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What do Suicide Survivors Tell Us They Need? Results of a Pilot Study

Jannette M. McMenamy, PhD, John R. Jordan, PhD,
and Ann M. Mitchell, PhD, RN

Few studies have examined the natural coping efforts used by suicide survivors, or have identified specific problems and needs survivors experience following the death of a significant other by suicide. In the present study we used a newly developed needs assessment survey to examine four areas of natural coping efforts: practical, psychological, and social difficulties; formal and informal sources of support; resources utilized in healing; and barriers to finding support since the loss. Sixty-three adult survivors of suicide were recruited from suicide survivor conferences and support groups. Results indicate that participants experienced high levels of psychological distress since the suicide, including elevated symptoms of depression, guilt, anxiety, and trauma. Participants experienced substantial difficulties in the social arena (e.g., including talking with others about the suicide). The majority of the sample viewed professional help as beneficial; although many informal sources of support were also valued (e.g., one-to-one contact with other survivors). Depression and a lack of information about where to find help served as barriers to help-seeking behaviors for our participants. Participants who reported higher levels of functional impairment were more likely to report higher levels of psychological distress, social isolation, and barriers to seeking help. Future research with a longitudinal and more inclusive sample is needed to build on these preliminary findings and to provide a solid foundation for evidenced-based interventions with survivors.

In recent years, the understanding that suicide survivors may be at risk for a variety of psychological, social, and bereavement complications, including elevated rates of complicated grief and suicide (Agerbo, 2005; Agerbo & Aarhus, 2003; Bailley, Kral, & Dunham, 1999; Clark, 2001; Farberow, 2001; Jordan, 2001; McIntosh, 2003; Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004; Qin, Agerbo, & Mortensen, 2002), has become more apparent. At the same time, interest in the forms of assistance that might be helpful to survivors has been emerging (Jordan & McMenamy, 2004). Recent reviews of the literature on grief counseling have suggested that

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formal interventions after a loss may be effective for people who are at an elevated risk for developing a complicated grief response (Jordan & Neimeyer, 2003). Since suicide survivors may be at risk, the question of how to help survivors is an important one; not only for secondary prevention efforts for an at-risk population, but also for the primary prevention of suicide (Moscicki, 1995; Runeson & Asberg, 2003; Qin, Agerbo, & Mortensen, 2002).

Our recent review of the literature on interventions for suicide survivors suggested that the state of knowledge about effective interventions is at best rudimentary (Jordan & McMenamy, 2004). In that review, a number of recommendations for future research with survivors were made. The first was to investigate the "natural" course of bereavement for survivors in the community. Many questions remain about how to define who a survivor is, how many people are impacted by a suicide, and in what ways the trajectory of bereavement after a suicide may be similar or different from other types of traumatic and nontraumatic losses (Cerel, Jordan, & Duberstein, 2006). For example, the widely cited figure of six survivors for every suicide is simply an estimate rather than a figure based on empirical study of the question (Cerel et al., 2006). In addition, the examination of existing community interventions, primarily survivor support groups, followed by the systematic comparative investigation of interventions specifically developed for this population has been suggested. With regard to studying community-based assistance programs which many survivors currently utilize, it was noted that:

> We also know very little about the coping strategies that survivors develop on their own, and only slightly more about what types of formal and informal assistance survivors receive from professional caregivers, family, friends, and others in their social network. Careful longitudinal research with a diverse, community-based sample of survivors would greatly increase our understanding of the challenges involved and the

coping skills required after a suicide. It would also provide much needed information about the large number of survivors (quite likely the majority) who never attend organized support groups or receive professional assistance. Such research would also allow us to generate creative strategies for interventions that build on the natural coping efforts that different types of survivors typically make and the support resources they utilize. (Jordan & McMenamy, 2004, pp. 19–20)

The present study is a beginning attempt to follow our aforementioned recommendation by examining the natural coping efforts of different suicide survivors through a newly developed survey instrument.

BACKGROUND

To the best of our knowledge, only two empirical studies have directly asked suicide survivors about their perceived needs following a death by suicide. In a telephone survey of 144 next-of-kin survivors, Provini, Everett, and Pfeffer (2000) found that approximately one quarter of their sample indicated specific concerns (18%) and needs (26%), while approximately one third indicated that they had no specific concerns (35%) or needs (31%). About one quarter reported that they had received either formal or informal help since the suicide, although professional help was listed as a type of assistance desired by almost three quarters of those who indicated a need for help. Family-related problems were the most frequently mentioned concerns, and families containing minor children expressed significantly more concerns than those without children. One limitation of that study was that bereaved parents appeared to be underrepresented in the study. This could be due to the fact that the sample was also relatively young, with nearly half (42%) of the respondents in the 25–44 year age range.◄

In a study of 179 Norwegian survivor parents, Dyregrov (2002) found that participants experienced high levels of psychosocial

distress on measures of general health, functioning, traumatization, and complicated bereavement. They also expressed considerably greater levels of perceived and unmet needs for services and support than the Provini et al. (2000) sample. More specifically, 88% of the participants expressed the need for professional help related to bereavement issues. Eighty-five percent reported that they had already received some kind of contact with community professionals, and about half had experienced direct outreach from professionals. This contact, however, was typically of short duration (67% reported it lasted less than 6 months) and had been offered shortly after the loss. Many respondents expressed the wish for ongoing and longer-term support from professionals because they had difficulty initiating the search for help on their own, given their emotionally traumatized state. Similar to the Provini et al. sample, respondents expressed a strong need for help with supporting minor children after the suicide, as well as targeted help for dealing with the posttraumatic experiences of intrusive memories and images.

In her 2002 study, Dyregrov also surveyed community professionals and found that while there was a general congruence between the type of help offered and help received, professionals tended to overestimate the percentage of survivors who actually received help from medical personnel (doctors, psychiatric nurses, or public health nurses). They also overestimated the number of survivors who participated in survivor support groups.

The purpose of the current pilot study is to investigate four areas of effects on and natural coping efforts of survivors: practical, psychological, and social difficulties encountered since the suicide; formal and informal sources of support that have helped them cope with the loss; resources utilized in healing; and barriers to finding support since the loss. These data will provide preliminary descriptive information about the relationship between levels of functional impairment reported by survivors and the difficulties they have encountered since the suicide; their use of different resources for healing; and the barriers they faced while trying to find support services.

METHODS

Sample

The sample consisted of 63 adult survivors of suicide (18 years of age or older). It was comprised of 45 females (71%) and 18 males (29%), with a mean age of 50.44 years ($SD = 9.9$ years). The sample was predominantly Caucasian (94%) and had at least a college education (81%). Forty participants were married (64%), 12 were widowed (18%), 6 were single (10%), and 5 were separated or divorced (8%).

In this sample, the kinship relationship to the deceased included 20 parents (32%), 18 children (29%), 11 siblings (18%), and 11 spouses (18%). One grandparent participated in the study and one friend of the deceased participated. One participant did not report his relationship to the deceased. The deceased were predominantly male (79%), with a mean age of 33.9 years ($SD = 15.2$ years). The length of time since the suicide was extremely varied, with a mean length of 47.9 months (range: 2 to 416 months [over 34 years]). Thirty percent of the sample had lost a significant other within 1 year of participating in the study, 22% within 1 to 2 years, 23% within 2 to 5 years, 11% within 5 to 10 years, and 14% experienced the loss over 10 years ago. Twenty-one participants (33%) witnessed the suicide.

Data Collection Procedures

Of the 63 participants, 42 were attendees at Survivors' Conferences sponsored by the American Foundation for Suicide Prevention (AFSP), the New England Chapter. The research team collected data at two such conferences, one during the fall and one during the spring meetings. Twenty-one participants were recruited from a second data collection site. These participants had been

members of an 8-week Survivor of Suicide Support Group for adult survivors in Pittsburgh, Pennsylvania. All data collection procedures at both sites were approved by university-based Institutional Review Boards (IRB) and all participants consented to participate.

Survivors' Conference Procedures. All the attendees at the two Survivors' Conferences were given an invitation letter and a packet of questionnaires as part of their registration materials for the conferences. At the beginning of each conference, the research team reviewed the aforementioned documents with the entire group of attendees. Participants were assured that participation was entirely voluntary and that their involvement in the conference or with AFSP would not be impacted by declining to participate. Participants were also given the opportunity to complete the questionnaires at the conference or at home after the conference. Thirty of the 42 participants (71%) recruited from one of the conferences chose to complete the questionnaires at home and to return them in the postage-paid envelope provided in the folder by the research team.

Support Group Procedures. The participants from the second data collection site were former participants in a closed-ended, 8-week long, Survivor of Suicide Bereavement Support Group for adult survivors. A member of the research team contacted participants in the support group to invite them to participate in the study. As with the participants recruited from the AFSP conferences, participants recruited from the second site were also assured that their participation was completely voluntary. The 21 participants from this site completed all the questionnaires prior to participating in a focus group designed to collect qualitative data regarding survivors' perceived needs and coping efforts.

Measures

Survivor Needs Assessment Survey. This survey was developed for the present study to gather data about four broad areas of interest: (1) practical, psychological, and social

difficulties encountered since the suicide (e.g., depression, anxiety, withdrawal from friends and family, etc.); (2) formal and informal sources of support that have helped them in coping with the loss (e.g., therapists, family members, friends, etc.); (3) resources utilized in healing (e.g., support groups, self-help books, etc.); and (4) barriers to finding support (e.g., feeling overwhelmed, not knowing where to turn, unavailability of resources, etc.). Participants were asked to make ratings on a 5-point Likert scale for each item within the four categories. For example, in the area of psychological difficulties, participants were asked to rate the degree to which depression has been a problem for them since their loss from 1 (*Very Little Problem*) to 5 (*Very Large Problem*).

Demographic Questionnaire. This questionnaire asked for specific demographic information about the participants, as well as for information surrounding the circumstances of their loss. Questions covered the age, gender, ethnic/racial background, level of education, and marital status of participants. Participants also were asked if they witnessed the suicide, about the nature of their relationship to the deceased, whether or not their significant other was receiving mental health treatment at the time of their death, and the number of prior suicide attempts, if any, made by their loved one.

Data Analyses Procedures

Descriptive analyses were conducted to ascertain the number of participants who reported moderate to high levels of the following: practical, psychological, and social difficulties; helpful informal and formal sources of support; helpful resources for healing; and barriers to finding support since their loss. For each item in the aforementioned categories, we defined moderate to high levels as a score of 3 or above on the Likert scale for that item.

Correlations were conducted to assess relationships between participants' reports of functional impairment since their loss (e.g., the degree to which their daily activities at

work and/ or home were affected) with their experience of selected psychological and social difficulties, their perceptions of the usefulness of specific resources for healing, and their report of barriers to finding support since their loss. These relationships were measured by the Pearson Product Moment (r) correlation.

RESULTS

Survey Results

Practical, Psychological, and Social Issues. See Table 1 for a summary of participants' responses to the survey items about the experience of practical, psychological, and social difficulties. The majority 61% ($n = 38$) of participants indicated that they experienced moderate to high levels of functional impairment signifying that their daily activities at home or work were greatly affected. Moderate to high levels of difficulty were also reported by 38% ($n = 24$) of participants regarding their ability to find support resources, by over 29% ($n = 17$) of participants regarding financial problems, and by 27% ($n = 17$) of participants regarding finding information.

A constellation of psychological difficulties were reported by participants. The highest frequency ($n = 52$, 84%) indicated they had experienced "intense sadness and yearning for [their] loved one." Approximately three quarters of participants reported moderate to high levels of depression ($n = 46$, 75%) and guilt ($n = 46$, 73%). The majority of participants experienced moderate to high levels of anxiety ($n = 39$, 64%), trauma symptoms ($n = 34$, 55%), sleep problems ($n = 33$, 53%), and anger and irritability ($n = 32$, 53%). Over one third of the participants experienced moderate to high levels of shame or stigma ($n = 26$, 42%). Twenty-two percent ($n = 14$) of participants reported moderate to high levels of their own suicidal thoughts.

Many participants reported that they experienced substantial difficulties in the social arena, particularly with sharing grief within the family ($n = 40$, 64%) and talking about suicide within the family ($n = 39$, 61%). Over one third of participants reported moderate to high levels of difficulty in the following areas: talking about the suicide with friends and relatives ($n = 29$, 48%), handling other people's questions about the suicide ($n = 25$, 40%), social isolation and withdrawal of family and friends ($n = 24$, 40%), and withdrawal of family members from one another ($n = 22$, 36%).

Formal and Informal Sources of Support. See Table 2 for a summary of participants' responses to survey items about both the utilization and helpfulness of various types of formal and informal sources of support. Among different types of formal support, mental health professionals were used most frequently and were reported as sources of support ($n = 49$, 78%). A majority of participants reported making use of funeral directors ($n = 43$, 68%); a member of the clergy ($n = 41$, 65%); police ($n = 39$, 62%); and primary care physicians ($n = 38$, 60%).

Thirty-nine of the 49 participants (80%) who sought assistance from mental health professionals indicated that the professionals were moderately to highly helpful. The majority of participants reported that the funeral directors ($n = 30$, 70%) and clergy members ($n = 26$, 63%) they relied on were moderately to highly helpful. Less than one half of the people that worked with primary care physicians ($n = 18$, 47%), the police ($n = 19$, 49%), or hospital emergency room staff ($n = 8$, 36%) reported moderate or higher levels of helpfulness from these individuals.

Participants also relied on a range of informal sources of support. For example, the majority reported that they had used their close friends ($n = 54$, 86%) and/or brothers or sisters ($n = 51$, 81%) for support. Approximately three quarters of participants relied on their children ($n = 47$, 75%) and/or their spouses/partners ($n = 45$, 72%) for support. All the sources of support listed in the survey (e.g., parents, spouses, children, other family members, and friends) were reported by the majority of participants as moderately to highly helpful since the time of the suicide. For example, 47 of the 54 (87%) participants

TABLE 1

Frequency of Moderate to High Levels of Practical, Psychological, and Social Difficulties Among Survivors of Suicide

Issue Category and Type	Moderate to High Level of Difficulty n/N (%)
Practical Issues (6 items)	
Obtaining services (e.g., medical care, transportation)	5/59 (9%)
Obtaining information (e.g., about grief or suicide)	17/62 (27%)
Legal or insurance issues	11/58 (19%)
Financial problems	17/59 (29%)
Finding support resources (e.g., therapist or group)	24/63 (38%)
Impairment of daily activities (work or home)	38/62 (61%)
Psychological Issues (9 items)	
Depression	47/63 (75%)
Guilt	46/63 (73%)
Anxiety symptoms	39/61 (64%)
Anger & irritability	32/61 (53%)
Shame or stigma	26/62 (42%)
Substance or alcohol abuse	3/60 (5%)
Sleep disorders	33/62 (53%)
Trauma symptoms	34/62 (55%)
Suicidal thoughts	14/63 (22%)
Intense sadness and yearning for your loved one	52/62 (84%)
Social Issues (9 items)	
Difficulty talking about the suicide within the family	39/63 (61%)
Family conflict and blame about the suicide	19/63 (30%)
Deciding what to tell children about the suicide	8/29 (16%)
Withdrawal of family members from one another	22/62 (36%)
Difficulty sharing grief within family	40/63 (64%)
Handling other people's questions about the suicide	25/62 (40%)
Difficulty talking about the suicide with friends & relatives	29/61 (48%)
Gossip/blame about the suicide from friends & relatives	9/57 (16%)
Social isolation and withdrawal of friends & relatives	24/60 (40%)

Note. N represents the number of participants that responded to each question. n represents the number of participants that reported moderate to high levels of each item.

who relied on friends for help viewed them as moderately to highly helpful.

Resources for Healing. See Table 3 for a summary of participants' responses to survey items about both the utilization and helpfulness of different resources for healing. Of the 17 items in the survey, over three quarters of the participants made use of one or more of the following resources: suicide bereavement support groups ($n = 53$, 85%), books on suicide and grief ($n = 53$, 85%), talking one-to-one with another suicide survivor ($n = 52$, 83%), and individual therapy ($n = 49$, 78%). Other frequently used resources included general grief support groups ($n = 33$, 53%), pastoral counseling ($n = 34$, 54%), psychotropic medications ($n = 32$, 51%), internet Web sites ($n = 32$, 51%), and advocacy organizations ($n = 32$, 51%). Few participants reported that they relied on substance abuse treatment, hotline/crisis centers, and elder services.

Unequivocally, talking one-on-one with another survivor was viewed as helpful by the

TABLE 2

Frequency of Moderate to High Levels of Helpfulness Reported by Survivors of Suicide that Made Use of Each Type of Formal and Informal Support

Support Category and Type	Moderate to High Level of Helpfulness n/N (%)
Formal Support (7 items)	
Police	19/39 (49%)
Hospital emergency room staff	8/22 (36%)
Funeral director	30/43 (70%)
Clergyperson	26/41 (63%)
Mental health professional	39/49 (80%)
Primary care physician	18/38 (47%)
Teacher	3/15 (20%)
Informal Support (8 items)	
Parents	24/36 (67%)
Spouse/partner	37/45 (82%)
Child or children	40/47 (85%)
Brother or sister(s)	36/51 (70%)
Grandparent(s)	3/8 (38%)
Extended family	21/35 (60%)
Close friend(s)	47/54 (87%)
Neighbor(s) or colleague(s) at work	29/39 (74%)

Note. N represents the number of participants that utilized each type of support. *n* represents the number of participants that reported moderate to high levels of helpfulness from each type of support.

participants in this study. Every one of the 52 participants that relied on another survivor for support viewed this resource as moderately to highly helpful. Fifty of the 53 (94%) participants who attended suicide survivor support groups rated these groups as moderately to highly helpful. Books on suicide and grief ($n = 45$, 85%), individual therapy ($n = 39$, 80%), advocacy organizations ($n = 25$, 78%), and internet Web sites ($n = 23$, 72%) were also viewed by many as being particularly useful resources.

Barriers to Obtaining Support. See Table 4 for a summary of participants' responses to survey items about barriers to receiving support. The majority of participants viewed depression and a lack of energy as a substantial barrier to seeking help ($n = 26$, 52%) since their loss. Over one third of participants reported moderate to high levels of difficulty with the two following areas: the lack of information available about where to find resources ($n = 25$, 45%) and/or the availability of actual resources ($n = 17$, 30%). Several participants reported that lack of time ($n = 12$, 25%), distrust of professionals ($n = 12$, 24%), reluctance to ask for help ($n = 16$, 30%), and/or concern about what others would think about them ($n = 13$, 27%) as moderate to high barriers to receiving support.

Correlations Between Functional Impairment and Survey Items. See Table 5 for the correlations between participants' reports of functional impairment since their loss (e.g., degree to which their daily activities at home and/or work were affected) and their experience of practical, psychological, and social difficulties; their perceptions of the usefulness of specific resources for healing; and their report of barriers to finding support.

Participants' reports of functional impairment were positively correlated with a

TABLE 3

Frequency of Moderate to High Levels of Helpfulness Reported by Survivors of Suicide Reporting that Made Use of Each Type of Resource

Resource for healing (17 items)	Moderate to High Level of Helpfulness *n/N* (%)
General grief support group	9/33 (27%)
Suicide grief support group	50/53 (94%)
Individual therapy	39/49 (80%)
Elder services	1/7 (14%)
Information and referral service (e.g., United Way Resource Hotline)	2/12 (17%)
Pastoral counseling with clergyperson	22/34 (65%)
School-based services	6/12 (50%)
Books on suicide and grief	45/53 (85%)
Hotline/crisis center	1/9 (11%)
Church or religious group	19/29 (66%)
Psychotropic medication	22/32 (69%)
Medical help from primary care physician	13/28 (46%)
Internet Web sites	23/32 (72%)
Substance abuse treatment centers	2/6 (33%)
Advocacy organizations (e.g., AFSP, SPAN)	25/32 (78%)
Couples or family therapy	11/16 (69%)
Talking one-to-one with another suicide survivor	52/52 (100%)

Note. N represents the number of participants that utilized each type of resource. *n* represents the number of participants that reported moderate to high levels of helpfulness from each type of resource.

TABLE 4

Frequency of Moderate to High Levels of Perceived Barriers to Obtaining Support Among Survivors of Suicide

Barrier Type (12 items)	Moderate to High Level of Presence of Barrier *n/N* (%)
Lack of information about where to find resources	25/56 (45%)
Family opposition to seeking help	9/52 (17%)
Lack of financial resources	9/49 (18%)
Personal shame about seeking help	7/49 (14%)
Lack of time	12/49 (25%)
Depression, lack of energy to seek help	26/50 (52.0%)
Distrust of professionals	12/51 (24%)
Fear about lack of confidentiality	2/48 (4%)
Unavailability of resources	17/50 (34%)
Reluctance to ask for help	16/52 (30%)
Fear that seeking help will be ineffective or make things worse	7/50 (14%)
Concern about what others will think of me and my family	13/49 (27%)

Note. N represents the number of participants that responded to each question. *n* represents the number of participants that reported moderate to high levels of each item.

TABLE 5

Correlations Between Reported Level of Impairment of Daily Activities and Selected Psychological and Social Issues, Use of Resources, and Barriers to Receiving Help

	Level of impairment of daily activities
Psychological Issues	
Depression	.63***
Anxiety	.29*
Anger & irritability	.33*
Suicidal thoughts	.26*
Intense sadness and yearning for loved one	.51***
Social Issues	
Withdrawal of family members from one another	.24*
Difficulty sharing grief within family	.24*
Difficulty handling other people's questions about the suicide	.27*
Difficulty talking about the suicide with friends and relatives	.39*
Social isolation and withdrawal of friends and resources	.43**
Helpfulness of Resources	
General grief groups	−.148
Suicide grief groups	−.053
Individual therapy	−.121
Books on suicide and grief	.35*
Psychotropic medications	.095
Internet Web sites	.45**
Talking one-on-one with another survivor	.139
Barriers	
Lack of information about where to find help	.26*
Depression, lack of energy to seek help	.50*
Unavailability of resources	.31*
Reluctance to ask for help	.031

*$p < .05$, **$p < .01$, ***$p < .001$, ****$p < .0001$

number of psychological and social issues. Higher levels of functional impairment were associated with higher levels of depression, intense sadness and yearning for their loved one, anxiety, anger and irritability, and suicidal thoughts. Participants who experienced higher levels of functional impairment also reported higher levels of withdrawal and social isolation from family, friends, and support resources, as well as higher levels of difficulty with sharing grief and talking about and answering questions about the suicide.

Regarding resources for healing, participants who experienced greater levels of functional impairment reported higher levels of helpfulness from books on suicide/grief and internet Web sites. No significant associ-

ations were found between functional impairment and any of the other resources for healing. Regarding barriers, participants who experienced higher levels of functional impairment also reported higher levels of depression as a barrier to obtaining support since the suicide. Higher levels of functional impairment were also positively correlated with the degree to which participants' reported a lack of information about where to find help and/or the unavailability of resources as barriers to obtaining support.

DISCUSSION

Our primary purpose in this present study was to examine the effects on, and nat-

ural coping efforts of, suicide survivors and to add to our knowledge of the self-reported difficulties, coping resources, and barriers to obtaining help for survivors of a suicide loss. We utilized a newly developed Survivor Needs Assessment Survey to provide preliminary data about the broad range of difficulties encountered by survivors in the areas of practical, psychological, and social domains, as well as the people and types of resources that have helped survivors cope with their loss. Also of interest were barriers to finding support since the loss. We also wanted to collect preliminary descriptive data about the potential relationship between survivors' perceived level of functional impairment and their perceptions of their coping efforts (e.g., practical, psychological, and social difficulties; use of resources; and barriers encountered).

Past research has reported that coping with a significant other's suicide can be a particularly difficult experience, with survivors being at an elevated risk for a number of negative psychological and social outcomes (see Jordan, 2001, and McIntosh, 2003, for reviews). The results of our present study provide a remarkable and disturbing confirmation of the findings from previous studies. Participants in our study reported that they had experienced exceptionally high levels of distress at some point in their grieving process. For example, the majority of participants reported moderate to high levels of impairment in their daily activities (at home or at work). Symptoms of depression, guilt, anxiety, and trauma were also frequently reported. Almost one quarter of our sample indicated that they had thought about suicide to a moderate to high degree. While caution must be exercised about the generalizability of these findings because of a number of methodological weaknesses (see below), we suggest that these findings indicate that many suicide survivors may be at risk for a prolonged and complicated bereavement trajectory, one that may be associated with high levels of mental health problems and psychological distress and impairment in functioning. These findings also support that working with survivors will be a crucial form for the primary prevention of psychological difficulties and suicide (Jordan & McMenamy, 2004; Moscicki, 1995; Runeson & Asberg, 2003; Agerbo, 2005; Qin et al., 2002).

Consistent with past survey research (Dyregrov, 2002; Provini et al., 2000), our sample reported substantial difficulties in the social arena. Predictably, talking about the suicide and handling questions about the suicide were noteworthy sources of difficulty for many participants. It is important to recognize, however, that social difficulties did not exist solely in interactions with friends, colleagues, and/or strangers. The majority of our sample reported that communication within their families was also a source of problems. Many felt uncomfortable or unable to discuss the suicide within their family and to share their grief with other family members. Several participants reported that family members had withdrawn from one another after the suicide. For some families, the suicide of a family member may have a serious and negative impact on family communication and developmental processes (Jordan, Kraus, & Ware, 1993).

Paradoxically, the survivors in our study also reported that families could be very helpful sources of support. The majority of our sample relied on (and viewed as helpful) their interactions with their spouses, children, parents, siblings, and/or extended family members. It appears that family members can be perceived as important sources of support, but that communication within families can also be difficult and relationships easily strained (Jordan, 2001; McIntosh, 1987). It also seems plausible that some survivors may rely on some family members for support, and turn away from or be in conflict with other family members whom they perceive to be unsupportive.

Turning to the issue of sources of support, our findings parallel those of Dyregrov's (2002) study. The great majority of our sample reported that they had received professional help for their bereavement. Mental health professionals were the most frequently reported source of assistance. At the same time, a broad range of sources provided sup-

port for individuals in our sample of survivors. At a professional level, funeral directors and clergy were frequently utilized and were found to be helpful. Informally, large numbers of participants turned to close friends, neighbors, and colleagues. These findings indicate that there are many types of formal caregivers who are likely to be sought out by survivors, and that educational efforts should be developed and expanded to help these caregivers understand the difficulties and needs of suicide survivors. Likewise, psychoeducational programs to help nonprofessional caregivers (friends, extended family members, employers, etc.) become more skilled at identifying and understanding the problems and needs of suicide survivors would be beneficial. These efforts would create a promising avenue for intervention efforts.

Participants reported that several different types of resources were particularly helpful in their coping efforts. Suicide bereavement support groups (as opposed to general bereavement support groups) were viewed by many to be as effective as individual counseling. At the same time, large numbers of participants reported that books and internet Web sites were also helpful. The broad range of resources that were endorsed by this sample supports the idea that a "one size fits all" approach to postvention services is not useful for the development of interventions for survivors. For some individuals, reading books and information seeking may be most helpful, for others, the support provided in groups may be particularly comforting. It also seems probable that survivors may need to use different types of resources at different points in their recovery process. Currently, we know very little about what kinds of resources may be most helpful for which survivors at which points in their bereavement trajectory. More research is needed to evaluate existing interventions and to identify the degree of fit between subgroups of survivors and different types of postvention services (Cerel et al., 2006). We should also consider the possibility that some resources and supports may actually be harmful for some survivors, a possibility that is now

being recognized in bereavement intervention research (Jordan & Neimeyer, 2003). Evaluation of survivor satisfaction with and the effectiveness and efficacy of such programs should become a necessary part of new program development.

Another interesting finding about support resources from this study was that survivor-to-survivor contact appears to be particularly useful. Every single participant who had relied on another survivor for support viewed this contact as moderately to highly helpful. Again, while cautions about overgeneralizing need to be observed, it seems plausible that programs that facilitate the linkage of survivors with one another may be a particularly useful form of intervention. Survivor-to-survivor programs such as those at the Baton Rouge Crisis Intervention Center (Campbell, 1997); the LINK Counseling Center in Atlanta (www.thelink.org); the Samaritans of Boston (Survivor to Survivor Network currently under development by the second author, www.samaritansofboston.org); and the family-focused crisis intervention program (with peer-survivors and mental health professionals) described by Mitchell, Evanczuk, and Lucke (1999) might be of particular value to many survivors.

In regard to the barriers to finding support, it appears that feelings of depression overwhelming grief, and trauma that accompany the loss may prevent some survivors from seeking support. The majority of our sample reported that feelings of depression were substantial barriers to seeking help. Many participants also indicated that there was a lack of information about where to find help as well as an unavailability of resources. These findings are of particular concern since the present sample was comprised of individuals who had already been "successful" in their help-seeking efforts (having found their way to a survivors' conference or a survivor bereavement support group). It is a disturbing possibility that there may be large numbers of survivors who are in need of and would make use of organized support services but do not receive them because they are too difficult to access.

The data regarding the relationships between functional impairment and survivors' coping efforts underscore the aforementioned point. The individuals who reported the highest levels of functional impairment were also those who reported the highest levels of psychological distress (e.g., depression). They also reported high levels of social isolation and impaired communication with family members and friends, and they were the participants who viewed solitary resources such as books and Web sites to be very effective. These participants also reported that depression, a lack of information about where to find help, and the unavailability of resources stood in the way of their help-seeking efforts.

These findings imply that passive mechanisms for linking survivors with resources might be ineffective in reaching those survivors who may be most in need of those services. For many survivors, accessing services is all too often a hit or miss proposition (Campbell, 1997) in which they may not receive help because they are unaware of where to find services and/or are too distressed to put a significant effort into locating them. We join with other authors (Campbell, Cataldie, McIntosh, & Millet, 2004; Dyregrov, 2002) in recommending that community professionals be proactive in reaching out to survivors and that this outreach continue for more than just the first few months after the death. We also see a need for much more intensive education and utilization of first-responders (e.g., funeral directors, clergy, emergency medical professionals, etc.) as gatekeepers who can help disseminate information about local services and facilitate referrals to these services for new survivors. Clearly, significant work needs to be done in our efforts to identify and reach out to those survivors that need, but have been unable to access, help.

LIMITATIONS

The findings of this study must be regarded as preliminary. Our sample was a convenience sample drawn from a group of in-

dividuals who had already been linked to services. It is impossible to generalize these findings to all survivors, since the sample excludes a significant segment of the population of survivors who may never have attended a group or received support services. Sample selection may be an important source of bias in the present study. Sample selection and bias and the need to address it in intervention research (Larzelere, Brett, & Byron, 2004) remains one of the most challenging methodological issues in survivor research. Furthermore, the demographics of the sample are not representative of the diversity of the population of the United States. The sample was overwhelmingly Caucasian and college-educated, with few young adults or widows. One other confounding variable within the sample includes the length of time since the suicide, with a mean length of 47.9 months. All of these factors limit the generalizability of our findings.

A further limitation to this study is its design, which involved a cross-sectional, self-report survey of survivors. No follow-up of participants was possible, but perhaps even more important was that there was no comparison group. We do not know how other survivors of suicide or other types of deaths would have responded to the same Survivor Needs Assessment Survey. Therefore, no claim can be made that the responses on this survey are unique to suicide survivors. In fact, it would not be surprising to find similar levels of psychological and social problems, types of resources utilized, and barriers to getting help in a sample of accidental death, homicide, or other types of sudden, traumatic loss survivors. Likewise, we cannot ascertain from this study how long the types of problems reported here have existed or how long resources were utilized for this group of survivors.

Finally, another limitation relates to the principal questionnaire used, the Survivor Needs Assessment Survey. This study was the first to use this survey and we received valuable feedback about ways to refine and improve it. In the course of collecting the data, we realized that our questions could be

confusing to respondents since they did not have clear time anchors. Participants were asked to recall feelings, the use of resources, and barriers "since their loss." Given the variability in time since their loss that many of our participants experienced, the reliability of this retrospective data can be questioned. For example, if a respondent reported a moderate to high level of depression, it is impossible to determine whether this is referring to immediately following the suicide or to present levels of depression. Furthermore, the wording of some of the questions leaves room for ambiguity. For example, we asked a question about "witnessing" the suicide. It is difficult to discern if that question means that the survivor was physically present at the time of the suicide or whether the survivors discovered the suicide.

IMPLICATIONS FOR
FUTURE RESEARCH

Since the implementation of this study, we have revised and shortened the survey to address many of the problems we discovered in the first iteration. For example, our revised version asks a respondent to respond from two different time frames that make a clear distinction between their responses during the first year after the death and the present (i.e., at the time of survey completion). With the improvements made to the survey, we believe that a larger, longitudinal study with a community-based and more representative sample of survivors is now warranted. This will allow us to evaluate the reliability and validity of the revised instrument, as well as to begin to define various bereavement trajectories through which differing survivors pass, and therefore indicate which types of interventions might best facilitate the recovery process at different points along those trajectories.

While preliminary in nature, this pilot data, along with the studies by Provini et. al. (2000) and Dyregrov (2002), suggest some directions for future program development. These suggestions mirror recommendations

from the recent review of the literature on the impact of suicide on survivors (Jordan, 2001). First, programs need to be developed to help both individuals and families. Interventions such as grief counseling and the typical survivor support group are primarily geared toward helping individuals, but do not directly address the destabilizing impact of suicide on family communicational patterns and developmental processes (Jordan 2001; Jordan et al., 1993). Typically, support groups also do not address the concerns about emotional injury to children and traumatization of adults that are evident in the responses of the participants in these studies. Our pilot data suggest that family members are both a key foundation of support and a potential source of difficulty for many survivors. With the exception of the family-focused crisis intervention pilot study described by Mitchell et al. (1999), to the best of our knowledge, interventions that specifically target the bereaved family as an entire unit after a suicide have yet to be developed and evaluated despite the potentially beneficial impact on survivor families.

Second, programs that facilitate the linkage of survivors with one another would seem to be an extremely efficient use of resources. Given the high levels of depression and traumatization reported by the survivors in the present study and in Dyregrov's (2002) study, coupled with the lack of information about where to find services, it is apparent that intervention programs need to be publicized and outreach directed toward survivors. A traditional medical model of service delivery that assumes distressed individuals will find their way to needed services is quite likely insufficient in the case of suicide survivors (and probably to survivors of most other traumatic deaths). Campbell et al. (2004) proposed an Active Postvention Model of services that greatly facilitates the process of accessing needed services by new survivors. Outreach teams, such as those currently being offered at the Baton Rouge Crisis Intervention Center (Campbell, 1997), the LINK Counseling Center in Atlanta (www.thelink. org), or the Samaritans of Boston (www.

samaritansofboston.org), show great promise in helping new survivors find the help that they need much earlier in the grieving process. These programs also help to reduce the isolation, stigma, and trauma often experienced after a death by suicide.

Finally, we believe that current studies suggest a need for greater training of first responders. Professionals who are the first to be encountered by survivors (such as police, emergency medical personnel, funeral directors, and clergy) are in a direct position to offer support, psycho-education, and referral information about available resources within the community at a critical time in the survivor's experience. Not only will their own responses have the potential to make a meaningful impact on the initial attempts of survivors to cope with the crisis, but their knowledge of local community resources can be invaluable in reaching the large group of survivors that may be missed through traditional intervention efforts. In order to maximize their potential to be of assistance, however, gatekeepers need training in how to

respond to new survivors and how to help with the referral process. Intervention programs and research efforts for survivors should make outreach to and education of these types of gatekeepers a priority in their efforts to provide comprehensive services for survivors.

SUMMARY

Given the findings from this study, and those described in previous reviews (Jordan, 2001; McIntosh, 2003), we believe that the time is right for a more refined and systematic study of what types of problems are experienced by what types of survivors; what survivors do to cope with those problems; and what interventions can facilitate those natural coping efforts (Jordan & McMenamy, 2004). With this knowledge, we can begin to design services that provide evidence- based, effective, and compassionate care for individuals experiencing the death of a significant other by suicide.

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*Au: update?

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