



**North American Association of Christians in Social Work (NACSW)**  
PO Box 121; Botsford, CT 06404 \*\*\* Phone/Fax (tollfree): 888.426.4712  
Email: [info@nacsww.org](mailto:info@nacsww.org) \*\*\* Website: <http://www.nacsww.org>

*"A Vital Christian Presence in Social Work"*

## **WORKING WITH SUICIDE SURVIVORS: OPPORTUNITIES AND CHALLENGES**

**Dr. Peter E. Grinion**

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### **Introduction**

The act of suicide is as old as the history of human existence (Fielden, 2003). People from all walks of life have committed suicide over the years. Societies, like Rome, Greece, and Egypt shared a history of forcing certain members to commit suicide for ritual purposes (Hutchinson Encyclopedia of Biography, 2000). For example, suicide was occasionally expected of the wives and slaves of deceased husbands or masters as an expression of fidelity and duty (Leming & Dickerson, 2007).

Suicide is a problem that cuts across racial, ethnic, and socio-economic boundaries. Among the famous people who died by suicide are Cleopatra VII of Egypt, Nero, Adolph Hitler, Mark Anthony, Ludwig Boltmann (Hutchinson Encyclopedia of Biography, 2000), George Eastman, John Fitch, and Edwin Armstrong. Whereas, you may not be familiar with any of the aforementioned names, you might be able to add a couple names to the list.

Suicide and suicidal behaviors are not normal responses to stress or the crises of life. Research data show that more than 90 percent of people who kill themselves have depression or another diagnosable mental or substance abuse disorder, often in combination with other mental disorder. Other risk factors include prior suicide attempts, family history of mental disorder, family history of suicide, and exposure to the suicidal behavior of others (Moscicki, 2001).

In military times, suicide sometimes followed defeat in battle to avoid capture and possible consequent torture, mutilation, or enslavement by the enemy (Cook & Oltjenbruns, 1998). King Saul, when critically wounded in a battle against the Philistines, committed suicide to avoid capture and consequent torture (1 Samuels 31:1-13).

Although for different reasons, there are 6 other cases of suicide in the bible: (Abimelech--Judges 9:54; Samson--Judges 16:28-31; Saul's Armor-bearer--1 Samuels 31:1-6; Ahithophel--2 Samuels 17:23; Zimri--1 Kings 16:18; Judas—Matthew 27:5. Each text gives the reason for the suicide.

French sociologist, Emile Durkheim, posits four explanations for suicide that incorporate some of the aforementioned reasons for people committing this act: anomic--related to suicide that occurs when people feel that their social institutions like family, investment company, place of employment or society have failed them and made life intolerable; egoistic--refers to suicide involving more or less isolated individuals; altruistic--related to suicide that results from an overinvolvement and overintegration between the individual and his/her social institutions, or society, to the extent that suicide is undertaken on their behalf; and fatalistic--refers to suicide undertaken by individuals who feel choked by excessive or oppressive regulations from social institutions or

society, for example, prisoners, slaves, or children (Leming et al., 2007; Corr, Nable, & Corr, 2000; Marrone, 1997). Notwithstanding Durkheim's sociological explanations, suicide is an enigmatic and disconcerting phenomenon among the American population. Because of our inability to directly occupy the mental world of the suicidal, suicide appears to elude easy explanation (Stanford Encyclopedia of Philosophy, 2004).

The suicide statistics among member nations of the World Health Organization show considerable variation. There are approximately 30,000 suicides annually in the United States. For each suicide, an estimated 6-8 survivor-victims are left bereaved, resulting in 5-6 million Americans in total being intimately affected by suicide (Kaslow, 2004). In 2001, the suicide rate was exceptionally high; it took the lives of 30,622 people in America (CDC, 2004). In recent years, suicide was the 3<sup>rd</sup> leading cause of death among children (NIMH, 2003); the third leading cause of death among ages 15-24; the 8<sup>th</sup> leading cause of death for all U.S. men (Anderson & Smith, 2003); the 19<sup>th</sup> leading cause of death among women (NIMH, 2003); and one of the leading causes of death among people 65 years and older (NCIPC, 2006). White men over 65 commit suicide at almost twice the rate of all other groups of male contemporaries (Yin, 2005). Survivors of suicide include but not limited to family members, friends, acquaintances, and helping professionals. From a societal perspective, this ever-growing segment of the population is often left to grieve, mourn, and heal within the health care and social systems that provide minimal support and assistance (Kalischuk & Hayes, 2003-4).

### **Factors Affecting Response to Suicide**

When one commits suicide, it is difficult to accept existentially because of feelings about the meaning of love, trust, and free will (Vugh-Cole, cited in Leming &

Dickerson, 2007). The survivors' recourse is bereavement over which they have no control. Bereavement is the state that results from a significant loss. Bereavement outcome among family survivors vary due to the presence of mediating or moderating factors, including the characteristics of the bereaved, nature of their relationship with the deceased, social support networks, and the amount of stability in the home and the care-taking environments (Barlow & Morrison, 2002).

Because suicide is an unexpected and sometimes violent death, the survivors of the suicide tend to experience a very complicated form of bereavement due to the combination of sudden shock, the unanswered question of "why," and possibly the trauma of discovering or witnessing the suicide (Zhang, Tong, & Zhou, 2005; Martocchio, 1985). The grief reactions can become even more exacerbated by inappropriate responses from the community to the suicide (Knieper, 1999). The more common experience is that grieving is generally socially unacceptable and as such, parents of the deceased may feel awkward with previous social supports and find themselves drawn to support with people who have experienced similar losses (Maple, 2005). Concomitantly, survivors of a suicide reportedly experience higher levels of abandonment, rejection, shame, and separation anxiety than survivors of other forms of sudden death (Silverman et al. 1994-5; Reed, 1998). Parents have reported feelings of moral guilt related to perceived punishment for past wrongdoings (Miles & Perry, 1985, p. 75). Researchers like Stroebe & Stroebe (1983) and Worden (1982) assert that suicide is the precipitant for the worst kind of bereavement experience and the most disturbed mourning. Consequently, survivors are at a risk for physical and mental health problems

greater than that for individuals bereaved due to other causes of death (e.g., Gonda, 1989; Osterweis, Solomon & Green, 1984).

Shame and self-blame are standard reactions of suicide survivors (Suguin & Kiely, 1995). Furthermore there may be feelings of rejection, abandonment, and/or personal diminishment (e.g. lowered self-esteem, shattered self-worth, feelings of inadequacy, deficiency, failure, and even guilt) and anger (Zhang et al., 2005). Numerous studies show that a moral stigma has been traditionally attached to a suicide's family (Achte, 1996; Young & Papadatou, 1997; Lester et al., 1991-92). Stigmatization deprives the survivors of necessary support and may interfere with the receipt or experience of appropriate social and religious ritual required for healthy confirmation of the death and mourning (Barlow & Morrison, 2002; Mishara, 1995). For example, during recent history, the dominant Christian church has viewed suicide as a crime, a type of murder, and a desperate moral sin. Therefore, people generally do not talk about or acknowledge suicide, which poses real difficulty for those bereaved in this manner (Maple, 2005).

Sometime grieving individuals present with symptoms characteristic of Major Depressive Episodes, which includes feelings of sadness, loss of interest and associated symptoms such as insomnia, poor appetite, and weight loss. The duration and expression of "normal" bereavement vary considerably among different cultural groups, and the diagnosis of Major Depressive Disorder (MDD) is generally not given unless symptoms are still present two months subsequent to the loss (American Psychiatric Association, 1994; Zisook & Schchter, 1991, 1993; Van Dongen, 1991; Clayton, 1990). As a result, requisite services and support from caregivers may be delayed. Suicide survivors may

also present with various forms of complicated (abnormal) mourning: absent, delayed, inhibited, distorted, conflicted, and chronic mourning.

### **The Child as Survivor**

Researchers assert that for children, coming to terms with a parent's suicide may be accompanied by persistent reminiscing, self-destructive behavior, suicidal ideation, depression, anxiety, psychotic complaints, disruptive behavior problems and age-aggression, academic and school problems, social withdrawal, and psychotic symptoms. These difficulties often persist unless the children receive the requisite support from caregivers (Grossman, Clark, Gross, Halstead, & Penninton, 1995; Pfeffer et al., 1997; Saارينen et al., 2000). The potential for enormous psychosocial problems also exists for sibling survivors. Ironically, these individuals may be overlooked or neglected while they suffer a double impact of the loss of a sibling and having to cope with grieving and withdrawing parents (Cerel, 1999; Demi & Howell, 1991).

Research on childhood responses to suicide in the family identified dynamics such as information and communication distortion, guilt, and identification (McNeil, 1988). According to Barlow & Coleman (2003) children over 10 years of age are more likely to be told that the death was a suicide, while children under four are usually told nothing. The concealment is motivated by a desire to protect the children, a need for avoidance on the part of the caretaker, and a sense that silence will preserve the fragile emotional stability following a suicide. Cerel (1999) argues that surviving parents may forbid discussion of the death and even keep the children away from others who might talk about it. Children who survive parental suicide may also experience a heightened sense of guilt, partially due to this distorted communication, occurring in the form of denial,

evasion, or closed discussion. Guilt may also stem from the child's belief that he or she could have done something to prevent the suicide or save the deceased (Cerel, 1999, cited in Barlow et al., 2002).

### **Youth and Young Adults as Survivors**

Youths bereaved by suicide reportedly have less stable family relationships than youths bereaved by other causes (Cerel, Fristad, Weller, & Weller, 1999, 2000). Complicated grief has also been found to be associated with a heightened risk of suicidal thoughts and actions among young adult friends of adolescent suicide victims (Prigerson, et al., 1999) and among bereaved older persons.

### **Parents as Survivors**

Parents who experience the death of a child by suicide face a particularly complex and intense grieving process marked by loss of their dreams and hopes, as well as feelings of guilt, self-blame, and social blame (Nelson & Frantz, 1996; Oliver, 1999). In addition, they experience more shame than parents who lose their child in an accident (Seguin, Lesage, & Kiely, 1995). Studies show that while mothers whose child commit suicide experience prolonged depression (Brent, Moritz, Bridge, Perper, & Canobbio, 1996; Knieper, 1999), fathers often evidence more impairment in social and occupational functioning, somatic symptoms, substance abuse, and guilt and grief accompanied by frequent denial (Grossman, Clark, Gross, Halstead, & Pennington, 1995; Pfeffer et al., 1997; Saarinen et al., 2000). As far as the parents are concerned, the deliberateness of suicide leaves a message of rejection and abandonment (Trolley, 1993)

## **Biblical and Theological Framework**

Modern Judaism, although officially regarding suicide as a sin rests upon a long tradition of honoring “heroic” suicide to avoid rape, forced slavery, or idol worship (Curran, 1987) or in the case of Saul, to avoid captured alive and taken to Philistia to be, like Sampson, an object of mockery and shame (1 Samuel 31:1-6). In both the Old and New Testaments’ references of suicide, was the act of taking one’s own life condemned? Should we condemn people who take their own life in the 21<sup>st</sup> century? Until the middle of the 20<sup>th</sup> century, the Roman Catholic Church denied Catholic ritual and burial to those who committed suicide (*Codex Juris Caonici, 1918*).

The Christian doctrine has held for centuries that suicide is morally wrong, despite the fact that there is no passage in Scripture that unequivocally condemns suicide. Although the early church fathers opposed suicide, St. Augustine, who, “drawing heavily from the philosophy of Plato and Aristotle, laid down rules against suicide that became the basis for Christian doctrine throughout the succeeding centuries” (Leming et al., 2007, p. 310). According to St. Augustine, suicide was an unrepentable sin. St Thomas Aquinas later defended the prohibition and asserted that (1) Suicide is contrary to natural self-love, whose aim is to preserve life; (2) Suicide injures the community of which an individual is a part; and (3) Suicide violates our duty to God because God has given us life as a gift and in taking our lives we violate His right to determine the duration of our earthly existence (Aquinas 1271, part II, Q64, A5, cited in Leming, 2007, p. 310). The Protestant Reformers, including Calvin condemned suicide as forcefully as did the established Church, but held out the possibility of God treating suicide mercifully and permitting repentance (Stanford Encyclopedia of Philosophy, 2004). Whatever is one’s



biblical, theological, and professional stance on suicide is a matter of one's freedom of conscience and self-determination. However, Christian social workers must be mindful that misinformation and inaccurate religious views of suicide create an environment that leaves survivors isolated and embarrassed, even though they may have been powerless to prevent the tragic event (Litts, 2004).

### **Implications for Social Work Intervention**

The social worker, who is likely to be among the first responders to suicide survivors, will most often find the survivors overwhelmed with grief, anger, or disbelief. The social worker should be aware that survivors are likely to experience some social distance and feelings of isolation even from those who try to be supportive (Calhoun & Allen, 1991). Thus our mission is to help alleviate the aftereffects of the tragedy and mollify the pain that occurs in response to the suicide (Kaslow & Aronson, 2004). Given the complex nature of bereavement and grieving in this context, I have created what I describe as a "To Know list" and a "To do list" to assist social workers in providing appropriate and effective service and support.

#### **The "To Know List"**

- When people die without warning, survivors often are troubled because they did not have a chance to mend a broken relationship or say goodbye.
- Suicide is a complex behavior with multiple determinants. No easy answers are found when family and friends ask "why?" with regard to the self-destructive acts of their loved ones (Cook & Oltjenbruns, 1998).

- Because people who lose a loved one to suicide may be at increased risk for suicide (Brent, Bridge, et al., 1996), each individual's suicidality needs to be explored and monitored periodically (Kaslow & Aronson, 2001).
- Cultural and religious beliefs that suicide is unacceptable may complicate the grieving process.
- Families feel blamed by society for the suicide and perceive that society blames their loved one for committing suicide.
- Survivors may experience psychiatric disorders ranging from adjustment disorders to major mood or anxiety disorders (Barlow et al., 2004).
- Parents may not recognize offerings of support, especially due to changes to their perceived social standing post-suicide (Van Dongen, 1993).
- Regardless of the reason, parents bereaved by the suicide death of a son or daughter need support (Maple, 2005).

### **The "To Do List"**

- Assess each member of the family to determine what treatments are indicated, for whom, and in what sequence (Bolton, 1984).
- Help the family develop a suicide story (Van Dongen, 1993). This process will help facilitate the grieving process by assisting the family coming to terms with the agonizing, unanswerable questions that often follow a suicide (Barlow et al., 2004).
- Help the children (when involved) to address the misconceptions held by peers, school personnel, and others in the community; have contact with

school personnel regarding the death and the child's progress and be realistic about the challenging reentry process (Kaslow, et al., 2004).

- Discuss with the family the multiple etiologies of suicide.
- Help the family to understand the grief process and normative responses to suicide; communicate to them the acceptability of open expression of all aspects of the grieving experience (Bolton, 1984; Kaslow & Aronson, 2001); and encourage them to conceptualize their loss.
- Use a biopsychosocial-spiritual methodological framework to guide your understanding of the multidimensional malasse of suicide and your mode of intervention, because suicide survivors' psychological, emotional, and spiritual needs are enormous at this time.

## **Conclusion**

This paper has presented research on an arena of need in the community that may or may not be of much concern to you. Probably, by reading its contents you have recalled missed opportunities to help a survivor of suicide. As Christians, we cannot ignore what it is to be neighborly and caretakers of one another. Neither can we afford to neglect our commission as Christian social workers—to rescue the perishing and to care for the dying (psychologically and emotionally). This large “grieving body” of people may be among members of our church family, neighbors, clients, or acquaintances. Understanding the complex and traumatic bereavement that parents, siblings and the extended family are faced with is vital to effective social work intervention. The immediate and long-term implications of suicide on families cannot be ignored.

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