will read a script written by Ann Brosnan further describing the study and its' intended purpose and thanking participants for taking the time to complete the survey. After the surveys are completed, the group facilitator will place them in a large envelope and seal it. The following day, Ann Brosnan will meet the group facilitator and collect the completed surveys for analysis. These surveys will be used to gain further insight and understanding of how the stigma of suicide affects loved ones of those lost in this manner.

I understand that Ann Brosnan will be keeping the surveys and coding material in a locked file cabinet and will destroy all information upon completion of the research project, which will occur on June 30th, 2013. I understand that our support group members will make their own decisions regarding whether to complete the survey and will not affect their membership in the support group.

I understand that this study will not proceed until it has been approved by Ann Brosnan's clinical research committee and the Institutional Review Board at St. Catherine University. I am aware that this research is part of her clinical research paper, which will be published and presented to the public in May 2013. All reports of this research will be done in a manner that protects the confidentiality of the participants in our support group.

I understand that there are no anticipated risks to our organization and that risk to study participants is minimal, however, it is acknowledged that the sensitive nature of this topic may trigger grief associated with member's loss. Group facilitator and support group members will be there to address and process such emotions. I understand that expected benefits of this research includes a better understanding of how stigma affects the grief process and assist practitioners in reducing this in their practice.

Sincerely,

Ann Brosnan

Appendix B

Dear participants:

My name is Ann Brosnan and I am an MSW graduate student at the College of St Catherine/St. Thomas University completing my clinical research project. I would like to take this opportunity to offer my condolences to each of you and thank you very much for taking the time to complete this survey.

The focus of my research project is to examine whether stigma has played a role in how those that have lost someone to suicide have sought support. I am also looking at whether the stigma of suicide and cultural/environmental attitudes toward suicide affect an individual's self-concept, world view, and how they are viewed by others. I am hoping this might be an opportunity to voice your varied experiences through the grief process. It is hoped that through this research, the field of social work can gain a better understanding of the grief process and help people begin to heal.

Please complete as much as you can of the survey. If there are some questions you cannot answer at this time, that is ok. Any information you give is greatly appreciated.

Thank you again,

Ann Brosnan

Appendix C: Survey

Please respond to the following questions:

*(Please note, you may skip a question if you feel you cannot answer it at this time).

1. Background

- How old are you? _____
- What is your gender?
- How much time has passed since the loss of your loved one? _____
- Have you lost more than one person to suicide? _____

2. Relationship to the suicide

- People work through their grief in different ways and there are many feelings associated with this. How do you describe dominant feelings toward your loss at this time?

___ anger ___ guilt confusion___
 ___ sadness ___ acceptance relief ___
 ___ Other? Please explain.

- Prior to this support group, did you mostly keep these feelings to yourself or had you been able to express them to others?

Kept to Myself	Occasionally to Others	Often to Others	Always to Others
----------------	------------------------	-----------------	------------------

1

2

3

4

- How do you think the way you expressed your feelings would be different if your loved one had died in a different way?

- How have your perceptions of the person you lost changed in any way because of the suicide or do you feel they have not changed?

2 Relationship to other

- How do you feel others have responded to your loss?

Supportive	Somewhat supportive	Often Supportive	Always Supportive
1	2	3	4

- Have you had difficulty speaking with others about your experience? How so?

- Have there been responses that have been helpful? How so?

- Have you felt a sense of blame by others in any way for the suicide?

Never	Sometimes	Often	Always
1	2	3	4

- Do you feel a sense of blame toward yourself in any way for the suicide?

Never	Sometimes	Often	Always
1	2	3	4

- Do you feel people see you differently because of the suicide?

Never	Sometimes	Often	Always
1	2	3	4

- Would you say your situation could have been made more tolerable by changes in society (attitudes, culture, other institutions, etc.)?

Yes_____ No_____

Please describe.

3 Relationship to self and the world

- Would you say your experience has changed the way you view yourself?

Yes, totally	A great deal	Not much	Not at all
1	2	3	4

How so?

- Changed the way you view the world or “life view”?

Yes, totally	A great deal	Not much	Not at all
1	2	3	4

How so?

- How has your experience affected the way in which you view your loss?

4 Is there anything else you would like to add?

Thank you very much for your participation in this survey.

Appendix D

Script to Facilitators

Hello!

My name is Ann Brosnan and I am a graduate student in the MSW program at St. Catherine University and St. Thomas University in St. Paul. I am in my last year in the program and am in the process of creating/conducting my clinical research project that is a requirement for graduation.

A topic that has become very dear to me is looking at how stigma affects individuals who have lost someone close to them through suicide in seeking out support from others. I am looking at how this may affect a person's perception of the loss itself, how they may perceive themselves, as well as, in society. I believe developing a greater understanding of stigmatized loss will help me and other social work practitioners in working with our clients that have suffered loss and help them work through the bereavement process and begin to heal.

What I am looking to do is to contact various support group facilitators within the Twin Cities area and ask group facilitators to approach group members in suicide support groups to complete a survey asking questions related to these perceptions. I realize this is a very sensitive topic and participation is optional. Also, if some questions on the survey are too difficult to answer, these can be skipped. After the surveys have been distributed and completed, I ask that you place them in the sealed envelope provided and I will pick them up at a time of your choosing when group members are not around to protect their confidentiality. I can also be reached via cell phone at 651-442-7873 or via email at annmbrosnan@gmail.com.

I greatly appreciate your time and participation in my research. Please feel free to contact me at any time with any questions or concerns you may have.

Best regards,

Ann Brosnan

References

Arboleda-Florez, J. (2002). What causes stigma? *World Psychiatry, 1*, (1): 25-26.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489829>.

Armour, M. (2006). Violent death: understanding the context of traumatic and stigmatized grief.

Journal of Human Behavior in the Social Environment, 14, 53-89.

Baohui Zhang, M, El-Jawahri, B, & Prigerson, H. (2006) Update on bereavement research:

evidence-based guidelines for the diagnosis and treatment of complicated bereavement.

Journal of Palliative Medicine, 9, 1188-1202.

Begley, M. & Quayle, E. (2007). The lived experience of adults bereaved by suicide: a

phenomenological study. *Crisis, 28*, 26-34.

Berg, B. L. (2008). *Qualitative research methods for the social sciences*. Boston, MA: Allyn and

Bacon, 7th ed., (ISBN 0-205-31847-9).

Boss, P. (2006). *Loss, Trauma, and Resilience: Therapeutic Work with Ambiguous Loss*. New York,

N.Y: W.W. Norton & Company.

Brink, G. & Phelan, J. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363-

385.

Bryant, C. & Peck, D. (2009). Disenfranchised grief. In K.J.Doka, *The Encyclopedia of Death*

and the Human Experience. Retrieved from <http://go.galegroup.com>. 9/13/12.

Coping with complicated grief. (2011). *Harvard Mental Health Letter*. Document URL

http://go.galegroup.com/ps/i.do?id=GALE%7CA274038784&v=2.1&u=clic_stthomas&it=r&p=ITOF&sw=w. Retrieved 9/13/12.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59, (7), 614-625. DOI: 10.1037//0003-066X.59.7.614

Cvinar, J. (2005). Do suicide survivors suffer social stigma: a review of the literature.

Perspectives in Psychiatric Care, 41, 14-21.

Dunn, R., & Morrish-Vidners, D. (1987). The psychological and social experience of suicide survivors. *Omega: Journal of Death and Dying*, 18, 175-215.

Feigelman, W., Gorman, B., & Jordan, J. (2009) Stigmatization and suicide bereavement. *Death Studies*, 33, 591-608.

Forte, J.A. (2007). *Human Behavior and the Social Environment: Models, Metaphors, and Maps for Applying Theoretical Perspectives to Practice*. Thomson/Brooks/Cole.

Fowles, M. (1990). The social regulation of grief. *Sociological Forum*, 5, 635-652.

Hawton, K. (2007). Complicated grief after bereavement: psychological interventions may be effective. *British Medical Journal*, 334, 962-963.

Hawton, K. (2000). Sex and suicide: gender differences in suicidal behavior. *British Journal of*

Psychiatry, 177, 484-485

Johnson, J., First, M., Block, S., Vanderwerker, L., Zivin, K. & Zhang, B. (2009). Stigmatization and receptivity to mental health services among recently bereaved adults. *Death Studies*, 33, 691-711.

Jordan, J. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior*, 31, 91-101.

Mitchell, A., Kim, Y., Prigerson, H., & Mortimer-Stephens, M. (2004). Complicated grief in survivors of suicide. *Crisis*, 25, 12-18.

Parker-Pope, T. (2013, May). Suicide rates rise sharply in U.S. *The New York Times*. Retrieved from <http://www.nytimes.com>

Shear, M. & Mulhare, E. (2008). Complicated grief. *Psychiatric Anals*, 38, 662-670.

Walsh, F., & McGoldrick, M. (2004). *Living Beyond Loss: Death in the Family*, Second Edition. New York: W.W. Norton and Company.

Worden, W. (2009). *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner*, Fourth Edition. New York: Springer Publishing Company.

Yang, L., Kleinman, A., Link, B., Phelan, J., Lee, S., & Good, B. (2007). Culture and stigma: adding moral experience to stigma theory. *Social Science & Medicine*, 64, 1524-1535.

Zhang, B., El-Jawahri, A., & Prigerson, H. (2006). Update on bereavement research: evidence-based guidelines for the diagnosis and treatment of complicated bereavement. *Journal of Palliative Medicine, 9*, 1188-1202.