Barriers and Supports to Help-Seeking in Survivors of Suicide Loss

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Barriers and Supports to Help-Seeking in Survivors of Suicide Loss

By

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
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Master of Social Work

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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 nor a dissertation.
Abstract

Objective: The purpose of this study was to explore barriers and supports to help-seeking in survivors of suicide loss. Methods: An anonymous online survey containing both quantitative and qualitative questions was developed with the goal of obtaining preliminary data using a mixed-methods approach in specific areas such as, experienced grief reactions, stigma from suicide, helpful and unhelpful forms of support. Sample: A total of 791 individuals completed the line survey about the barriers and supports to help seeking in survivors of suicide loss. Female participants accounted for 93% of the sample (N=735), males accounted for 6% of participants (n=52), transgender (n=1) and agender (n=3) made up the remaining 1% Results: Survivors of suicide loss report multiple difficulties in navigating their grief. 99.5% of respondents experienced intrusive thoughts about the suicide to a moderate to high degree. The most significant grief reactions included Shock 98% (n=729/747), Unhappiness 95% (n=705/739), Disbelief 93% (n=659/747), Regret 92% (687/740), and Guilt 89% (n=665/747). The most helpful supports were peer who have experienced a loss from suicide 85% (n=460/541), and support groups specific to suicide loss 83% (n=387/468). Participants noted that the most helpful interactions with professionals were those where the professional was responsive to their needs and helped the survivor process the death. The most unhelpful interactions with professionals were those notes as being empathic failures and when the survivor felt blamed for the suicide.

Keywords: Survivors of suicide loss, help-seeking, grief, social work, complicated grief
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Barriers and Supports to Help Seeking Behaviors in Suicide Survivors

117 people die from suicide each day in the United States (AAS, 2015). The most recent data available reports 42,773 individuals lost their lives to suicide in 2014 (AAS, 2015). Men die from suicide at 4 times the rate of women (AAS, 2015). Suicide is the 2nd leading cause of death for individuals between the ages of 15-34 (AAS, 2014). Suicide disproportionately affects the Native Americans/Alaska native communities where suicide is the 8th leading cause of death across all ages (AAS, 2014). It is estimated that 90% of those who die from suicide had a diagnosable mental health condition and/or substance use disorder at the time of their death (AFSP, 2014). Depression is the most common psychiatric diagnosis associated with suicide accounting for at least 50% of known suicides (CDC, 2015). Recent research by Cerel, (as cited in Drapeau, & McIntosh, 2015) states that for every one person that dies from suicide 147 people are left to grieve and of these 147 individuals, 18 people experience significant difficulties in their lives due to their grief, the survivors of suicide loss.

The term survivor of suicide loss refers to the family and friends that are left behind after a loved one dies by suicide. Survivor defines the individuals who are left in the wake of suicide trying to navigate their grief with immense pain, unanswered questions, guilt, anger, and shame. There is a social stigma associated with suicide that compounds the difficult grieving process and ultimately this stigma can act as a barrier for many to seek the support they need. According to Cvinar: “Bereavement following suicide is further complicated by the societal perception that suicide is a failure by the victim and the family and ultimately society affixes blame for the loss on the survivors” (2005, p. 14).

Experiencing a death by suicide from an immediate family member increases the risk for suicide in the survivor anywhere from 2-10% (Qin, Agerbo, & Mortensen, 2005). With suicide
rates rising nearly 30% in the past 15 years, it is imperative that evidence based interventions are available to the survivors of suicide loss not only to assist this population in effectively integrating their grief but to also prevent future suicides from occurring (CDC, 2015). Currently, 60% of the mental health work force are clinically trained social workers (NASW, n.d.). With over 750,000 new survivors of suicide loss each year in the U.S alone it is crucial that social workers are prepared to intervene with this population (Drapeau, & McIntosh, 2015).

Only 29% of masters of social work (MSW) programs in the United States offer courses specific to suicide prevention, intervention, and postvention (Scott, 2015). Feldman and Freedenthal (2006) describe the responsibility of clinical social workers and the educational institutions entrusted in preparing them to intervene with clients experiencing suicidal thoughts, and/or a loss from suicide by stating:

“The social work Code of Ethics emphasizes that a social worker’s primary responsibility is to promote the well-being of clients and that the interests of the clients are primary. The preservation of human life clearly falls within this key ethical tenet...” (2006, p. 475).

The responsibilities set forth by the National Association of Social Workers Code of Ethics serve as a guideline to the profession; with the rising suicide rates in the United States there is a growing need for more professional support from social workers to be prepared in working with those left behind to grieve a death from suicide. Therefore, the goal of this research project is to provide insight into the grief experience of survivors of suicide loss by exploring the self-identified barriers and supports to help-seeking behaviors to assist social workers in best serving this population.
Literature Review

To fully understand the aspects of loss by suicide the literature reviewed will cover aspects of grief are different for survivors of suicide loss. Many survivors are faced with grief reactions specific to suicide loss such as stigma, a lack of social support, as well as aspects unique to loss by suicide such as, guilt, avoidance, anger, guilt and shame all of which can interfere with healing and lead to complicated grief (Prigerson et al., 1999). When complicated grief occurs survivors can benefit from intervention services specific for suicide survivors. Postvention is defined as the services targeted to “facilitate recovery after suicide and to prevent adverse outcomes including suicidal behavior” (Krysinska, & Andriessen, 2012, p.25). The lack of evidenced based postvention services for survivors can further complicate the grieving process for these individuals (McMnemy, Jordan, & Mitchell, 2008). Formal supports such as clinically trained social workers serve can serve survivors of suicide loss by obtaining formal training to intervene and being proactive in their approach to assisting this population.

Grief Reactions in Survivors of Suicide Loss

Most people will experience the death of a loved one in their lifetime. Grieving is a difficult experience to live through; for survivors of suicide loss their grief is compounded by additional variables relating to the way their loved one died. Emotional reactions to suicide include rumination over the death, avoidance of stimuli associated with the death, anxiety, depression, anger, feelings of hopelessness, shame, self-blame, and guilt (Feigelman and Fiegelman,2008; McMenamy, et al., 2008). Knowing the complications associated with grief after suicide researchers have identified a need for interventions specific to survivors of suicide loss (Mitchell, Gale, Garand, &Wesner, 2003). The difficulties expressed by survivors revolve around social aspects of grieving. Stigma around the manner of death often leaves survivors of
suicide loss feeling socially isolated and uncomfortable discussing the suicide with others (McMenamy, et. al., 2008).

Survivors receive less emotional and social support during their time of grieving than those who are bereaved by other manners of death (Mitchell, et. al., 2003). A pilot study conducted by McMenamy, Jordan and Mitchell (2008) explored the natural coping effort of 63 suicide survivors revealed 61% of the participants experienced moderate to severe levels decreased functioning in daily life, 73% stated that they felt guilty for not preventing the death, 55% endorsed trauma symptoms and nearly a quarter of the participants endorsed suicidal ideation. Social difficulties present within family systems as well following suicide, survivors report a lack of open communication among family members regarding the death caused by suicide (McMenamy, et. al, 2008). The social isolation and stigmatization experienced by suicide survivors’ correlates to an increased risk of mental health issues such major depression, post-traumatic stress disorder (PTSD) and Complicated Grief (CG) which are more common among this group of bereaved (Feigelman and Feigelman, 2008).

There is conflicting information in existing research regarding which individuals who are impacted the most as survivors. According to Mitchell, Kim, Prigerson, and Mortimer-Stephens (2004) survivors of suicide loss closely related to the deceased experience rates of complicated grief at twice the level as friends, coworkers and relatives. Individuals from the same study who developed complicated grief were almost 10 times more likely to have reported suicidal ideation 1 month after the death of their loved ones. In contrast, a study conducted by Cerel, Maple, Aldrich, and van de Venne (2013) found the familial relationship was unable to predict grief difficulties and the identification as a survivor. The authors conclude that individuals who identify as being very close to the deceased were impacted the most by the death regardless of
biological connection (Cerel, et al., 2013). Although death by suicide will impact a wide range of survivor’s previous research consistently identifies those with a close attachment to the deceased is the population most effected by the loss and these individuals have a significantly higher chance of developing complicated grief as a result.

**Stigma**

A defining characteristic of suicide bereavement is the impact of stigma in survivor of suicide loss’ grief experience. The word stigma has a variety of definitions and meanings depending on the source. The Merriam-Webster dictionary (n.d.) defines stigma as “a set of negative and often unfair beliefs that a society or group of people have about something; a mark of shame or discredit”. According to the U.S. Department of Health and Human Services publication *Mental Health: A Report of the Surgeon General* stigma is “manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance” (1999. Pg.6). The Surgeon General’s Report goes on to describe the impact of stigma by stating, “In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society” (1999. Pg.6). Stigma has also been categorized as real or perceived. Perceived stigma has been described as an individual’s assumption of social condemnation, in turn this self-stigmatization results in social isolation in an attempt to avoid social rejection (Feigelman, Gorman, & Jordan, 2009; Cvinar, 2005; Cerel, & Maple, 2014). Stigma is a central element of loss from suicide, whether it is real or perceived, stigma can be a critical barrier for survivors of suicide loss in accessing the social and formal supports needed on their journey to healing.

The historical stigmatization of suicide dates back centuries. In the middle ages bodies of suicide victims were often mutilated to the point of being unrecognizable by community
members in an attempt to “prevent the unleashing of wandering spirits from affecting the local community” (Cvinar, 2005, p.14). Survivors of suicide loss were often punished for the manner of death of their loved one, their possessions were seized and they were often forced to leave their communities left with nowhere to turn for support. Up until the 20th century many churches and cemeteries refused services to those who died by suicide. Modern day practices have changed in most religions, however stigmatized areas do still exist such as in the life insurance industry where death by suicide often voids the insurance policy more often than not (Cvinar, 2005). Although there have been many societal advances to alleviate the effects of stigma surrounding suicide, the effects can still be seen in modern times. Until recently condolence letters were not sent to families of United States military members that died by suicide in combat zones. President Barack Obama repealed the long-standing policy in 2011. In a moving statement president Obama incites:

“This issue is emotional, painful, and complicated, but these Americans served our nation bravely. They didn’t die because they were weak. And the fact that they didn’t get the help they needed must change. Our men and women in uniform have borne the incredible burden of our wars, and we need to do everything in our power to honor their service...” (Obama, 2011, para 2).

Stigma affects many individuals and pertains to situations in a variety of different ways. For the survivors of loss by suicide, stigma has a profound impact on their everyday lives. Modern stigmatization is often subtle, it can be manifested in blatant actions or statements inflicted on the survivor of suicide loss, as well as actions or statements that are omitted (Feigelman, Gorman, & Jordan, 2009). A quantitative study of 462 participants conducted by Feigelman, Gorman, and Jordan (2009), the researchers found that stigma was the strongest...
single correlate with grief difficulties and was significantly associated with suicidal thinking. Within the same survey the most frequently experienced negative reaction survivors of suicide loss experienced was avoidance, many thought people purposely avoided them due to the manner of death of their loved one.

In a review of the literature pertaining to the effects of social stigma on suicide loss survivors Cvinar concludes: “Stigma has a profound effect on the survivors and that stigma is attached uniquely to death from suicide” (2005, p. 20). The author goes on to discuss there is substantial proof that survivors feel more socially isolated and stigmatized than other mourners. Although significant progress has been made in bringing attention to mental health and substance use component that often precede a death from suicide. Survivors of suicide loss continue to experience the negative effects of stigma in their grieving process. The presence of stigma hinders the survivor’s ability to connect with others for social support and deters this group of individuals from seeking assistance from mental health professionals (Cerel, & Campbell, 2008).

**Complicated Grief**

Complicated grief (CG) is considered to be the result of the inability to navigate through grief towards healing (Prigerson et al., 1999). It is estimated that anywhere from 10-20% of individuals whom experience grief will develop CG. Symptoms of CG include: invasive thoughts of the death, longing for the deceased, inability to accept the loss, as well as persistent trauma symptoms (Prigerson et al., 1999). A quantitative study conducted by Mitchell, Kim, Prigerson, & Mortimer-Stefens (2004) explored the relationship between loss by suicide and complicated grief within one month of the death with a sample of 60 participant recruited from coroner’s offices, funeral homes, mental health and social service agencies. The results from this study conclude that 43.3% of those who completed the survey met the clinical criteria for
complicated grief. (Mitchell, et al., 2004). The authors conclude that relationship to the victim effects the incidence of CG, indicating that the closer the survivor was to the deceased the higher rate of incidence of complicated grief for example. Children of suicide victims met criteria for CG at a rate of 80%, spouses 77.8%, parents 66.7%, and siblings 57.1%, while distant family members were all below 20% (Mitchell et al., 2004). Although this study shows the significance relationship has in developing complicated grief it does not report the incidence of perceived closeness to the deceased of the extended family members whose rate of complicated grief was much lower that close family.

The incidence of complicated grief is believed to be higher among survivors of suicide loss as they receive limited social support to a stigmatized loss, and carry unique burdens such as guilt, shame, and rumination over why the death occurred, all of which contribute to CG (Sakinofsky, 2007). The risk of developing mental health issues such as CG, PTSD, and depression are deepened in instances of sudden violent death which is often the case in death by suicide (Mitchell et al., 2004; Sakinofsky, 2007). The difficulty of coping with a loss by suicide along with the hesitation to reach out for support, stigmatization and social isolation in this group of individuals suggests that interventions for suicide survivors should be targeted to their unique bereavement needs (Mitchell et al, 2004; McMenamy, Jordan, &Mitchell, 2008).

**Complicated Spiritual Grief**

In general, most religions until the recent century considered death by suicide an immoral sin. As an example, the Christian Church has viewed suicide as a crime, a type of murder that violated the one of the Ten Commandments in the Christian religion, ‘thou shall not kill’. Because of this, people have traditionally not talked about or acknowledged suicide, which poses difficulty for those bereaved by suicide (Maple, 2005). This type of historical stigmatization of
suicide from a religious viewpoint has resulted in misinformation and inaccuracies related to the modern religious views on suicide. The misinformation and inaccurate religious views of suicide create an environment that leaves survivors isolated and ashamed even though they were powerless to prevent the tragic event (USDHHS, 2001).

In times of turmoil many individuals turn to their spirituality in search of solace. Spiritual beliefs and practice aide in healthy coping with loss, reduced distress, and increased socialization. A cross-sectional study conducted by Burke, and Neimeyer (2014) investigated the multidimensional aspects of complicated spiritual grief (CSG) in 150 mourners who experienced traumatic loss. CSG is defined as “a spiritual crisis precipitated by traumatic loss which can violate mourners' basic assumptive worldviews” (Burke, & Neimeyer 2014, p. 259). The finding’s showed that survivors of suicide loss were at an increased risk for developing CSG secondary to CG. The authors state that bereaved who had difficulty in their grieving process often times developed “anger or distance from God and from their church, and wondered whether God abandoned them…” (Burke, & Neimeyer 2014, p. 260). These findings conclude that there is a need for clergy to address CSG in an educated compassionate manner especially with survivors of suicide loss (Burke, & Neimeyer 2014). Drescher and Foy (2010) address the difficulties faced by individuals whom experience traumatic death such as the case with suicide in an article aimed at providing psychoeducation to clergy about the traumatically bereaved. The authors discuss the important role clergy have in facilitating healing and positive religious coping to aide in healing process. There is an emphasis on eliminating stigma associated with suicide among clergy members and providing psychological first aid to the survivors to reduce the incidence of maladaptive religious coping and CSG (Drescher and Foy, 2010). The Christian religion has modified their view of suicide in recent years. Leaders in this faith are moving
towards the view that suicide is a result of a mental health condition not a deliberate act of self-murder (DHHS, 2001). Many survivors of suicide loss find comfort in their faith, the modifications of religious guidelines regarding suicide is a promising step in the right direction.

**Postvention**

The overall consensus in postvention research for survivors of suicide loss is that more research is needed, in that there is an overall lack of evidenced based support options for this unique group of individuals (Jordan & Mcmnemy, 2004; Feigelman & Feigelman, 2008; Cerel &Campbell, 2008; Mitchell et al., 2004; Szumilies &Kutcher, 2011; McKinnon &Chonody, 2014; Sveen &Walby, 2008; Schneider et al. 2011; Aguirre &Slater, 2010). A systematic review conducted by Szumilies and Kutcher (2011) was aimed at discovering which postvention programs had the results of reducing mental distress and grief symptoms in survivors which were empirically based. The authors identified only 16 studies that met criteria for being considered evidenced based. Szumilies and Kutcher (2011) concluded that only three methods of intervention showed promising results. These strategies include gatekeeper training for professionals in contact with survivors of suicide loss to increase their knowledge and skills in crisis intervention, active postvention where survivors received access to outreach services and information on how to access services shortly after the death, as well as support groups specific to suicide loss conducted by trained facilitators (Szumilies &Kutcher, 2011).

Although there were differences in opinions relating to the significance of suicide survivors verse survivors of other traumatic deaths, there was a common theme that suicide survivors may benefit from different forms of support than other groups (McMenamy, et. al, 2008). This is supported by research done by Feigelman and Feigelman (2008) who have concluded that suicide survivors attending generalized support groups often feel isolated from
the group because of the stigma surrounding the suicide. Alternatively, survivors report the opposite feeling in peer led support groups as they felt other survivors could offer a more genuine understanding.

The small numbers of studies that have been conducted relating to grief interventions for survivors of suicide loss have been limited in their results. Of those that exist, the literature is consistent in showing that survivors benefit from a group support setting and that most survivors report feeling isolated and unsure of how to handle the loss by suicide. Costantino and Sekula and Rubinstein (2001) evaluated the effectiveness of a survivor of suicide loss bereavement support group intervention model compared to a social support group intervention model, compared to a control group receiving no intervention with 60 survivors. The study measured the level of depression and social withdraw before and after the support groups met for eight weeks. The results showed a similar decrease in depression and an increase the group’s social interaction. The only result that showed to be statistically significant was the group which received no treatment, where the level of depression and social withdrawal stayed the same or increased.

The active postvention model (APM) sends trained peer counselor who are survivors of suicide loss along with a mental health professional to the scene of a suicide to assist the newly bereaved survivors of suicide loss. The professionals who facilitate this intervention have received training and have been successful in integrating their grief and have found meaning in being able to support of survivors of suicide loss (Campbell, 2006). Cerel and Campbell (2008) studied the effect of early intervention after a death by suicide in a retrospective review of crisis intervention centers in which they looked at admissions of individuals who had experienced loss by suicide. The results indicated 1,411 individuals who were provided information about
resources for suicide loss survivors immediately following a suicide sought professional help or resources forty-eight days earlier than the 335 who were not provided information about suicide in the early stages. Campbell (2011) followed up his research reporting the long term effects of the Active Postvention Model (APM), stating that Suicide survivors on average sought help within 39 days of outreach compared to the national average of 4.5 years for survivors who did not receive outreach. The APM is a promising intervention as it aligns with the evidence that the initial stages after loss by suicide are critical for the survivor in reducing the incidence of complicated grief and a major barrier most suicide survivors encounter after loss is not knowing how to access services (Campbell, 2011; Sakinofsky, 2007; McMenamy, et. al, 2008).

Need for Formal Support

Intervention with suicide survivors can come from many different areas in social work. The crisis worker can be faced with a patient with suicidal ideation who is also a suicide survivor, the therapist may be aiding a self-referred client through the grieving process, and some clinicians who have lost a patient to suicide, are confronted with not only becoming a survivor themselves but are also left with the task of communicating with the family members. Current estimates indicate that 72% to 88% of survivors of suicide loss indicate they are in need of professional assistance due to difficulties navigating their grief; with 60% of mental health professionals being clinically trained social workers it is imperative that these professionals are educated on the grief reactions specific to loss from suicide so they are prepared to respond to the survivors (Dyregov, 2002; Provini, Everett, & Pfeffer, 2000; NASW, n.d.).

Jordan et al. (2011) outline goals for social change to address barriers to seeking services by providing suicide survivors with the resources to find support shortly after the death of their loved one. The authors describe that first responders as well as mental health professionals who
have served the individual who has died can aide the survivor by initiating contact with the 
bereaved and providing information on where to access services. Although many survivors may 
by traumatized in the wake of a death from suicide, providing printed materials for survivors to 
access services at their own pace will aide in reducing barriers for this population (Jordan et al., 
2011).

Difficulties identified in grieving a loss by suicide stem from the unique features that 
often complicate the loss. Suicide survivors are at an increased risk for developing complicated 
grief as they often feel shame surrounding their loss, and difficulty reaching out for help 
(Feigelman, & Feigelman, 2008; Mitchell et. al., 2004). The lack of evidenced based 
postvention services for suicide survivors is worrisome for the individuals trying to navigate 
their grief (Szumilias, & Kutcher, 2011). McKinnon, & Chonody, describe how the initial 
reactions toward survivors from professionals can influence how survivors react to the trauma 
writing:

“Empathy, compassion, and non-judgmental communication in the immediate aftermath of a 
suicide create an atmosphere for those bereaved to feel supported. Ongoing supports that 
normalize the experience and offer healing strategies can facilitate the grief journey” (2014, p. 
244).

Professional social workers are facilitators of hope. It is a trademark of the profession and, in a 
community of individuals such as survivors of suicide loss who are in the depths of grief, hope is 
the lifeline they need.
Social Work Graduate Programs

Currently, only 29% of masters of social work (MSW) programs in the United States offer courses specific to suicide prevention, intervention, and postvention (Scott, 2015). The lack of curriculum specific to suicide prevention, intervention, and postvention was discussed in a teaching note published in the *Journal of Social Work Education* by Scott (2015) who conducted a pilot course on the topic in an MSW program. The articles findings are based on a pre-test post-test design where a questionnaire implemented before the course and after as well as feedback from the second year MSW students. According to Scott (2015) half of the students reported being comfortable with suicide risk assessment prior to taking the course with one third stating they were very uncomfortable with suicide risk assessment. The post course questionnaire concluded that after taking the course on suicide prevention, intervention, and postvention 100 percent of students felt comfortable with suicide risk assessment (Scott, 2015). Overall, the author stated that the course was seen as extremely helpful in clinical practice by the enrollees with a majority of the students questioning why this course was not required by all students completing the program (Scott, 2015).

Feldman and Freedenthal (2006) conducted a study of 598 social workers who had a minimum of an MSW degree regarding their views of suicide prevention and intervention curriculum in MSW programs. The study was conducted using a web based questionnaire and had a 22% percent response rate which limits the generalizability of its findings. Although the response rate was low, the sample size was large enough to obtain information regarding the future research needs and implications for social work education and practice. The results indicated that over 92% of social workers who responded have worked with suicidal clients, with 78% having done so within the last year (Feldman, &, Freedenthal, 2006). 79 percent of
respondents stated that their MSW program offered no coursework specific to suicide intervention and prevention and of the training received within MSW courses 76% stated that less than four hours total in their MSW education was dedicated to the topic (Feldman, & Freedenthal, 2006). The essence of the information received from Master’s level social workers is that they did not feel prepared by their educational institutions to work with suicidal clients upon graduation.

Summary

It is evident from reviewing the literature on survivor of suicide loss that there is a need for trained professionals to assist this population and promote healing. The grief reactions that are uniquely attached to a loss from suicide including stigma, social isolation, self-blame, and guilt create difficulties in navigating grief. The lack of evidence based interventions adds to the complications survivors encounter. The goal of the current research is to further explore the barriers as well as the supports to help-seeking in survivors of suicide loss to determine how social worker can best serve this population. An anonymous online survey distributed to survivors of suicide loss contains both quantitative and qualitative responses in hope of obtaining a comprehensive understanding of the difficulties experienced by survivors of suicide loss in their grieving process.
Conceptual Framework

The framework selected for this project is the ecological model. The ecological model emphasizes the reciprocal relationship between a person and their environment (Gitterman, & Heller, 2011). The ecological model was chosen for this research project as it provides a comprehensive view of the difficulties faced by survivors of suicide loss internally, within their family and community, and within larger systems. The ecological model stresses the importance of examining the impact of deficient environmental transactions rather than individual behaviors (Gitterman, & Heller, 2011).

Common elements of the grief experience in survivors of suicide loss include emotional reactions such as shame, guilt, blame, and shock as well as, environmental factors including stigma, and lack of professional and social support. The principles of the ecological model broaden the interpretation of issues faced by survivors of suicide loss as it illuminates barriers and supports to adaptation for survivors of suicide loss in context of the larger environment. The models emphasis on the influence of social, cultural, and environmental factors that contribute to the individual’s well-being provides the social worker with a framework to explore intervention methods with multiple systems for survivors of suicide loss (Gitterman, & Germain, 2008).

Ecological Concepts

Key concepts from the ecological model used in the conceptualization and implementation of this project include, *coping, micro-systems, meso-systems, and macro-systems.*
As defined in the ecological model *Coping* refers to “Behavioral and cognitive measures to change some aspect of oneself, the environment, the exchanges between them, or all three in order to manage negative feelings aroused” (Gitterman, & Germain, p. 16, 2008). The concept of coping was used in this project to explore literature on elements of coping in survivors of suicide loss. Survey questions were designed to illustrate coping measures used by survivors and their perceived effectiveness.

*Micro-systems* include the individual and their interpretation of their experiences with their immediate environment (Forte, 2007). In this project survey questions were designed to explore informal supports used by survivors of suicide loss such as family and friends, the impact of negative social interactions, and the emotional response of the survivor.

*Meso-system* is the interaction between an individual and two or more settings (Forte, 2007). For this project meso-systems of survivors of suicide loss include interactions between the survivors and formal supports such as, mental health professionals, clergy, police officers, and medical professionals. Questions on the survey were designed to elicit responses regarding which formal supports were utilized by the survivors and the quality of interactions between the survivor of suicide loss and formal supports.

*Macro-systems* are responses and patterns of a cultures social context (Forte, 2007). For this project macro-systems were explored in the literature review and in the questionnaire. Questions on the survey pertained to the effects of stigma on the survivor’s grief experience and informal supports utilized by survivors such as advocating for suicide prevention and suicide survivors.
Methods

Research Design

The research design selected for this study was a concurrent mixed methods approach (Creswell, 2009). The mixed methods approach was chosen to expand on what is already known by providing a comprehensive understanding through the integration of both quantitative and qualitative data within a single sample of the barriers and supports to help-seeking encountered by survivors of suicide loss. The quantitative data was aimed at providing a foundation for interpreting the impact of suicide on the survivors while the qualitative data aides in completing the story of the grief experience of the survivors of suicide loss.

Instrument

An online survey was created by the researcher consisting of twenty-nine questions with a majority being quantitative in nature (Appendix A). There were five qualitative questions asked within the survey to help support the quantitative data obtained. The first five questions of the survey focus on demographic information such as sex, age, relationship to the deceased, length of time since death occurred, and grief support already received. The remaining quantitative questions were developed through the lens of the Ecological model were aimed at discovering barriers (psychological, social, and societal difficulties) as well as supports (formal and informal supports utilized). Most quantitative questions used a 5 point Likert scale (1= Not at all/very unhelpful to 5= a great deal/ very helpful) addressed barriers and supports to help seeking behaviors in suicide survivors. Five open ended questions were included in the survey to discover the most significant barriers encountered by survivors, what they believed to be the
most helpful and unhelpful aspect of their interactions with formal supports as well as, survivors opinion on how professionals best assist this population.

**Data Collection**

Recruitment for this research study took place first via identifying survivors of suicide loss outreach organizations. Multiple organizations were identified and a request for participation in the research project was submitted to the leadership of each organization including a copy of the survey and the IRB approval letter for the research project. Three organizations agreed to participate, American Foundation for Suicide Prevention Greater Minnesota, Suicide Awareness Voices of Education (SAVE) and Alliance of Hope for Survivors of Suicide Loss. Once the organizations were identified the next step was to promote the survey via the organizations social media sites. A link to the survey including a brief description was made available on each organizations Facebook page. The survey was made available for 30 days and allowed participants to complete the survey at their own pace. After day 30 the link to the survey was disabled so evaluation of the responses could begin.

**Sample**

A convenience sample was obtained through the support of three suicide outreach organizations. The criteria for participants included only those individuals whom were over the age of 18 and had experienced the death of a loved one via suicide. There was not a predetermined sample size, the survey was made available for 30 days and the number of participants at the time of the survey closing determined the sample size. An evaluation was conducted of the survey responses and only those with a completion rate of 40% or more were
considered as part of the research data. Surveys that were partially completed (under 40%) were deleted from the data set.

**Protection of Human Subjects**

A final research proposal was submitted to St. Catherine University Institutional Review Board (IRB) and received approval before the data collection process began. Informed consent was provided to all participants electronically prior to completion the survey (Appendix B). The informed consent contains background information regarding the purpose of the study, researcher contact information, and procedures involved such as anonymity, time commitment, collection process, risks and benefits, and voluntary nature of the study. The participants will also be provided with information on when the data will be collected and analyzed. The participants will be aware that the records of this study will be kept confidential in a locked filing cabinet in my home office with all identifying information removed and the electronic copy of completed surveys will be secured in a password protected file on my computer and all records will be destroyed by June 1st, 2016. Participants will be supplied with the above information electronically on a single screen prior to beginning the survey. Consent will be given on this screen by participants in the form of a yes, “I agree to be in the study” or “No, I do not wish to continue in this study”. Due to the sensitive nature of the questions asked within the survey a list of resources specific to survivors of suicide loss was distributed on a screen before the survey began (Appendix C).

**Data Analysis**

The SPSS statistical analysis software was used to assist with the analysis of the quantitative data sets. A variety of statistical tests were used to analyze the data. To determine the correlation between specific quantitative data the Pearson Correlation test was run. Chi
Square was also used in certain instances to determine the strength of association between variables.
Results

Quantitative

Sample. A total of 791 individuals completed the line survey about the barriers and supports to help seeking in survivors of suicide loss. Female participants accounted for 93% of the sample (N=735), males accounted for 6% of participants (n=52), transgender (n=1) and agender (an individual who does not identify as either male, female, or transgender) (n=3) made up the remaining 1% (Appendix B).

The age of participants was divided into 4 ranges (18-34, 35-54, 55-74 and 75+) with participants selecting the appropriate range according to their age at the time of survey completion. The 35 – 54-year-old range consisted of 53% of participants (N=422) which was the largest. The 55-74-year range made up 27% of participants (N=210), followed by 20% in the 18-34-year range (N=156), and the group of 75 years and older was the smallest with less than 1% (N=3).

Participants were also asked how long it had been since the death of their loved one. The multiple choice answers included ranges of less than a year, 1-5 years, 6-10 years and over 10 years. 55% of the participants (N=432) responded it had been 1-5 years since the death which is over half of all participants. Less than a year had 21% of respondents (N=167). The timeframe of 6-10 years (N=94) and over 10 years (N=98) each accounted for about 12% of the participants.

Much like the age demographic the relationship to the deceased had a clear majority with immediate family accounting for 80% of the responses (N=633). Extended family made up 11% (N=88), friends had 10& (N=81) and the category of other made up the remaining 8% (N=66).
Table 1 displays the results of whom survivors first came into contact with following the death of their loved one by suicide. A majority of the responses \((n=423, 53\%)\) indicated that police officers were the first professionals that survivors interacted with immediately after the death. All other professional categories were under ten percent with the exception of the “other” category \((n=166, 21\%)\).

<table>
<thead>
<tr>
<th>Professional</th>
<th>n/N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police Officer</td>
<td>423 (55%)</td>
</tr>
<tr>
<td>Paramedic</td>
<td>59 (8%)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>17 (2%)</td>
</tr>
<tr>
<td>Mental Health Professional</td>
<td>45 (6%)</td>
</tr>
<tr>
<td>Emergency Room Mental Health Staff</td>
<td>4 (1%)</td>
</tr>
<tr>
<td>Emergency Room Medical Staff</td>
<td>21 (3%)</td>
</tr>
<tr>
<td>Clergy</td>
<td>40 (5%)</td>
</tr>
<tr>
<td>Other</td>
<td>166 (21%)</td>
</tr>
</tbody>
</table>

16 participants of the survey did not respond to the type of first responder they first came into contact with.

Table 2 shows a summary of participant responses relating to grief reactions experienced and identified barriers to seeking help and support. The survey question related to grief reactions experienced had 14 different reactions which respondents had the option to answer to what extent they experienced the reaction after the loss by suicide. Of the 14 possible reactions nine of them showed that 75% or more of the time these reactions were experienced a moderate to a great deal of the time. Four of those reactions were experienced at a frequency of greater than 90%, shock (98%), unhappiness (95%), disbelief (93%) and regret (92%). Additionally, a moderate to great deal of guilt was experienced at a frequency of \(n=665\) (89%). The grief
reaction with the lowest frequency $n=102 (14\%)$ was the reaction of grief. The other reactions with low frequencies compared to a majority of the others included shame $n=349 (47\%)$ and rejection $n=376 (50\%)$.

<table>
<thead>
<tr>
<th>Grief Reactions</th>
<th>$n/N= (%)$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shame</td>
<td>349 (47%)</td>
</tr>
<tr>
<td>Guilt</td>
<td>665 (89%)</td>
</tr>
<tr>
<td>Resentment</td>
<td>436 (58%)</td>
</tr>
<tr>
<td>Shock</td>
<td>729 (98%)</td>
</tr>
<tr>
<td>Disbelief</td>
<td>659 (93%)</td>
</tr>
<tr>
<td>Anger</td>
<td>538 (72%)</td>
</tr>
<tr>
<td>Blame</td>
<td>561 (75%)</td>
</tr>
<tr>
<td>Loneliness</td>
<td>615 (82%)</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>572 (77%)</td>
</tr>
<tr>
<td>Helplessness</td>
<td>632 (85%)</td>
</tr>
<tr>
<td>Relief</td>
<td>102 (14%)</td>
</tr>
<tr>
<td>Rejection</td>
<td>376 (50%)</td>
</tr>
<tr>
<td>Unhappiness</td>
<td>705 (95%)</td>
</tr>
<tr>
<td>Regret</td>
<td>687 (92%)</td>
</tr>
</tbody>
</table>

The reported frequencies of responses to survey questions relating to potential barriers to help and support seeking by survivors of loss by suicide (Table 3) showed nearly 100% of respondents ($n=744 \ 99.5\%$) identified they think about the individual and circumstances surrounding the death by suicide a moderate to a great deal of the time. Over half of respondents experienced a moderate to a great deal of difficulty in discussing the circumstances of the death by suicide with others ($n=408, 55\%$). A majority of respondents indicated their social life has been negatively impacted by the death of their loved one by suicide ($n=488, 65\%$). Respondents who indicated their social life had been negatively impacted were asked if their social life improved over time. Under half of those respondents ($n=239, 39\%$) indicated they experienced moderate to a great deal of improvement. Just under half of respondents also indicated they have
experienced loved ones and people they cared about distancing themselves from them after the death of their loved by suicide ($n=322, 43\%$). Lastly, nearly three fourths of respondents identified they felt stigma related to suicide had a negative impact on their grieving process ($n=531, 71\%$).

<table>
<thead>
<tr>
<th><strong>Table 3</strong> Barriers to Seeking Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N=747</strong> Frequency of participants whom experienced barriers to seeking help and support a moderate to great amount.</td>
</tr>
<tr>
<td><strong>Barriers to seeking help/support</strong></td>
</tr>
<tr>
<td>Intrusive thoughts and rumination about the circumstances of death</td>
</tr>
<tr>
<td>To what extent has stigma related to suicide had a negative impact on you?</td>
</tr>
<tr>
<td>Experienced difficulty discussing the circumstances of death?</td>
</tr>
<tr>
<td>Have people distanced themselves from you after the suicide</td>
</tr>
<tr>
<td>To what extent has your social life been negatively impacted?</td>
</tr>
<tr>
<td>If your social life has been negatively impacted did it improve over time</td>
</tr>
</tbody>
</table>

Table 4 displays the data related to the response survivors received from mental health professionals following a loss by suicide. 75\% ($n=241$) of individuals whose loved one was in regular contact with a mental health professional reported that the mental health professional did not reach out to the family after the death. contact Only 25\% of respondents ($N=80$) who had a loved one that was receiving care from a mental health professional at the time of the death reported that the mental health professional caring for their loved one reached out to them after the death. Three quarters of respondents indicated it would have been helpful to have a mental health professional reach out to the after the death to provide resources specific to suicide loss ($N=536, 76\%$).
Table 4

Response from Mental Health Professionals After the Loss

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the loved ones mental health professional reach out after death: Yes</td>
<td>80/321 (25%)</td>
</tr>
<tr>
<td>Did the loved ones mental health professional reach out after death: No</td>
<td>241/321 (75%)</td>
</tr>
<tr>
<td>Would it have been helpful if a MH professional reached out after the death</td>
<td>536/711 (76%)</td>
</tr>
</tbody>
</table>

Table 5 shows a summary of participant’s responses to the impact of various types of social support related to the experienced death by suicide. The highest frequency of response was peers who have experienced loss by suicide (n=460, 85%) followed by survivors of suicide support group which was found to be somewhat to very helpful by over three quarters of the respondents (n=387, 83%). Support from friends (n=572, 78%), support from family (n=543, 74%) and participation in suicide prevention efforts (n=326, 77%) were the only other groups with frequency percentages greater than 70%. The question asking the impact of various forms of support offered two types of support groups as options. The general grief support group was identified as somewhat to very helpful by over a half of the respondents (n=200, 60%) where the survivors of suicide support group was viewed as helpful at a rate of greater than 80%. Besides the general grief support group, the other type of support with the lowest frequency was the support of clergy (n=209, 56%).
Table 5

Social Support

Frequency of participants whom responded somewhat helpful and very helpful to various forms of social support.

<table>
<thead>
<tr>
<th>Impact of various forms of support</th>
<th>n/N (% )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>543/730 (74%)</td>
</tr>
<tr>
<td>Friends</td>
<td>572/731 (78%)</td>
</tr>
<tr>
<td>General Grief Support Groups</td>
<td>200/334 (60%)</td>
</tr>
<tr>
<td>Support groups for suicide survivors</td>
<td>387/468 (83%)</td>
</tr>
<tr>
<td>Peers who have experienced loss by suicide</td>
<td>460/541 (85%)</td>
</tr>
<tr>
<td>Mental Health Professional</td>
<td>360/523 (69%)</td>
</tr>
<tr>
<td>Participation in suicide prevention efforts</td>
<td>326/422 (77%)</td>
</tr>
<tr>
<td>Clergy</td>
<td>209/372 (56%)</td>
</tr>
</tbody>
</table>

N represents the number of participants that responded to each question. The N varies for each category as participants had the option to select all that apply to their experience.

A Pearson Correlation test was conducted to determine the relationship between the various grief reactions and the time since the death by suicide. Table 6 shows the result of correlation between two ranges of time since death and four different grief reactions. The test was conducted to determine if there is a difference in correlation between grief reactions and the time since the loss occurred. The strongest positive correlation was the relationship between the time since loss being less than 1 year and the experience of disbelief. There were also positive correlations between survivors experiencing guilt and shame when the loss has been less than 1 year ago. In testing the relationship of the same grief reactions compared to the group of participants whom responded their loss was between 1-5 years ago the results show a decrease in the strength of positive correlation for each grief reaction. The reaction of disbelief went from a moderate positive correlation when the loss was less than a year ago to a slight negative correlation for those whose loss had been in the 1-5 year timeframe. A similar result was observed for the reaction of guilt, at less than a year there was a slight positive correlation which shifted to a slight negative correlation in the 1-5 years since loss. These results show that
survivors of loss by suicide experience strong grief reactions within the first year after the loss and the strength of the grief reactions will decrease as the years since the loss increase.

<table>
<thead>
<tr>
<th>Table 6</th>
<th>Timing of Grief Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Guilt</td>
</tr>
<tr>
<td><strong>Less than 1 year post death</strong></td>
<td>.179*</td>
</tr>
<tr>
<td><strong>1 to 5 years post death</strong></td>
<td>-.089*</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

What Survivors Need After a Loss

The qualitative data proved to be a valuable part of this research project. The open ended questions within the survey yielded a total of 1,705 responses. With the response rate being high and the total volume of open ended questions that were answered the results were analyzed and 21 grouped into main themes. The themes were then broken down into subthemes for further evaluation. To be considered a subtheme it was determined that there would need to be a minimum of 20 responses. The qualitative data was analyzed using a grounded theory approach (Berg, 2004). The responses to the qualitative questions were grouped into main themes and then further analyzed to which sub themes were developed. A secondary coder was utilized in order to establish validity and reliability on the findings (Berg, 2004). The secondary coder and researcher compared the emergent themes. Initial inter rater reliability for the qualitative data was 80%. Disagreements were discussed and resolved resulting in 100% agreement. The data
based on the themes were then entered into tables including the frequency of each theme as well as the percentage compared to the total number of responses.

Of note, although not asked about suicidal ideation of survivors was mentioned a total of 30 times throughout the qualitative data.

Table 7 shows a summary of the qualitative data collected from the survey on what survivors of suicide loss found the most helpful about their interaction with professionals following the loss. There were a total of 330 responses to this question. Two main themes were identified based on the participant responses. Sub themes were also utilized to better categorize the data within each theme.

There were 330 responses which were grouped into two main themes, survivors of loss by suicide wanted professionals to be responsive to their needs (n=185) and they wanted help in processing the death and grief they experienced (n=145). Sub themes were identified within each main theme.

Professionals being responsive to needs There were a total of 185 responses identifying the need for survivors wanting professionals to be responsive. Three sub themes emerged from the responses grouped into this section. Those sub themes included communication, empathy, and sincerity as being of support to professionals being responsive to the needs of survivors.

Communication. Communication had the highest frequency of the sub themes related to professional being responsive (n=78, 24%) with many comments about the talking and listening aspects of communication. The following examples of participant responses highlight the theme of communication:

“They allowed me to tell my story”
“Having someone to talk to, who would listen to my story was helpful”

“Being able to talk with someone who didn’t pass judgement”

“Listening. I guess I had to tell it over and over until I couldn’t tell it anymore. Honestly I hardly remember”

**Sincerity.** Sincerity was another sub theme of professionals being responsive to survivors needs. Sincerity was the second largest sub theme with nearly a quarter of respondents (n=70, 21%) indicating sincerity by professionals was helpful. The following responses by participants reinforce the impact sincerity had on survivors:

“Patience, sensitivity, supportive, nonjudgmental, seemed to generally care. Supplied useful information”

“The police officer that stayed with me the whole evening in the ambulance and talked with me.”

“They were concerned for me. They also still treated {him} with respect and dignity”

“My therapist appeared to genuinely care about what happened to me. It felt comforting.”

**Empathy.** The third sub theme of professionals being responsive was the empathy showed by professionals and how helpful it was. Empathy was identified within the main theme at the lowest frequency (n=37, 11%). Many of the responses relating to empathy being helpful were similar, some of which included:

“Validation and empathy”

“They helped me make phone calls to my other immediate family members, I was so shaky that I could barely hold my phone, let alone to scroll through the names to make the calls”

“Allowing me my grief, without judgement, without trying to fix it”

“I had access to support from a counselor who specialized in suicide loss bereavement. It was amazingly helpful. She was very experienced and understood. I called her my lifeline
at the time. It was the one place I felt understood. I think this is fairly rare...to find someone like that.”

Help Processing the Death by Suicide The theme of survivors identifying help processing the death as being a helpful form of support had a total of 148 responses. 3 sub themes that were identified which included, the processing of feelings, fears and skills and or resources.

Processing of Grief. The sub theme of processing grief (n=97, 30%) had the highest frequency among all the sub themes. Participants had many specific comments related to feelings and the unfamiliarity of what they were experiencing. Some comments related to feelings included:

“Processing the death and suicide. It is a dual issue. Still working on feelings of guilt, and I did not do enough for myself and family members”

“Understanding the mental illness that caused the suicide. Reading words from other survivors and talking with them”

“My therapist that I decided to see 9 months later. I seriously started to break down and being able to talk about it, away from my family, was and continues to be most helpful.”

Addressing Religious Stigma. 8% (n=25, 8%) of participants identified addressing religious stigma. The following comments from participants’ highlight examples of how addressing religious stigma was found to be helpful to survivors.

“He told me he didn’t think a person who commits suicide would go to hell because ‘God would understand his state of mind at the time and know he must have been so desperate to have committed such an act’”

“My priest assured me my daughter would be ok, that she would be with god”

“The kindness, concern, he showed my family, and the assurance my son was no longer being tormented by whatever was tormenting him. As a catholic I was concerned if he would suffer in hell, our priest told us our son was in heaven with god”
Peer Support. Peer support was (n=26, 8%) identified as a significant help by survivors of suicide loss. The themes identified below relate to the value obtained through peer support.

“Support group of other survivors- telling my story and hearing their stories. It was very hard but good to know I wasn’t alone.”

“The group settings were best for me. I was able to see other people go through the same process, I could see what works for them and pick and choose what I thought would work for me. And most of all I could share my story and help others.”

“This is a monthly support group for survivors of suicide loss. I couldn’t talk for three years, but yet I went to the meeting every month. Hearing everyone else in the room speak of their experience helped me to know that I was not alone and that I was not crazy for feeling everything that I was feeling”

“The group provided a safe place for whatever I was feeling in the first year that was all over the map. Since everyone there experienced the same kind of loss there was a great bond established”

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Sub theme</th>
<th>n/N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being Responsive</td>
<td>Communication</td>
<td>78 (24%)</td>
</tr>
<tr>
<td></td>
<td>Empathy</td>
<td>37 (11%)</td>
</tr>
<tr>
<td></td>
<td>Sincerity</td>
<td>70 (21%)</td>
</tr>
<tr>
<td>Processing Grief</td>
<td>Help articulating feelings</td>
<td>97 (30%)</td>
</tr>
<tr>
<td></td>
<td>Addressing Religious Stigma</td>
<td>25 (8%)</td>
</tr>
<tr>
<td></td>
<td>Peer Support</td>
<td>26 (8%)</td>
</tr>
</tbody>
</table>

$N$ represents the total respondents to the question. $n$ represents the number of responses categorized in the sub themes.

Table 8 shows a summary of the qualitative data collected from the survey on what survivors of suicide loss found was the most unhelpful about their interaction with professionals
following the loss. Two main themes were identified based on the participant responses. Sub themes were also utilized to better categorize the data within each theme.

There were 185 responses within the two identified themes. The themes included survivors of loss by suicide found any action that reinforced blame and any empathic failure as the most unhelpful part of interaction with professionals following the loss. Within the two identified themes the responses were categorized further into two sub themes.

**Reinforcing Blame.** Of the 185 responses within the main themes reinforcing blame comprised a little under half of these responses \((n=72, 39\%)\). In evaluating the responses within the theme it became clear there were two sub themes of importance which included reinforcing blame via death investigation and via stigma associated with loss by suicide.

**Death Investigation.** Death investigation had the lowest frequency among the sub themes \((n=29, 16\%)\). Although this sub theme had the lowest frequency the comments by the participants were very powerful and highlighted how the investigation following the death by suicide reinforced blame. Some of the comments identified in the analysis are provided below.

“I was investigated by homicide detectives, I was in shock, scared, traumatized and treated as a suspect of his death”

“The coroner was horrible and extremely rude. He made us feel like it was our fault because we had no idea or inclination he was going to commit suicide. It was awful! The police treated us like we were suspects in a murder and they wouldn’t let us help my nephew... Who just found his father. It was horrible!”

“My life had just shattered and I was treated like a murder suspect when your son is on the garage floor, and you’re trying to render first aid, to have the police officer with his hand on his pistol, order you away from him”

“One of the police officers asked if we were having any problems. This was on the same day and at the same time they turned up. I blame myself already and was astounded by that question and disgusted”
Stigma Associated with Loss by Suicide. The second sub theme of reinforcing blame was identified as stigma related to the loss by suicide. Stigma was identified in just under a quarter of the responses (n=43, 23%) grouped into the main themes. Examples of respondents identifying stigma as unhelpful in the responses included:

“It’s a taboo topic. We felt like we weren’t allowed to talk about it”

“There was a male and a female that came to my door to inform me of my husband’s death. I felt that they wanted to leave as soon as they could”

“I felt as if I was being told to get over it and move on because nothing could really be done”

“My [dad] started the car in a closed garage and killed himself. I found him. My mother told the police that the garage door was opened so they never knew he committed suicide. I was just a kid at the time. But he had tried to kill himself previously. Mom was thinking that she had 3 kids to support and would need the life insurance which she would not have received if the death certificate read suicide.”

Empathic Failure. Over half of the participants that responded to the question of what was unhelpful relating to their interaction with professionals fit into the theme of empathic failure (n=113, 61%). The two identified sub themes of empathic failure included insensitivity by professionals and professionals lack of knowledge about loss by suicide.

Insensitivity. Professionals being insensitive had the highest frequency (n=71, 38%) of all the sub themes identified within the main themes. The sub theme of insensitivity included many examples from the survey responses, the following are a small portion of those examples:

“I reached out to clergy with spiritual questions as to whether he would go to hell or not and was told I needed to worry about where I was going instead of him”

“I had grief therapist tell me that this was “just part of the job”. And another social worker say, I guess that’s a lesson in boundaries”

“Police were very cold and blunt, (calling the death a) “Routine suicide”
“I was the only one in the family my brother was talking to. The doctor told me I should’ve seen the signs”

**Lack of Knowledge about Suicide Loss.** The final sub theme identified within the main themes was the lack of knowledge by professionals relating to suicide loss. Nearly a quarter of the responses \((n=42, 23\%)\) related to how unhelpful survivors felt it was to interact with a professional who did not have knowledge of suicide loss. The following comments taken from the survey response to the question relate to a lack of knowledge:

“My therapist limited experience with suicide was unhelpful. I don’t actually know how to help”

“There wasn’t enough, and perhaps that was me needing answers that no one could give, but it didn’t seem enough, and I felt awfully alone in my grief”

“Distant... No guidance or suggestions on how to cope... I felt like a statistic not a mother trying to understand...”

“ Asking me to understand the choice.”

“People seem to believe suicide was a choice”

<table>
<thead>
<tr>
<th>Table 8</th>
<th>Unhelpful Responses from Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N=185</strong></td>
<td>Themes with identified sub themes from the qualitative analysis of what survivors of suicide loss found the most unhelpful about their interaction with professionals.</td>
</tr>
<tr>
<td><strong>Main Theme</strong></td>
<td><strong>Sub theme</strong></td>
</tr>
<tr>
<td>Reinforcing Blame</td>
<td></td>
</tr>
<tr>
<td>Death Investigation</td>
<td>29 (16%)</td>
</tr>
<tr>
<td>Stigma</td>
<td>43 (23%)</td>
</tr>
<tr>
<td>Empathic Failure</td>
<td></td>
</tr>
<tr>
<td>Insensitivity</td>
<td>71 (38%)</td>
</tr>
<tr>
<td>Lack of knowledge on suicide loss</td>
<td>42 (23%)</td>
</tr>
</tbody>
</table>

\(N\) represents the total respondents to the question. \(n\) represents the number of responses categorized in the sub themes.
Table 9 shows a summary of the qualitative data collected from the survey question on how professionals can help survivors following the loss. Two main themes were identified based on the participant responses. Sub themes were then utilized to better categorize the data within each theme.

There were 485 responses within the two identified themes. The themes of how professionals can help included being proactive following the loss and understanding a loss by suicide is unique compared to other forms of loss. Within the two identified themes the responses were categorized further into two sub themes.

**Professionals Being Proactive Following a Loss by Suicide.** A theme identified by review of the responses included how helpful it would be for professionals to be proactive following the loss. The responses fitting this theme accounted for just under half of the total responses (n=233, 48%). The responses in the professionals being proactive theme were then categorized into two sub themes, reaching out after the death and providing resources.

**Reaching Out After the Death** was a sub theme of professionals being proactive after the death (n=100, 21%). A sample of the responses relating to survivors believing professionals reaching out after the death would be helpful have been included below.

“It would’ve been helpful for her mental health professionals to reach out with me with resources. I felt very isolated”

“Reach out, I never sought support myself and probably should have but it was overwhelming”

“By reaching out and letting survivors know that there are people available to help guide us through this horrible maze we are in”
“A simple phone call, just to reach out and possible help for those left behind. No professional involved in my mother’s case reached out to me on their own. I had to call and get information from them.”

**Providing resources** was a sub theme identified in just over a quarter of respondents \((n=133, 27\%)\). Providing resources is the second sub theme of professionals being proactive after a loss by suicide. The following are comments taken from survey responses relating to the helpfulness of being provided resources.

“Provide resources and support. To know that this is a thing that exists and that we are not alone. That there are people like us who can identify in this singularly unique form of loss. Even a care package of materials to read on the subject would be welcome”

“Have updated materials and knowledge of suicide. The way to talk about suicide and the ability to steer people to organizations that can help”

“I really think a person has to be ready to find help but I think if I would have received information sooner I would’ve found help sooner”

“To provide resources, to provide someone who has experienced this same kind of loss”

**Suicide Bereavement is Different.** The second theme identified in the responses to the question of how professionals can help was suicide survivors want professionals to understand that loss as a result of suicide is a unique type of loss. This theme accounted for a little over half of all responses within the two themes identified \((n=252, 52\%)\). From these responses two subthemes were identified which included survivors commenting that it would be helpful if professionals were better educated/informed about suicide and that it is helpful to survivors if professionals are willing to listen to what they have to say.

**Professionals Being Educated about Suicide Bereavement** was identified as a sub theme. Survivors responses indicating professionals need to be better educated/informed about loss by suicide occurred in just over a quarter of the responses \((n=139, 29\%)\). This was the
highest frequency among all of the sub themes identified within the responses for the question of how professionals can help. Some of the specific comments related to being educated/informed included:

“Either become familiar with the process of losing someone to suicide or refer individuals to someone who specializes or is aware of the complications of this grieving process”

“To be aware not everyone is a textbook”

“Become more aware of the unique needs of survivors”

“Become more educated. Get involved support groups and activism to see how suicide affects people”

“Never ever tell me that you understand what I’m going through (unless you actually do). Ask me how I’m doing, it’s not a stupid question. Tell me it’s okay to talk about how he died. I need to talk about it. Ask me what I feel I need from you at that moment? – to cry? To be heard?”

“Help us understand that this is different than normal grieving. Tell us and feeling suicidal our self is part of the process”

Professionals need to listen was the second sub theme identified within professionals needing to understand loss by suicide is unique was that it is helpful to survivors to have professionals listen to them. Listening had a frequency close to a fourth (n=113, 23%). Some comments related to how helpful listening can be included:

“Listen; I didn’t need exercises, or tasks to complete, either physical or symbolic. I needed to talk yell, vent, and cry...”

“To be able to listen to their story. We are all different and grieve differently”

“My therapist listened. Everything, the guilt. The blame, backtracking, the anger I felt, replaying the days before in my head, going to the cycle of emotions with me. She even cried with me. And it was all helpful. To know that it was okay to feel whatever it was feeling at the time”

“They can LISTEN, listen, listen. Not rush the process or show frustration with the repetitiveness of our questioning (e.g. why did he do this?). Definitely don’t judge our grief or the way we express it”
Table 9

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Sub theme</th>
<th>Number of responses n/N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be Proactive following the death</td>
<td>Reach out</td>
<td>100 (21%)</td>
</tr>
<tr>
<td>Provide Resources</td>
<td></td>
<td>133 (27%)</td>
</tr>
<tr>
<td>Suicide Bereavement is Different</td>
<td>Educated about suicide loss</td>
<td>139 (29%)</td>
</tr>
<tr>
<td>Willing to listen</td>
<td></td>
<td>113 (23%)</td>
</tr>
</tbody>
</table>

N represents the total respondents to the question. n represents the number of responses categorized in the sub themes.

Table 10 shows a summary of the qualitative data collected from the survey question on what difficulties survivors experienced in seeking support following the loss. Two main themes were identified based on the participant responses. Sub themes were then utilized to better categorize the data within each theme.

There were 400 responses within the two identified themes. The themes of what difficulties survivors experienced in seeking support following the loss included access to support and stigma related to the death by suicide. Within the two identified themes the responses were categorized further into two sub themes. Of note, although suicidal ideation in participants was not addressed within the current study it 30 participants mentioned their struggle with suicidal ideation in their qualitative responses.

**Access to Support** The first theme identified was the difficulty survivors of suicide loss had in accessing support. Over half of the overall responses to the question belong to the theme of access to support (n=270, 68%). Three sub themes were identified which include survivors...
not being aware of the support available, the overall lack of support available to them, and mental health reasons that made it difficult to access support.

**Not Aware Support was Available.** Survivors who indicated they were not aware of any support being available to them accounted for the second highest frequency among the sub themes (n=112, 28%) Some of the responses and comments of not being aware of support include:

“I wish I would have known that someone could help me before finding me so isolated and lonely”

“I was not aware of where to get support”

“I wish I would’ve known where the support groups were sooner, and resources to get me through the different stages”

“I didn’t know where to go”

**Lack of Support Available.** Lack of support available to survivors of suicide loss had the highest frequency among all of the sub themes (n=126, 32%). There were many different types of comments relating to the lack of support available. A sample of the comments have been provided below.

“I couldn’t afford counseling”

“Cost and availability, could not stop working to attend things”

“Our son died January 10 this year. The first available support group for suicide survivors won’t start until March 20. Wish there was something sooner.”

“We live in a small town in a state with a very high suicide rate but there was very little to nothing available when I was searching for help with the first 4 to 6 months”

“Rural area-no suicide survivors support groups. Grief retreats are expensive and faraway”
**Difficulty accessing support due to mental health reasons.** Difficulty accessing support due to mental health reasons was observed at the lowest frequency of all the sub themes ($n=32, 8\%$). Comments related to the difficulty experienced accessing support based on mental health reasons included:

“It didn’t even occur to me to go to a support group specific to suicide loss, and when it did/someone brought it up, I was too tired/depressed/raw to go. I felt like my situation was too unique for other people to understand”

“Being in such a vulnerable state and feeling so down, and made it hard to reach out. Going to a counseling appointment felt like only one more thing to do. Friends do not understand and gave lots of advice when I didn’t need it. I ended up pulling inward because it takes more energy to deal with other people’s reactions than just deal with it myself. I wish I would’ve known about alliance of hope online group sooner”

“The hardest thing with the callousness of the people I talked to initially. I was very vulnerable and really, this could have led to death like this for myself. I think people need protection for mental health outreach in the immediate aftermath. I was extremely disturbed and went PTSD for two full weeks,-severely… Over blaming myself…”

“The hardest part was getting the energy to seek help”

**Stigma** The second theme of the experienced difficulty in seeking support survivors of suicide loss have was the stigma they felt related to the loss by suicide. A third of the responses ($n=130, 33\%$) identified the stigma survivors experienced made it difficult for them to seek support. Three subthemes were identified within the stigma theme which included stigma felt from, social, family and professional sources.

**Social Stigma.** Survivors of suicide loss identified social stigma as an experienced difficulty in seeking support after a loss by suicide. Social stigma occurred at the second lowest frequency of the sub themes ($n=48, 12\%$). Comments identified relating to survivors experiencing social stigma included:

“Stigma and denial as cultural norm has been greatest barrier to healing in my family. My family has suffered damage so deeply. I advocate versus stigma for this reason. No
family should have to carry the weight of shame on top of their loss. Stigma suffocates hope”

“The biggest barrier was because of the sin that religion said he had committed and that it was not okay to talk about it due to his going to hell”

“Asked to not talk about into evangelical churches because others were “uncomfortable” with my story”

“I didn’t know there was any support at the time. My family muddled through together. I suffered great anxiety due to a tragic loss. We couldn’t even be open. I told people dad had a heart attack”

“I was so angry that people could or would not be there with me and my pain. Incredibly isolating. It just added to the torture. People withdrew, never mentioned my partner’s name, acted like it never happened. It added shame to the mix. It’s changed me. I know I can only turn to myself for support”

**Stigma within the family.** Stigma associated with family members occurred at the lowest frequency ($n=36, 8\%$), the same percentage as mental health reasons. Responses from the survey question highlighting stigma from a family source included:

“I attempted suicide a few days later, and people focus entirely on my attempt instead of supporting my grieving”

“Some of my family did not want me to make it public that he died by suicide. They were lying and telling people that he had a heart attack”

“I wish I would’ve stopped trying to receive support from friends and close family. It has driven most of them away. So painful to be excluded at holiday events”

**Professional Stigma.** The sub theme professional stigma includes comments related to stigma from a professional source and comments made indicating that unhelpful professionals contributed to difficulty in seeking support. The frequency of professional stigma within the survey question was tied with social stigma for the second lowest frequency ($n=46, 12\%$). A sample of comments about professional stigma are included below.
“The most significant disappointment/difficulty I had in seeking support was at my regular pastor never followed up with me after initially talked with his assistant”

“Funeral homes and clergy should be more knowledgeable about support and also the police. These are the first ones we deal with”

“Someone responded to the 911 call, firemen, police or clergy should have followed up after the immediate shock and given my information to a professional to follow up. Also the fact that I had to call church after church before I found a minister willing to do a service for my son. The judgment from the churches was astonishing”

“My mother’s negative experiences with mental health professionals prevented me from seeking their assistance…”

“My regular doctor’s office was not helpful in providing direction or support information”

“I saw a therapist within two weeks-and he had his own agenda and ideas of what happens after death-- that did not coincide with mine. The visit seemed useless and a waste of my time and money”

<table>
<thead>
<tr>
<th>Table 10</th>
<th>Barriers to Seeking Support After Loss by Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=400</td>
</tr>
<tr>
<td></td>
<td>Themes with identified sub themes from the qualitative analysis of survivor responses to what difficulties they experienced in seeking support after the loss by suicide.</td>
</tr>
<tr>
<td>Main Theme</td>
<td>Sub theme</td>
</tr>
<tr>
<td>Access to Support</td>
<td>Not aware support was available</td>
</tr>
<tr>
<td></td>
<td>No access to support</td>
</tr>
<tr>
<td></td>
<td>Difficulty do to mental health reasons</td>
</tr>
<tr>
<td>Stigma</td>
<td>Social</td>
</tr>
<tr>
<td></td>
<td>Family</td>
</tr>
<tr>
<td></td>
<td>Professionals</td>
</tr>
</tbody>
</table>

* N represents the total respondents to the question. * n represents the number of responses categorized in the sub themes.
Discussion

The purpose of the current research project is to provide insight into the grief experiences of survivors of suicide loss by exploring the self-identified barriers and supports to help seeking behaviors to assist professionals in better serving this population. An anonymous online survey containing both quantitative and qualitative questions was developed with the goal of obtaining preliminary data using a mixed-methods approach in specific areas such as, grief reactions, stigma from suicide, as well as, helpful and unhelpful forms of support.

Sample

The survey received a completion rate of 90%. Interestingly, a significant amount of the participants came from three demographic categories. 93% of respondents were female, 73% of respondents were age 18 to 54 years and 76% of respondents indicated the loss from suicide had occurred within the last 5 years. Although there were still a significant number of respondents from the other demographic categories a more evenly distributed sample may have provided different results. Additionally, the sample was a convenience sample recruited through organizations that provide services to survivors of suicide loss and may not be representative of all survivors of suicide loss, therefore the results cannot be considered generalizable to the population of suicide loss survivors as a whole. In future studies it would be beneficial to identify a specific size sample from each demographic category to ensure an evenly distributed sample.

Grief reactions

Previous research has identified that survivors of suicide loss experience intense grief reactions. A study conducted by McMenamy, Jordan and Mitchell (2008) analyzed 10 psychological issues survivors experienced after a loss by suicide. A majority of the issues were
experienced at a moderate to high level over 50% of the time with the highest being experienced at 84%. The current study confirmed what others have found, that survivors of suicide loss experience intense grief reactions at a high rate. Although this research confirmed previous findings it is important to note the frequency in which participants experienced the different grief reactions was consistently higher in the current study than previous research studies (Jordan, McMenamy, Mitchell, 2008). For example, the five largest frequencies of grief reactions in the current study were all experienced at a moderate to high level at or above 89%.

Another area of interest from the data analysis which supports that survivors experience intense grief reactions came from testing the relationship of the grief reactions to the time since the death by suicide. A summary of results displayed in table 6 shows the grief reactions of survivors whom experienced loss by suicide less than a year ago experienced the reactions a low to moderate amount. The same reactions compared to those whom experienced a loss by suicide 1 to 5 years ago experienced the reactions at a lower rate. This is important information for first responders as it identifies an opportunity for them to be more aware of what grief reactions survivors may be experiencing after a death from suicide. It also has the potential to act as a guide to better prepare professionals on how to be a resource to those who have experienced a loss by suicide.

These results also confirm that it is likely a survivor of suicide loss will experience multiple grief reactions at a single point in time over the first year after the death. The high incidence of multiple grief reactions within survivors in this study confirms that this group of bereaved are at a higher risk for experiencing complicated grief as concluded in previous studies (Mitchell, Kim, Prigerson, and Mortimer-Stephens, M., 2004; Shear, 2010).
Barriers

Being able to better understand the grief experiences of survivors was an important part of the current research. 99.5% of respondents reported a moderate to high occurrence of intrusive thoughts and rumination about the suicide of their loved one indicates that grief reactions including trauma symptoms are a significant barrier to seeking support from professionals. This contradicts previous research by Sveen and Walby (2008) which concluded that survivors of suicide loss do not experience a greater incidence of trauma symptoms (Sveen, and Walby, 2008) and is significantly higher than the 55% of survivors that reported trauma symptoms in a study conducted by Mcmnemy, Jordan, and Mitchell (2008).

Table 3 provides a summary of responses related to experienced barriers to seeking support. It shows that 71% of participants believed that stigma had a substantial impact on their bereavement while 65% reported their social life had been negatively impacted as a result. Participants also identified difficulty in talking about the death and experienced people close to them distancing themselves after the death by suicide. Stigma is an important aspect of the experience survivors of suicide loss face following the death. Professionals need to be aware of the effects of stigma on the survivor so they can provide the most effective support. It is important to note that with these experienced barriers 76% of participants identified it would have been helpful to have a mental health professional reach out to them immediately following the death.

The responses from the qualitative survey questions further illuminate the specific aspects of stigma related to barriers in help-seeking. 23% (table 10) identified experiencing stigma from professionals they interacted with following the death as unhelpful while 32% reported that stigma experienced within the family, socially and from professionals was viewed
as a significant difficulty (Table 10). The high rate of stigmatization reported by participants confirms what other studies have concluded—stigma is a barrier for survivors of suicide loss in seeking support (Cerel, & Campbell, 2008; Cvinar, 2005; Feigelman, Gorman, Jordan, 2008).

**Supports**

It is clear from the results that survivors of suicide loss value the support received from peers who have experienced a loss from suicide and suicide loss support groups. 85% of participants viewed support received from peers who have experience a loss from suicide as helpful while suicide loss supports groups were a close second at 83%. While 77% stated participation in suicide prevention advocacy efforts was helpful. The qualitative data suggests that the support received from fellow survivors is invaluable in processing the grief experience with others who understand their loss, as these interactions tend to be received as sincere and empathetic to the survivors (table 7). This supports previous research in this area which suggests that connecting with other survivors whether it be through supports groups or advocacy efforts is helpful in mitigating their grief experience. (Feigelman, et. al., 2008; McMenamy et. al., 2008).

**Implications for Social Work Practice**

76% of participants identified it would have been helpful to have a mental health professional reach out to them immediately following the death yet only 25% of participants whose loved one was in regular contact with a mental health professional were contacted after the death. The qualitative data confirms the need for social workers to be proactive in reaching out to survivors of suicide loss as 68% of participants indicated the most significant barrier in their grieving process was difficulty accessing supports due to financial issues, long wait times, psychological distress, or they were unaware that supports specific to suicide loss existed.
Current estimates indicate that there are 18 survivors of suicide loss for each person that dies from suicide which means that last year alone there were roughly 750,000 new survivors whom experienced difficulty in navigating their grief reactions (Drapeau, & McIntosh, 2015). Social workers are taught the importance of seeking social justice for disenfranchised groups. We are inspired to advocate for others on micro, meso, and macro levels. 71% of the participants in the current study reporting stigma as a significant barrier to healing which indicates social justice advocacy efforts are clearly needed for this population.

Social workers should employ advocacy efforts by partnering with first responders, local medical examiners, and organ donation organizations. Partnering with agencies that have early interactions with survivors of suicide loss to provide resources specific to suicide loss can significantly reduce barriers in accessing services for this population. Ideally, Active Postvention should be standard practice in the United States. The Active Postvention Model (APM) designed by Campbell (2008), is an exemplary intervention model used to intervene with survivors of suicide loss. Survivors of suicide loss who are provided outreach through the APM have accessed services within 39 days of contact compared to the national average of 4.5 years (Campbell, 2011). Knowing the effectiveness of active outreach to survivors of suicide loss it is a necessity that social workers advocate for the needs of survivors of suicide loss within their communities, and at a policy level. With such a large group of individuals experiencing mental health concerns and barriers related to suicide bereavement it is essential that social workers respond by fulfilling the obligation to provide social justice to marginalized population’s such as survivors of suicide loss.

The results of this study indicate that there is a need for social workers to be prepared in working with this population of grievers as they occupy a majority of the mental health
workforce (NASW, n.d.). Social workers can alleviate distress among suicide survivors by reaching out to survivors of suicide loss, being educated on the unique aspects of suicide loss, being prepared with resources specific to grief after suicide, and connecting them with other survivors of suicide loss whether it be informal peer support or formal support groups’ specific to loss from suicide. Social workers should be responsive and genuine in their interactions with survivors by listening to their stories, providing empathic responses, and assist survivors in processing the death at their own pace. It is important to assess for suicidal ideation, complicated grief and PTSD among survivors. As a majority of the participants in the current study experienced difficulties coping with the loss which is evident by the incidence of psychological difficulties reported such as, intrusive thoughts of the death, hopelessness, guilt, regret, unhappiness, shock, anger and stigma which are all significant barriers to healing.

The lack of time spent on suicide prevention and assessment skills in MSW programs is disheartening. Education pertaining to grief after suicide is nearly nonexistent. The participants of this study identify a shortcoming of mental health professionals in their being unprepared to meet their needs as they are uneducated on the complexities of grief after suicide. For current and prospective graduate students this barrier can be addressed by providing education and skills within MSW programs to ensure social workers are prepared to effectively intervene with survivors of suicide loss. As for social workers employed in the mental health field, training should be obtained in their current agencies or within the community.

Limitations/Recommendations for Future Research

Due to this studies using a convenience sample the findings are unable to be generalized to the population of suicide loss survivors as a whole. The survey instrument was created by the researcher in an attempt to elicit specific information not present on standardized measures
related to suicide survivor’s grief experiences. Future research should consider obtaining a random sample with a more balanced ration of participants (age, gender, time since loss).

Previous research indicates that stigma is the greatest predictor of suicidal ideation amongst suicide survivors (Feigelman, et. al., 2008). Suicidal ideation among suicide survivors was not measured in the current study although it was noted that 30 respondents specifically mentioned their own suicidal ideation in the qualitative data. With the high amounts of stigma and trauma symptoms reported it is recommended that future studies include this component when researching survivors of suicide. Another area of interest is the utilization of internet forums and supports groups for survivors of suicide loss. Previous studies have concluded that web based resources address barriers to seeking resources due to stigma and isolation experienced by the survivors as well as difficulties pertaining to time, distance, and financial ability to obtain resources (McMenamy, Jordan, Mitchell, 2008). Web based support (e.g. online support groups, forums, groups specific to suicide loss) were mentioned 39 times in ‘other’ category of the survey question which support have you utilized? These responses were then analyzed to determine the degree of helpfulness reported by, 100% of the 39 responses indicated web bases support to be helpful.

**Researcher Reaction**

I was amazed at the amount of support this study received from the agencies who were asked to distribute the survey as well as the participants. I have a unique perspective into the world both as a survivor of suicide loss myself, and as social worker. I was dismayed at the amount of participants that state mental health professionals are unable to help them unless they have experienced a loss from suicide. I assume that their experiences in navigating their grief have led them to this conclusion. I believe that as mental health professionals, we can help. We
can ensure our effectiveness in intervening with this population by becoming educated on the
grief experiences of survivors, reaching out to survivors, being prepared to address their
concerns, and above all by being genuine and empathic in every interaction we have with
survivors of suicide loss.

**Conclusion**

Interestingly, 500 of the responses received came within the first day of Alliance of Hope
for Suicide Survivors distributing the link to the survey. This may indicate the bond among
survivors and the aspiration to help others bereaved by suicide as well as the desire to share their
experiences. The data was collected using a mixed methods approach which resulted in a high
volume of both quantitative and qualitative data. This made the statistical significance of the data
much stronger and the number of qualitative responses made using the grounded theory approach
to identify themes more impactful. The mixed methods approach allows for the voice and
experience of the survivors of suicide to permeate the quantitative data, resulting in a
comprehensive understanding of the barriers and supports to help-seeking for survivors of
suicide loss.

It was evident in the themes throughout the qualitative data that a majority of survivors
feel alone in their grief, and believed that it was nearly impossible for those who have not
experienced a death from suicide to understand their experience. They found comfort in the
presence of other survivors whether it be through informal meetings or formal support groups.
Being able to tell their story and hear the stories of others gives him strength, it gives them hope
that there are better days ahead. Survivors of suicide loss that report that helpful interactions with
professionals were ones in which the professionals are compassionate, empathetic, and allowed
them to grieve on their own timeline. What can be learned from this is that each individual
The barriers this population experiences are overwhelming. The stigma alone can be enough to stop help-seeking in its tracks. For survivors who have either witnessed the death or been present at the scene of the death, first responders that reinforced the guilt and blame they experienced only increased the traumatization in the survivor. The empathic failures of professionals have notably stuck with the survivors throughout their grieving process. Survivors of suicide loss do not expect mental health professionals to be perfect, what they do expect is for them to be genuine in their response, knowledgeable about grief after suicide, including the need for many survivors to search for the answer to why their loved one died from suicide. Professionals should support this by providing resources, examining the evidence with the survivors, and providing psychoeducation on the mindset of the person who dies from suicide. The high degree of intrusive thoughts, guilt, shock, blame, and unhappiness reported by the participant in this study indicates there is a need for mental health professionals to assess for complicated grief, PTSD, Major Depressive Disorder, and suicidal ideation.

Survivors need for open, honest communication with professionals cannot be undervalued. Multiple participants state that they just needed to talk; they needed to talk about the death over and over again; being able to do this in an environment that felt safe and was outside the family was helpful in their journey to healing. It can be concluded that even when professionals are unprepared to work with survivors of suicide loss if the survivors experienced the interaction as genuine, compassionate, and nonjudgmental their perceptions of the professional were generally positive. Mental health professionals who understand the complexity
of the grief experience of the survivor of suicide loss are in a place to support this population in reconciling their grief. A quote from one participant sums up the journey through grief of survivors of suicide loss eloquently:

“Survivors need to learn healthy ways to move through the initial stages of grief: while your head will swim with emotional thinking, you must live each day, second by second, putting one foot in front of the other, doing what needs to be done, expecting a long-term recovery and expecting setbacks, realizing that there is no answer to “why” but you can reach a place of acceptance and forgiveness of both your loved one and his actions and your own actions/inaction and feelings of culpability. This place of acceptance and forgiveness can be reached, but it is a new normal, one in which you can find happiness again, but you and your world will never be the same.”
References


Appendices

Appendix A

Survey: Barriers and Supports to Help Seeking in Survivors of Suicide Loss

The following information relates to your relationship with your love one who died from suicide. Please select the answer that best fits.

Q1 What is your gender?

- Male (1)
- Female (2)
- Transgender (3)
- Agender (4) ________________

Q2 What is your age?

- 18 - 34 (1)
- 35 - 54 (2)
- 55 - 74 (3)
- 75 or older (4)

Q3 How long has it been since the death of your loved one?

- Less than a year (1)
- 1-5 years (2)
- 6-10 years (3)
- Over 10 years (4)
Q4 What is your relationship to the deceased? (If you have lost more than one loved one to suicide please select all that apply)

- Immediate family (Parent, Sibling, Child, Spouse/Partner) (1)
- Extended family (Grandparent, Aunt/Uncle, Niece/Nephew, Cousin, Brother/Sister in-law) (2)
- Friend (3)
- Other (Please Specify): (4) ____________________

Q5 Did your loved one have a diagnosed mental illness at the time of their death?

- Yes (1)
- No (2)
- Unsure (3)

Q6 Did your loved one have substance abuse issues prior to their death?

- Yes (1)
- No (2)
- Unsure (3)

Q7 Prior to their death, which of the following professionals did your loved one have contact with regarding their mental health? (Select all that apply)

- Primary care doctor (1)
- Psychiatrist (2)
- Therapist (3)
- Social worker (4)
- Emergency room mental health staff (5)
- Emergency Room Medical Staff (6)
- Unsure (7)
- Clergy (8)
- Police Officer (9)
- Paramedic (10)
- Other: (please list) (11)
- None of the above (12)
Q8 Which of the following professionals did you come into contact with FIRST regarding the death of your loved one?

- Police Officer (1)
- Paramedic (2)
- Psychiatrist (3)
- Mental health professional (4)
- Emergency room mental health staff (5)
- Emergency room medical staff (6)
- Clergy (7)
- Other: (please list) (8) ____________________

Q9 How would you rate the quality of the interaction with professionals you came into contact with immediately following the death of your loved one?

- Extremely helpful (5)
- Somewhat helpful (4)
- Neither helpful nor unhelpful (3)
- Somewhat unhelpful (2)
- Extremely unhelpful (1)

Q10 What aspect of the interaction with professionals did you find most helpful to you in your grieving process?

Q11 What aspect of the interaction with professionals did you find unhelpful to you in your grieving process?

Q12 In the MONTH following the death of your loved one which of the following professionals did you come into contact with? (Select all that apply)

- Police Officer (1)
- Psychiatrist (2)
- Mental health professional (3)
- Clergy (11)
- Other (please list) (12) ____________________
- Does not apply (13)
Q13 If your loved one was regularly seen by a mental health professional did this person reach out to you or a family member after the death?

- Yes (1)
- No (2)
- Not applicable (3)

Q14 If you had contact with a mental health professional who worked with your loved one, how was contact made?

- I initiated contact with the mental health professional (1)
- The mental health professional contacted me (2)
- They attended the funeral (3)
- Other (please specify) (4) ________________

Q15 Did your opinion of the mental health professional working with your loved one change after contact was made?

- Much better (5)
- Somewhat better (4)
- About the same (3)
- Somewhat worse (2)
- Much worse (1)

Q16 The following questions relate to aspects of coping after the death of your loved one from suicide.
Q17 After the death of your loved one from suicide, to what extent did you experience the following grief reactions?

<table>
<thead>
<tr>
<th></th>
<th>A great deal (5)</th>
<th>A lot (4)</th>
<th>A moderate amount (3)</th>
<th>A little (2)</th>
<th>Not at all (1)</th>
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</thead>
<tbody>
<tr>
<td>Shame (1)</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Guilt (2)</td>
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<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
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<tr>
<td>Resentment (3)</td>
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<td>●</td>
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<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Blame (7)</td>
<td>●</td>
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<td>Regret (14)</td>
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Q18 After the death of your loved one, how often did you think about this person and the circumstances of their death? (examples: I continually searched for the reason why they ended their life; I experienced frequent intrusive thoughts regarding the manner of death)

- ● A great deal (5)
- ● A lot (4)
- ● A moderate amount (3)
- ● A little (2)
- ● Not at all (1)
Q19 In general, how much do you believe that stigma regarding suicide had a negative impact on your grieving process? (example: People refrained from discussing the death of my loved one with me because they died from suicide)
- A great deal (5)
- A lot (4)
- A moderate amount (3)
- A little (2)
- Not at all (1)

Q20 Have you experienced difficulty discussing how your loved one died with others?
- A great deal (5)
- A lot (4)
- A moderate amount (3)
- A little (2)
- Not at all (1)

Q21 Immediately following the death of your loved one did people you care about and trust distance themselves from you?
- A great deal (5)
- A lot (4)
- A moderate amount (3)
- A little (2)
- Not at all (1)

Q22 To what extent has your social life been negatively impacted by the death of your loved one from suicide?
- A great deal (5)
- A lot (4)
- A moderate amount (3)
- A little (2)
- Not at all (1)
Q23 How much did your social life improve over time?

- A great deal (5)
- A lot (4)
- A moderate amount (3)
- A little (2)
- None at all (1)
Q24 How helpful have the following forms of social support been to you in your grieving process?

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<th>Very helpful (6)</th>
<th>Somewhat helpful (5)</th>
<th>Neither helpful or unhelpful (4)</th>
<th>Somewhat unhelpful (3)</th>
<th>Very unhelpful (2)</th>
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</table>
Q25 The following questions relate to the mental health professionals role in working with survivors of suicide loss. Please describe what you believe mental health professionals should know about suicide survivors as it relates to your experience of losing a loved one to suicide.

Q26 Would it have been helpful to have a mental health professional reach out to you immediately after the death to provide information on where to find resources specific to grieving a loss from suicide?

- Definitely yes (5)
- Probably yes (4)
- Might or might not (3)
- Probably not (2)
- Definitely not (1)

Q27 In your opinion, how can professionals best help individuals who have lost a loved one to suicide?

Q28 If you experienced difficulties in seeking support in your grieving process which would you consider the most significant and why? (example: I wish I would have known that there were resources specific to grief after suicide earlier)

Q29 Is there anything else you think might be helpful for this study regarding your experience as a suicide survivor?
Appendix B

BARRIERS AND SUPPORTS TO HELP SEEKING BEHAVIORS IN SUICIDE SURVIVORS
INFORMATION AND CONSENT FORM

Introduction:

My name is Nicole Kurtzbein. I am a graduate student in the school of social work at the University of St. Thomas/St. Catherine University under the supervision of Dr. Michael Chovanec, a professor at the school. I am conducting a research project on the grief experiences of suicide survivors. Suicide survivors are the family and/or friends who have experienced the death of a loved one from suicide. I am seeking adults (age 18 or above) who identify as suicide survivors that would like to participate in this project. The goal of this research is to gain a greater understanding of the difficulties faced by suicide survivors in their grieving process in hopes of providing clinical social workers as well as other mental health professionals, insight on how to best intervene with suicide survivors.

Participation:

You are invited to participate in this project because you have identified yourself as being a suicide survivor (family member or friend who has experienced the death of a loved one from suicide). The purpose of this survey is to explore grief experiences of suicide survivors. The survey includes items about your grief experience including barriers and supports to seeking help from mental health professionals. It will take approximately 10-20 minutes to complete.

Anonymity:

Your responses to this online survey will be anonymous and results will be presented in a way that no one will be identifiable. Confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties.

Voluntary nature of the study:

Your decision to participate in this study is completely voluntary. Your decision whether or not to participate will not affect your relationships with the researcher, your instructors, or St. Catherine University. If you decide to participate, you are free to end the survey at any time without penalty. You may also skip any item that you do not want to answer. Should you decide to withdraw, data collected from incomplete surveys may be used for educational purposes.

Risks:

The information contained within this survey may be considered sensitive in nature. Questions will pertain to your personal grief experience losing a loved one to suicide. Questions
are designed to obtain responses on your relationship with your loved one, elements of coping, barriers encountered in your grieving process, the impact on your social life, as well as interactions with professionals after your loss. To address the risk of potential emotional distress you will be provided with a list of resources and contact information for suicide survivors.

**Benefits:**

Although there are no direct benefits to individual participants the research obtained will assist clinical social workers and other mental health professionals identify how they can best serve suicide survivors in their grieving process. The results will also contribute to the existing research in suicide prevention and loss.

**Contacts and questions:**

If you have any questions about this project, please contact Nicole Kurtzbein at nekurtzbein@stkate.edu.

**Statement of Consent:**

By responding to items on this survey you are indicating that you understand what is being asked of you and, you are giving us your consent to allow us to use your responses for research and educational purposes.
Appendix C

Research Study Disclaimer

The information contained within this survey may be considered sensitive in nature. Questions will pertain to your personal grief experience losing a loved one to suicide. Questions are designed to obtain responses on your relationship with your loved one, elements of coping, barriers encountered in your grieving process, the impact on your social life, as well as interactions with professionals after your loss. By continuing onto the survey you are providing your consent and indicating that you understand the potential emotional nature of the questions.

Below is a list of resources for suicide survivors for your reference

If you or a loved one are in a crisis please call the National Suicide Prevention Lifeline a free 24-hour confidential service.

1-800-273-8255

Finding a Mental Health Professional

American Psychiatric Association
1-888-357-7924
Provides information about mental health and about how to choose a psychiatrist.

American Psychological Association
1-800-374-2721
Provides referrals to licensed psychologists.