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# Perceived Social Support of Survivors of Suicide Who Attend a Support Group Compared to Those Survivors of Suicide Who Are Non-Attendees

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# PERCEIVED SOCIAL SUPPORT OF SURVIVORS OF SUICIDE WHO ATTEND A SUPPORT GROUP COMPARED TO THOSE SURVIVORS OF SUICIDE WHO ARE NON-ATTENDEES

TINA M. MURPHY, B.S.W.

An Abstract Presented to the Graduate School of

Lindenwood College in Partial Fulfillment for the Requirements for the

Degree of Master of Arts in Counseling

2000

**ABSTRACT**

Death from suicide results in a troublesome and complex adjustment for the surviving friends and family members. As compared to other forms of bereavement, suicide survivors are likely to experience different grief reactions than people dealing with other types of loss. The survivor of suicide may suffer from social rejection and alienation. In this study, the level of perceived social support of survivors of suicide who attend a support group (n=22 ) was compared to the level of perceived social support in survivors of suicide who do not attend a support group (n=20). Subjects had lost a friend or family member to suicide within the last 3-12 months. Each participant was given the Perceived Social Support - Friend Scale and the Perceived Social Support - Family Scale. It was hypothesized that survivors attending a support group will report a higher level of social support compared to those survivors not attending a support group. The results of the study indicated there was no significant differences in the level of perceived social support between the two groups.

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TINA M. MURPHY, B.S.W.

A Culminating Project Presented to the Graduate School of

Lindenwood College in Partial Fulfillment for the Requirements for the

Degree of Master of Arts in Counseling

2000

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For your seemingly endless support, your willingness to discuss my ideas and share yours, your belief in me, and for sharing your expertise, knowledge of survivors of suicide, therapy and life experience, I feel much gratitude.

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DEDICATION

To Edith, Sharon, Carolyn, Kathy, Sandy, Betty, Ralph, Bobby, Jimmy and Jeff:

You are survivors.

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# CHAPTER 1

## INTRODUCTION

Losing a friend, family member or loved one to suicide can be a very painful experience. Death by suicide can have serious and extended effects on those left behind. Those who have been impacted by this most stigmatizing cause of death known to our society are termed survivors of suicide. A survivor of suicide is someone who has lost a friend, family member or loved one to suicide (Campbell, 1997).

Silverman, Range & Overholser (1994) state that "most individuals bereaved by suicide, experience reactions that are common to other types of bereavement. However, reactions to suicide may be more intense and may involve contributing factors which are unique to the cause of death" (p. 42). One of the greatest public health problems in the case of suicide is the alleviation of the effects of stress in the survivors whose lives are forever changed. The health risk is to the survivors who suffer immensely from some severe consequences in the aftermath of someone else's destruction. In a study done by Barrett and Scott (1990), survivors of suicide consistently were reported to have experienced more grief reactions than other types of survivors. The grieving period of the survivor can be complicated by feelings of isolation, a more intense search for meaning, anger, guilt, and shame (Van Dongen, 1993). Thus, survivors of suicide can experience an especially severe form of bereavement that differs both qualitatively and quantitatively from other types of bereavement.

Suicide bereavement consists of four different types of grief reactions. These reactions include common grief reactions, other-than-natural-death reactions, unexpected-death reactions, and suicidal-death reactions that are rarely experienced in other bereavements. The latter reactions may include feeling rejected by the deceased, feeling a sense of embarrassment over the type of death, wondering about the deceased's motivation for the suicide, and wondering if the deceased was trying to get even with the survivor by taking his or her own life (Barrett & Scott, 1989).

Survivors often experience additional psychological responses stemming from encounters within their societal networks (Van Dongen, 1993). For example, society's inability to deal with survivors of suicide in a tactful and caring way has remained a negative legacy of suicide. There can even be an inflexibility that remains within the survivor's family. This is often reinforced by society's standard, which often creates role reversals and confusion (Campbell, 1997).

Previous studies examining societal responses to survivors of suicide have indicated that there are a number of potential negative behaviors from others that survivors are likely to confront, including blame, rejection, the lack of understanding, the inability of others to understand the survivor's sadness, contrived and stylized behavior, negative attitudes about the deceased, and pressures to stop grieving. Survivors who attempt to reach out to others and talk about their tragedies, find they are denied the chance to communicate. The

survivor feels isolated from family and friends and feels a sense of blame from the community (Wagner & Calhoun, 1991). These behaviors may lead to the survivor's perception of lack of social support from others.

The increasing amount of research and literature on the subject of suicide is evidence of an overwhelming need to identify understand, predict, deter and prevent life-taking behaviors. Although there have been several studies done on suicide and bereavement from suicide, there has been little research done on those left with the aftermath of its destruction (Barrett & Scott, 1990). There is a distinct need for more research to be done on understanding survivors of suicide and what can be done to help them. In order to design effective postvention models, it is important to study the role of societal support in the treatment of survivors.

Although the survivor may experience a powerful need for support, their support system's capability to fulfill this need adequately may be adversely affected by the suicide (Wagner & Calhoun, 1991). Bereaved survivors of suicide often indicate that friends and family do not seem to be as supportive as they would like. The survivor may deem this a form of avoidance and abandonment of friendship. They may feel rejection and perceive an unwillingness to be listened to during this grief period. The survivor may experience isolation or a lack of empathy and caring. Although the real or perceived loss of support from family and friends occurs with other types of loss, a family member or friend

grieving over suicide is given even a less degree of social support than other types of bereavement (Barrett & Scott, 1990).

The role of support groups in the treatment of survivors of suicide has become a topic that is debated. Clark, Jones, Quinn, Goldney and Cooling (1993) found that support groups have developed in response to the lack of societal support for survivors of suicide. Their effectiveness lies in fostering a caring circle of community and the helper therapy principle, which states that those who help are helped the most. Support groups can be used in addition to other more formal professional resources and are relatively low cost or free. There is still a deficiency of current research as to whether the lack of perceived social support from others is why survivors attend support groups and if over time, the support group does increase a sense of perceived social support in the survivor.

The purpose of this study is to determine the perceived social support among survivors of suicide who choose to attend a survivor support group compared to those survivors who do not choose to attend a survivor support group. It is hypothesized that there is a significant difference in the level of perceived social support between survivors of suicide who attend a support group and survivors of suicide who do not attend a support group.

# CHAPTER II

## REVIEW OF THE LITERATURE

### Suicide & Who is Affected

What is suicide? Grollman (1988) states: "To be classified a suicide, a person must intend to kill him or herself and must actually do so" (p.5). Suicide is a whispered word, not suitable for polite company. Family and friends often pretend they do not hear the sound of the dreaded word even when it's whispered. Suicide is a taboo subject that stigmatizes not only the victim but the individuals who are left behind as well. It does not discriminate; no single group, race, or class of people is free from its possibility.

Sprang and McNeil (1995) and Knieper (1999) report that suicide in America is listed as the eighth leading cause of death with approximately 30,000 persons committing suicide annually. McIntosh (1991) has conservatively estimated that the annual rate is 12.8 per 100,000, which translates into 85 suicides per day or one every 17 minutes. According to Sprang and McNeil (1995), that leaves a large number of family members and friends who are affected by or left to grieve the loss. The individuals affected are termed Survivors of Suicide and are estimated to be in excess of 3,000,000 (Sprang & McNeil, 1995).

Edwin Schneidman, considered to be the founder of the

suicide prevention movement in the United States, has said in Worden (1991):

> I believe that the person who commits suicide puts his psychological skeletons in the survivor's emotional closet- he sentences the survivors to deal with many negative feelings, and, more, to become obsessed with thoughts regarding their own actual or possible role in having precipitated the suicidal act or having failed to abort it. It can be a heavy load. [Worden, 1991, p. 93]

Theoretical Framework of Grief

The phases of normal bereavement as identified by Bowlby and Parks (1970), are shock, yearning and protest, disorganization, and reorganization. The first phase is described by the individual's initial reaction, shock. It is characterized by numbness and disbelief. This is a time when the individual's usual coping mechanisms are overloaded. This time period usually last for 7 days rarely going past 2 weeks.

The next phase in normal bereavement is yearning and protest. It is characterized by a rise in the level of affect. Crying, outburst, sleeplessness, irritability, extreme yearning and panic are typical. This is an extremely difficult period that affects one's self-perception, life patterns, and social relations. This phase seems to peak 2-4 weeks after the death but continues with varying degree for 3 months or longer.

The third phase of normal bereavement is disorganization. This stage is characterized by feelings of indifference and purposelessness. There is a sense of confusion, not knowing how to act or where to go next. This phase of disorganization alternates with the preceding period during the first year after the death. Assorted patterns of physical and psychological problems can become evident in this period.

Lastly, the reorganization phase is the most difficult to describe. It involves letting go of the past and rebuilding the future. This includes working toward a life with an altered self-image, new roles and different social networks. It is most prevalent about one year after the suicide. The physical and emotional symptoms of bereavement are lessened but can continue and/or reemerge at some point, indicating that the grief process has not ended.

Hauser, (1987) states that grief is a homeostatic process that allows the bereaved to withdraw, react, deal with the loss, then move on with life. While this can be the usual process for grief, it can become complicated. Certain factors such as the circumstance of the death, the biological, psychological and social characteristics of those involved, as well as the individuals relationships with others and the type of support available from their social network play an important role in bereavement outcome.

Since the bereavement process is affected by so many situations and factors, Bowlby (1980), identified variants of this process that can lead to increased physical and psychological stress. The end result of their affect can result in poor bereavement outcome or unresolved grief. These variants are: denial, chronic mourning, and euphoria. Bowlby describes denial as a fixation in the phase of shock. Mental processes and behaviors are used out of awareness to avoid cognitive and affective reactions that are too large for the individual to grasp. The second variant, chronic mourning, is characterized by a persistent and intense mimic of the second and third phases of normal bereavement. Anger and hostility at self and others are frequently present along with anguish and depression. Euphoria, the least common variant, is an unstable reaction that leads to intense grief. It is based upon gross reality distortions. An incredible sense of release that becomes exaggerated into a euphoric state may happen after the death, leaving the individual with a sense of relief or independence. Eventually the individual realizes that the aloneness is not fulfilling and a deep despondency follows.

As compared to Bowlby and Parkes (1970) phases of normal bereavement, Hauser (1987) discusses the differences between normal bereavement reactions in other types of loss and those factors associated with a sudden or unexpected,

violent or traumatic death such as suicide. Because of the mode of death, survivors of suicide can have a more difficult time integrating and resolving their grief. This can lead to the identified variants described above- by Bowlby (1980) and disrupt the normal grieving process.

Hauser found that survivors of the following types of deaths usually experience some specific factors that are related to poor bereavement outcome. These factors include the death being sudden and unexpected, violent, or the bereaved feeling responsible for the tragedy. If there are a number of other stressors present (economic, legal, etc.) then the grief is likely to be debilitated.

In conclusion, Hauser suggests that the physical and psychological systems of the person grieving death to suicide may be overwhelmed and stressed by the demands placed on them causing physical distress and feelings of helplessness and depression. The suddenness of the loss leaves the survivor no time to work on pre-existing problems within the relationship or closure with the loved one. Common reactions of shock, guilt, disbelief, and denial are emphasized and ultimately result in unresolved grief within the survivor.

## Survivor of Suicide Bereavement

Literature on the aftermath of suicide suggests that bereavement for survivors of suicide, family members and friends who have experienced the loss of a significant other by suicide, may be particularly complicated (Bailley, Kral and Dunham, 1999; Silverman, Range & Overholser, 1994; Van Dongen, 1993;

Wagner & Calhoun, 1991; Silverman, Range, & Overholser, 1994; Worden, 1991; Barrett & Scott, 1990; Grollman, 1988; Hauser, 1987, McIntosh, 1987).

According to Hauser, (1987) suicide has special circumstances that can propel the survivor into a state of unresolved grief or poor bereavement outcome. The following factors may lead to poor bereavement outcome. The lack of funeral rites and usual mourning rituals can deprive the community's access to surviving family members and limit a valuable source of comfort and support. Suicide may also lead to harmful expressions of unconscious anger and ultimately to distorted communication patterns between the survivor and other relationships. Another factor that can complicate the bereavement outcome of a survivor is that their usual social supports may withdraw more quickly following the suicide.

According to Grollman (1988), any natural death has emotional repercussions: loneliness, disbelief, heartache, and torment. With self-inflicted death, the emotions are heightened to extreme and unbearable proportions. If a loved one succeeds in taking his or her life, those left behind experience not only the pain of separation but aggravated feelings of guilt, shame, anger and self-blame. The suicidal act raises questions "Why?" and "What could I have done to change things". Anxious and grief stricken survivors ask: "How can I face my friends and family?" "What will they think about me?" Death in general, robs

people of their stability and norms. "Death by suicide, however, represents the greatest of all affronts to those who remain" (Grollman, 1988, p.1).

Similarly, Bailley, Kral & Dunham's (1999) research supports findings that grief experienced by suicide survivors includes elements that are less frequently seen in the case of non-suicidal deaths. This study investigated the influence of suicide on grief. There were 350 previously bereaved college students who completed a

questionnaire package that included three standardized measures. The participants were separated into four groups based on if their loved one died from suicide, accident, unanticipated natural death, or anticipated natural death. Hierarchical multiple regression analyses found that survivors of suicide had more frequent feelings of responsibility, guilt, rejection, "unique" grief reactions (wondering about the persons' motivation for killing themselves, feeling they should have prevented it, telling others the death happened in another way) and more total grief reactions as compared to the other groups.

> "These results suggest that survivors of suicide, as compared to non-suicide survivors, may be more likely to experience an accentuated overall combination of grief reactions in response to the loss" (Bailley et al., 1999, p. 266).

Wagner and Calhoun (1991) in concordance with Bailley et al. (1999) and Hauser (1987), report that death by suicide appears to carry with it a certain likelihood of complications. These complications can produce difficulty within

the grief process. Individuals who survive the suicidal death of someone close to them appear to be at greater risk of disturbed grief reactions than individuals who lose a loved one to other types of circumstance. According to Hauser (1987), survivors of suicide have the tendency to become "stuck" in some phase of grief and fail to progress into a successful reorganization of their lives.

Societal Responses Toward Survivors of Suicide

A pertinent reason that death by suicide is more difficult to deal with than other types of death is the responses from friends and family toward the bereaved. These responses have been categorized as less supportive, including blame towards the survivor and/or other negative behavior. Research has indicated that the ways others perceive the grief stricken family members following a death by suicide are far less sympathetic and more negative than other types of death, particularly naturally caused deaths (Calhoun, Selby and Selby; 1984; Reed & Greenwald, 1991).

A study done by Calhoun, Selby, and Faulstich (1989) presented to a sample of adults a brief newspaper account of a youth's death by different means. They found that the parents of a child who committed suicide were less liked and blamed more for the death of the youth than when the child died from a viral illness. These reactions further emphasized additional negative reactions and stigma toward parents of children who commit suicide.

Range and Calhoun's (1990) study found similar aspects of societal response. Their research compares the bereavement experience following different modes of death. The investigators designed the study to obtain the perspectives of grieving individuals themselves on how others reacted towards them after the death of a loved one. The authors were especially interested in whether survivors of suicide would report different experiences than those reported by individuals who lost a loved one to another mode of death.

The study includes a control group of those bereaved through accidental death that is important in determining if these deaths produced different community responses, even though they might have some commonalities. There were 57 students (15, men and 42, women) who participated in the study. They ranged in age from 18-36. The participants were divided into 5 groups based on if the death of their relative or friend was accidental, anticipated natural death, unanticipated natural death, suicide or murder.

The sample participated in a structured literature based interview that focused on social responses to survivors of suicide. Important components of the interview that dealt with the social aftermath of suicide included: things said and done that were helpful or hurtful, the occurrence of questions about the nature and cause of death, the way the individual was treated by others in the time immediately following the death, with a particular focus on perceived comfort/discomfort on the part of the respondent and suggestions on how the respondents would treat the bereaved individuals.

The results of the study found that those bereaved through suicide appeared to share a common core of experiences with other types of groups. However, those bereaved through either suicidal or accidental death, more than other types, said that people treated them differently after the death. Survivors of suicide reported less positive responses than those of accidental death.

The authors noted that a unique finding of the study was that those bereaved by suicide said they were expected to explain the nature of death to others in the community. Range and Calhoun reported the survivors lying about the cause of death because of the stigma surrounding suicide. "The results imply that those bereaved through suicide apparently receive less community support than survivors of accidents and other types of death" (Range and Calhoun, 1990, p.311).

Lester's (1991) research supports the findings in Range and Calhoun's (1990) study. The authors reported that individuals in the community found it harder to express support to survivors of suicide. Participants in his study agreed that there is a stigma attached to death by suicide. Respondents who were not survivors of suicide said that it would be harder to express sympathy toward the survivor who expressed self-blame for the suicide. In this study it was determined that the stigma experienced by the survivor, may not be relieved by an explanation of the motive for suicide. Even if the suicide action takes on full

responsibility for the death, others may still see the survivor as responsible.

Barrett & Scott's (1990) findings also concur with those of Range and Calhoun's (1990) study. The authors compared courses of bereavement over time in survivors of suicide and survivors of other forms of death. The findings reported significantly higher levels of stigmatization in survivors of suicide than in survivors of other types of death.

According to Barrett & Scott, "a natural death does not typically stigmatize the survivor to any degree. It is frequently suggested, however, that suicide not only stigmatizes the survivor; it also results in more negative views of the family than do other types of death" (p. 205). Death by suicide has been customarily stigmatized in our society as cowardly, irresponsible, or selfish. Therefore, if the survivor of suicide is a victim of gossip, negative attitudes, isolation, hints of family discord or mental illness, or blame for the death, he or she is likely to feel stigmatized by the suicide. This measure is based on the common suggestion that suicide is ill reflected on and permanently marks the suicide survivor as different from other survivors.

Clark and Goldney (1995) also report that many of their subjects experienced a sense of shame and stigma related to the suicidal death. Participants in the study regarded this as a unique burden to suicidal bereavement; they felt additional stigma from the illegality of the suicide, churches' current and previous attitudes, the association between suicide and mental illness, tainting of

the family tree and being gossiped about within the community. Many survivors in this study had problems telling others that the death was a suicide. They either lied about the cause of death or skirted the issue. This ultimately leads to long term deception of family and friends.

Bailley et al.'s (1999) results corroborate with the above research, finding that increased levels of shame and perceived stigmatization do set survivors of suicide apart from those who mourn non-suicidal deaths. The author's share their view that attention should be directed at the feelings of shame and rejection. These processes can play a significant role in the survivor reaching out for help within the community.

Similarly, Silverman, Range, and Overholser's (1995) study indicated that suicide survivors experience higher levels of shame and rejection as compared to other bereavement groups. Findings suggest that shame may occur because of the stigma surrounding death by suicide. The survivor may have more trouble discussing the death with others, trying to hide the circumstance surrounding the death. The survivor may be criticized or rejected by others. Survivors may be blamed for the death with others suggesting "they didn't see it coming" or "weren't able to stop it". Social rejection may increase the survivor's feelings of self-reproach. In response to societal actions, Wrobleski in Van Dongen (1993), stated that people often speculate that if a person is willing to commit suicide, someone must have "drove him or her to it" and that somebody must be to blame.

Role of Support Groups in Treatment of Survivors of Suicide

There is often a lack of support for survivors of suicide due to societal attitudes and the fragmentation of family and community networks (Doka, 1989; Goldney et al., 1987). Self-help groups have developed in response to this need. The effectiveness of these types of caring community groups rely on the principle of "those who help are helped the most." They complement other psychological services within the community, are accessible, and focus on a specific need (Clark & Marley, 1993). Evaluation has shown that they may reduce morbidity and emotional aftermath of those left behind while facilitating recovery by changing attitudes (Farberow, 1992).

According to Clark, Jones, Quinn et al. (1993) there is a need to form and evaluate self-help groups for those bereaved by suicide. The article was written in response to request from medical, social, and lay agencies for guidance in establishing similar support groups. The authors outlined the history of establishing a support group for those who had lost someone to suicide in an Australian city. They described the importance of establishing a group, its structure, management, helping functions, difficulties and the experiences gained from the first seven years of existence.

Clark, Jones, Quinn et al. found that services are helpful when they provide regular support meetings, 24-hour telephone support, individual support,

education in grief management, guest speakers, literature on grief, information on how to tell others about the suicide (primarily children) and a non-judgmental attitude.

The study involved 97 bereaved individuals who made 435 personal attendances over a 2-year period. All socioeconomic groups were represented with a wide variety of kinship losses, including spouse, sibling, parent, grandparent, child and friend.

Clark, Jones, Quinn et al. (1993) reported that those individuals have different needs. Some members may come every week, while others may have their needs filled after one or two attendances. These needs are often reassured that their grief experience is normal and that others are going through the same thing. Those who attended regularly seem to need more long term support. They are often people living on their own, with unsupportive partners or consider themselves to have a lack of social support.

Several authors have noted the lack of current research that describes the nature or effectiveness of group programs which have been directly targeted toward helping survivors of suicide (Rubey & McIntosh, 1996; McIntosh, 1993; Farberow, 1992; Grollman, 1988). It has been found that the existing research is focused on populations that have experienced losses from many different types of death and not suicide specifically.

Due to the lack of research previously done in this area, Faberow (1992) conducted a study that evaluated a Los Angeles' "Survivors after Suicide"

Support Program. The program was set up with controls and therefore avoided some of the shortcomings of previous research results. Kinship losses were purposely mixed, as well as sex and age of adults who are involved. The program offered weekly meetings and open-ended membership.

The sample consisted of 60 participants in the Survivors After Suicide (SAS) program who completed eight-week courses and completed questionnaires before and after. The control group consisted of survivors who filled out the pre-program questionnaire but did not attend the meetings or dropped out after attending only one.

Farberow's study found that the Survivors After Suicide program was indeed helpful. A very solid 92% of those who attended the Survivors After Suicide groups rated their experience favorably. Farberow asked specifically how the group had been helpful and some participants replied: "It lessened the shock", "It made me more aware of my feelings", "I was helped to face the reality of my loss", "It was helpful to talk and share with others", "I feel more normal, it put things in perspective" and "I feel more in control" (p.32).

Farberow, reported that a major contribution of the Survivor After Suicide program, similar to that reported by Rubey and McIntosh (1996) had been to provide support through the sharing of mutual support experiences, problems and losses. Many of the participants reported difficulties in their grief process because their usual sources of support were lost when others found out the death

had been a suicide. Friends distanced themselves, turned away or were unable to get over their own feelings of awkwardness. They avoided discussing the situation and could not provide the support they once did. The participants reported this occurring within families and among friends.

The author noted that the sample group, who attended the Survivor after Suicide program had lower levels of grief, shame and guilt. According to Farberow "sharing and learning about the ubiquity of such feelings had apparently lessened their intensity" (p.33). The control group, who did not participate in the Survivor After Suicide program, had significantly higher levels of grief, shame, and guilt

The participants in Clark and Goldney's (1995) study also reported that knowing a support group existed was helpful in lessening the shame and stigma of suicide. Knowledge about mental illness and suicide and that it can happen to anyone, also lessened the stigma surrounding the cause of death. In addition, survivors who attended the support group longer were successful models of survival, and so provided hope for grief recovery and knowledge in survival techniques. Meeting others going through the same crisis dispelled the loneliness of the experience and enabled some members to reach out for additional help.

Similarly, Hopemeyer and Werk (1994) found that self-help groups can be a useful tool in assisting bereaved persons come to terms with different phases of grief and move forward. According to the authors, normalization is an important process for bereaved individuals. Seeing others with similar grief reactions helps

members to recognize that their responses are neither irrational nor unnatural. As one participant in Hopemeyer and Werk's study stated:

> In the group I felt a sense of acceptance, of being more among others who understand and therefore don't expect more of me than I can do. Especially the reassurance that I am part of a very diverse and normal group of people who have in common the loss of a loved one by suicide. The reassurance that I am still a good-o.k-person, not a pariah. Our common experience of helplessness before another suicide allow me to believe that I am not to blame – none of us are – and that I can go on with my life (p.253).

Their study focused on evaluating and improving group services offered to survivors of five different modes of death, including suicide. Members who attended one of the five groups over a period of several years were mailed an adapted version of the Social Support Project Questionnaire. They were asked to describe their social support experience, identify their reasons for attending the group, to indicate their satisfaction or dissatisfaction with their group and to identify their ideal group format.

The group members appeared to benefit from sharing experiences with other group members who had lost someone to the same mode of death. Members could often be helped by one another to regain hope for their own lives. They had a chance to see how others how others survived.

Perceived Social Support

Societal support seems to be the most crucial element in helping someone who is bereaved, regardless of the type of death. In the case of suicide, the needed social support may be absent. There has been a variety of speculation about the type of support systems that exist for survivors of suicide and whether that support is positive and helpful or contradictory. The most hasty and readily available support would seem to be offered from family and friends. Some research points to the fact that this support may not be present to the extent that the survivor wants it to be, while others claim that although the support is there, survivors perceive it as missing (Sequin et al., 1995; Thompson & Range, 1992; Van Dongen, 1993; Wagner & Calhoun, 1991).

Wagner and Calhoun's (1991) study used a group of survivors and a group of social network members to examine the differences in social support received or perceived by both. The research determined that survivors reported receiving a high instance of negative support and finding that others often avoided them, not knowing what to say. When faced with uncomfortable situations such as funerals, people would make inappropriate or careless remarks, not realizing how to offer helpful support to the suicide survivor. Van Dongen (1993) postulates that people may avoid interactions with survivors of suicide because they perceive it as more stressful than interacting with those who have lost someone to another type of death.

In contrast, Van Dongen's (1993) study explored social context of postsuicide bereavement. The author reported that sixty nine percent of his subjects experienced strong social support. Yet, nearly all subjects perceived friends and relatives (outside the immediate family) as uncomfortable when around them. There were 26% participants who reported at least one experience of perceived stigmatization related to the suicide. They perceived that an individual(s) was more than ambivalent or uncomfortable and actually seemed to reject them. Nearly all subjects reported role uncertainty in themselves as to how they should behave as a survivor of suicide. A subject in Van Dongen's study states "Nobody wants to listen to you. Everybody expects you to forget it and to get on with your life" (p.135).

The participants in Van Dongen's research were 35 adults who had lost a family member to suicide during the previous three to nine months. The names and addresses of the potential subjects were obtained from the county records offices, accessing the mailing list of a Survivors of Suicide organization, and through referrals by subjects already in the study. A letter regarding the study along with a return envelope was sent to persons who met the study criteria.

In regard to family relationships, Van Dongen, reported that thirty of the 35 survivors indicated that the tragedy had drawn their family together and that their perceived family relationships were the same or closer than before the death.

In the case of some participants, a possibility of another suicide or tragedy was a reason for the closeness or better communication within the family.

Interestingly, the author reported that as time passed, most survivors of suicide indicated that they ceased expressing their concerns related to the death even within the family, though they still perceived them as supportive. In relationship to how her family tried to cope, a survivor in Van Dongen's study states:

> Sometimes you don't want to bring it (the suicide) up. You just don't want to go through any more emotionally or to put them through more. It's very painful. It's hard to talk because each of us wants the other to respond. Like I want him to respond to my pain, yet I know he's in pain and wants me to respond too. So it's hard to learn that you have to take turns. It's very, very difficult (p. 131).

According to Thompson and Range (1992) when non-bereaved people were asked how they would provide support, most responses contained positive feedback, yet 62% of bereaved individuals reported that supporters had responded in negative or unhelpful ways. They found that out of a sample of 158 responses bereaved individuals received up to 5 years after their loss, 20% were helpful and 80% were harmful. The authors also noted that the majority of survivors reported that the most useful and sincere support was from other survivors.

The importance of social support in the bereavement process has been recognized in a study done by Pennebaker and O'Heeron (1984). The authors found that after a one year time period, bereaved survivor spouses who received more "expressive support", had less health problems than spouses who experience none. The research defined "expressive support" as other friends or family members reaching out to the survivors verbally. Reed's (1993) findings also concur by concluding that suicide survivors who received more "expressive support" felt they had a closer bond with their families, and those with closer family bonds had experienced lower levels of bereavement.

Farberow, Gallagher-Thompson, Gilewski, and Thompson (1992), did a study using survivors who lost a wife or a husband by suicide and natural death, using a composite index of social support. They found that survivors of suicide received less support than survivors of natural death or non-bereaved controls, particularly at 6 month post death. The authors found that women received more support than men during this time. This study concluded that the quality and type of support received may be more important than the quantity.

According to McIntosh (1987), in his book chapter on the aftermath of suicide in families, parents who lost a child to suicide had experienced feelings of blame, stigma, and non-support by members of their families and friends. The parents treated by Hatton and Valente (1981) in McIntosh, (1987) describe their confusion at the avoidance of the death of their child as a topic of discussion by others and the absence of condolences from relatives.

McIntosh also reports that spouses of a death by suicide, incur lower levels of perceived social support as well. The stigma surrounding suicide and spouse survivors commonly leads to blaming, gossip, and finger pointing at the spouse by the community, neighbors and in-laws. It is not exclusively neighbors who blame, avoid and fail to provide social support, survivors report relatives as well do these very things. McIntosh attributes lack of societal norms for what others should do for a survivor of suicide as a possible cause of withdrawal.

The emotion of guilt in the survivor may lead them to experience feelings of self-reproach. They may begin to imagine that they have done something to cause or instigate the suicide. Embarrassment and humiliation imply dishonor or disgrace, suggesting to the survivor that he or she has failed their loved ones. These emotions can sometimes lead the survivor to isolation. They do not feel worthy of companionship, often searching for their own meaning. These behaviors can make it difficult for family and friends to give support (Knieper, 1999).

According to Knieper (1999), perceived societal support seems to be the most crucial element in aiding someone who is recovering from a loss to death, regardless of the type of death. For suicide, the crucial support may not be readily available. The most need immediate and available support would seem to be given by family and friends. Sometimes this support may not be present to the

extent the survivor needs or wants it to be and sometimes although the support is there, survivors perceive it as missing.

While some researchers (Seguin et al., 1995; Reed, 1993; Range and Calhoun, 1990; Calhoun, Selby and Selby, 1982) state emphatically that survivors of suicide receive less social support than those suffering from other types of loss, others (Knieper, 1999; Calhoun and Range, 1991) state that it is not clear whether survivors actually are given less support or whether they only perceive a lack of support. Knieper (1999) recounts from a survivor who lost her mother to suicide " I don't know how much of it (stigma) is actually out in the public and how much is just within yourself" (p. 356). Van Dongen (1993) explains that the perceptions of stigma by survivors may only be a projection of their own feelings, and not an actual fact.

Rationale for Study

Recently there have been a number of studies devoted to the areas of suicide dealing with grief symptomology (Reed, 1998), parental bereavement (Nelson and Frantz, 1996), recovery and survivors of suicide support groups (Rubey and McIntosh, 1996; Clark and Goldney, 1995; Clark et al., 1993; Farberow, 1992) yet, research is lacking in the area of survivors of suicide and their support networks.

Some studies have established that suicide survivors receive less social support than survivors of other types of death (Sequin et al. 1995; Reed, 1993; Range and Calhoun, 1990; Calhoun, Selby and Selby 1982) and others have explored whether survivors actually receive less social support or whether they perceive it as less social support, (Knieper, 1999; Wagner and Calhoun, 1991). However, there have been no studies that measure perceived social support in survivors of suicide who attend a support group versus those who do not attend a survivor group. There is need to investigate this valuable element of coping with suicide employing a standardized instrument for social support (McIntosh and Kelly, 1992).

Acknowledging several authors' pleas for more current research in this important but rarely studied area of the social support network of the survivor (Knieper, 1999; Reed 1993; Wagner and Calhoun, 1991; Range and Calhoun, 1990; Dunne, McIntosh, et al. 1987, Hauser, 1987; Calhoun, Selby and Selby, 1982), the purpose of this study is to compare the perceived social support of survivors of suicide who attend a support group compared to those survivors of suicide who do not attend a support group.

# CHAPTER III

## METHOD

### Subjects

The population from which the sample was drawn were from two different groups of people: (1) survivors of suicide who attend a support group and (2) survivors of suicide who do not attend a support group. For the purpose of this study, volunteer sampling was used. Only those survivors of suicide who had lost a family member to suicide within the last 3-12 months were included in the study.

The first sample was drawn from a Missouri Crisis Centers' "Survivor of Suicide" support group roster. The support group meets weekly to provide individuals with a safe and comforting setting where group members can begin working toward understanding, healing, and acceptance of the loss of a family member or loved one through suicide.

The control group of those not in the support group, was derived from a list of St. Louis city and county public coroner reports on suicide deaths that are sent to the crisis center. The coroner's records list the date of the suicide and the names and addresses of the surviving family members. According to Hoff (1989) "One means of reaching a large number of survivors is through coroners' offices. It is there that every death is eventually reported and recorded" (p. 241).

Within both groups, persons who met the study criteria were sent a letter describing the study and a return envelope. Of the 170 letters sent to both potential participant groups, 42 were returned. The participants of this study were comprised of 22 individuals who attended a survivors of suicide support group and 20 individuals who were survivors of suicide but did not attend a survivors of suicide support group.

The mailing included surveys sent to both male and female survivors of suicide. Overall, the majority of respondents in the sample were females at 66.7% (n= 28) and 26.2 % (n= 11) total male respondents. It should be noted that of the 42 total respondents, three did not answer the gender category on the demographics questionnaire

TABLE 1

| | TOTAL | | SUPPORT GROUP ATTENDEES | | NON SUPPORT GROUP ATTENDEES | |
|---|---|---|---|---|---|---|
| GENDER | N | % | N | % | N | % |
| Male | 11 | 26.2 | 5 | 22.7 | 6 | 30.0 |
| Female | 28 | 66.7 | 16 | 2.7 | 12 | 60.0 |
| Missing | 3 | 7.1 | 1 | 4.5 | 2 | 10.0 |
| Total | 42 | 100 | 22 | 100 | 20 | 100 |

GENDER DISTRIBUTION OF RESPONDENTS

With regard to race and ethnicity, the largest number of participants were Caucasian at 85.7 % (n = 36). The rest of the race/ethnicity categories were represented by one participant each. One respondent identified him/herself as Other. See Table 2.

TABLE 2
NUMBER OF RESPONDENTS
TO SURVEY BY RACE/ETHNICITY

| | TOTAL | | SUPPORT GROUP ATTENDEES | | NON SUPPORT GROUP ATTENDEES | |
|---|---|---|---|---|---|---|
| RACE/ETHNICITY | N | % | N | % | N | % |
| African American | 1 | 2.4 | 1 | 4.5 | | |
| Caucasian | 36 | 85.7 | 19 | 86.4 | 17 | 85.0 |
| Latino/Hispanic | 1 | 2.4 | 1 | 4.5 | | |
| Native American | | | | | 1 | 5.0 |
| Other | 1 | 2.4 | 1 | 4.5 | | |
| Did not answer | 1 | 2.4 | | | 2 | 10.0 |
| TOTAL | 42 | 100 | 22 | 100 | 20 | 100 |

The ages ofparticipants who attended the support group ranged from nineteen to seventy three years old with a mean age of 47.9. The age range of the participants who did not attend a support group were twenty four to eighty years old with a mean age of 47.1. The mean ages for both groups were similar. For this study, participant's age was broken down into 5 categories. Of these five age groups, the largest percentage 28.6% (n = 12) of

participants fell into the fifty six or greater category. While the least number of participants, 7.1% (n = 3), were less than 25 years old. There were two participants who did not report their age. Table 3 lists age group information.

TABLE 3
NUMBER OF RESPONDENTS TO SURVEY BY AGE GROUP

| | TOTAL | | SUPPORT GROUP ATTENDEES | | NON SUPPORT GROUP ATTENDEES | |
|---|---|---|---|---|---|---|
| AGE GROUP | N | % | N | % | N | % |
| 25 or less than | 3 | 7.1 | 2 | 9.1 | 1 | 5.0 |
| 26 - 35 | 11 | 26.2 | 6 | 27.3 | 5 | 25.0 |
| 36 – 45 | 7 | 16.7 | 3 | 13.6 | 4 | 20.0 |
| 46 – 55 | 7 | 16.7 | 3 | 13.6 | 4 | 20.0 |
| 56 or greater | 12 | 28.6 | 8 | 36.4 | 4 | 20.0 |
| Did not answer | 2 | 4.8 | | | 2 | 10.0 |
| TOTAL | 42 | 100 | 22 | 100 | 20 | 100 |

In the present study, the respondents reported losing a son to suicide more often than any other family member, including a spouse. Overall, 38.1% (n = 16) respondents had a son die by suicide. For the survivors of suicide attending a support group, 45.5% (n = 10) had lost a son. In the non-support group attendees 30% (n = 6) of the respondents indicated it was a son who committed suicide. Table 4 provides a representation of the relationship of deceased to the survivor.

TABLE 4
RELATIONSHIP OF DECEASED TO SELF

| | TOTAL | | SUPPORT GROUP ATTENDE ES | | NON SUPPORT GROUP ATTENDEES | |
|---|---|---|---|---|---|---|
| RELATIONSHIP | N | % | N | % | N | % |
| Son | 16 | 38.1 | 10 | 45.5 | 6 | 30.0 |
| Daughter | 3 | 7.1 | 3 | 13.6 | | |
| Husband | 8 | 19.0 | 4 | 18.2 | 4 | 20.0 |
| Wife | 1 | 2.4 | | | 1 | 5.0 |
| Brother | 7 | 16.7 | 5 | 22.7 | 2 | 10.0 |
| Sister | 2 | 4.8 | | | 2 | 10.0 |
| Father | 2 | 4.8 | | | 2 | 10.0 |
| Mother | 2 | 4.8 | | | 2 | 10.0 |
| Didn't answer | 1 | 2.4 | | | 1 | 5.0 |
| TOTAL | 42 | 100 | 22 | 100 | 20 | 100 |

Instruments

There were two related scales used in this study. The Perceived Social Support- Friend Scale (PSS-Fr) and the Perceived Social Support- Family Scale (PSS-Fa). These scales are used to measure fulfillment of social support from friends and family.

The PSS-Fr and PSS-Fa are two 20-item instruments designed to measure the degree to which the subject perceived his/her needs for support as fulfilled by friends and family. Social support varies between friends and family in that one's network of friends is comparatively less long-term than the family network and requires more social competence in maintenance than is demanded of one's

family network. In, part, this difference is because people assume the family network is their birthright (Fischer & Corcoran, 1987).

This instrument is appropriate for adult subjects. The items of two scales were developed from a pool of 84 items and were selected by the magnitude of item correlation. Factor analysis suggests the instruments each measure a single domain (Fischer & Corcoran, 1987).

Normative data were derived from a sample of 222 (mean age = 19 years) undergraduate psychology students. The mean and standard deviation for the PSS-Fr and PSS-Fa were 15.15 (SD = 5.08) & 13.40 (SD= 4.83).

The PSS-Fr and PSS-Fa are scored "yes" and "no" and "don't know" (don't know is scored "0" on both scales). For the PSS-Fr an answer of "no" is scored +1 for items 2,6,7,15,18 and 20. For the remaining items "yes" is scored +1. For the PSS-Fa, answers of "no" to items 3,4,16,19, and 20 are scored +1, and for all other items a "yes" answer is scored +1. Scale scores are the total of items scored and range from 0 to 20 for the PSS-Fr and the PSS-Fa. Higher scores reflect more perceived social support (Fishcer & Corcoran, 1987).

The PSS has excellent internal consistency, with an alpha of .90. The test-retest coefficient of stability over a one-month period was .83. The reliability data are based on the original 20-item PSS before the items were anchored for

separate perceived support from friends and family. Alphas for the final PSS-Fa ranged from .88 to .91 and .84 to .90 for the PSS-Fr (Fischer & Corcoran, 1987; Eskin, 1993).

Both the PSS-Fr and PSS-Fa have good concurrent validity. Scores are correlated with psychological distress and social competence. Both measures were associated with psychological symptoms (Fischer & Corcoran, 1987).

The reliability and validity of the PSS-Fr and PSS-Fa is a strength of each instrument. According to an analysis done by Eskin, (1993) the PSS-Fr and PSS-Fa scales are reliable methods for assessing perceived social support from friends and family.

Procedure

This researcher sent the participants in both groups, a cover letter explaining the type and importance of this study along with a demographics questionnaire, The Perceived Social Support- Friend Scale (PSS-FR) the Perceived Social Support- Family Scale (PSS-Fa), and a self-addressed return envelope. Included in the material sent was a telephone number the participants could call if they had questions or concerns as well as a pamphlet on coping with with grief after suicide.

For the purpose of this study, volunteer sampling was used. Only those survivors of suicide within both groups, who met the criteria of losing a family member to suicide within the last 3 - 12 months were included in the study.

A causal comparative research design was selected because in causal comparative research, the researcher attempts to determine the cause or reason for preexisting differences in groups. In this research, the hypothesis was that those survivors of suicide who attended a support group would have a higher level of perceived social support compared to those survivors of suicide who did not. A distinguishing feature of this design is that there is no manipulation of the independent variable and the individuals are not randomly selected. In this study subjects had already been selected into two groups before the research began.

This researcher selected two groups of participants referred to as comparison groups. The groups differed in that one group comprised of survivors of suicide who attended a support group meetings and the other group consisted of survivors of suicide who did not attend survivors of suicide group meetings.

Some potential threats to the study are lack of randomization, manipulation and control. These could be sources of weakness in causal comparative design. In order to help minimize the threat of randomization, this researcher tried to have groups as similar as possible on all relevant variables except the independent variable. In order to determine the equality of groups, information on a number of background and current status variables were collected and compared for each group (Gay & Airasian, 2000). For example, information on relationship of deceased to self and when the suicide occurred was gathered. The more similar the two groups were on such

variables, the more homogenous they were on everything but the independent variable.

An independent t-test was the type of data analysis used to determine if there was a significant difference in perceived social support among survivors of suicide support group attendees compared to survivors of suicide non-support group attendees

# CHAPTER IV

## RESULTS

Of the 42 surveys, 22 were from survivors of suicide who attended a support group and 20 were from survivors of suicide who did not attend a support group. For the present study, the Perceived Social Support Family (PSS-Fa) and Perceived Social Support Friend (PSS-Fr) were scored. The higher the scores on the PSS-Fa and PSS-Fr, the higher the level of perceived social support.

The mean for family support in survivors of suicide attendees was 14.05 with a standard deviation of 4.52. and for friend support was 13.14. with a standard deviation of 6.01. In the non-attendee group, the family support mean was 12.25 with a standard deviation of 7.16 and for friend support, the mean was12.95 with a standard deviation of 5.09. Please refer to Table 1.

The hypothesis for this study was that there was a significant difference in the level of perceived social support between survivors of suicide who attended a support group and survivors of suicide who did not attend a support group. An independent t-test was run to determine whether or not there would be a significant difference in perceived social support between the two groups with $p = 0.05$ level of significance.

As shown in Table 1, the p-value for the t-test results suggested that there was no significant difference found in the perceived social support from family

between survivors of suicide who attend a support group and those survivors of suicide who do not attend ($t = .956$, $p = .346$). The results also indicated that there was no significant difference found in the level of perceived social support from friends between survivors of suicide who attend a support group and those who do not attend ($t = .109$, $p = .914$). Table 5 describes the results of the independent t-test.

TABLE 5

RESULTS OF T-TEST OF DIFFERENCE IN PERCEIVED SOCIAL SUPPORT

| Variable | Group | n | Mean | SD | t | p |
|---|---|---|---|---|---|---|
| Perceived Family Support | Support Group Attendees | 21 | 14.05 | 4.52 | .956 | .346 |
| | Support Group Non-Attendees | 20 | 12.25 | 7.16 | | |
| Perceived Friend Support | Support Group Attendees | 22 | 13.14 | 6.01 | .109 | .914 |
| | Support Group Non-Attendees | 19 | 12.95 | 5.09 | | |

$p > 0.05$

# CHAPTER V

## DISCUSSION

The findings of this study suggest that, in this sample, overall levels of perceived social support were not significantly different between survivors of suicide in a support group compared to those survivors of suicide who were not in a support group. These findings were different from the previous studies (Clark and Goldney, 1995; Hopemeyer and Werk, 1994) that indicate survivors who attend a support group felt more supported in general.

There may be possible explanations for why the survivors who attend a support group did not have significantly higher levels of perceived support than non-attendees. Perhaps, the findings of this study suggest survivors who attend a support group do not have the societal support networks they need. They may seek social support from a survivors of suicide group to gain the support they lack from family and friends. Non-support group attendees may already have enough perceived support from family and friends. Therefore, this group may not need to supplement their support network with additional means.

Secondly, in some cases, the suicide of a family member has actually been reported to bring family members closer than they were prior to the suicide (Van Dongen, 1993). Some members become more observant and protective toward

other family participants. The family unit is held together by the fear of another tragedy or suicide.

Lastly, do survivors who attend a support group lack the ability to perceive enough social support than those who would not attend a support group? This suggests that further research needs to be done to identify those characteristics found in survivors who attend a suicide support group.

Implications

Research in the area of survivors of suicide has made an impact on therapists' and other professionals' understanding of societal responses and social support, however implementing ways to help them has been slow. Therapists and other professionals working with survivors of suicide can benefit from a thorough understanding of perceived social support and how it affects the coping and recovery process in survivors. The literature presented emphasizes the importance of finding ways to assist survivors of suicide in healthy recovery. There is nothing in this study that suggests differently.

Campbell (1997) states the importance of postvention and training of mental health professionals as an appropriate way to spend time and money. Therapists and other professionals working with survivors of suicide can provide these services by acting as mediators between survivors and society.

Knieper (1999) claims that professionals in this role can promote understanding by working to educate the survivor about what to expect

concerning their bereavement as well as possible societal responses and support from others.

Van Dongen (1993) suggests that in the case of suicide there is confusion about societal norms and how to act. Many individuals fear doing or saying the wrong thing, so they do or say nothing. Knieper (1999) suggests "mental health professionals can fill that role by exhibiting caring acceptance of the bereaved. Most of all, they can be unbiased empathetic listeners who are comfortable with various emotions the griever will display" (p. 358). Before society, therapists, and professionals can help survivors of suicide realize their own need for support, survivors must be comfortable and willing to look at their own perceived level of support and societal networks that already exist.

Limitations

Limitations of the present study must be acknowledged. There was a small sample size of 42 adult survivors of suicide. A larger sample would have been more representative of the survivor population. There are possible sources of sampling bias in this study. The study involved predominately Caucasian survivors of suicide group members and non-attendees. Previous research indicates this is typical in similar studies due to suicide statistics being significantly higher for Caucasians than any other race, therefore, resulting in more Caucasian suicide survivors (Clark et. al. 1993). There are also more females than male members of the sample and control group. Several samples

and control groups in previous studies on survivors of suicide have consisted of more females than males. This gender distribution is consistent with other similar research studies (Callahan, 2000; Hopemeyer and Werk, 1994; Range and Calhoun, 1990). Using a group of survivors of suicide who dropped out of a suicide support group after one meeting may have been a better control.

## Recommendations

The emotional uniqueness of those bereaved by a death from suicide is diverse and proposes a challenge for society and therapists alike. In this study, the focus is on the perceived social support within survivors who attend a support group and those who do not. A death by suicide leads to a profound and agonizing bereavement as well as interpersonal implications for the survivors. A description of the social experiences of survivors of suicide must include a description of the circumstances that influence both survivors and the individuals reacting to them. Although each survivor's reaction may be different, this study suggests that survivors of suicide who do not seek outside services may have more social support than has often been assumed.

In this study, getting additional data to compare family support vs. friend support may have provided an important distinction in this area. Perceived social support scores of survivors who attend a suicide support group compared

to those survivors who dropped out of a suicide support group after one or two meetings would be a future suggestion at duplicating this research.

There are several elements of coping within the social support network of survivors that have yet to be studied. Future research may ask the question "How does this network react under various survivor circumstances?" and "Do survivors withdraw from previous support systems?" or "How does the network and its extensiveness affect survivor reactions, their intensity and duration and recovery?" Further study, especially longitudinal research, exploring these social contexts of postsuicide grief is recommended.

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