SURVIVORS OF SUICIDE: WHAT ARE THEIR STRUGGLES AND HOW DO THEY HEAL?

by

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Presented to the Faculty of the Graduate School of

The University of Texas at Arlington in Partial Fulfillment

of the Requirements

for the Degree of

MASTER OF SCIENCE IN SOCIAL WORK

THE UNIVERSITY OF TEXAS AT ARLINGTON

May 2013

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ACKNOWLEDGEMENTS

Dr. Regina T. P. Aguirre, thank you very much for your knowledge and patience on this research journey. You have helped me become a stronger writer, and even managed to help me understand statistics! Your passion for research has fueled mine and I cannot wait for the next research adventure! Thank you also to Dr. Norman Cobb and Dr. Janet Finch for their involvement in my thesis committee.

My endlessly patient husband, JR, there are not enough pages for me to say thank you and acknowledge you sufficiently, so I will just say, Go Team Honeycutt!!

Victoria McWilliams, thank you so much for your encouragement and support. Thank you for listening to me when I needed it

To my amazing friends, Laura and Leticia, I am forever indebted to both of you. The willingness you both had to help me with at any given time is amazing. I consider myself very lucky to have you both in my life.

To my mom and sister, you both have encouraged me to pursue my dreams so much. You are the best cheerleaders that I could ever ask for. You are there to kick me when I need it and lend an ear when I need to scream. Thank you both so much for everything.

Finally, to my dad, I am so happy that I was given a chance to get to know you. You are the best dad that I could ever want. I love laughing with you and cannot wait to finally go on that fishing trip. This is dedicated to you Daddy, I am so happy that we got a second chance.

April 16, 2013

ABSTRACT

SURVIVORS OF SUICIDE: WHAT ARE
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The University of Texas at Arlington, 2013

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The purpose of this study was to answer five questions: 1) what are the coping strategies of suicide survivors?; 2) what percentage of survivors have post-traumatic stress?; 3) what percentage of survivors are at risk of suicide?; 4) what percentage of survivors experience post-traumatic growth?; and 5) what are the relationships among these variables? Four standardized assessments on suicide risk, post-traumatic stress and post-traumatic growth were administered along with a questionnaire covering demographics and coping strategies. Results provided support that survivors do experience post-traumatic stress and that they are at risk of suicide. The findings suggest that survivors need help individually identifying what coping strategies help the them heal.

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CHAPTER 1

INTRODUCTION

About one million people die by suicide globally each year. To put that in perspective, one suicide occurs every 40 seconds worldwide ("Suicide prevention (SUPRE)," 2012). In 2006, more than 33,000 suicides occurred each year in the United States (McIntosh, 2012)

In the United States, ages 45-54 have steadily increased the rate of suicide since 1999. In that same year, an estimated 14 people suicided per every 100,000 people compared to a rate of approximately 19 per 100,000 people in 2009. This age group is also has the highest rate of suicide completions. In the 25-34 year old range, suicide is the second leading cause for death and the third cause for death for ages 15-24. Across all age ranges, suicide is the tenth cause of death in the United States as of 2010 (McIntosh, 2012).

1.1 Definition of Survivors

For every suicide, an estimated minimum of six people is affected by the suicide (Begley & Quayle, 2007; Cerel & Campbell, 2008; Jordan, 2008). Jordan (2008) argued that the number of actual survivors is underestimated due to a clear definition of what a survivor is and to the extent to which a person was affected. Jordan (2008) also suggested that there is a “lack of epidemiological studies to refine or clarify it“ (p. 146). This raises the question, who exactly is a survivor of suicide? McIntosh (1993) defined a survivor as “the family members and friends who experience the suicide of a loved one” (p. 146). Andriessen (2009) suggested that a survivor of suicide is a person whose life is affected and changed by the loss. He further suggested that a train conductor’s life would be changed and even traumatized even though he or she did not know the person in the way of the train. Andriessen (2009) further went on to state that other research suggested (McIntosh, 2003) that the quality of the relationship may be more significant than bloodlines. For the extent of this paper, suicide survivor and survivor will

be used to refer to those who have experienced a loss by suicide. In addition, the definition that Andriessen (2009) used to identify whom a survivor is will be used for this paper.

1.2 Bereavement

Losing a loved one is hardly ever easy. Even if a person knows his or her loved one is going to die it is a difficult thing to go through. Losing someone to suicide is no different. However, there is an argument about whether or not suicide bereavement is different than bereavement by other forms of death. Campbell (2001) suggested taking into account what stage of life the survivor is in but also suggested that how a person copes depends on how open he or she is to explore the topic.

Suicide bereavement can be more complicated due to stigma that may follow the loss. As Jordan (2008) suggested, the stigma could be condemnation or it could be uneasiness about the subject of suicide. In spite of how many people are affected by suicide, this type of death is still very much a taboo topic and not understood by the general public, which could lead to the condemning stigma, or the survivor could self-stigmatize (Jordan, 2008). Survivors may also be reluctant to reach out for help due to the stigma. This reluctance could be due to shame and the unwillingness to be open about the true cause of death (Cerel, Jordan, & Duberstein, 2008; Grad, Clark, Dyregrov, & Andriessen, 2004). Additionally, Grad et al. (2004) found that one of the best ways to overcome stigmatism was to embrace openness. Once a survivor spoke openly and honestly about the true cause of death, "life became easier" (p. 135).

Jordan (2008) stated that common forms of bereavement for any death are "sorrow and yearning" (p. 680). Jordan (2008) went on to say:

> Beyond this, many studies have found that high rates of problematic grief experiences in survivors, such as intense guilt or feelings of responsibility for the death, a ruminative need to explain or make sense of the death, strong feelings of rejection, abandonment, and anger at the deceased, trauma symptoms, complicated grief, and shame about the manner of death (p. 680).

Jordan (2001) argued that bereavement after suicide is different from other losses and suggested there are three themes to the bereavement process of suicide survivors. In the first theme, the survivor feels guilty, blaming himself or herself, and holding themselves responsible for the death. The second theme is an increase in feeling rejected, abandoned, and angry toward the deceased (Jordan, 2001; Jordan, 2008). The third theme is the survivor questioning the meaning of the death or the "why" (Campbell, 2001; Jordan, 2008, p. 681) question such as "why did this happen," or "why did they do it" (Campbell, 2001; Jordan, 2008, p. 681). The three themes help to differentiate bereavement of suicide versus bereavement of other types of losses.

Campbell (2001) used the metaphor of the "Canyon of Why" to illustrate how a survivor of suicide might be at risk to take their own life. The metaphor starts in the river of life with a person contemplating suicide and comes to a fork in the river: on one side is opportunity; on the other is danger. The person makes a choice and if the choice is danger, the person is moving closer toward death. If a person suicides, the survivors of the suicide are immediately thrown into the river of risk and move quickly to the fork (Campbell, 2001). This metaphor along with the themes of bereavement shed light on how survivors of suicide might be a risk of taking their own lives. Another component of risk is if a survivor develops posttraumatic stress disorder (PTSD)

1.3 Posttraumatic Stress Disorder

When a survivor is suddenly thrown into the metaphorical river of risk (Campbell, 2001), the survivor may be at risk of developing PTSD. In order to be diagnosed with PTSD a person must meet the criterion specified in the DSM-IV-TR by experiencing a traumatic event, such as but not limited to war or rape (4th ed., text rev.; *DSM–IV–TR*; American Psychiatric Association, 2000). Zisook, Chentsova-Dutton, and Shuchter (1998) asked if bereavement could be classified as PTSD. They found that PTSD was higher for those participants who were survivors of suicide or accidental deaths by 36% (Zisook, Chentsova-

Dutton, & Shuchter, 1998). These findings showed that method of death causes trauma but the study did not go much further than a person could experience trauma when bereaved.

1.4 Interpersonal Theory of Suicide

Even with the complications of suicide bereavement and PTSD, one may wonder why a survivor would choose suicide after being so impacted by a loved one's suicide. Van Orden et al. (2010) proposed the Interpersonal Theory of Suicide (ITS). This theory proposes that there are three constructs, that when present, can increase the risk of suicide. The first construct is thwarted belongingness or loneliness because they are isolated from others along with the lack of reciprocal care, meaning the person feels that he or she has no social support. The second construct is perceived burdensomeness where the person feels they are a liability and self-hate is present. The final construct is the acquired capability of suicide (Van Orden et al., 2010).

This raises the question, are survivors of suicide at risk of taking their own lives? Based on ITS mixed with suicide bereavement, it appears that the formula for suicide has been created. If a survivor feels stigmatized he or she may not be able to open up about the loss, feel intense guilt, isolate and fall into the constructs of ITS (Aguirre & Terry, forthcoming; Cerel et al., 2008; Grad et al., 2004). Are all survivors destined to become suicidal? While they are thrown into the river of risk in Campbell's (2001) "Canyon of Why," there is another side in the fork: opportunity.

1.5 Posttraumatic Growth

While some survivors get caught in the danger fork of the river of risk, others overcome the danger and get help. The flip side to PTSD is posttraumatic growth (PTG). PTG occurs when a person takes the trauma and grows from traumatic loss. This can happen at different speeds and on different levels based on the closeness of the relationship between the deceased and the bereaved (Feigelman, Jordan, & Gorman, 2009). Feigelman, Jordan, and Gorman (2009) investigated if there is a correlation between time bereaved and signs of PTG and better mental health. Their findings showed that almost two thirds of the participants who

had been bereaved for five years or more had higher personal growth scores than the mean. Other findings showed that personal growth had a negative correlation with mental health problems (Feigelman et al., 2009).

1.6 Purpose of the Study

The purpose of this study was to answer five questions: 1) what are the coping strategies of suicide survivors?; 2) what percentage of survivors have post-traumatic stress?; 3) what percentage of survivors are at risk of suicide?; 4) what percentage of PTG do survivors experience?; and 5) what are the relationships among these variables measured?

CHAPTER 2

LITERATURE REVIEW

The previous chapter briefly mentioned several issues that can affect survivors of suicide. This chapter will address the literature on survivors of suicide and expand on several topics to show that survivors of suicide are a population that needs more attention. First, survivors of suicide will be addressed and the question of "who is a survivor" will be answered. Also, the label of "survivor" will be discussed and how there are various labels among the population. Second, bereavement will be discussed and how the survivor of suicide may be stigmatized because of the cause of death. Third, the three themes of bereavement will be discussed to help gain an understanding of why suicide bereavement is more complicated than other forms of bereavement. The three themes are: "why didn't I prevent it," "how could they do this to me," and " why did they do it." Fourth, following the three themes, survivor risk will be addressed. Fifth, survivors can be at risk of posttraumatic stress disorder (PTSD) that can further complicate bereavement. Sixth, the Interpersonal Theory of Suicide (ITS) will pull together all of the previously mentioned pieces into an explanation of why survivors of suicide are at risk themselves. Finally, posttraumatic growth (PTG) will be discussed as the coin flip to PTSD.

2.1 Survivors

2.1.1. Who is a Survivor

Throughout the research, there is no clear qualification for being a survivor. Simply experiencing a loss of suicide does not necessarily make someone a survivor. The quality of the relationship needs to be examined (Andriessen, 2009). McIntosh (2003) argued that different relationships may experience a loss in various ways. While a person may lose someone in his or her immediate family by suicide, if the relationship is non-existent for whatever reason, that person may not identify with being a survivor of suicide. This idea goes

along with the suggestions of Jordan and McMenamy (2004): exposure to suicide may not have a negative impact on the person's life. However, a close friend experiencing the same loss might be more inclined to use the label of survivor (Cerel et al., 2009). Researchers may primarily address the family but the friends who are affected by the loss may not be considered. That being said there exist various definitions of who is a survivor. McIntosh (1993) limited the definition to simply experiencing a loss of suicide by family and friends. Jordan (2008) defined a survivor as anyone in the social network who is "significantly negatively impacted" (p. 680) by the suicide loss. Andriessen (2009) had a more complex definition. He stated that a survivor is "a person who has lost a significant other (or a loved one) by suicide, and whose life is changed because of the loss" (Andriessen, 2009, p. 43). He qualified this definition by stating that to experience a significant loss by suicide does not mean that it is by a loved one. As mentioned in the first chapter, Andriessen (2009) used an example of a train conductor being the innocent accomplice in a person's method of suicide. While the conductor may not have known the person, his or her life can be negatively impacted. Does this person fit the definition of a survivor? Is this person able to grieve for the loss of the person even though he or she did not know the person?

2.1.2. Label of Survivor

There appears to be a debate between what to label people who are affected by suicide. Two major terms are suicide survivor and bereaved by suicide. The latter term appears to be common outside of the United States as Cerel et al. (2009) stated. McDaid, Trowman, Golder, Hawton, and Sowden (2008) in the *British Journal of Psychiatry* refered throughout their article and include in their title to the target population as "bereaved through suicide" (p. 438). Others go on to use the term "suicide survivor" (Jordan, 2008, p. 679) or simply "survivor" (Andriessen, 2009, p. 43). The question then arises; what does the person want to be labeled as? Allen, Calhoun, Cann, and Tedeschi (1993) used various terms throughout their report to identify someone who has been affected by suicide. While the

researchers define what they mean by “survivor of suicide” using different terms interchangeably may create some confusion. Schnell and Cerel (2011) conducted a survey to gain a better understanding of what this particular demographic wanted to be labeled as. The results of the survey showed that there is not a clear label that people identify with. Schnell and Cerel (2011) suggested that the discrepancy in labels could be because there is not a consistent label in the support group community. While using the term “bereaved of suicide” is clear that someone has lost a loved one to suicide, the term “suicide survivor” or “survivor of suicide” may indicate to some people that the person has attempted suicide. A clear label appears to be important so that the people who have experienced a loss can get the support needed. However, multiple labels may be used because there is no clear label of who is a survivor. As stated in the previous chapter, survivor of suicide and survivor will both be used throughout.

2.2 Bereavement

Multiple studies suggest that survivors of suicide experience a more complicated grief than those people who have experienced a loss by other causes and compare the bereavement of suicide to that of other traumatic deaths such as homicide, natural disasters, and Sudden Infant Death Syndrome (SIDS) (Begley & Quayle, 2007; Cerel et al., 2009; Dyregrov, 2005; Jordan, 2001; Jordan, 2008). While survivors may have some similarities in bereavement of other sudden, traumatic deaths, a survivor’s bereavement can consist of guilt, isolation, stigmatization, self-blame, wondering “why,” and developing mental heath issues such as posttraumatic stress disorder, depression, and anxiety (Begley & Quayle, 2007; Campbell, 2000; Campbell, 2001; Cerel et al., 2008; Jordan, 2001; Jordan, 2008; Sheehy, 2001; Sudak, Maxim, & Carpenter, 2008). Understanding the bereavement of survivors may give some insight as to why the survivor is at an increased risk of suicide. Jordan (2001) suggested multiple issues that can further complicate bereavement for the survivor. The first suggestion is that the survivor may become stigmatized. Secondly, there are three thematic questions of

suicide bereavement: “why didn’t I prevent it?;” “how could they do this to me?;” “why did they do this?” (p. 92). Finally, Jordan (2001) along with other researchers suggested that survivors may be at risk of taking their own lives.

2.2.1. Stigma

Jordan (2001) suggested that survivors of suicide experience more stigma than other causes of death. Also, survivors may feel judgment from other people and may isolate themselves from social situations in order to avoid that judgment. This feeling of judgment could be because community members do not understand suicide and they are unsure how to help in the situation. This may cause the community to avoid the survivor (Jordan, 2008). The survivor may also self-stigmatize by projecting that judgment will occur before it actually does (Cerel et al., 2008). Campbell (2000) stated that society may stigmatize and put blame on a survivor because, the survivor in society’s eye, they did not do all that was necessary to prevent a suicide, which can further isolate the survivor.

2.2.2. Themes of Bereavement

2.2.2.1 “Why Didn’t I Prevent It?”

The first theme of suicide bereavement is guilt and self-blame. The survivor is left wondering if something he or she said or did caused the suicide. The survivor also wonders if they could have done something differently to help prevent the suicide. Hutchinson (2001) is a mother whose son suicided. She recalled that after her son’s death she felt angry toward herself and blamed herself for the loss. Hutchinson (2001) blamed herself, “why did I leave the house that night? If he was feeling so bad why had he not felt able to talk to me? What kind of mother was I?” (p. 40). Begley and Quayle (2007) found that survivors blame themselves for not seeing the signs or preventing the suicide. Also, the survivors in the aforementioned study qualified statements about blame by saying that “…I should have done something” (Begley & Quayle, 2007, p. 30). Allen, Calhoun, Cann, and Tedeschi (1993) reported that survivors of

suicide mentioned guilt and blame more spontaneously than people who were bereaved of other kinds of death.

2.2.2.2 “How Could They Do This To Me?”

The second theme of bereavement that Jordan (2001) suggested survivors experience is anger, rejection, and abandonment. Hutchinson (2001) stated that after her son died the feelings of rejection were the worst part of bereavement and questioned why he would do this to the people he loved. Jordan (2008) stated that the survivor may have intense anger toward the deceased especially if the act is seen as voluntary.

2.2.2.3 “Why Did They Do It?”

The final theme of bereavement is why. After a suicide, the survivor may be left with many questions. Did he or she really know the person who suicided? Why did this person do this? Suicide is not a traditional way to die and is not accepted in the modern society. To deviate from the norm creates this confusion for the survivors. The survivor is left questioning if he or she really knew the person who suicided. Begley and Qualye (2007) explored the “why” theme in a study based out of Ireland. They found a common theme was that the participants not only questioned why their loved one would take his or her own life but also questioned other aspects of the world that were thought to be predictable such as the relationship with the person who suicided, and his or her own beliefs (Begley & Qualye, 2007).

Campbell (2001) addressed the “why” question beautifully with the metaphor of Canyon of Why. This idea is that there is a river of life. Along this river is a “Y” fork one side is danger and the other opportunity. Choosing the danger side gets the person closer to death while choosing the opportunity side means the person has chosen to get help. When someone is taken over by the rapids and allows the current to dictate which fork in the river of life to take the river evolves into the river of risk. When someone has a loss by suicide, the survivor is instantly thrown into the currents of the river of risk and forced to face the fork of “Y.” As long as the survivor can maintain some kind of healthy self-care techniques (eating, sleeping, exercising)

the survivor has a better chance to survive the rough waters. The other side is the survivor struggles and has to fight getting taken over by the currents and swept down the river of risk. Once the river calms down the survivor can climb out of the canyon. Climbing out of the canyon symbolizes the healing process and the pain and fear that goes with climbing (Campbell, 2001). This metaphor of the “Canyon of Why” helps to explain why someone would take their own life and also how a survivor of suicide could also contemplate taking his or her own life. This can be “why” a survivor can be at risk of developing PTSD and taking their own lives.

2.2.3. Survivor Risk

While the “Canyon of Why” (Campbell, 2001) metaphor suggests that a survivor can get swept into the river of risk, is a survivor more at risk of taking their own life? Risk can include guilt, stigma, shame, suicide, and PTSD (Jordan, 2001). The themes of complicated bereavement can only get worse if PTSD is introduced. There is some question whether or not a person who has experienced a loss of any kind can experience PTSD. Witnessing the death of a loved or finding them after they have passed away can be traumatic. This can be made worse depending on the circumstances of how the person died (Campbell, 1997; Jordan, 2008). Jordan (2008) suggests that survivors can show signs of PTSD even if they were not eyewitnesses. Zisook, Chentsova-Dutton, and Shuchter (1998) found that those participants who experienced a sudden death (suicide and accidental death combined) had a higher rate of PTSD when compared to people who experienced a loss by natural causes. Also in this study, the researchers found that people who developed PTSD were more prone to isolating themselves.

2.3 Suicide Risk

Research suggests that some survivors of suicide are at greater risk of taking their own lives after a loss by suicide (Brent, Bridge, Johnson, & Connolly, 1996; Cerel et al., 2009; Jordan, 2001; Jordan, 2008; Prigerson, 2003; Qin, Agerbo, & Mortensen, 2002; Runeson & Åsberg, 2003; Sheehy, 2001). Brent et al., (1996) found that both suicides and attempted

suicides increased in survivors who were first-degree family members compared to the first-degree family members in the control group. A Danish study by Qin, Agerbo, and Mortensen (2002) also found that family members who experienced a loss by suicide had an increased risk of suicide. Runeson and Åsberg (2003) had similar findings when they compared families who had a loss by suicide to families who did not in the years 1963 to 1997. Of these families they compared the number of survivors who themselves suicided to those families who also had a family member suicide without a family history. They found that the rate of suicide doubled (n=287) in those families of survivors compared to the rate of suicide in the control group (n=120) (Runeson & Åsberg, 2003). Finally, Prigerson (2003) found that survivors with complicated grief were five times greater to experience suicidal ideation.

2.3.1. Interpersonal Theory of Suicide

The Interpersonal Theory of Suicide (ITS) can help further explain why a survivor might be at risk of suicide. In short, ITS states that in order for someone to be at high risk of suicide thwarted belongingness and perceived burdensomeness along with the capability for suicide must all be present. Thwarted belongingness is defined by the idea of the person feeling alone. In the previous section of bereavement, isolation was a common theme throughout. Whether the isolation is due to the survivor avoiding the community or the community avoiding the survivor, the isolation is present. This isolation can lead the survivor down the path of suicide. Van Orden et al., (2010) stated that social isolation is one of the leading predictors of suicide. This fits perfectly into thwarted belongingness because there are two parts: loneliness and the absence of reciprocal care. Complicated bereavement may create this thwarted belongingness because the survivor isolates. Also, due to stigma, the community may avoid the survivor and the survivor may not feel cared for.

Perceived burdensomeness is where someone feels that they are a burden to others through self-hate and liability. This self-hate can be described as, "I am useless" (Van Orden et al., 2010, p. 583). In regards to the survivor of suicide, this idea that they are useless could

stem from the guilt that they could not prevent the suicide. This plays into the liability piece because the survivors not only blame themselves but perceive others to blame them as well (Jordan, 2008).

The final piece to the puzzle of ITS is the acquired capability. In order for acquired capability to be present a person's fear of death is lowered and a higher pain tolerance is present. Van Orden et al. (2010) suggested that a person cannot die by suicidal ideation alone; a lowered fear of death and higher pain tolerance is key. An example was given of a woman ingesting chemicals that caused fatal internal bleeding. In order to actually ingest something that can cause that much pain, an argument can be made that a person almost has to have a heightened pain tolerance along with a lowered fear of death (Van Orden et al., 2010).

It appears that the platform for survivors of suicide to suicide themselves as been set. Only not every survivor actually does suicide. Some actually grow through the tragedy but why would some grow and others not?

2.4 Posttraumatic Growth

With all that has been written in the current study, it appears that survivors of suicide are doomed to continue the cycle. Why do some survivors not take their own lives? Trauma can be described to be on a coin; on one side exists PTSD and on the other side of the coin exists PTG. While the foundation is set for PTSD and the survivor taking his or her own life, it is possible that the foundation can also be laid down for PTG. Feigelman et al., (2009) cited a study (Hogan et al., 2001) where the authors found that the people who were newly bereaved experienced less growth than those who had been bereaved for longer. This possibly suggests that over time, people do climb out of the "Canyon of Why" (Campbell, 2001), heal, and even take a step further and grow. Feigelman et al., (2009) found that one of the main reasons survivors grow again is time and that over time mental health increases.

CHAPTER 3

METHODOLOGY

The purpose of this study was to answer five questions: 1) what are the coping strategies of suicide survivors?; 2) what percentage of survivors have post-traumatic stress?; 3) what percentage of survivors are at risk of suicide?; 4) what percentage of PTG do survivors experience?; and 5) what are the relationships among these variables measured? The study was approved by the University of Texas at Arlington's Institutional Review Board (IRB approval #: 2012-0223, Appendix A).

3.1 Sample

The data was gathered electronically via a web-based survey using Survey Monkey. A link to the survey was sent out electronically via the American Association of Suicidology (AAS) Survivors of Suicide Newsletter, *Surviving Suicide*. Also, the survey was sent out through the Local Outreach to Suicide Survivors (LOSS) Teams in Baton Rouge, Louisiana (see Appendix B for a copy of letter of support from Baton Rouge); Indiana (see Appendix C for a copy of letter of support from Indiana); Nebraska (see Appendix D for a copy of letter of support from Nebraska); Ohio (see Appendix E for a copy of letter of support from Ohio); Rapid City, South Dakota (see Appendix F for a copy of letter of support from Rapid City); and Tarrant County, Texas (see Appendix G for a copy of letter of support from Tarrant County) to survivors they have served. The survey was sent out with the intent of collecting data three times, a baseline, at three months, and at six months. For the purpose of this study, only one administration of the survey was analyzed.

3.2 Description of Instruments

Four assessments and one survey were administered: a questionnaire, Interpersonal Needs Questionnaire (INQ), Acquired Capability for Survivor Scale (ACSS), Posttraumatic Stress Disorder Checklist (PCL) and the Post-traumatic Growth Inventory short form (PTGI-SF).

3.2.1. Questionnaire

A questionnaire was developed by a survivor of suicide and was used with permission. The questionnaire consisted of 38 questions. The questionnaire was set up so that if a series of questions does not pertain to the participant based on his or her answers then the survey would skip ahead to the next relevant question. The questionnaire was looking at the amount of support and coping mechanisms of the survivor (Anonymous, 2011). The questionnaire has been examined by the chair of this project and a committee member who are both survivors adding face validity.

3.2.2 Interpersonal Needs Questionnaire

The Interpersonal Needs Questionnaire (INQ) was a questionnaire developed by Van Orden, Witte, Gordon, Bender, and Joiner, Jr. (2008) that measures a person's sense of belongingness and how much of a burden the person perceives to be to others. There was a total of 18 questions, nine questions measuring a person's sense of belongingness and nine questions measuring perceived burdensomeness. Each item was measured on a 7-point Likert scale where the higher score indicated the persons thwarted belongingness and perceived burdensomeness (Van Orden, Witte, Gordon, Bender, & Joiner, Jr., 2008)

This questionnaire was relevant to the current study because it tests the thwarted belongingness and perceived burdensomeness that a survivor may feel based on ITS. ITS suggests that when thwarted belongingness, perceived burdensomeness, and the capability for suicide are present a person is at risk of a lethal suicide attempt (Van Orden et al., 2010).

3.2.3 Acquired Capability for Suicide Scale

Van Orden et al. (2008) also developed the Acquired Capability for Suicide Scale (ACSS). The questionnaire consisted of 20 items each ranked on a 5-point Likert scale measuring the lack of fear of pain and or death. The ACSS was relevant to the current study in part because it looks at the capability aspect of the ITS (Van Orden et al., 2010).

3.2.4. Post-traumatic Stress Disorder Checklist

The Post-traumatic Stress Disorder Checklist (PCL) measured post-traumatic stress symptoms per the Diagnostic and Statistical Manuel of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000). It was a self-report scale with 17 questions representing the 17 characteristics (American Psychiatric Association, 2000, National Center for PTSD, n.d.).

3.2.5. Posttraumatic Growth Inventory-short form

The Posttraumatic Growth Inventory-short form (PTGI-SF) was a 10-item questionnaire where the participant ranked each statement on a 6-point Likert scale where a rank of 0 was where the participant did not experience change and 5 was where the participant experienced change a great degree as a result of the crisis.

Two questions each represented the five domains of PTG (relating to others, new possibilities, personal strength, spiritual change, and appreciation of life (Cann et al., 2010)). The PTGI-SF came from a longer version with 21 items. A shorter scale was created in order to decrease the discomfort that may go with taking a longer test.

3.3 Data Analysis

The purpose of this study was to answer five questions: 1) what are the coping strategies of suicide survivors?; 2) what percentage of survivors have post-traumatic stress?; 3) what percentage of survivors are at risk of suicide?; 4) what percentage of PTG do survivors experience?; and 5) what are the relationships among these variables measured? An alpha of

.05 was used to interpret the findings (Black, 1999). SPSS was used for data analysis as follows:

1) Information about coping strategies was collected from the questionnaire. Descriptive statistics (Frequencies and Percentages) will be reported.
2) The PCL was scored and percentages reported.
3) The INQ and ACSS was scored and percentages reported using.
4) The PTG was scored and percentages reported.
5) Pearson's correlation coefficients was calculated to assess the following relationships:
    a. Suicide risk and PTG
    b. Suicide risk and Post-traumatic stress (PTS)
    c. Suicide risk and number of coping strategies
    d. Number of coping strategies and PTG
    e. Number of coping strategies and PTS
    f. PTG and PTS

CHAPTER 4

RESULTS

The purpose of this study was to answer five questions: 1) what are the coping strategies of suicide survivors?; 2) what percentage of survivors have post-traumatic stress?; 3) what percentage of survivors are at risk of suicide?; 4) what percentage of PTG do survivors experience?; and 5) what are the relationships among these variables measured?

4.1 Demographics of Participants

The sample consisted of 337 people. Of those 337 people, 122 participants were taken out due to incomplete responses, not consenting, or not meeting research criteria for the intended survey leaving a total of 215 participants. Of these 215 participants, 188 identified as female (87.4%), 26 identified as male (12.1%), and 1 (.5%) identified as being transgender. The sample was predominately White (n=194, 90.2%), followed by Hispanic (n=8, 3.7%), Black/African American (n=4, 1.9%), Asian (n=1, .5%), American Indian/Native Alaskan (n=2, .9%), Other (n=4, 1.9%), and did not report (n=2, .9%). The ages of the participants ranged from 19 years to 83 years with an overall mean of 46.33. The 215 participants reported 236 total losses with 12 participants who reported losing more than one person to suicide. There were 35 unique relationships reported between the survivor and the person who suicided. Of these 35 unique relationships, the brother relationship was reported the most (n=42) followed by the son relationship (n=38), then by the husband relationship (n=33). See Appendix N for full list of relationships.

4.2 Objective 1

Objective 1 asked what are the coping strategies of suicide survivors. To answer this objective, responses from two questions were analyzed. The first question asked the

participants, “what services did you access following the loss of your loved one?” The 215 participants reported using 16 unique services. The most frequent answer was individual therapy (n=178, 40.7%) followed by support group not specific to suicide (n=63, 14.4%), then by support group specific to suicide (n=47, 10.8%). Thirty-four people (7.8%) reported not accessing services. For a full list of services, please see Appendix O.

The second question asked the participants “what other types of activities did you use to heal?” The 215 participants reported using 25 unique activities. The most frequent answer was reading (n=129, 21.2%) followed by writing (n=107, 17.6%) and outdoor activities (n=79, 13%). Twenty-four people (3.95%) reported using no activities. For a full list of activities, please see Appendix P

4.3 Objective 2

Objective 2 investigated what percentage of survivors had an indication of posttraumatic stress. To measure this, the PTSD Checklist-Civilian Version (PCL) was used. In order to find this out, scores were totaled. Participants that had a score of 30 or above had an indication of posttraumatic stress (PTS) and would need further evaluation in order to get a diagnosis for PTSD. Of the 215 participants, 65.1% scored 30 or above (n=140), 33% scored 29 or less (n=71), and 1.9% did not report (n=4) with a mean of 42.01. This suggests that 65.1% of the participants showed a significant level of posttraumatic stress.

4.4 Objective 3

Objective 3 investigated what percentage of survivors are at risk of suicide. K. Van Orden stated that there is no cut off for suicide risk (personal communication, January 27, 2013). She went further to state that based on the Interpersonal Theory of Suicide (ITS) the participants with the highest scores in perceived burdensomeness, thwarted belongingness, and acquired capability would predict the highest risk (K. Van Orden, personal communication, January 27, 2013). For the purposes of this objective, a self-report variable was created based on four questions: 1) “After your loved one died by suicide, did you have thoughts of suicide?;”

2) “Did you attempt suicide after the loss of your loved one?;” 3) “Did you have thoughts of suicide before the loss of your loved one?;” 4) Did you attempt suicide before the loss of your loved one?.” Anyone who said no to all four questions was considered to have no risk. Anyone who said yes to any of the four questions was considered to have no risk. The group considered to have no risk was treated as a control. Once the control and experimental groups were identified, a total score was calculated by summing the INQ and the ACSS scores rather than finding the mean to get a total survivor risk score. The hypothesis is that the people in the variable group, those who answered yes, would have higher total scores than those in the control group, those who answered no. Those that answered yes (n=123, 57.2%) had a minimum total score of 80, maximum total score of 175 and a mean of 120.56. Those that answered no (n= 92, 42.8%) had a minimum total score of 70, maximum total score of 145, and a mean of 114.43. An independent t-test was run on the two means. Levene’s Test for Equality of Variance was not significant ($F = .21$, $p = .65$) and equal variances were assumed. The t-test showed that the group with risk had a different mean than the group without risk ($t_{(213)} = 3.29$, $p < .001$). Anyone scoring 115 and above (66.98%, n=144) is in the at risk group.

4.5 Objective 4

Objective 4 investigated what percentage of survivors experience posttraumatic growth (PTG). To measure this, the Posttraumatic Growth Inventory-Short Form (PTGI-SF) was used. A mean of zero indicated an absence of growth. The mean score was 29.02 with two participants scoring zero. Along with the mean, the PTGI-SF looks at five factors of growth and a score of zero in the factor indicates an absence of growth in that area. The following is a breakdown of the growth in each of the factors:

1) Relating to others, mean 5.28 (n=195, 90.7%)
2) Looking at new possibilities, mean 5.38 (n=191, 88.8%)
3) Personal strength, mean 6.81 (n=203, 94.4%)
4) Spiritual change, mean 4.86 (n=170, 79.1%)

5) Appreciate of life, mean 6.69 (n=204, 94.9%)

4.6 Objective 5

Objective 5 considered the relationships between the measured variables. A Pearson's correlation coefficient was computed to assess the relationship between these variables. Davis descriptors were use were a value of .70 or higher could be interpreted having a very strong association, .50 to .69 a substantial association, .30 to .49 a moderate association, .10 to .29 a low association, and .01 to .09 a negligible association (Kotrlik & Wiliams, 2003). The following relationships were calculated using Pearson's correlations coefficient:

1) Suicide risk and PTG had a negligible but not significant positive association ($r = .043$, $p = .534$).
2) Suicide risk and PTS had a low positive association ($r = .284$, $p > .01$).
3) Suicide risk and number of coping strategies had a low positive association ($r = .169$, $p = .013$).
4) Number of coping strategies and PTG had a low positive association ($r = .200$, $p = .003$).
5) Number of coping strategies and PTS had a low positive association ($r = .155$, $p = .023$).
6) PTG and PTS had a low negative association ($r = -.117$, $p = .087$)

CHAPTER 5

DISCUSSION

5.1 Summary of Purpose and Objectives

The purpose of this study was to answer five questions: 1) what are the coping strategies of suicide survivors?; 2) what percentage of survivors have post-traumatic stress?; 3) what percentage of survivors are at risk of suicide?; 4) what percentage of PTG do survivors experience?; and 5) what are the relationships among these variables measured?

5.1.1 Summary of Demographics

The majority of the participants were female (87.4%) and White (90.2%). The mean age of the participants was 46.33 and 35 unique relationships between the participant and the deceased were reported.

Implications

The demographics of the participants show that White females were the majority of the participants. This does not come as a surprise since White males continue to be the population most likely to die by suicide (McIntosh, 2012). For this study, the age of the deceased was not addressed however participants were asked to give their ages. The age range with the highest rate of surviving a suicide was 45-54 years old. An assumption can be made that since the mean age of the participants was 46.33 and that the most frequent relationship was the brother relationship (n=42) that the deceased mean was similar. However, the son relationship was the second most frequent (n=38). Looking at the age of the parent and amount of time removed from the death, a better assumption could be made about the age of the deceased and whether it reflects what the research shows. The number of unique relationships is important and reflects what the research has suggested (McIntosh, 2003)–the depth of the relationship may be more important than the type of relationship.

Recommendations

This study did not ask the participants how far removed the participant was from the death or the age of the deceased at the time of death. Both of these questions are important because they can help to further validate previous research or provide new insight for further investigation. Asking how far removed someone is from the death of their loved one can be important to compare with PTG, PTS, and suicide risk to evaluate if time really is a factor. It is also important to understand that the depth of the relationship is more important than the type. This could help therapists and group facilitators serve survivors of suicide better. A person who lost their neighbor to suicide might not be referred to a suicide specific support group but if the group facilitator knows that the relationship was meaningful, the facilitator would be more inclined to not refer the person to a general grief group.

5.1.2 Summary of Objective 1

Objective 1 asked, “what are the coping strategies of suicide survivors?” When the participants were asked what services they accessed following their loss, a little under half of the participants stated individual therapy (n=178, 40.7%) with a support group specific to suicide bereavement following (n=63, 14.4%) and 34 people (7.8%) reported not accessing any services.

When asked about healing activities, reading was the most common answer (n=129, 21.2%) with writing following (n=107, 17.6%) and 24 people (3.95%) using no activities.

Implications

It was surprising that individual therapy was as highly accessed because it was believed that the most common referral made to survivors of suicide is a support group specific to suicide bereavement. This could imply that a support group specific to suicide bereavement was not available in the survivor’s area. The last question asked on the survey was if the participant wanted to receive information on services in their area. Out of the 215 participants, 62 indicated that they wanted more information on services. Fourteen participants were sent

information between 30 minutes and over an hour away. The other 48 participants were sent information that was 20 minutes or less. In rural areas, individual therapy might be the only type of service available to some of the participants.

Reading was the most used healing activity by the participants. This implies that reading is a valuable tool to help the survivor heal. It is possible that participants supplemented reading for the lack of services available in their area. If individual therapy was only available to the participant, the therapist might provide information on books that could help the survivor.

Recommendations

The most frequent service answer was individual therapy and contradicts that the support group specific to suicide is the most common type of service accessed. This is important because it shows that people are utilizing individual therapy more. However, if the therapist does not understand that survivors of suicide experience complicated bereavement the therapy may not be effective. Educating therapists on complicated bereavement may help the survivor of suicide get help and heal. Asking the participants if the individual therapy accessed was specific to suicide bereavement could provide more information on how often suicide bereavement individual therapy is accessed.

It is important to know what specific books the survivors are reading because some books may be more helpful than others may. Asking the participants to name the books read can help show what books are helpful. This information can then be shared with individual therapists and group facilitators to make recommendations on what to read.

5.1.3 Summary of Objective 2

Objective 2 asked, “what percentage of survivors have post-traumatic stress?” A score of 30 or above indicates a significant level of PTS and that the participant may meet the DSM-IV-TR criteria for diagnosis of PTSD. The maximum score that a participant could receive on this measurement was 80. Of the participants, 140 scored above 30 with 19 scoring between 70 and 80, 22 scoring between 60 and 69, and 32 scoring between 50 and 59. Over half of the

participants (n = 140, 65.1%) reported significant levels of post-traumatic stress (PTS) with a mean score of 42.01.

Implications

The findings support Zisook, Chentsova-Dutton, and Shuchter (1998) in that survivors of suicide do experience significant levels of PTS. Not only do they experience a significant level of PTS the mean score is above the cut off to indicate a significant level of PTS warranting further clinical assessment for PTSD. This shows that not only do survivors of suicide experience significant levels of PTS, but also they do so at possibly high levels. Outliers that existed in this area of the study were four people scoring zero indicating that they did not complete the questionnaire.

Recommendations

Over half the population indicated significant levels of PTS with almost the same number of participants being at risk of suicide themselves. Active postvention models, like the LOSS Team, may be able to help because this model provides resources that are specific to suicide bereavement. In addition, the LOSS Team generally has an understanding about complicated bereavement because this model consists of both survivors of suicide and mental health professionals. With an active postvention model such as the LOSS Team in the community, survivors of suicide can utilize services quicker and more efficiently. However, the referral to services can be problematic if the therapist and/or group facilitator does not know that survivors of suicide experience PTS. Educating therapists and facilitators on how to screen and treat PTS in survivors of suicide will address the issue. Administering the PCL-C during the initial intake for individual or group therapy can address the PTS quickly. If PTS is present, individual therapy rather than group therapy may help at first so the survivor is not further traumatized.

5.1.4 Summary of Objective 3

Objective 3 asked, “what percentage of survivors are at risk of suicide?” Suicide risk was measured in two ways, using a combination of the Interpersonal Needs Questionnaire (INQ) and Acquired Capability to Suicide Scale (ACSS) and using a self-report measure. While the INQ and ACSS measures the three constructs of the Interpersonal Theory of Suicide (i.e. perceived burdensomeness, thwarted belongingness, and acquired capability), the INQ and ACSS measurements do not have a standard way to show suicide risk. It was suggested that who ever scores the highest in perceived burdensomeness, thwarted belongingness and acquired capability should have the highest risk of suicide (K. Van Orden, personal communication, January 27, 2013). This would also reflect what the Interpersonal Theory of Suicide states in that all three constructs must be present in order for someone to complete suicide (Van Orden et al., 2010). In theory, summing the scores for the INQ and the ACSS should indicate who is at risk of suicide. Summing the INQ and ACSS showed that the 123 participants at risk had a mean score of 120.56 with a minimum of 80 and a maximum of 175. The 92 participants not at risk had a mean of 114.43 with a minimum of 70 and a maximum of 145.

Comparing the self-report measure, the idea was to create a control group and an experimental group that would have a distinct separation of INQ and ACSS scores. Unfortunately, this did not happen. However, the mean scores of the two groups were statistically different even though they were relatively close in number. This implies that the two groups are different. It was decided that anyone who scored 115 and above (66.98%, n=144) combined INQ and ACSS scores would be in the risk of suicide group. The cut-off of 115 was chosen because of the conservative nature. Having participants who are not at risk added to the at risk group is safer than having people who are at risk overlooked. The self-report measure showed that 123 (57.2%) participants were at risk while 92 (42.8%) were not at risk.

Implications

The findings suggest that using the combined INQ and ACSS or the self-report measure, survivors of suicide are at risk of taking their own lives. This implies that losing a loved one by suicide increases the risk of suicide. This further implies that suicide prevention efforts need to focus on this population.

Recommendations

There is no standard way to measure survivor risk using the INQ and ACSS because there exists no score that is a statistically significant cut-off point that delineates between those people who are at risk of suicide and those who are not. The INQ and ACSS measure the constructs for the Interpersonal Theory of Suicide but there is no way to effectively measure suicide risk. With suicide rates increasing, having a strong evidenced-based practice is vital. More research is needed to find a standard way to separate those at risk of suicide and those not at risk based on the Interpersonal Theory of Suicide.

While there may not be a standard way to measure suicide risk with the INQ and ACSS, knowing that survivors of suicide are at risk is the first step to suicide prevention. Again, active postvention models can help the survivors by referring them to resources quickly and providing them with the help they need. Educating the community as a whole that survivors of suicide are at risk of suicide can help. Law enforcement, the medical examiner, doctors, nurses, social workers, etc. are all on the front lines and possibly work with survivors of suicide. If they know that survivors are at risk of suicide, the survivor has a better chance of getting help.

5.1.5 Summary of Objective 4

Objective 4 asked, "what percentage of PTG do survivors experience?" All but two participants (99.1%) indicated some levels of posttraumatic growth (PTG). The mean score was 29.02 with a maximum score of 50 and a minimum score of 0. Looking at the individual factors of PTG, 204 participants indicated growth in the appreciation for life factor while 170 participants

indicated growth in the spiritual change factor. The other factors include personal strength (n=203), relating to others (n=195), and looking at new possibilities (n=191).

Implications

The findings imply that the participants experienced some level of PTG. With the exception of the two participants who scored 0, scores ranged from 1 to 50 implying that most of the participants experienced some level of growth even though the growth may have been relatively small. Two participants scored 0 indicating an absence of growth.

The PTGI-SF also looked at the five factors of PTG. The five factors were relating to others, looking at new possibilities, personal strength, spiritual change, and appreciation for life. The factor that had the most participants showing growth was the appreciation for life factor. This finding is based on two questions asked on the PTGI-SF, “I changed my priorities about what is important in life;” and “I have a greater appreciation for the value of my own life” (Cann et al., 2010, p. 130). These findings imply that survivors of suicide have a better appreciation for their own lives after the loss of their loved one, that they are able to identify what is important in their lives, are able to change their priorities accordingly.

The factor that the fewest participants showed growth in was the spiritual change factor. This finding is based on two questions, “I have a better understanding of spiritual matters,” and “I have a stronger religious faith” (Cann et al., 2010, p. 130). These findings suggests that through the loss of their loved one, the participants’ religious beliefs grew stronger.

Recommendations

All but two people indicated a level of personal growth. Currently, with the PTGI-SF, the only way to show an absence of growth is if a participant answers with a zero. Anything above a zero indicates growth. This may not be the most effective way to show that someone has experienced personal growth. Future research should focus on developing ranges of growth rather to better categorize growth rather than this all or nothing growth or no growth system currently in place with this instrument. Another issue could be that this measurement was the

last thing the participants saw. The questionnaire was 103 total questions so the participants might have been exhausted by the time they completed this part of the survey. For next time, it might be better to spread the measurements out instead of lumping them altogether at the end. Also, asking time passed since the death is important because it would help better understand if it was too soon after the death.

Also, further investigating the spiritual change factor could provide insight why it showed the least amount of growth. The absence of growth by so many participants in this factor might be an aspect to pursue in treatment.

5.1.6 Summary of Objective 5

Objective 5 asked, "what are the relationships among these variables measured?" There was not a statistically significant relationship between PTG and suicide risk however the relationship was positive. There were low positive correlations between suicide risk and PTS, suicide risk and number of coping strategies, number of coping strategies and PTG, and number of coping strategies and PTS. There was a low negative correlation between PTG and PTS.

Implications

The positive relationship between number of coping strategies and suicide risk implies that as the number of coping strategies increases so does suicide risk. This finding indicates that the more a person is at risk of suicide, the more coping strategies are utilized by the participant. This could imply that the survivor is attempting to avoid suicide but they may not know what actually helps them heal.

The positive relationship between number of coping strategies and PTS implies that the number of coping strategies needs to increase. This also implies that the type of coping strategy utilized is important. In this study, individual therapy was the service accessed most frequently. If the therapist does not believe that suicide bereavement can be traumatic, this issue may not

be addressed in therapy. Again, this could imply that the survivor is attempting to avoid suicide but they may not have identified what coping strategies are helpful for them.

Recommendations

While the relationship between PTG and suicide risk is not significant the fact that the relationship is positive is very interesting. This might imply that survivors of suicide need more time to heal before they seek out survivor advocacy activities. It is recommended that a screening be done before the survivor is able to participate in whatever advocacy avenue they seek out. If the participant has indicated that they have not accessed any services then make a recommendation of services available in their location.

In order to gain more information on the relationship between the number of coping strategies and survivor risk, asking what the participants did for themselves when they were feeling low could have addressed this relationship. It is clear that survivors need help identifying what coping strategies are helpful for them individually. Administering a risk assessment for each survivor can help identify what coping strategies are useful for that individual person. This can help the survivor turn to the coping strategies that are beneficial for them rather than the ones that are not.

Asking more questions about the type of coping strategy utilized can help to understand if the trauma was addressed. If the trauma was not addressed then that could explain why there was a positive relationship between number of coping strategies and PTS.

Conclusion

This study offers more insight into the life of a survivor of suicide and what they have to deal with after the loss of their loved one. More insight was given into their struggles with post-traumatic stress and suicide risk. Survivors of suicide do experience both of this things on a large scale. Over half the participants experience both of post-traumatic stress and suicide risk. More insight was given into their coping strategies and that survivors need help identifying what coping strategies work for the individual person. If a person is seeking individual therapy but the

therapist is not educated on suicide bereavement, the individual therapy will not be effective. The survivor will still be at risk, with post-traumatic stress. The research on survivors of suicide is limited and the studies that do exist typically have smaller sample sizes. This study can help to create a better picture due to the number of participants and with the various factors measured. Further research is needed to help not only understand this population even more but to put it in practice with evidence to back up the theory.

APPENDIX A

IRB APPROVAL

December 19, 2011

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The University of Texas at Arlington
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EXPEDITED APPROVAL OF HUMAN SUBJECT RESEARCH

IRB No.: 2012-0223
TITLE: *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition*
Effective Date: December 9, 2011
Expiration Date: December 9, 2012

Approved Number of Participants: 300 (Do not exceed without prior IRB approval).

The University of Texas Arlington Institutional Review Board (UTA IRB) has made the determination that this research protocol involving human subjects is eligible for expedited review in accordance with Title 45 CFR 46.110(a)-(b)(1), 63 FR 60364 and 63 FR 60353, category(6)(7). The IRB Chairman (or designee) approved this protocol effective December 9, 2011. IRB approval for the research shall continue until December 9, 2012.

APPROVED NUMBER OF PARTICIPANTS:
This protocol has been approved for enrollment of a maximum of 300 participants and is not to exceed this number. If additional data are needed, the researcher must submit a modification request to increase the number of approved participants **before** the additional data are collected. Exceeding the number of approved participants is considered an issue of non-compliance and will result in the destruction of the data collected beyond the approval number and will be subject to deliberation set forth by the IRB.

INFORMED CONSENT DOCUMENT:
The IRB approved and stamped informed consent document (ICD) showing the approval and expiration date must be used when prospectively enrolling volunteer participants into the study. The use of a copy of any consent form on which the IRB-stamped approval and expiration dates are not visible, or are replaced by typescript or handwriting, is prohibited. The signed consent forms must be securely maintained on the UT Arlington campus for the duration of the study plus a minimum of three years after the completion of all study procedures (including data analysis). The complete study record is subject to inspection and/or audit during this time period by entities including but not limited to the UT Arlington IRB, Regulatory Services staff, OHRP, and by study sponsors (if the study is funded).

MODIFICATION TO AN APPROVED PROTOCOL:
Pursuant to Title 45 CFR 46.103(b)(4)(iii), investigators are required to, "promptly report to the IRB ***any*** proposed changes in the research activity, and to ensure that such changes in approved research, during the period for which IRB approval has already been given, are **not initiated without prior IRB review and approval** except when necessary to eliminate apparent immediate hazards to the subject." Modifications include but are not limited to: Changes in protocol personnel, number of approved participants, and/or updates to the protocol procedures or instruments and must be submitted via the electronic submission system. Failure to obtain approval for modifications is considered an issue of non-compliance

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and will be subject to review and deliberation by the IRB which could result in the suspension/termination of the protocol.

ANNUAL CONTINUING REVIEW:

In order for the research to continue beyond the first year, a Continuing Review must be completed via the online submission system within 30 days preceding the date of expiration indicated above. A reminder notice will be forwarded to the attention of the Principal Investigator (PI) 30 days prior to the expiration date. Continuing review of the protocol serves as a progress report and provides the researcher with an opportunity to make updates to the originally approved protocol. Failure to obtain approval for a continuing review will result in automatic ***expiration of the protocol*** all activities involving human subjects must cease immediately. The research will not be allowed to commence by any protocol personnel until a new protocol has been submitted, reviewed, and approved by the IRB. Per federal regulations and UTA's Federalwide Assurance (FWA), there are no exceptions and no extensions of approval granted by the IRB. The continuation of study procedures after the expiration of a protocol is considered to be an issue of non-compliance and a violation of federal regulations. Such violations could result in termination of external and University funding and/or disciplinary action.

ADVERSE EVENTS:

Please be advised that as the principal investigator, you are required to report local adverse (unanticipated) events to The UT Arlington Office of Research Administration; Regulatory Services within 24 hours of the occurrence or upon acknowledgement of the occurrence.

HUMAN SUBJECTS TRAINING:

All investigators and key personnel identified in the protocol must have documented Human Subjects Protection (HSP) training or CITI Training on file with The UT Arlington Office of Research Administration; Regulatory Services. Completion certificates are valid for 2 years from completion date.

COLLABORATION:

If applicable, approval by the appropriate authority at a collaborating facility is required prior to subject enrollment. If the collaborating facility is *engaged in the research*, an OHRP approved Federalwide Assurance (FWA) may be required for the facility (prior to their participation in research-related activities). To determine whether the collaborating facility is engaged in research, go to: http://www.hhs.gov/ohrp/humansubjects/assurance/engage.htm

CONTACT FOR QUESTIONS:

The UT Arlington Office of Research Administration; Regulatory Services appreciates your continuing commitment to the protection of human research subjects. Should you have questions or require further assistance, please contact Robin Dickey at robind@uta.edu or you may contact the office of Regulatory Services at 817-272-3723.

Sincerely,

Patricia Turpin, Ph.D., RN, NEA, BC
Clinical Associate Professor
UT Arlington IRB Chair

APPENDIX B

SUPPORT LETTER FROM BATON ROGUE

Board of Directors
President—Jo Ellen Kearny
Vice President—Yvette Marsh
Secretary—Gwynn Shamlin, Jr.
Treasurer—David Lee
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Joe Gendron
Cynthia Michael
George Sells
Katie R. Sternberg
Renita Williams Thomas

Executive Director
Norma W. Rutledge

October 13, 2011

Dear Dr. Aguirre,

On behalf of our team, I am pleased and excited to offer our support and collaboration to the research study: *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition*. Our commitment to survivors of suicide can only be strengthened by participating in such an important research study.

As one of the sites chosen to from which to elicit data, we commit to providing historical data where available on the survivors we have served prior to the September 2012 and data on at least 100 survivors whom have been touched by services provided by our program from September 2012 through August of 2014. Basic demographic data will be collected on those we serve and reported to the project coordinator monthly. As a part of this research project, we will also facilitate qualitative data collection with our survivors. The data from phenomenological interviews with survivors will include data collection about how the APM delivery format impacts survivor outcomes. We have been made aware of the following outcomes and agree to collect data in line with these constructs:

- further evidence as to whether the APM reduces elapsed time between death and accessing services;
- findings indicating whether the APM complements the survivor support group in reducing suicidality and increasing post-traumatic growth;
- whether the delivery format of the APM impacts survivor outcomes.

We also agree to help facilitate data collection from support groups including:

- outcome measures of the impacts of survivor support groups on both suicidality and post-traumatic growth;
- information as to whether group design issues impact outcomes for survivors.

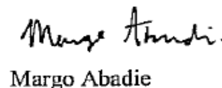
Much of the data requested is already part of our data collection process, and therefore I see no problem adding some additional elements and delivering all data requested. Upon signing this agreement we agree to provide the research team with the above data per the grant timeline.

Given the impact of suicide on those left behind to grieve, the difficulty in connecting these survivors with services, and the lack of research on whether services such as support groups are effective, *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition* is poised to address a critical gap in suicide research if funded.

Collectively, findings in these domains have the potential to inform improvements to service delivery through both the survivor support group and the APM modalities. Furthermore, the study findings have the potential to guide the creation of best practices for those wishing to begin a new postvention service or improve existing services.

I look forward to collaborating with you on this work.

Sincerely,



Norma W. Rutledge   Margo Abadie

4837 REVERE AVENUE ▪ BATON ROUGE, LA 70808 ▪ (225) 924-1431
THE PHONE ▪ (225) 924-3900 ▪ ▪ ▪ UNITED WAY 2-1-1

APPENDIX C

SUPPORT LETTER FROM INDIANA

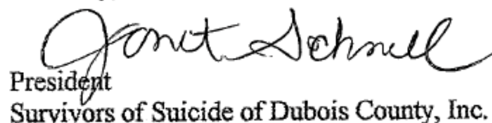
Survivors of Suicide of Dubois County, Inc.
104 South Sycamore
Huntingburg, Indiana 47542
Phone: 812-630-6770
Email: SuicideSurvivor@Insightbb.com

Dear Dr. Aguirre,
I am pleased and excited to offer my support and collaboration to the research study: *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition.* The commitment to survivors of suicide can only be strengthened by participating in such an important research study.

I understand the intention of the research aims for support groups is to evaluate effectiveness of support groups through long-term assessment of survivors at beginning of group, and at three-month intervals thereafter on the three constructs of the Interpersonal Theory of Suicide (i.e. Thwarted Belongingness, Perceived Burdensomeness, and Acquired Capability for Suicide) and Post-Traumatic Growth. I am committed to providing members of my support group with the following measures as requested: The Interpersonal Needs Questionnaire, the Acquired Capability for Suicide Scale, The Post-traumatic Growth Inventory, and a survey with basic demographic information. I understand that these will be administered via online survey every three months and we commit to collecting this data on at least 7 group members per year (based on the average number of people we serve in group per year). For those group members who do not use email and the internet, I understand that paper copies will be provided to me and I will secure responses from members and mail these back using postage provided. For the purposes of qualitative data collection, I am committed to assisting you in arranging interviews with survivors to learn the strengths and weaknesses of support groups as an intervention.

Given the impact of suicide on those left behind to grieve and the lack of research on support groups, *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition* is an endeavor we are excited to participate in to advance the knowledge of the impact of support groups. We look forward to collaborating with you on this work.

Sincerely,



President
Survivors of Suicide of Dubois County, Inc.

APPENDIX D

SUPPORT LETTER FROM NEBRASKA

Nebraska LOSS Team

Lincoln Lancaster Local Outreach to Suicide Survivors

http://NELOSSTeam.nebraska.edu/

October 14, 2011

Dear Dr. Aguirre,

On behalf of our team, I am pleased and excited to offer our support and collaboration to the research study: *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition.* Our commitment to survivors of suicide can only be strengthened by participating in such an important research study.

As one of the sites chosen to elicit data from, we commit to providing historical data where available on the survivors we have served prior to the September 2012 and data on survivors whom have been touched by services provided by our program from September 2012 through August of 2014. Basic demographic data will be collected on those we serve and reported to the project coordinator monthly. As a part of this research project, we will also facilitate qualitative data collection with our survivors. The data from phenomenological interviews with survivors will include data collection about how the APM delivery format impacts survivor outcomes. We have been made aware of the following outcomes and agree to collect data in line with these constructs:

- further evidence as to whether the APM reduces elapsed time between death and accessing services;
- findings indicating whether the APM complements the survivor support group in reducing suicidality and increasing post-traumatic growth;
- whether the delivery format of the APM impacts survivor outcomes.

We also agree to help facilitate data collection from support groups including:

- outcome measures of the impacts of survivor support groups on both suicidality and post-traumatic growth;
- information as to whether group design issues impact outcomes for survivors.

Much of the data requested is already part of our data collection process, and therefore I see no problem adding some additional elements and delivering all data requested. Upon signing this agreement we agree to provide the research team with the above data per the grant timeline.

Given the impact of suicide on those left behind to grieve, the difficulty in connecting these survivors with services, and the lack of research on whether services such as support groups are effective, *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition* is poised to address a critical gap in suicide research if funded.

Collectively, findings in these domains have the potential to inform improvements to service delivery through both the survivor support group and the APM modalities. Furthermore, the study findings have the potential to guide the creation of best practices for those wishing to begin a new postvention service or improve existing services.

I look forward to collaborating with you on this work.

Sincerely,

David Miers, PhD
Nebraska LOSS Team

Site	Contact Person	# of Years of Service Delivery	# of Clients Served to Date	Process	Support Groups used for Referrals
Lincoln, NE	Dave Miers, PhD 402-481-5165 or dave.miers@bryanlgh.org Or Don Belau, PhD, 402-759-0573 or donald.belau@doane.edu	2 years	Approx. 25	1. A team of 3 on call each month (2 survivors and 1 clinician) 2. When a suicide occurs police call chaplain and chaplain pages/calls LOSS team after talking to family and letting them know about team 3. Team coordinator contacts family to arrange for a visit if desired 4. Following visit team members debrief, leave a packet with the family, one member of team does follow-up contacts with family	Survivors of Suicide, Ray of Hope Contact Person: Phone: Email: Length of Group: Frequency of meeting: Ray of Hope – Survivors of Suicide Support Group Meets 1st and 3rd Mondays at 7:00pm Our Saviour's Lutheran Church East parking lot 40th & "C" Street Lincoln, Nebraska Contact: Gary and Jennifer Nelson, (402) 477-8610 or Delmary Wiltshire, (402) 488-3827

APPENDIX E

SUPPORT LETTER FROM OHIO

HERE4HOPE
HELP. OUTREACH. PREVENTION. EDUCATION.

Dear Dr. Aguirre,

On behalf of our team, I am pleased and excited to offer our support and collaboration to the research study: *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition*. Our commitment to survivors of suicide can only be strengthened by participating in such an important research study.

As one of the sites chosen to elicit data from, we commit to providing historical data where available on the survivors we have served prior to the September 2012 and data on at least 50 survivors whom have been touched by services provided by our program from September 2012 through August of 2014. Basic demographic data will be collected on those we serve and reported to the project coordinator monthly. As a part of this research project, we will also facilitate qualitative data collection with our survivors. The data from phenomenological interviews with survivors will include data collection about how the APM delivery format impacts survivor outcomes. We have been made aware of the following outcomes and agree to collect data in line with these constructs:

- further evidence as to whether the APM reduces elapsed time between death and accessing services;
- findings indicating whether the APM complements the survivor support group in reducing suicidality and increasing post-traumatic growth;
- whether the delivery format of the APM impacts survivor outcomes.
- We also agree to help facilitate data collection from support groups including:
- outcome measures of the impacts of survivor support groups on both suicidality and post-traumatic growth;
- information as to whether group design issues impact outcomes for survivors.

Much of the data requested is already part of our data collection process, and therefore I see no problem adding some additional elements and delivering all data requested. Upon signing this agreement we agree to provide the research team with the above data per the grant timeline.

Given the impact of suicide on those left behind to grieve, the difficulty in connecting these survivors with services, and the lack of research on whether services such as support groups are effective, *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition* is poised to address a critical gap in suicide research if funded.

131 N. Main St., Suite H
Marysville, OH 43040

"Prevent Suicide, Prevent Substance Abuse, Preserve Life"
info@here4hope.org • www.here4hope.org

Collectively, findings in these domains have the potential to inform improvements to service delivery through both the survivor support group and the APM modalities. Furthermore, the study findings have the potential to guide the creation of best practices for those wishing to begin a new postvention service or improve existing services.

I look forward to collaborating with you on this work.

Sincerely,

Ashley S. Garrett, MSW
Sudden Loss Team of Union County

131 N. Main St., Suite H
Marysville, OH 43040

"Prevent Suicide, Prevent Substance Abuse, Preserve Life"

info@here4hope.org • www.here4hope.org

APPENDIX F

SUPPORT LETTER FROM RAPID CITY

FRONT PORCH COALITION

A united front for suicide prevention

Dedicated to helping those people who have tragically lost someone to suicide while working to reduce the incidence of suicide within our community, through available education, awareness, and prevention services.

October 17, 2011

Dear Dr. Aguirre,

On behalf of our team, I am honored and excited to offer our support and collaboration to the research study: *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition.* Our commitment to survivors of suicide can only be strengthened by participating in such an important research study.

As one of the sites chosen to elicit data from, we commit to providing data where available on the survivors we have served and data on at least 100 survivors whom will be serviced by our program from September 2012 through August of 2014. Basic demographic data in its generic form to maintain confidentiality of our clientele will be collected on those we serve and reported to the project coordinator monthly. As a part of this research project, we will also facilitate qualitative data collection with our survivors. The data from phenomenological interviews with survivors will include data collection about how the APM delivery format impacts survivor outcomes. We have been made aware of the following outcomes and agree to collect data in line with these constructs:

- further evidence as to whether the APM reduces elapsed time between death and accessing services;
- findings indicating whether the APM complements the survivor support group in reducing suicidality and increasing post-traumatic growth;
- whether the delivery format of the APM impacts survivor outcomes.

We also agree to help facilitate data collection from support groups including:

- outcome measures of the impacts of survivor support groups on both suicidality and post-traumatic growth;
- information as to whether group design issues impact outcomes for survivors.

Much of the data requested is already part of our data collection process, and therefore I see no problem adding some additional elements and delivering all data requested. Upon signing this agreement we agree to provide the research team with the above data per the grant timeline.

Given the impact of suicide on those left behind to grieve, the difficulty in connecting these survivors with services, and the lack of research on whether services such as support groups are effective, *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition* is poised to address a critical gap in suicide research if funded. Collectively, findings in these domains have the potential to inform improvements to service delivery through both the survivor support group and the APM modalities.

915 Mountain View Road, Rapid City, SD 57702

Furthermore, the study findings have the potential to guide the creation of best practices for those wishing to begin a new postvention service or improve existing services. So few services of this kind exist for survivors of a loss to suicide and research into what improves outcomes for those who endure this devastation is long overdue. I commend your efforts and again am honored to be a part of this endeavor.

I look forward to collaborating with you on this work. Should you have any questions or concerns please feel free to contact me at: 605-348-6692 or at frontporch@midconetwork.com.

Sincerely,

Stephanie Schweitzer Dixon
Community Services Director

APPENDIX G

SUPPORT LETTER FROM TARRANT COUNTY

Mental Health Association

of Tarrant County

3136 West 4th Street, Fort Worth, Texas 76107
(Main Phone) 817-335-5405 (Fax) 817-334-0025
www.mhatc.org Email: mhatc@mhatc.org

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Dear Dr. Aguirre,

On behalf of our team, I am pleased and excited to offer our support and collaboration to the research study: *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition.* Our commitment to survivors of suicide can only be strengthened by participating in such an important research study.

As one of the sites chosen to elicit data from, we commit to providing historical data where available on the survivors we have served prior to the September 2012 and data on at least 100 survivors whom have been touched by services provided by our program from September 2012 through August of 2014. Basic demographic data will be collected on those we serve and reported to the project coordinator monthly. As a part of this research project, we will also facilitate qualitative data collection with our survivors. The data from phenomenological interviews with survivors will include data collection about how the APM delivery format impacts survivor outcomes. We have been made aware of the following outcomes and agree to collect data in line with these constructs:

- further evidence as to whether the APM reduces elapsed time between death and accessing services;
- findings indicating whether the APM complements the survivor support group in reducing suicidality and increasing post-traumatic growth;
- whether the delivery format of the APM impacts survivor outcomes.

We also agree to help facilitate data collection from support groups including:

- outcome measures of the impacts of survivor support groups on both suicidality and post-traumatic growth;
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Given the impact of suicide on those left behind to grieve, the difficulty in connecting these survivors with services, and the lack of research on whether services such as support groups are effective, *Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition* is poised to address a critical gap in suicide research if funded. Collectively, findings in these domains have the potential to inform improvements to service delivery through both the survivor support group and the APM modalities. Furthermore, the study findings have the potential to guide the creation of best practices for those wishing to begin a new postvention service or improve existing services.

United Way
of Tarrant County

I look forward to collaborating with you on this work.

Sincerely,

An Affiliate of Mental Health America

APPENDIX H

INFORMED CONSENT

INFORMED CONSENT

PRINCIPAL INVESTIGATOR NAME:
Regina T. P. Aguirre, PhD, LMSW-AP

TITLE OF PROJECT:
Suicide postvention as prevention: A multi-site evaluation of Shneidman's Proposition

INTRODUCTION
You are being asked to participate in a research study. Your participation is voluntary. Please ask questions if there is anything you do not understand.

PURPOSE:
The purpose of this research study is to evaluate effectiveness of the support group through long-term assessment of survivors over 6 months on post-traumatic growth and the three constructs of the Interpersonal Theory of Suicide as measured by the Post-Traumatic Growth Inventory (Short form; PTGI-SF), Post-Traumatic Stress Disorder Checklist (PCL), the Interpersonal Needs Questionnaire (INQ), and the Acquired Capability for Suicide Scale (ACSS). Survivors will also provide information about their loss and other demographic information through a demographic survey.

DURATION:
Participation in this study will involve 3 assessments at 3 month intervals to be completed via the website or paper form if you do not have access to the website.

PROCEDURES:
Data collection procedures. You will be asked to complete 4 surveys that will cover the following topics: your own capability for suicide, perceived burdensomeness and belongingness, and post-traumatic stress and growth. At the end of the survey, you will be invited to send the survey link to survivors your know who may wish to participate. This process will be repeated every 3 months until 3 assessment cycles take place. Participants will be chosen at random to complete a qualitative interview with the project coordinator via phone or video conference when available. The interview aims to gather more in-depth knowledge about the effects of the LOSS Team and the support group through your healing and recovery process. These interviews will be audio-recorded.

POSSIBLE BENEFITS:
You may not benefit from the research personally but the research may help in the improvement of the LOSS Team and support group curriculums.

COMPENSATION:
You will be paid in the form of a $25 gift card for those who complete the 3 administrations of the assessments.

DEC 0 9 2011

POSSIBLE RISKS/DISCOMFORTS:

APPROVED

DEC 0 9 2012

Institutional Review Board

16 October 2007

1

This research will deal with potentially emotional and sensitive issues related to the loss of your loved one to suicide. Should you become distressed during the process, the project coordinator, Laura Frank, is available to assist you in coping and is equipped with valuable resources in the community to assist you as well. Among these resources are the support group in your area and the national crisis hotline, **1-800-273-TALK (8255).** Your participation in this research is voluntary and should you decide that the emotional discomfort is too great, you may end your participation at any time with no penalty or loss of benefits, to which you are otherwise entitled.

ALTERNATIVE PROCEDURES/TREATMENTS:
There are no alternatives for this research study; your choice to participate or decline will have no effect on your experience with existing support group.

WITHDRAWAL FROM THE STUDY:
You may discontinue participation at any time without penalty or loss of benefits, to which you are otherwise entitled.

NUMBER OF PARTICIPANTS: We expect up to 300 participants to enroll in this study.

CONFIDENTIALITY:
Confidentiality of the one-time interview will be maintained. Details of this include:

- Data collected directly from survivors will include identifying information (name, email, etc.) that will be linked to their responses on the demographic survey, INQ, ACSS, PCL, and PTGI-SF and qualitative interview data.
    - Quantitative data will be collected through an online data collection system and, when necessary, paper versions. Online data will be downloaded to the principal investigator and project coordinator computers, which are password protected. Data will also be backed up on a secure, online backup system that is password protected and only accessible by the principal investigator. Paper versions will be stored in the principal investigator's locked office; paper will be input by the work-study once s/he is approved by the IRB to be on the protocol. This approval will require the work-study to first complete human subjects training. Further training and supervision will be provided by the principal investigator and project coordinator.
    - Qualitative data in the form of digital audio files and transcriptions will be stored in similar manner as defined above: on principal investigator and project coordinator computers, which are password protected. Data will also be backed up on a secure, online backup system that is password protected and only accessible by the principal investigator.

If in the unlikely event it becomes necessary for the Institutional Review Board to review your research records, then The University of Texas at Arlington will protect the confidentiality of those records to the extent permitted by law. Your research records will not be released without your consent unless required by law or a court order. The data resulting from your participation may be made available to other researchers in the future for research purposes not detailed within this consent form. In these cases, the data will contain no identifying information that could associate you with it, or with your participation in any study.

If the results of this research are published or presented at scientific meetings, your identity will not be disclosed.

APPROVED
DEC 0 9 2012
Institutional Review Board

16 October 2007

DEC 0 9 2011

CONTACT FOR QUESTIONS:
Questions about this research or your rights as a research subject may be directed to Regina T.P. Aguirre at (682)-225-7180. You may contact the chairperson of the UT Arlington Institutional Review Board at (817)-272-3723 in the event of a research-related injury to the subject.

CONSENT:
Signatures:
As a representative of this study, I have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study:

____

Signature and printed name of principal investigator or person obtaining consent   Date

By signing below, you confirm that you have read or had this document read to you.

You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time

You voluntarily agree to participate in this study. By signing this form, you are not waiving any of your legal rights. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled, and the you may discontinue participation at any time without penalty or loss of benefits, to which you are otherwise entitled.

____

SIGNATURE OF VOLUNTEER   **DATE**

DEC 0 9 2011

APPROVED

DEC 0 9 2012

Institutional Review Board

APPENDIX I

SURVEY

1. What is your name?

***2. Age**

3. Please provide your email address and phone number.

1. Email address:

2. Phone number:

***4. Gender**

- Male
- Female
- Transgender

5. Race

- White/Caucasian
- Black/African-American
- Hispanic
- Asian
- Native Hawaiian/Pacific Islander
- American Indian/Native Alaskan

Other (please specify)

6. Are you attending a support group specific to suicide loss?

- Yes
- No

7. What support group are you attending? (Name of group, city, and state)

8. Did you have a visit from an outreach group for those bereaved by suicide?

- Yes
- No

9. What is the name of the group that visited you?

10. If you received an outreach visit, was it within hours of you learning about the death, or was it delayed (next day, week, other)?

- Within Hours
- Delayed

11. If your visit was delayed, how were you contacted?

- ○ Face-to-face
- ○ Over the phone
- ○ Other

12. What was your relationship with the person you lost to suicide (e.g. husband, wife, brother, sister, etc)?

*** 13. What method did your loved one use to kill him or herself?**

- [ ] Firearms
- [ ] Drug overdose
- [ ] Hanging
- [ ] Poisoning
- [ ] Suffocation
- [ ] Not sure
- [ ] Drowning

Other (please specify)

*** 14. Did you find your loved one's body?**

- ( ) Yes
- ( ) No

*** 15. Who was with you at the scene of the suicide?**

- [ ] Police
- [ ] Chaplain
- [ ] Fire
- [ ] Other family members
- [ ] Paramedics
- [ ] Friends
- [ ] Suicide response team

Other (please specify)

*** 16. How did the police react to the suicide? Please describe their reactions and your feelings.**

***17. After your loved one died by suicide, did you have thoughts of suicide?**

- ◯ Yes
- ◯ No

***18. Please elaborate on your thoughts of suicide following the loss of your loved one.**

***19. Did you attempt suicide after the loss of your loved one?**

- ◯ Yes
- ◯ No

*20. Did you have thoughts of suicide before the loss of your loved one?**

- ◯ Yes
- ◯ No

***21. Did you attempt suicide before the loss of your loved one?**

- ◯ Yes
- ◯ No

***22. Following your loved one's suicide, who gave you information about services and resources?**

- [ ] Police
- [ ] Victim Advocate
- [ ] Suicide response team
- [ ] Medical Examiner/Coroner
- [ ] Friend
- [ ] Family Member
- [ ] Chaplain
- [ ] Church
- [ ] No one

Other (please specify)

***23. How did you find out about the suicide response team?**

- [ ] They were at the scene of my loved one's suicide
- [ ] They contacted me after the suicide
- [ ] Police
- [ ] Medical Examiner/Coroner
- [ ] Chaplain

Other (please specify)

***24. Do you think the suicide response team was helpful?**

Yes

No

***25. What was most helpful about the Suicide response team?**

***26. Why was the suicide response team unhelpful to you?**

***27. What services did you access following the loss of your loved one?**

- [ ] Therapist
- [ ] Psychiatrist
- [ ] Support group (not specific to suicide)
- [ ] Internet support group (not specific to suicide)
- [ ] American Association of Suicidology Healing Conference
- [ ] None

Other (please specify)

***28. Is the support group you attend an open or closed group? (i.e. does it go on indefinitely or is it limited by time such as 8 weeks, etc.)**

- ○ Open
- ○ Closed

***29. Who facilitates the group?**

- ○ Survivor
- ○ Professional

Other (please specify)

***30. Was the group specific to suicide survivors or was it a general grief and loss group?**

◯ Suicide survivors ◯ Grief and Loss group

***31. Was the group designed to be relationship specific (e.g. family members, mothers, sisters, spouses, friends)?**

◯ Yes ◯ No

***32. How long after your loved one's suicide did you access services?**

***33. What other types of activities did you use to heal?**

- [ ] Gardening
- [ ] Writing
- [ ] Cooking
- [ ] Collage
- [ ] Nature
- [ ] Memory quilt
- [ ] Faith-related activities
- [ ] Sports
- [ ] Reading
- [ ] None

Other (please specify)

***34. What did you read?**

- [ ] Self help
- [ ] Fiction
- [ ] Suicide-specific

Other (please specify)

***35. What was most helpful to your healing?**

***36. What was the hardest issues you faced after losing your loved one?**

***37. What were the most prominent feelings you experienced after losing your loved one?**

***38. What reference do you prefer?**

- Suicide Survivor
- Bereaved by Suicide

Other (please specify)

APPENDIX J

PTSD CHECKLIST – CIVILIAN VERSION

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: ____________________________________

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience were *happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

This is a Government document in the public domain.

APPENDIX K

ACQUIRED CAPABILITY FOR SUICIDE SCALE

Acquired Capability for Suicide Scale (ACSS)

- Construct measured: acquired capability for lethal self-injury (i.e., suicide; see Joiner, 2005).

- Reverse score items 3, 6, 8, 10, 12, 13, 18 to make higher numbers indicate higher levels of acquired capability.

- Current citation:

Van Orden, K. A., Witte, T. K., Gordon, K. H., Bender, T. W., & Joiner, T. E. Jr. (in press). Suicidal desire and the capability for suicide: A test of the interpersonal psychological theory in adults. *Journal of Consulting and Clinical Psychology, 76*, 72-83.

ACSS

Please read each item below and indicate to what extent you feel the statement describes you. Rate each statement using the scale below and indicate your responses on your answer sheet.

0	1	2	3	4
Not at all like me				Very much like me

_______ 1. Things that scare most people do not scare me.

_______ 2. The sight of my own blood does not bother me.

_______ 3. I avoid certain situations (e.g., certain sports) because of the possibility of injury.

_______ 4. I can tolerate a lot more pain than most people.

_______ 5. People describe me as fearless.

_______ 6.The sight of blood bothers me a great deal.

_______ 7. The fact that I am going to die does not affect me.

_______ 8. The pain involved in dying frightens me.

_______ 9. Killing animals in a science course would not bother me.

_______10. I am very much afraid to die.

_______11. It does not make me nervous when people talk about death.

_______12. The sight of a dead body is horrifying to me.

_______13. The prospect of my own death arouses anxiety in me.

_______14.I am not disturbed by death being the end of life as I know it.

_______15. I like watching the aggressive contact in sports games.

_______16. The best parts of hockey games are the fights.

_______17. When I see a fight, I stop to watch.

_______18. I prefer to shut my eyes during the violent parts of movies.

_______19. I am not at all afraid to die.

_______ 20. I could kill myself if I wanted to. (Even if you have never wanted to kill yourself, please answer this question.)

APPENDIX L

INTERPERSONAL NEEDS QUESTIONNAIRE

Interpersonal Needs Questionnaire

- **Constructs measured**: thwarted belongingness and perceived burdensomeness (see Joiner, 2005). Items 1-9 were designed to measure the extent to which participants feel like a burden on the people in their lives (i.e., perceived burdensomeness/thwarted interpersonal effectiveness). Items 10-18 were designed to measure the extent to which participants feel connected to others (or disconnected, i.e., thwarted belongingness).
- Here are the items you need to **reverse score** so that higher numbers represent higher levels of thwarted belongingness and perceived burdensomeness: 5, 9, 10, 11, 13, 16, 17, 18.
- **current citation**: Van Orden, K. A., Witte, T. K., Gordon, K. H., Bender, T. W., & Joiner, T. E. Jr. (i2008). Suicidal desire and the capability for suicide: A test of the interpersonal psychological theory in adults. *Journal of Consulting and Clinical Psychology, 76*, 72-83.
- Questions? email Kim: vanorden@psy.fsu.edu
- Sample **scoring syntax**:

```
RECODE
  inq5
  (1=7) (7=1) (2=6) (6=2) (3=5) (5=3) (4=4) INTO inq5r.
 exe.
 RECODE
 inq9
  (1=7) (7=1) (2=6) (6=2) (3=5) (5=3) (4=4) INTO inq9r.
 exe.
 RECODE
 inq10
  (1=7) (7=1) (2=6) (6=2) (3=5) (5=3) (4=4) INTO inq10r.
 exe .
  RECODE
 inq11
  (1=7) (7=1) (2=6) (6=2) (3=5) (5=3) (4=4) INTO inq11r.
exe.
 RECODE
 inq13
  (1=7) (7=1) (2=6) (6=2) (3=5) (5=3) (4=4) INTO inq13r.
 exe.
 RECODE
 inq16
  (1=7) (7=1) (2=6) (6=2) (3=5) (5=3) (4=4) INTO inq16r.
 exe.
 RECODE
 inq17
  (1=7) (7=1) (2=6) (6=2) (3=5) (5=3) (4=4) INTO inq17r.
 exe.
 RECODE
 inq18
  (1=7) (7=1) (2=6) (6=2) (3=5) (5=3) (4=4) INTO inq18r.
 exe.

COMPUTE burden = MEAN.9(inq1, inq2, inq3, inq4, inq5r, inq6, inq7, inq8, inq9r).
exe.

COMPUTE belong = MEAN.9(inq10r, inq11r, inq12, inq13r, inq14, inq15, inq16r, inq17r, inq18r).
exe.
```

INQ

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what *you* think and feel.

1	2	3	4	5	6	7
Not at all true for me			Somewhat true for me			Very True for me

_____ 1. These days the people in my life would be better off if I were gone.

_____ 2. These days the people in my life would be happier without me.

_____ 3. These days I think I have failed the people in my life.

_____ 4. These days I think I am a burden on society.

_____ 5. These days I think I contribute to the well-being of the people in my life.

_____ 6. These days I feel like a burden on the people in my life.

_____ 7. These days I think the people in my life wish they could be rid of me.

_____ 8. These days I think I make things worse for the people in my life.

_____ 9. These days I think I matter to the people in my life.

_____ 10. These days, other people care about me.

_____ 11. These days, I feel like I belong.

_____ 12. These days, I rarely interact with people who care about me.

_____ 13. These days, I am fortunate to have many caring and supportive friends.

_____ 14. These days, I feel disconnected from other people.

_____ 15. These days, I often feel like an outsider in social gatherings.

_____ 16. These days, I feel that there are people I can turn to in times of need.

_____ 17. These days, I am close to other people.

_____ 18. These days, I have at least one satisfying interaction every day.

APPENDIX M

POSTTRAUMATIC GROWTH INVENTORY – SF

Posttraumatic Growth Inventory –SF

Indicate for each of the statements below the degree to which this change occurred in your life as a result of your crisis [or researcher inserts specific descriptor here], using the following scale.

0= I did not experience this change as a result of my crisis.
1= I experienced this change to a very small degree as a result of my crisis.
2= I experienced this change to a small degree as a result of my crisis.
3= I experienced this change to a moderate degree as a result of my crisis.
4= I experienced this change to a great degree as a result of my crisis.
5= I experienced this change to a very great degree as a result of my crisis.

1. I changed my priorities about what is important in life. (V-1)
2. I have a greater appreciation for the value of my own life. (V-2)
3. I am able to do better things with my life. (II-11)
4. I have a better understanding of spiritual matters. (IV-5)
5. I have a greater sense of closeness with others. (I-8)
6. I established a new path for my life. (II-7)
7. I know better that I can handle difficulties. (III-10)
8. I have a stronger religious faith. (IV-18)
9. I discovered that I'm stronger than I thought I was. (III-19)
10. I learned a great deal about how wonderful people are. (I-20)

Note: Scale is scored by averaging all responses. Factors can be scored by adding responses to items on each factor. Caution should be used when using factor scores based on only two items. When using the PTGI-SF the total score should be used, rather than factor scores. Items to which factors belong are not listed on the form administered to participants. Number in parentheses with Factor is the item number from the original PTGI.

PTGI Factors

Factor I: Relating to Others
Factor II: New Possibilities
Factor III: Personal Strength
Factor IV: Spiritual Change
Factor V: Appreciation of Life

APPENDIX N

RELATIONSHIP TO SURVIVOR

	Frequency (n=)
1. Brother	42
2. Son	38
3. Husband	33
4. Father	19
5. Daughter	13
6. Mother	11
7. Sister	8
8. Boyfriend	7
9. Cousin	7
10. Fiancé	5
11. Neighbor	5
12. Aunt	3
13. Nephew	3
14. Co-Worker	2
15. Wife	2
16. Uncle	2
17. Grandfather	2
18. Significant other	2
19. Step Son	2
20. Not Specified	1
21. Parent	1
22. Niece	1
23. Step-child	1
24. Cousin/brother	1
25. Client	1
26. Grandson	1
27. Ex-husband	1
28. Mother-in-law	1
29. Ex-Wife	1
30. Sister-in-Law	1
31. Step Sister	1
32. Ex-Fiancé	1
33. Grandfather	1
34. Partner	1
35. Step dad	1

APPENDIX O

SERVICES ACCESSED BY SURVIVOR

	Frequencies (n=)	Percentage (%)
1. Individual Services	178	40.7
2. Support Group not specific to suicide	63	14.4
3. Support Group specific to suicide	47	10.8
4. Internet support group not specific to suicide	40	9.2
5. None	34	7.8
6. AAS Conference	22	5
7. Internet Support group specific to suicide	12	2.7
8. Social Support	8	1.8
9. Spiritual Resources	6	1.4
10. Online Resources	6	1.4
11. Other	5	1.1
12. Advocacy	4	.9
13. Reading	4	.9
14. Medical Resources	3	.7
15. Time	3	.7
16. Work related services	2	.5
Total	437	

APPENDIX P

ACTIVITIES USED TO HEAL

	Frequency (n=)	Percent (%)
1. Reading	129	21.2
2. Writing	106	17.6
3. Outdoor Activities	79	13
4. Faith Related Activities	64	10.5
5. Activities of Reminiscence	34	5.6
6. Sports	24	3.95
7. None	24	3.95
8. Survivor Advocacy	15	2.5
9. Talking	16	2.3
10. Arts & Crafts	15	2.3
11. Other	14	2.3
12. Cooking	13	2.1
13. Exercise	11	1.8
14. Work	9	1.5
15. Family Related Activities	9	1.5
16. Education	8	1.3
17. Music	8	1.2
18. Bereavement	6	1
19. Support Groups	5	.8
20. Maladaptive Self-Care	6	.8
21. Friends	5	.8
22. Alternative Medicines	4	.7
23. Travel	4	.7
24. Not Healed	2	.3
25. Pets	2	.3
Total	612	

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BIOGRAPHICAL INFORMATION

Amy Crow received her Bachelor of Arts in Psychology and History both from the University of Texas at Arlington in December of 2009. Upon successful defense of her thesis, she will receive her M.S.S.W, also from the University of Texas at Arlington. Amy plans to pursue a doctoral degree in either Social work or Psychology after gaining field experience. Among her interests, Amy is interested in the aftermath of an attempted suicide as well as further researching survivors of suicide. Amy plans to continue working with the LOSS Team in Tarrant County and advocating for survivors.