Resiliency and Buffering Contrasts Between Military and Civilian Families as Factors in Suicidality

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A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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Abstract

Much has been discussed and researched regarding suicide in the general population as well as among military members and veterans, but far less attention has been given to the subject of suicide among military family members. The purpose of this qualitative study was to explore and describe the phenomena experienced by families who have lost someone to death by suicide, with the most salient point and objective being to offer insights that may lead to preventing further suicide deaths. The scope of this study encompassed survivors of suicide loss, some selected for their affiliation with the U.S. uniformed services and others without this affiliation. The study proceeded in a pyramidal fashion from a generic overview of suicides to a more specific focus on young people, especially those who are part of the military family system who experience suicidal ideation or behaviors. The hermeneutic phenomenological experiences of surviving family members were examined. Interviews were conducted face to face or through video interface, the latter being the preferred method due to the social distancing restrictions secondary to the covid epidemic. Some interviews were conducted electronically when the participant chose to do so, and verifications were done by telephone. Twenty-one open-ended questions were asked of the participants. Responses were analyzed for content and for nuances of experience and for similarity and uniqueness of individual experience for comparison. It is my hope that shedding light upon and examining in depth the factors that may emerge as causative or influential may be used as roadmaps in furthering the prevention of suicide moving forward, especially in the military family system and in younger populations.

Keywords: suicide prevention and postvention, at-risk populations, buffering, bullying, self-esteem, resiliency, support systems, connectedness

Dedication

Ad maiorem Dei gloriam

I dedicate this work to my beloved daughter, Kristina Maria Dempsey, who faced the world with enormous beauty, strength, and courage up until her last moments, and to all of those who die by suicide or are affected by suicide. May they find refuge and solace in the loving, merciful, and all-forgiving arms of the all-knowing and eternal Lord.

Acknowledgments

I would like to thank and acknowledge the participants in this study, and all those who gave so generously of themselves and continue to do so in the name of helping others—and ourselves—process the tremendous and pervasive grief that characterizes the loss of a loved one to suicide. Each of these individuals has demonstrated courage and fortitude in the presence of great tribulations, and has chosen to share their individual experiences, often at risk to themselves, for the higher order of shedding light by sharing insights, resilience factors, coping skills, and other personal thoughts that others may benefit from.

I thank my professors, past and present, for their coaching and support through a long, arduous but worthwhile journey. I thank my fifth-grade teacher, Miss Hess, for assuring me that I was okay just as I was.

I especially thank my family, Karen, Kristina, Sara, Brian, and Kevin, for having sacrificed immensely by supporting me through the years through deployments and absences which took an unanticipated toll upon all. I love you more than you'll ever know. I also acknowledge my loving parents, brothers, and sister who never stopped believing in me even if I had.

If you or someone you know is dealing with severe depression or suicidal thoughts, please call the National Suicide Prevention Lifeline at 988 or 1-800-273-8255, or see the resource list in Appendix D.

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List of Abbreviations

Adverse childhood experiences (ACEs)

Coronavirus disease of 2019 (COVID-19)

Institutional review board (IRB)

King James Version (KJV)

Lesbian, gay, bisexual, transgender, questioning, plus others (LGBTQ+)

Measure of Adolescent Potential for Suicide (MAPS)

Posttraumatic stress disorder (PTSD)

Risk of Imitative Suicide Scale (RISc)

Subjective Units of Distress Scale (SUDS)

Survivors of Suicide (SOS)

Tragedy Assistance Program for Survivors (TAPS)

United States (U.S.)

U.S. Department of Defense (DoD)

U.S. Department of Health and Human Services (USDHHS)

U.S. Veterans Administration (VA)

U.S. Veterans Administration/U.S. Department of Defense (VA/DoD)

World Health Organization (WHO)

Chapter One: Introduction

Overview

Suicide is an unfortunate reality in every society but is not necessarily evenly distributed across demographic or cultural lines, as some populations have higher suicide prevalence and rates than others (Beaudoin et al., 2018). There has been an alarming increase in rates of suicide among young people in the wake of the internet and social media pressures (Cheng et al., 2018; Daine et al., 2013). Military and veteran populations have higher incidences of suicide than civilian populations (Clements-Nolle et al., 2021). Similarly, there is a disproportionately high rate of suicides among Non-Hispanic Whites and Native American and First Nation populations in North America (Chandler et al., 2003; Kelley et al., 2018). Lesbian, gay, and bisexual youths are also more vulnerable to suicidal behavior (Mustanski & Liu, 2013).

Contemporary youth, weaned on the internet and social media, are particularly vulnerable to peer and other outside influences on a daily basis without familial buffering, which was once a major factor in protecting them from outside ideas. Influential suicide implies that external factors act upon internal belief systems in such a way as to lower the protective threshold which prevents a person from self-destructing (Bailey & Robinson, 2021). An already vulnerable person may be exposed to a "last straw," a stressor that overwhelms and overrides the erstwhile protective mechanisms, allowing the more spontaneous part of the brain to acquiesce to suicide. A multitude of factors may contribute to suicidal ideation, including exposure to social media and the internet, peer pressure (Ivey-Stephenson et al., 2020); degree of familial buffering (Lamis & Lester 2013); spiritual and religious values (Tan, 2010); isolation, confusion, and feeling disconnected (Foster et al., 2017; O'Neill et al., 2020); hopelessness, feeling

overwhelmed, anger, drug or alcohol use (Philip et al., 2016); depression; and other mental illnesses (Borowsky et al., 2013).

The continuous upheaval that characterizes the military family milieu is a strong indicator of emotional and relational strife (O'Neal et al., 2018; Peterson et al., 2020). The journey of the surviving family members through suicide and aftermath leads toward a deliberate and intentional building of recognition skills and prevention strategies, and fostering new resiliency (Galligan et al., 2010). A high degree of intervention in the postsuicide journey is paramount in aiding and encouraging families to move forward with new resiliencies (Harrington-LaMorie et al., 2018).

An interpretive hermeneutic approach was used in the present study to obtain richness and depth in participant responses and to embrace the uniqueness of each person's experience to help uncover nuanced lived experiences. Comparisons were then made between military families and their civilian counterparts, with a focus on markers such as connectedness and buffering in adolescents and young people. Similarities and differences were discerned and compared.

Background

Suicide rates increased by 33% from 1999–2019, with 46,000 total deaths in the United States alone in 2020 (U.S. Department of Defense [DoD], 2021). Perhaps more importantly, suicide is the second leading cause of death among individuals 10–34 years of age (Centers for Disease Control and Prevention, 2019). Suicide rates differ between ethnic groups, with Native Americans, First Nation people, and non-Hispanic Whites having the highest rates (Beaudoin et al., 2018). The rate of veteran suicides is about double that of the nonveteran population, with recent data indicating an incidence of 28 suicides per 100,000 while the nonmilitary rate is 16 per 100,000 for 2021 (DoD, 2021). Youth who identify as gay, lesbian, or bisexual are at greater

risk for suicidal behavior and ideation (Ivey-Stephenson et al., 2020). Children, adolescents, and adults who have experienced trauma such as bullying, cyber harassment, intimidation, child abuse, or rape, have higher incidents of suicide attempts (Ferráns & Selman, 2014).

Social media plays a role in influencing suicides (Philip et al., 2016). Television, movies, and literature can likewise strongly influence a vulnerable or immature mind and reinforce negative cognitions leading to suicidal ideation. Adolescents who are often already doubting their self-image, their purpose, and their meaning in life are particularly susceptible to strong extrinsic influences (Burke et al., 2016; Cha & Nock, 2009). A simple post on social media can be met with a myriad of negative, hurtful, and mean-spirited replies that may unduly affect the individual who posted. Especially vulnerable children in the military family system spend many hours on social media in the absence of parents (Clements-Nolle et al., 2020; Foster et al., 2017). Chandra et al. (2011) posited that military childrens' well-being is inversely proportional to the length of their parent's deployment, indicating that the longer the deployment, the more traumatic the outcomes for children and adolescents in the military family system might be.

Situation to Self

The topic of suicide is not an easy one to study. Nor is it one that will interest everyone unless they are stakeholders—people who have had the misfortune of having lost a person close to them to suicide. The language I used in this study neither condemns nor romanticizes this subject. Instead, I strove to present the subject as an important worldwide health care concern that needs to be addressed. This study focused on aspects of suicidality that have received less attention than others. As a survivor of familial suicide, I hoped to shed some light on signs and markers that may lead to recognizing suicidal ideation or potential behaviors, which may in turn prompt proactive prevention strategies.

Problem Statement

Exposure to suicide in a family or group increases the likelihood of further suicides as well as a host of other mental health challenges, including anxiety and depression (Jordan, 2017). The problem is that suicide studies most often focus on the individual who died. Less is known or researched about suicide's effect on the family system. Although suicidality in military individuals has been explored by numerous authors, fewer researchers have examined from a military family system perspective. As such, I focused on the increased presence of suicide in military family systems, which is higher than that in the general nonmilitary population (Clements-Nolle, 2021).

Losing someone to suicide can be devastating to an individual but can have long-term effects on families as well, which has been less examined, leaving a gap in the literature. Freytes et al. (2017) called for further advancement of the current knowledge base on the long-term effects of deployment on the mental health of dependent children of military members and the development of stronger coping strategies. Freytes et al. focused their study on child and adolescent stressors that may lead to suicidal ideation or behavior, with a bias toward prevention as well as postvention.

Hom et al. (2016) acknowledged that additional study is needed on the relationships between bereavement and suicidal thoughts in the bereaved, which ties in with the subject of focusing on those most vulnerable. Exposure to suicide may also increase the risk of further copycat or contagion suicides (Taliaferro & Muehlenkamp, 2014). The present study focused on revealing details and effects that may not have been previously observed or documented by conducting personal interviews with people who have experienced suicide in their immediate

families and who have developed insights, coping strategies, and resiliency skills related to these experiences.

Purpose Statement

Given the higher rates of suicide in vulnerable youth and in military families, more attention is needed in research and clinical settings. The purpose of this hermeneutic phenomenological study was to examine more subtle factors in suicidality in families—particularly military families, one of the most vulnerable yet least investigated populations—to better understand the dynamics present in this system and to raise awareness of possible contributory factors. The theory guiding this study is that there is a high rate of suicide in vulnerable youth in military families that is less studied than the suicides among the military members themselves (Gilreath et al., 2016).

Suicide prevention is critical. Postvention, rather than simply responding to a death, assumes a proactive stance. Ruocco et al. (2021) examined the Tragedy Assistance Program for Survivors (TAPS), a formalized postvention program for military families who have been exposed to suicide. This program offers support and solace for military families through organized classes to help reduce copycat or contagion suicides, which often follow one suicide. Ruocco et al. concluded that the TAPS model was broadly applicable to *anyone* who has lost a loved one to suicide.

Cederbaum et al. (2014) stated that children of deployed military members are at greater risk for depression and suicidal behavior. Hom et al. (2016) noted the lack of information on coping with suicide in military families. Seshadri et al. (2018) noted disparities in the quality of care using the military's preferred provider, creating a potential barrier to high-quality care for military dependents. In addition, Hajal et al. (2020) posited that younger military children are

particularly vulnerable to the stressors of the military milieu. The present study focused on early recognition of suicidal ideation and prevention of suicide in military families by examining stressors and indicators of potential suicidality.

Significance of the Study

Suicide prevention and postvention must involve a wide array of stakeholders, including family members, friends, school and work partners, government agencies, and the community overall (Han & Procter, 2020). Among those most vested should be educators, who are in a unique position to affect recognition and prevention (O'Neill et al., 2020). By conducting the present study, I sought to contribute to the wider body of literature about suicidality by focusing on recognition and preventive strategies. Insights from the interviews with study participants deepened my understanding of contributory factors and influences of suicidal behavior. The participants' insights might help families examine their own situations, be more sensitive to the needs of other family members, and develop new means of solving problems in the family system.

The military family system is characterized by frequent change and instability marked by rapid deployments and upheaval throughout one's military career (Hajal et al., 2020). Support is uneven, especially for the families, and especially for reservist families. Stressors peculiar to families, including reservist and active duty family units, who experience frequent social upheaval and unpredictability (Hom et al., 2016), were the focus in the present study. Examining unique individual experiences and how continuous uncertainty and upheaval can lead to suicide resulted in findings that added to the understanding of this underresearched group.

Research Questions

The following research questions guided this study:

RQ1: What insights can be gained from suicide family survivors that can contribute to the understanding of familial factors?

RQ2: What markers may be present in the military family system that may be absent in the civilian family, as the suicide rate is significantly higher in the military family system?

RQ3: What can be learned from the suicide family survivors that can inform efforts in possible prevention and postvention strategies?

RQ4: What can be learned about relationships with the decedents that will inform the understanding of survivor guilt, feelings of having failed, and the duration of the grief process?

Interviews with 21 open-ended questions that were amenable to hermeneutic examination were used in this study. Participants were encouraged to answer freely in order to elicit spontaneous data points and to express unique and nuanced phenomenological experiences.

Definition of Terms

The following terms were used in the present study:

1. *ACEs*—ACEs are adverse childhood experiences, especially experiences that may lead to harmful behaviors later in life. ACEs can have lasting negative effects on a child's self-esteem (Ivey-Stephenson et al., 2020).
2. *At-risk populations*—At-risk populations are susceptible persons, including impressionable youth, marginalized social or demographic groups, military-affiliated people, Indigenous populations, people who have experienced ACEs, and other similar populations. Some at-risk populations have been close to a suicide in the family or among peers or friends (Taliaferro & Muehlenkamp, 2014).

3. *Buffering*—Buffering denotes the supportive, nurturing process often seen in loving and caring parents and guardians (Ohlmann et al., 2014).
4. *Bullying*—Bullying encompasses actions such as taunting, teasing, assaulting, battering, or other threatening behaviors directed toward children, adolescents, or adults. Social media content is particularly important in bullying as many youth can receive negative comments and feedback from multiple sources (Turner et al., 2017).
5. *Connectedness*—Connectedness refers to a comfortable feeling of belonging to another person or to a group in a positive way (Jobes et al., 2011).
6. *Drivers*—Drivers are motivating behaviors that may reveal risk factors seen in vulnerable populations (Shahram et al., 2021).
7. *Influential suicide*—Influential suicide is defined as an individual succumbing to peer, media, or social pressure, bullying, or the suicide of a friend in deciding that suicide may be the only alternative for them at a certain point. Similar terms such as contagion and copycat suicide are often used synonymously (Bureau et al., 2012).
8. *Markers*—For the present study's purposes, markers were defined as signs of change in levels of stress and coping that may predispose to suicidal ideation (Malgaroli, 2020).
9. *Mentorship*—For the present study, mentorship was defined as a cooperative partnership between a mature guiding individual and a person at risk (Han & Procter, 2020).
10. *Resiliency*—Resiliency may be defined as the set of healthy building blocks assembled through healthy, sustained, and supportive processing of trauma and grief (Ohlmann et al., 2014; Ungar, 2013).

11. *Self-esteem*—Self-esteem is the image one has of himself or herself based on a plethora of contributing factors (Ivey-Stephenson et al., 2020).
12. *SUDS*—SUDS stands for subjective units of distress scale, and is a tool used in therapy and counseling to help both the client and counselor understand the level of anxiety being experienced. The scale is often given as 1 through 10, the higher number representing the greatest stress imaginable. Participants were explained the meaning of the scale, and self-reported their level.
13. *Suicide postvention*—Suicide postvention encompasses methods and instruments used after suicides to ameliorate the grieving process, help build resiliency, and help decrease the chances of further suicides (O'Neill et al., 2020).

Summary

Suicidality is widely researched, as demonstrated in a large collection of quality, peer-reviewed, evidence-based empirical studies. Still, the subset of suicides among military family members is not well researched and remains underdeveloped in the literature. The present study's focus was on adding to the understanding of the phenomena experienced by families with the hope of uncovering risk factors or markers not previously examined in depth. The goal was to reveal extenuating circumstances, contributory factors, and nuances specific to military families and to identify specific characteristics and peculiarities of military family systems in hopes of gaining insights into early recognition and prevention strategies.

Chapter Two: Literature Review

Overview

Suicide among military members and veterans has increased during the 20-plus years since the 9/11 attacks, which led to Operation Enduring Freedom (the Afghan War), Operation Iraqi Freedom (the Iraqi War), and Operation New Dawn (the second part of the Iraqi War). Current statistics from the DoD (2022) noted suicide rates in veterans and military-affiliated populations of 28 in 100,000, compared with 16 per 100,000 in the nonveteran population. Native American and First Nation peoples have higher suicide rates as well (Beaudoin et al., 2018; British Columbia Coroners Service, 2019; Kelly et al., 2018). There has also been an alarming increase in suicide rates among young people in the wake of the internet and social media pressures (Canadian Council of Child and Youth Advocacy, 2019; Daine et al., 2013).

The present study reflects hermeneutic interpretations of the experiences of people who lost a loved one by suicide. As this was a phenomenological study, participants were chosen for their willingness to share some very emotional, poignant, and heart-wrenching descriptions of their individual trauma following a suicide. From these phenomenological expressions, I hoped to gain knowledge and insights into how a person reaches a point of deciding on suicide as the only alternative, extrapolating further how one may intervene to prevent the suicide. From this discourse, I hoped to gain insights into some of the influences, noted by those interviewed, that enable a person to accept suicide as a viable alternative based on a multitude of factors, including exposure to suicide in family or friends, media and internet information, peer pressure, degree of familial buffering, depression, pain, lack of connection, and social and cultural influences.

The journey of the family member through suicide and its aftermath leads toward building recognition skills, prevention strategies, and the fostering of new resiliency (Cederbaum

et al., 2014). Sharing their knowledge and insight may inform our ability to prevent further suicides. The present study complemented several empirical studies on the topic of suicide with additional factors obtained from the experiences of families who have survived suicide loss.

The following literature review is approached thematically by subject. It begins with a broad overview on suicide in general. The focus then narrows to other topics that helped to inform this study, including the experiences of coping with the aftermath of suicide.

Theoretical Framework

Suicidologists have approached the subject of suicide from various perspectives, including physical, emotional, and developmental. Some have focused on mental disorders as causative factors (Cavanagh et al., 2003). Much research on suicide has been done in the community, some of it focusing on reasons for suicidality. Suicide causative theories have focused on different areas throughout the years and in different disciplines. Some theorists have proposed that connectedness, comradery, and community are simply the best buffers against suicide (U.S. Department of Veterans Affairs [VA], 2021). Through evidence-based feedback, people who remain connected are less likely to die by suicide.

Historically, several theories have been developed to address aspects of causes of suicide or have presented specific lenses through which to view suicidality. Perhaps the more salient and relevant theories for the present study focus on the desire to escape severe emotional pain and turmoil (Baumeister, 1990). Other theories involve more existential feelings of emptiness and searching for meaning in life (Rogers, 2001). Still others focus on some sort of intrinsic drive toward self-destruction, seeing a competing dichotomy of self-preservation versus self-destruction (Menninger, 1938). Each theory contributes some understanding of the wide spectrum of possible causes for suicidal behavior. Keefner and Stenvig (2020) theorized that

there were multiple risk factors and reasons for suicide, rather than one reason alone. The present study built upon these theoretical frameworks.

The practice-based theory that led to this study is that there are effective strategies for suicide prevention available (Stone et al., 2017). The key concepts are that suicide can be decreased by education in homes, in schools, and in the wider community. While there is no shortage of studies on suicide and suicide prevention and postvention in the literature, there is a gap between available educational resources and access to these resources within our communities.

The suicide rate has increased dramatically worldwide in the last few years. The rate of suicide in military members and veterans is roughly double that of the general population in the United States. There are many studies on suicide from many approaches, including military-affiliated people. There are far fewer studies on suicide within the military family system which focus on the nonmilitary members of the families.

The study was a phenomenological and experiential study of survivors of familial suicide. The study was conducted to complement existing evidence-based studies involving characteristics of suicide, contributing factors, recognition, and prevention strategies. The focus was on recognizing the potential for suicidal behavior and the prevention of suicides.

Prevention requires cooperative efforts between all community stakeholders at various levels. Everyone can be trained to identify potential warning signs of suicide and take action to prevent it. Multiple studies examined offer insights into the recognition and prevention of suicide, and also adjustment after a suicide, postvention, with a focus on preventing contagion suicides.

Suicide: Risks and Causes

Suicide is the taking of one's life either through active or passive means (Haw et al., 2013). A person who jumps off a bridge with the intent of dying clearly is actively seeking death, but a person who engages in self-harm behavior, such as smoking, drug use, or risky behaviors, over a long period of time, cognizant of the inevitable outcome, can be viewed as seeking to cause their own deaths (Cha & Nock, 2009). People who refuse to take care of essential needs such as eating, drinking, or taking needed medication may be passively but consciously contributing to their own demise (Du et al., 2016).

Factors included in suicide risk include mental health diagnoses, most notably depression (O'Neal et al., 2018). It is well established that suicides may occur in connection with impulsivity in instances of crises with accompanying inability to cope with stressors (World Health Organization [WHO], 2019). Similarly, exposure to violence, war, abuse, or loss as well as feelings of isolation and lack of connectedness are implemented as possible variables in suicidal ideation (Hom et al., 2016). Further study of the absence of connectedness or belonging is warranted (Foster et al., 2017).

Just as there is no one cause for suicide, there are many reasons for a person to choose suicide. In some instances, suicide can be linked to climate, as in seasonal affective disorder. Northern Europeans, for instance, experience higher suicide rates in the late winter and early spring months (Shapiro, 2019). It is postulated that the lack of sunlight, causing and coupled with months of sadness or melancholy, can increase depressive symptoms, overwhelming the person until he or she sees no alternative other than to take his or her life (Shapiro, 2019). Social and cultural pressures often contribute to suicide. The recent dependence on and prevalence of social media can contribute to feelings of embarrassment and humiliation on the part of someone who

has been criticized or ridiculed socially, leading to self-harm, especially among youth populations (Ungar, 2013).

Physical illnesses with poor prognoses can lead to people, often older individuals, taking their lives (Heisel & Flett, 2008). Isolation, including social distancing during the prolonged COVID-19 pandemic, can be a contributory factor in a person who is already compromised by physical debilitating disease and mental health diagnoses (Hope et al., 2019). A young person overwhelmed with childcare, joblessness, fear, intimidation, and legal custody issues may see no other way out than suicide (Harrison et al., 2014). A youth, pummeled by criticism in a public social media forum or in the school environment may resort to suicide, and undertrained school psychologists may miss valuable opportunities to recognize the risk factors (O'Neill et al., 2020).

Populations With Higher Suicide Rates

Suicide is a major health concern and is especially prevalent among military members and veterans and their families, as well as in the Native American populations in the United States and the First Nation populations in Canada (Beaudoin et al., 2018; Government of Canada, 2021; Kelly et al., 2018; Philips et al., 2015). Several populations in the United States and Canada are at greater risk for suicidal ideation or behavior than others. Ungar (2011) noted that resiliency varies across cultures. People who are gay, bisexual, lesbian, or transgender can be less resilient and at higher risk of suicide (Eisenberg et al., 2017; Galligan et al., 2010; Ohlman et al., 2014; WHO, 2019). Non-Hispanic Whites also have a high rate of suicide (Franklin et al., 2017). These studies shed some light on these groups but did not address the root causes of suicidal ideation in these populations.

Worldwide, suicide is the second leading cause of death among young adults as well as a major cause of preventable death. Notably, there has been an upturn in deaths by suicide in youth

globally (WHO, 2019). Among U.S. military and veteran populations, suicide rates are nearly twice the rate in a comparable selection of civilians (Hom et al., 2016). Despite supports put in place by the DoD, suicide rates in the military still remain high (DoD, 2019).

At-risk adolescent populations are particularly sensitive to peer, social media, and television and cinema influences. Influential suicide implies that external factors act upon internal belief systems in such a way as to lower the protective threshold, which prevents a person from self-destructing (Cheng et al., 2018). An already vulnerable person, lacking solid buffering support form family or friends and exposed to extreme stressors may acquiesce to suicide (Batterman et al., 2014). Much literature addresses the subject of suicide from a myriad of approaches and through multiple lenses but does not expose core reasons for suicide among youth and adolescents.

Methods for Recognizing Suicidality

In exploring root causes of suicidality, Shahram et al. (2021) discussed drivers and warning signs of pending suicidal ideation and behaviors in a systematic literature review. One question posed was how drivers function as warning signs or determinants of suicidal behavior. Shahram et al. used critical interpretive synthesis to examine 474 articles on resiliency factors and suicidality. They stated that this methodology related well to the hypotheses, allowing for a clearer examination of results. Thirty-seven articles were included in their study.

The literature reviewed described resiliency as a complex interaction between relationships, protective factors, and risk factors, all mitigating eventual outcomes (Shahram et al., 2021). Results demonstrated that internal factors such as positive self-appraisal, zest for life, personal traits, and coping skills, and external factors such as social support systems and inclusive environments all contributed to resilience among youth. Shahram et al. also noted that

gender, age, and indigenous identity played key roles. This review of the literature suggested that internal factors such as zest for life and external factors such as support from parents and community can have a major impact on fostering and strengthening resiliency in youth. Shahram et al. suggested that a larger study of cross-sectional groups might have increased their study's external validity by expanding the study to multiple cultures and other geographical areas.

Tucker et al. (2015) also examined causal factors, emphasizing collaboration between partners in assessing and managing suicide prevention. The researchers studied individual vulnerabilities, in recognition of the potential for suicide in youth, reflecting their hypothesis that suicide drivers reflected an emerging therapeutic focus reflected in the Collaborative Assessment and Management of Suicidality Framework (Jobes, 2006). In describing suicide drivers, Tucker et al. posited that there are identifiable markers that can point toward the potential for suicidality. They investigated which drivers were considered protective factors and how warning signs could be discerned and acted upon. Based on their findings, Tucker et al. proposed that person-specific drivers be studied and understood in recognition of potential suicidality in a specific person.

Several scales have been developed to assess suicidal potential, including the Measure of Adolescent Potential for Suicide (MAPS; Eggert et al., 1994). In their seminal early study, Eggert et al. described the MAPS as an instrument for recognizing and assessing the potential for suicidal ideation and behavior in ninth-through 12th-grade students. The assessment reflects three main constructs: direct suicide risk factors, related risk factors, and protective factors.

Methods applied by Eggert et al. (1994) in one study of five urban high schools in the northwestern United States represented both White and minority students. Commonalities in their backgrounds in all groups that may have led to suicidal ideation or behavior were explored. A total of 5,000 students in Grades 9 through 12 were surveyed and their responses tabulated.

Almost one half of the youths' parents were divorced, and 58% of those studied had changed addresses one or more times since junior high.

External validity was measured by comparing the MAPS with the Los Angeles Suicide Prevention Scale. Nine of 12 scale items aligned (Eggert et al.). A correlation between instability in familial buffering and an increase in suicidal ideation was implied in the findings. Further studies with larger numbers of cases could increase the measure's external validity.

Contributing Factors to Suicidality

Mental Health Disorders

A large number of people who die by suicide have a diagnosed or undiagnosed mental health disorder such as depression or anxiety (Burke et al., 2016; Collishaw et al., 2016). Many military members who have deployed have developed posttraumatic stress reactions or acute stress reactions, sometimes coexisting with major depressive disorders (Carroll et al., 2017). Certain factors predisposing to posttraumatic stress disorder (PTSD) have been identified, including the severity of the trauma, proximity to the trauma, duration of the traumatic event, individual resiliency strengths, and gender, as females have been shown to be more susceptible to PTSD in the deployed environment (DoD, 2021; Soor et al., 2012). A broader and deeper discussion of posttraumatic stress is outside of the parameters in the present study.

Childhood Trauma

Adverse childhood events (ACEs), including toxic stressors in the context of a lack of parental buffering, can strongly influence suicidality in children and adolescents (U.S. Department of Health and Human Services [USDHHS], 2020). In a 2021 qualitative study, Shahram et al. examined prolonged exposure to stressors, the severity of the stressors, and the presence or absence of essential nurturing and buffering support. Greater or longer-lasting

trauma required greater and more consistent support and the presence of a caring adult. Stressors were an expected part of development, but more severe stressors required a greater degree of resiliency, buffering, and support (Shahram et al.). Findings validated Shahram et al.'s hypothesis that fostering resilience is a primary suicide prevention strategy for youth but offered little explanation for how these factors may work to protect youth from suicidality. Continued research in this area requires a focus on how to promote resilience at the community and family systems levels.

ACEs are stressful or traumatic childhood events that include neglect; physical, emotional, or sexual abuse; and general dysfunction, including witnessing domestic violence or parental substance abuse (Carroll et al., 2017). Studies have shown that adolescents in military families have higher rates of suicidal behaviors compared to their nonmilitary peers (Clements-Nolle et al., 2021). Suicidal behaviors among students in military families are typically attributed to military-specific stressors such as the deployment of a parent (Chandra et al., 2011). However, exposure to ACEs may also play a role (Thompson et al., 2019).

Children in military families are exposed to other traumas beyond stressors associated with military life, and it is important to explore a range of childhood stressors to guide suicide prevention efforts (Thompson et al., 2019). In Thompson et al., mediation analyses showed that cumulative exposure to ACEs mediated the relationship between military family involvement and attempted suicide, resulting in more suicidal ideation and behavior. Study results highlighted the need for trauma-informed approaches to mental health promotion in military families (Thompson et al.).

Bullying, Harassment, and Intimidation

Ferráns and Selman (2014) explored how school attitudes and rules created cultures of tolerance and certain *climates* that affect students' perceptions of what is allowed. They concluded that bullying and school climate affect peer attitudes about what level of bullying is allowed and tolerated. Ferráns and Selman examined the perceptions of students in an urban school (40% Black, 35% Latino, and 25% White) regarding the degree to which school officials tolerated bullying behavior. The degree of violence appeared to directly reflect the degree of tolerance demonstrated by the actions or inactions of the school administration when faced with harassment and bullying incidents; if the reaction was tepid, students may have felt that there were acceptable levels of behavior allowed and that rules would not be enforced. The degree of perceived lack of enforcement of the rules thus was shown to enable bullying behaviors (Ferráns & Selman).

Ferráns and Selman (2014) also examined the degree of perceived quality and authenticity in teacher–student relationships and the level of perceived support and opportunities teachers offered students to help them develop conflict resolution skills. After careful analysis, the researchers concluded that in schools where a culture of respect for rules is in place, ordering, empowering, and caring fostered a climate conducive to feelings of safety and connection for students. This climate encouraged students to step forward when they encountered an instance of student bullying or abuse of another, which further enabled an atmosphere where adolescents did not have to fear intimidation (Ferráns & Selman).

Freytes et al. (2017) examined post-deployment integration and rebonding as resiliency factors in military families. Findings underscored the importance of continuing to research the long-term impact of deployment on veterans and their families, especially factors that contribute

to positive post-deployment family functioning. Additional empirical studies are needed to provide a more in-depth understanding of the long-term post-deployment reintegration experiences of veterans and their families (Freytes et al.).

Regarding suicide risk, Hom et al. (2018) posited that military personnel who have been exposed to a suicide are at greater risk for suicide themselves. Accordingly, greater closeness to the decedent implies greater risk. Hom et al.'s study findings complemented and reinforced other empirical evidence that the rate of suicide is higher in military populations, supporting further investigation efforts, and that being close to one who has died by suicide increases one's own risk of suicidality.

Increased Risk of Suicide in Military and Veterans

The National Violent Death Reporting System (2021) noted that there was a higher risk of death by suicide in 2021 among U.S. veterans when compared to the general population, with an average of 20 completed suicides per day. Identifying suicidal ideation and plans in a timely manner may be the best way to reduce the risk of actual suicidal behavior (Peterson et al., 2020; Tucker et al., 2015). Longitudinal studies conducted by the VA have been incorporated into the Skills Training for Evaluation and Management of Suicide (STEMS) training platform. When considering suicidality in the veterans' milieu, studies have shown that suicidal behavior and ideation are not limited to veterans diagnosed with a mental health disorder but can extend to veterans with other medical issues or without diagnosed disorders (VA, n.d.-a). Recognizing this, the VA has initiated a population-based approach by screening all veterans for suicide risk regardless of whether they are seeking medical or behavioral health treatment. These screens often take the form of verbal or written questionnaires administered at each visit (U.S.

Department of Veterans Affairs, 2021). Of note, more suicides among veterans have occurred in those who have not sought mental health treatment (VA/DoD, 2019).

Identifying Risk Factors in Veterans

When considering what to assess in patients regarding suicidality, VA studies have shown several categories of risk factors. Psychological risk factors include the availability of lethal means in the presence of suicidal ideation, previous attempts at suicide, mental health diagnoses, and increased substance abuse. Other factors are previous hospitalizations for mental health issues and current symptoms such as hopelessness and self-neglect. Social risk factors include life events that are stressors, such as illness or death of family members, relationship losses, divorce, financial issues, debt, unemployment, and housing issues or homelessness. Legal and criminal problems as well as lack of social support systems and the lack of presence of a buffering individual contributed to suicidal behaviors (VA/DoD Clinical Practice Guidelines for Suicide Risk Management, 2019). Medical risk factors are chronic or severe pain, traumatic brain injury (Dempsey et al., 2009), worsening of existing conditions, increasing loss of function, or newly diagnosed major or progressively debilitating diseases (VA/DoD, 2019).

Identifying Warning Signs for Suicide

Suicidal warning signs or signals noted in VA/DoD study sources included a change in a person's level of suicide risk, indicating that a person is at risk for attempting suicide (VA/DoD, 2019). Some of the signs identified as more common warning signs include behavioral modifications such as stopping medications, not sleeping or eating as usual, increasing substance abuse, isolation, and lack of connectedness (VA/DoD). The individual may have stopped responding to calls or texts, not shown up for work or social activities, or may have stayed secluded in a particular location.

Other behavioral signs noted are physical or verbal aggression, agitation, preparing for suicide by giving away belongings, and researching suicide methods (VA, 2021). Others use means such as pill hoarding or obtaining weapons. Some develop passive suicidal thoughts or tunnel vision where there seemed to be no hope or way out of their situation at the time. Some may make statements about not wanting to wake up or being better off dead.

Astute clinicians may notice changes in negative cognitive patterns, including getting stuck on thoughts of death or having more frequent thoughts of despair or hopelessness (Steenkamp et al., 2019). Some people may experience more active suicidal ideation such as making plans or fantasizing or fixating on death to the exclusion of other thoughts (Andriessen et al., 2019). Seeking peace or a way out of troubling feelings of shame, guilt, anger, hopelessness, anxiety, or sadness have been verbalized by some individuals planning on suicide (Tucker et al., 2015). Still others may show sudden signs of feeling better, as they had perhaps reached a decision to die by suicide. There are often physical symptoms present when a person is considering suicide such as tightness in the chest, increased heart rate, feeling hot or cold, or feeling disconnected from their own bodies or from others (Steenkamp et al., 2019).

Identifying Suicide Protective Factors in Veterans

VA therapy protocols call for identifying protective factors, which can be gleaned by evaluating reasons for living and personal values, whether spiritual or other, and validating and reinforcing these with veteran clients (Steenkamp et al., 2019). Protective factors include religious, spiritual, or moral views about life, death, and suicide (O'Neal et al., 2018). The presence of family, including children, can be a protective factor but can paradoxically increase the chances of suicide when these factors became stressors (Kleiman & Beaver, 2013).

Interpreting and Evaluating Suicidal Thoughts

Several VA studies have employed open-ended questioning to gather objective and personal information useful in predicting and preventing suicidality. An example of these questions is “What do your suicidal thoughts look like?” while close-ended questions may ask for yes or no answers or might ask how they are planning the suicide (VA/DoD, 2019). These studies emphasized the need to summarize the client’s words using common language, reinforcing the fact that they are being listened to and heard as well as having their experiences validated. Findings suggested that validating experiences, even suicidal ideation and behavior, provided clients with recognition without judgment (VA/DoD, 2019).

Additionally, the researchers supported the premise that asking veterans/clients if they are considering suicide is valid and does not contribute to an increased incidence of suicidal behavior (VA/DoD, 2019). Reflective language and reinforcing positives helped continue constructive engagement and decreased the distress levels in interviews. Importantly, among the veteran population, giving early reassurance that merely admitting to suicidal thoughts does not warrant hospitalization has been shown to be an effective means of encouraging them to open up more about their thoughts (VA/DoD, 2019). Imminent suicidal intent, on the other hand, may require protective hospital admission for the client (VA, n.d.-b).

Suicidal Factors Specific to Military Family Systems

More frequent and longer deployments have become de rigueur in modern conflicts and are often associated with higher rates of both interpersonal violence and suicide among military members and families (Hom et al., 2016). The person who has been involved in killing in wartime has been found to be more susceptible to perpetrating violence on others as well as themself. Study findings reflect previous traumas, cumulative effects, and underlying

mechanisms are also contributory. Further studies on the reserve component have been suggested (DeGraff et al., 2016).

Military deployments often lead to trauma, both in the war zone and on the home front. Suicidal behavior is one of the most extreme traumatic events that may occur in the family system at home during or following parent deployment (Gilreath et al., 2016). Deployments are stressful for the military member who may be going into harm's way and for the spouse and children, despite careful preparations for the event (Hajal et al., 2020). Marginalized and powerless, children of military members often feel vulnerable and may experience higher levels of depression, anxiety, and suicidal thoughts (Cederbaum et al., 2014; Ivey-Stephenson et al., 2020; Peterson et al., 2020).

Of note, military children often have a heightened sense of what their parents are feeling about the separation and often act accordingly (Hajal et al., 2020). In the absence of the deployed parent, children and adolescents often experience a range of traumatic stressors (Wadsworth et al., 2016). The suicide of one profoundly affects all other members in this system, warranting immediate interventions to help the survivors deal with the traumatic loss and to help prevent copycat suicide (O'Neal et al., 2018; Peterson et al., 2020).

The studies discussed in this section provided insights into the traumatic impact and implications of suicide on the military family system. The literature reviewed included evidence-based research that mostly aligns with a Christian worldview and Biblical tenets of caring and nurturing families, as described in Tan (2011). I examined the traumatic effects of suicide, postvention measures, resiliency, adjustment, and coping mechanisms used by families, with an emphasis on the mediating factor of close, continuous communication before, during, and after deployment. In the next section, I focus on issues specific to military deployments.

Issues Peculiar to Military Deployments

Military deployments are stressors for all members of the military family system, and stress is increased in the presence of existing trauma and mental health challenges. Sbarra (2019) addressed trauma history and attachment anxiety among military partners, positing that these unique factors may accurately predict levels of adjustment to deployment and aftermath. DeGarmo (2016) examined military deployment, experiential avoidance, trauma, PTSD, and family interaction, particularly in returning to the home setting following deployment and attempting to resume life in a changed environment. This research focused on the connection between deployment-related exposures, PTSD when present, and avoidance factors in social engagement, social isolation, hyperarousal, and triggering. Other contributory factors were examined such as post-deployment family interactions that were either healthy or dysfunctional (DeGarmo).

DeGarmo (2016) acknowledged deployment's impact on the deployed service member and the entire family system as being significant and advocated for strategies for reducing adverse mental health outcomes in the military population. DeGarmo's emphasis was on the degree of the service member's acceptance of the deployment as a determinant or as a factor in the overall resilience of all family members. Multiple contextual challenges may obscure hard and fast facts, as changes in the family dynamics may have occurred during the time of absence. When the service members adjusted to and accepted their position, there were marked improvements in the family's sense of well-being. The military member's avoidance issues played a role in how the family adapted to the challenges encountered after the member's return and during the reintegration process (DeGarmo, 2016).

Children of military families most likely experience more stressors than their civilian counterparts and accumulate risk factors specific to the military family system (Gilreath et al., 2016; Wadsworth et al., 2016). Saltzman et al. (2016) outlined positive pathways of resilience to counteract the risks present and achieve homeostasis in the family system. Using these pathways and focusing on better communication and buffering support appeared to promote increased resiliency for military families

Clements-Nolle et al. (2021) studied the mediating role of ACEs as they relate to suicidality among military dependent children. They noted that the trauma of the parent's deployment, plus other stressors, combine to increase the risk of mental health issues, including depression, anxiety, and suicidal ideation and behavior, contributing to the higher instance of suicide in the military family system population. Park (2011) found that ongoing development in military children and adolescents was particularly affected by the absence of the father or mother, the changes in home dynamics, school issues, and the missing parent in the home.

Military members and their families can expect to relocate to a new station every 3 to 4 years, starting all over again in a new location (Saltzman et al., 2016). While military members may have sponsors and measures to ease the transition, services for their families are less consistent and often piecemeal as their lives are interrupted and uprooted (Schoenbaum et al., 2014). Supports for spouses and children mirror that of military members to an extent but do not sufficiently address the full emotional impact of being uprooted without the more formalized in-processing that active duty members or reservists experience (Turner et al., 2017).

Families are too often without scheduled counseling opportunities at the new assignment post or base, exacerbating the feeling of alienation and disenfranchisement often felt by military dependents (Turner et al., 2017). Reservist families have even fewer amenities and supports

(Ruocco et al., 2021). In a sample of secondary school students, Cederbaum et al. (2015) found a measurable increase in experiencing depressive symptoms, sadness, hopelessness, and suicidal thoughts among youth with at least one parent deployed. For families of reservists, in particular, support was woefully lacking, and symptoms often went unrecognized or untreated (Cederbaum et al.).

Turner et al. (2017) examined feelings of victimization and disenfranchisement experienced by many of the children of deployed parents, noting that the longer the absence, the more serious the issues became. Sbarra (2019) noted the mediating influence of attachment anxiety and trauma history as contributory factors in stress levels among military children and the particularly difficult challenges inherent in membership in reserve or guard components of the U.S. military. These military members and their families enjoy far fewer emotional, financial, and legal support services benefits and normally have two jobs to juggle—a full-time occupation and a part-time reserve engagement—creating further burdens and more stress for all when the time for deployment occurs (Wadsworth et al., 2016).

Far from bases or posts, reserve component military families must make do without the established benefits afforded active duty members and are often left to their own means and devices (Gilreath et al., 2016). These families are at increased risk when traumatic stress occurs. Though efforts are ongoing to provide services to guard and reserve units that match resources for active duty forces, there remains greater disparities and an immediate need for improvement to reach an equal footing (Cederbaum et al., 2015; Ruocco et al., 2021).

DeGraff et al. (2016), who examined 236 military families, posited that these families were affected by both formal systems and informal networking for support. The formal systems were put in place by the military services and the informal were established by families

supporting each other. DeGraff et al. used frameworks consisting of social, organizational, and contextual models to analyze the dimensions of military cultural influence on the parents' satisfaction with their lives and looked for key developmental outcomes among their adolescent children. The focus was on mental health issues such as depression, anxiety, and suicidal ideation. A key finding was a positive correlation between strong parental support and adolescents' feelings of security (DeGraff et al).

Collishaw et al. (2016) found that military members and spouses were more likely to model a sense of well-being when they received strong moral and spiritual support from military superiors, leaders, and peers, causing the children to also feel a sense of well-being. The multiple mediators found confirmed the presence and importance of multiple contexts in establishing healthy resilience in the military family system (Collishaw et al., 2016). In Flouri (2005), a sense of belonging in the family, the community, and the military milieu was found to be a critical factor in nurturing resiliency.

Resiliency and Protective Factors in the Military Family System

True resiliency is formulated in a family atmosphere of open communication, trust, and true nurturing on the part of the parents toward the children and each other (Ungar, 2018). Military families live in close proximity to the potential for trauma in that one member may at any time be called into a wartime scenario in which they must participate, leaving the other members at home to fend for themselves. During the recently ended conflicts in Afghanistan, Iraq, and elsewhere in Asia, multiple and frequent deployments dominated the military milieu for 20 years and are the most salient point in the dynamics of the contemporary military family. DeGraff et al. (2016) noted positive satisfaction and self-image outcomes among military family adolescents when counseling and therapy are offered, allowing military family members to share

thoughts and communication outside of the house. However, these services are too often unavailable or inaccessible for military reserve families (DeGraff et al.).

Gosselin (2019) posited that military children mirror their parents, as the parents model certain behaviors and feelings through body language, attitudes, mood, and subtle cues that military family members, attuned to potential crises, keenly detect and internalize. This is quite a reality in the military family system. Children and adolescents in these families have a particularly well-developed sense of anticipating what may happen next, as they are often called upon to uproot and move to another unfamiliar place or anticipate a parent's deployment as a part of military life (Matel-Anderson & Bekhet, 2016). This heightened alertness and vigilance often came from subtle actions, clues, and nuances gleaned from their parent's demeanor, and were embraced and internalized by the children and adolescents in Gosselin's study as an adaptive coping mechanism.

Blalock et al. (2015) outlined strategies for developing *grit*, or toughness and resilience, which can develop and thrive in an atmosphere of support and nurturing. Unfortunately, buffering support can be uneven, inadequate, or absent among youth, leaving them more vulnerable to outside distractors and influences (Collins et al., 2016). These outside influences have been magnified exponentially in recent decades due to the ubiquitous and often damaging media exposure (Kleiman et al., 2013).

The Traumatic Impact of Suicide on the Military Family

Families who experience the suicide of a family member are never prepared for the life-altering effects that emerge. The full gamut of responses, such as denial, anger, bargaining, depression, and acceptance first outlined by Elizabeth Kubler-Ross (Yanke, 2019), can be experienced, plus many more less well-defined and not easily understood emotions. These

emotions are not experienced in any predictable linear projection, but rather as ad hoc or spontaneously occurring feelings that may overwhelm at any given time and may proceed in any random order, often returning to previous states of processing. Survivors of suicide; that is, the family members of the person who died by suicide, are themselves pulled into a surreal existence wherein there are constant attempts to piece together the events in an often-futile attempt to comprehend the incomprehensible (Yanke).

The period immediately following the suicide is characterized by disbelief, punctuated by thoughts aimed at undoing or negotiating the events after the fact in a vain attempt to prevent the death after it has occurred. These attempts are more a wishful appeal to God or to the person who died to tell the survivors that it really was a bad dream from which they will wake up relieved; this wish is never granted, as it is and remains unrealistic (Harrington-LaMorie et al., 2018). While feeling these thoughts and experiencing these emotions, the survivors are not living in a delusional state but rather forcing prayerful, wishful, or willful thinking to try and undo that which cannot be undone (Peterson et al., 2020). This is not an abnormal or unexpected reaction, but rather a natural response to an overwhelming event. This pattern may continue for months, years, or a lifetime at different levels of intensity (Yanke, 2019).

During the aftermath of a suicide, many or most people turn to their religious roots, alternately praying to or blaming God for the incident. Common thoughts or words may include Where was God when this happened? She was a loving person, and How could a supposedly loving God turn his back on this person in turmoil? (Tan, 2011). The early intervention of clergy and counselors is crucial and can be effective in ameliorating the survivors' feelings, perhaps not as much to understand as to process and accept. Comfort measures along with sympathetic listening, rephrasing, and offering unconditional support can go a long way in helping the

survivors feel less alone. Simple statements such as “God has given us all free will” are not therapeutic at this time. A better way of phrasing this idea may be to say: “Remember that under the terrible burden of depression and despair, one may lose sight of the fact that God is present and give up” (Tan, 2011).

Going forward despite the overwhelming grief and sorrow and loss takes determination, belief in God, and often—very often—help from others, whether professional counselors or family supporters (Jordan, 2017). Deficiencies in access mark the military support systems, with the reserve component most underserved. For the military family, these measures may be present on a military base or nearby, with a full support apparatus in place (O’Neal et al., 2018). Just as likely, these family supports are not fully in place, so that the military family members, especially reserve and guard, must search for adequate support systems elsewhere (Hajal et al., 2020).

Crisis Intervention and Postvention

Brechlin and Myers (2015) emphasized the importance of teamwork among multiple resources in the community in the early recognition and prevention of suicide. Suicide prevention is crucial, and postvention and the prevention of further suicides in vulnerable populations exposed to a suicide proactively foster a new resiliency rather than just a response to a death by suicide. Jordan (2017) noted empirical evidence that exposure to suicide in a family or group increased the likelihood of further suicides, in a copycat fashion, as well as a host of mental health challenges including anxiety and depression.

Many studies on suicide focus on the individual who died, but less is known about suicide’s effect on the family system, and in particular, the special circumstances found in the military family system. Batterham et al. (2014) advocated for using testing to measure the extent

of suicidal ideation and behavior in order to identify people most at risk for suicide and in the development and evaluation of suicide prevention programs in the community. Some questionnaires recommended by Batterham et al. (2014) were the Depressive Symptom Index Suicidality Subscale, the Suicidal Behaviors Questionnaire-Revised, and the Suicidal Ideation Attributes Scale. These can be administered at military base support facilities focused on military family care, but were not part of the present study.

Building Resiliency in the Military Family System

The mediating effects of resiliency in the military family system are seen as the single most important factor in preventing self-harm in military children (Clark et al., 2017). Hajal et al. (2020) confirmed the critical role of military parents' perceived threat during deployment as being central to their children's attitudes and perceptions of the dangers thereof. Strong communication and robust buffering parental support are becoming recognized as the key factors in maintaining homeostasis during deployment, lessening the traumatic effects of separation for all family members and thereby decreasing mental health symptoms in families (O'Neal et al., 2018). DeGarmo (2016) noted that the service member's acceptance of deployment promoted familial adaptation and resilience.

While increased efforts are now being made to foster resiliency in the military family system, comprehensive and coherent formal training is still in its infancy (Messecar, 2017). Saltzman et al. (2016) posited that family programs focusing on resiliency can greatly impact behavior in military family systems in a measurable fashion. As mentioned earlier, TAPS, a program for military members who have been exposed to suicide, incorporates postvention elements in its didactics (Ruocco et al., 2021). Shahram et al. (2021) delved into successful strategies for preventing suicide in children, including developing and refining of strengths and

resiliencies through buffering. As previously noted, resiliency in the military family system is seen as the single most important barrier to self-harm in the military child (Clark et al., 2017). Shahram et al. considered resiliency factors in preventing suicide in young people and noted that the presence or absence of these factors as well as their quality can prove critical in saving lives.

For Christians, revelations through the teachings of Jesus Christ reveal humankind's fragile and God-dependent status in this earthly world, very imperfect yet meant to be. Man, made in God's image yet falling short of His perfection, grovels and seeks his way in this earthly existence, finding sadness and grief but also love and hope. Jesus admonishes us sinners to love one another as He has demonstrated love (John 13:34, King James Version [KJV]). During the aftermath of the trauma of a suicide, family members are deeply in need of spiritual care. For many, this involves Christian agape love and kindness for the hapless survivors. For others, similar forms of loving spiritual nurturing are called for (Tan, 2011).

Substance Use in Suicide

Metsala et al. (2017) posited that little is known about substance abuse at the time of death in those who die by suicide and aimed to examine the relationship between substance abuse and subsequent suicide. Methods used involved accessing coroner's reports for some 403 patients who died by suicide in a 2-year period. The researchers questioned how data on drug and alcohol use affected suicidality studies. They also examined the relationship between lifelong drug use and drug use at the time of death. Results indicated that 67% of those studied who had died by suicide had previously sought help for alcohol issues and that 39% were under the influence of alcohol at the time of their suicide. For drug abuse, only 54% of the cohort was tested for substances at the time of suicide. Of them, almost 1 in 4 tested positive, with levels

over the therapeutic dosage and prescribed range and/or illicit substances detected. Those tested were more likely to be young and have a history of drug misuse (Metsala et al.).

Metsala et al. (2017) concluded that a deeper understanding of the relationship between substance misuse and suicide could contribute to prevention initiatives and that using standardized toxicology screening processes could avoid diminishing the importance of psychosocial factors involved in suicide as a cause of death. They further posited that substance abuse is often a key factor in suicide, yet insufficient evidence has been obtained. Some of the more crucial points in this study are that Metsala et al. reported in the positive even when the negative may have had more importance. As an example, they reported that 38% of the sample was employed, whereas the most important feature may have been that 62% were unemployed (a subtle distinction), leaving room for further exploration of the role of unemployment in suicide.

Media and Other Influences in Suicidality

Today's world, and particularly the United States and Canada, is characterized by an overwhelming exposure to media, all day and night, with a gradually less secretive socialist, secular, morally relative agenda (Tan, 2011). The treatment of suicide, homicide, and violence in general in the cinema, television, videos, and video games, and the wider media perhaps desensitizes people to the true impact of violence, lowering the threshold for copycat suicidal behaviors (Cheng et al., 2018). At times, suicide is portrayed in a sympathetic, acceptable, even romantic light, influencing and swaying marginal, vulnerable, or impressionable youth (Ungar, 2011, 2013). Thus, the threshold for suicidality is lowered in populations who are younger, less experienced, more vulnerable, or who have less parental or adult buffering (Shahram et al., 2021).

Social Media Effects on Suicidal Ideation and Behavior

Contemporary generations are deeply immersed in social media, opening another huge avenue of information, disinformation, influence, and potential degradation (Bailey & Robinson, 2021). In an earlier study, Daine et al. (2013) explored the internet and media's effects on impressionable youth and how they impact suicidal ideation and behavior. As it is open to any sort of comments and photographs, social media can destroy a vulnerable person when targeted by a predator or even a mischievous person (Daine et al., 2013). Vulnerable populations can internalize critical comments and feel hopeless, helpless, or out of control, and endorse suicidal ideation. Suicidal behavior has been reported in children and adolescents who have been shamed, harassed, or targeted on social media platforms (Daine et al., 2013).

Sisask and Värnik (2012) conducted a systematic review of 56 articles on media influence roles in suicide to provide an overview of research on the media's roles in reporting suicidal behavior. The authors looked at media reporting from a preventative lens to discern the media's impact on promoting versus preventing copycat suicides. Of these articles covered, most authors concluded that the media plays a significant role in suicide prevention, postvention, or promotion depending on the narratives used (Sisask & Värnik, 2012). This finding supports the assertion that the media *creates* the message rather than just reports on it.

Nutt et al. (2015) noted that evidence supports the existence of the Werther effect, a hypothesis that media reports of suicide can encourage copycat suicides. The authors noted that there were no established tools for quantifying the quality in the media's reports about suicide deaths and that the media have often dramatized and even romanticized suicide in popular figures and celebrities. As such, Nutt et al. sought to develop and validate a tool, the Risk of Imitative Suicide Scale (RISc), as a recognition and preventive measure against copycat suicides.

Findings in Nutt et al. (2015) indicated that adherence to guidelines in media reporting is inconsistent, though the RISc appeared to be useful for tracking effective, quality, and preventative messages in reporting on suicide deaths. The RISc also appeared to be able to reliably discern between adherence to values and nonadherence as well as differences between web-based and print media. Overall, this tool can be efficacious in evaluating the consistency of media coverage of suicide and can be a weapon in suicide prevention and postvention (Nutt et al.). Noting the elements in reporting that have a preventative effect versus those that are inflammatory or tend to increase the likelihood of imitation suicide can provide valuable information for formulating further prevention and postvention strategies.

Nutt et al. (2015) found that the media focused their reporting along age and gender lines, perhaps providing an unintended modeling effect. Persons with similar demographic backgrounds to the decedent appeared to be more vulnerable to the suggestion of suicide, or the Werther effect, whereas those who identified less with the victim were less likely to imitate the suicide (Nutt et al.). Modifying reporting in a responsible way can result in the Papageno effect, decreasing the tendency to imitate a suicide. Both Nutt et al. (2015) and Sisask and Värnik (2012) noted that strategies should be target - group specific, as more universal approaches seemed less promising.

Contagion, Copycat, and Influential Suicide

Zimmerman et al. (2002) posited that peers are vulnerable to suicide after a friend has attempted or completed suicide. Copycat suicide, imitative suicide, or suicide contagion is a phenomenon that often follows the death of a friend, student, or peer, prompting questions about how the contagion spreads. Zimmerman et al. examined the accuracy of the friends' perceptions

of peers' suicidal behavior. Peer perceptions of suicide seemed to be critical in the spread of copycat suicide or contagion (Zimmerman et al.).

Zimmerman et al. (2016) presented hypotheses on the best suicide prevention and intervention methods. They also examined the importance of friendship networks as both buffering elements and contagion elements. Data gathering included having student study volunteers take self-report surveys measuring their perceptions of their friends' attitudes toward suicide, the results of which were then compared with suicidal behaviors. Study results indicated that at-risk youth often misinterpreted or overestimated their peers' suicidal behaviors, increasing their own risk of suicidal ideation or behavior. Zimmerman et al. called for future use of similar tools to measure vulnerability in peers of suicide victims as well as more effective ways to tap into their peer support networks.

Haw et al. (2013) conducted a quantitative study on contagion and clusters of suicides. The researchers scoured world literature on the subject of suicide clusters to describe risk factors and psychological mechanisms underlying space and time clustering of suicides (point clusters). Their main hypotheses suggested that suicide clusters, while uncommon, are nonetheless devastating to communities when they do occur. A key research question was, What factors can cause or encourage copycat suicide or clusters of suicide?

Haw et al. (2013) found that being male, being an adolescent or youth, being a drug or alcohol user, and having a past suicidal history were contributing risk factors for suicide. Noted in this study, and self-reported by the authors, was a lack of rigor in their study methodology. Supportive empirical evidence was lacking for contagion, imitation, suggestion, learning, and assortative relating, prompting Haw et al. to call for more scientifically rigorous studies to

improve the understanding of suicide clusters. The authors noted that additional studies can contribute to external validity as the numbers of participants increase.

Resiliency

Acknowledging that military deployments affect not just the military member but the whole family system at home, Clark et al. (2018) probed for resiliency processes that seemed to be effective in reducing adverse mental health outcomes. Some focal points were the continued closeness of communications within the family unit, at home or deployed, and successful household management during the military member's absence. Clark et al. questioned whether close communications would foster easier reintegration processes upon the service member's return and which factors would most affect the family.

For deployed service members, frequency of communication with their families back home was the crucial factor in personal reintegration (Clark et al, 2018). The members could more readily restore their place in the family if that continuity had been observed. For the nondeployed partner, household management was the primary factor in reintegrating. Both factors, communication and household management, were of primary importance for the adolescent children and other family members. Clark et al. measured these factors through several indicators of feelings of well-being.

Other subjective determinants of well-being reflected negative or positive outcomes (Clark et al., 2018). Some crossover effects related to the age of the adolescent and other factors were found. Reintegration was more problematic with a lower level of resilience present in military family systems, which correlates to comparable studies (Clark et al.).

Similarly, in an examination of 236 military families, DeGraff et al. (2016) found that these families were affected by both formal systems and informal networking. The researchers

used frameworks composed of social organizational and contextual models to analyze the dimensions of military cultural influence on the parents' satisfaction and to look for key developmental outcomes in the adolescent children. The focus once again was on mental health issues such as depression, anxiety, and suicidal ideation (DeGraff et al.).

Some of DeGraff et al.'s (2016) key findings were a positive correlation between strong parental support and adolescents' feelings of security. Military members and spouses were more likely to model a sense of well-being when they received strong moral and spiritual support from military superiors, leaders, and peers, which also caused the children to feel a sense of well-being. The multiple mediators DeGraff et al. found confirmed the presence and importance of multiple contexts in establishing healthy resilience in the military family system. A sense of purpose and belonging in the family, the community, and the military milieu was a critical resiliency factor. These findings align with previous comparable studies.

Regarding post-suicide scenarios, Ohlmann et al. (2014) studied at-risk high school students 15 to 18 years of age in several middle schools and high schools. These students had attended schools wherein a student died by suicide. Their study found that the participating students who had been affected by the suicide of a peer with whom they could identify learned to support each other, became literate in mental health issues, and created and performed presentations on suicide prevention to peers. This creative drama approach appeared to have been successful as evidenced by participant feedback embracing and endorsing resilient factors. Ungar (2011, 2013, 2018) examined resiliency in adolescence and in cultural contexts. Study findings provided insights into how to foster true resilience in building strength to resist suicidal ideation and behavior. Prominent in these approaches were familial support, inclusiveness, buffering, being connected, and remaining a part of a group (Ungar, 2011, 2013, 2018).

Connectedness Versus Isolation

Connectedness implies being engaged with others in either intimate closeness, social closeness, or being engaged in employment entailing meaningful and supportive interactions with others (Foster et al., 2017). The loving relationship between parent and child, the trusting friendship between two or more people, the intimate partnership with another, or a caring, buffering relationship may constitute connectivity (Ohlman et al., 2014). When connectivity exists, a person is able to confide in, relate to, and trust another individual in a way that can foster feelings of safety and reliance, thus building a resilient relationship.

The presence of such a relationship can strongly affect a person's decision regarding suicidality (Shahram et al., 2021). Children who grow up in a loving, caring, and spiritually rich environment are more likely to develop and nurture an inner resiliency that will greatly assist them in processing trauma and making sound decisions (Tan, 2011). Trauma and stress are inevitable and often strengthening factors in growing up. Some stressors are more tolerable than others, while some can be profoundly toxic (USDHHS, 2020). The ability to survive the effects of these stressors is directly proportional to the amount of loving support and buffering given to children and adolescents in the familial setting (USDHHS, 2020).

Prevention and Postvention Strategies

Suicide prevention efforts need to be carefully orchestrated with collaboration between multiple factions and sectors, including schools, communities, law enforcement, media, and parental groups. Suicide often can be prevented with coordinated measures taken on several levels (WHO, 2019). Prevention strategies include limiting access to means of suicide such as weapons, interactions with media to effect responsible reporting (Cheng et al., 2016), identifying

and observing for high-risk factors, and promoting social and emotional skills (Daine, 2016; WHO, 2019).

Ungar (2013) examined the extent to which engaging and transformative youth–adult relationships can impact youth who are the most marginalized and at risk for suicide. These youth often include children and adolescents from abusive homes or poverty cultures. They also include sexual minorities and those who feel isolated and disconnected from society and from families (Ungar).

Similarly, Andriessen et al. (2019) conducted a systematic review of suicide postvention models and guidelines in schools with a focus on students processing the trauma of a friend's suicide and developing coping skills for self-resiliency. Study questions were, How is the field of postvention evolving? and, What are the identified tools used most effectively? Data were gathered on programs from 2014 to 2019. The study aim was to increase awareness of coping skills that may reduce the incidence of suicide. Findings included an evolution in postvention to emphasize recognition of potential copycat suicide.

Brechlin and Myers (2015) reviewed community teamwork, including police, schools, and others in recognizing and preventing suicides. Close cooperation between community entities promoted better preventive outcomes as evidenced by a drop in the number of suicides. Ungar (2013, 2018) further discussed resilience as more of an environmental factor than a child's capability, noting that some individuals may be less capable of self-improvement, less able to use learned and intrinsic skills in adapting, and more dependent on outside forces in the social environment for success. Ungar (2013) also identified strengths contributing to well-being under adverse conditions as being more important depending upon the degree of adversity, with severe stressors calling for an increased level of adult–child partnering. The USDHHS (2020) reached

similar conclusions regarding the need for buffering and strong adult support in childhood and adolescence, with a higher level of support essential when the child or adolescent faces more serious and toxic stressors. These findings emphasize the importance of loving and buffering support by parents starting in early childhood, which will endure through adolescence and beyond, reinforcing resiliency tools learned as well as validating intrinsic resilience.

Jobes et al. (2011) suggested a way to organize warning signs and risk factors regarding contextualizing a patient's specific painful experiences and pain. Drivers, warning signs, and risk factors in assessment were discussed in some detail. Kim and Woo (2015) addressed efforts to dissuade adolescents from suicide through feedback and education. They studied a program in Korea with 12 weekly sessions. Analysis methods were paired-sample *t* tests, pre- and posttherapy questionnaires, and saliva tests as data points. Saliva could be measured for levels of anxiety through an assay. Electroencephalographs were used to compare brain waves in various stages. Feedback was given to the participants. Study participants were also administered a happiness index and a depression index. Subjects in Kim and Woo learned to recognize the seriousness of suicide through various methods. The researchers claimed a measurable ability to decrease impulsivity and increase happiness, with pre- and postintervention tests contributing to data validation.

O'Neill et al. (2020) examined school personnel preparedness to respond to suicide and its inevitable aftermath in a high school setting. This study of several schools in North Carolina underscored a significantly inadequate and unprepared capacity for effective response to a suicide. O'Neill et al. provided recommendations for educating staff on postvention techniques.

Ruocco et al. (2021), discussed earlier, provided a close examination of TAPS, a suicide postvention and grief support model that offers military families solace and support as well as

organized programs to help reduce the suicides which often follow one suicide. This tool was developed by survivors of familial suicide to address recognized unmet needs. The emphasis is on pathways to promoting healing as well as decreasing suicide risk (Ruocco et al.). Again, this tool can be utilized outside the military milieu as well for those who have suffered the loss of a loved one through suicide and other complex traumatic issues.

This postvention model is therapeutic for all survivors and supporters through educational offerings, promoting growth and healing (Ruocco et al., 2021). In addition, TAPS offers a peer-based model of care that has supported more than 16,000 military suicide loss survivors at the time of the Ruocco et al. study. Guidance is provided on adaptive grief based on research and empirical evidence.

Results suggested that TAPS may benefit all survivors and their supporters by promoting an understanding of the survivor experience. Ruocco et al. (2021) encouraged using TAPS as a means of decreasing risk and promoting healing and growth. They further stated that the model could benefit all survivors and their supporters by helping them better understand the survivor experience and how to approach their journeys in a more intentional way.

Art and Drama Therapy

Several approaches are used in addressing suicidality and attempting to prevent further suicides, especially in younger populations. Various approaches, including art and drama therapy, discussed in this section, have been studied internationally, with varying degrees of success reported. Sonke et al. (2021) analyzed art-based interventions for suicide prevention and survivorship in Australia, Canada, the United Kingdom, and the United States. After comparing results from these programs, they concluded that similarities outweighed differences between the

countries, with comparable outcome rates, and recommended further research on interventions and underlying frameworks and logic models utilized.

Testoni et al. (2018) studied postvention strategies to strengthen student resiliency in Italy. Their theory was that death education would be useful for exploring various ways of conceptualizing death and lead to a greater understanding and clarification of personal value systems. They also posited that death education lessened anxiety and did not exacerbate it.

Testoni et al. (2018) demonstrated the efficacy of death education using psychodrama education methods. Participating students used artistic productions of theatrical activities to affect other students under the guidance of educators. Also involved in the project were three psychologists who were experts in psychodrama and death education and two other psychologists with expertise in religious sciences. Testoni et al. used regression analysis to analyze the results from four administered scales. The results indicated a significant decrease in students' viewing of death as annihilation. This Italian study demonstrated positive effects of psychodrama education with wide implications for reducing suicidality following a peer suicide.

Self-Care Among Therapists and Counselors

Self-care and mutual support of counseling staff are important in the realm of suicidal studies and in dealing with actual suicide. Erlich et al. (2017) studied mental health staff who experience the loss of a patient to suicide. Based on study findings, they recommended that psychiatrists and other staff needed self-care and peer-supportive measures to adjust to losing patients to suicide.

Gaps in the Research

I found several gaps in the current body of literature on suicidal behavior. Several authors of the articles included in this review also called for future investigation. Metsala et al. (2017)

noted that little is known about long-term versus pre-suicide misuse of substances, suggesting further investigation is needed. Hom et al. (2018) called for increased studies of the effect of suicides on military personnel. Sonke et al. (2021) noted that similarities outweighed differences between the various countries they surveyed, with comparable outcome rates. Further studies should be designed with clear descriptions of the interventions and the underlying theories or logic models used.

A deficiency in recognizing depressive symptoms and suicidal ideation in vulnerable populations presents an opportunity to increase screening in schools and in primary care venues, including health and wellness checks and doctor appointments as well as community mental health centers. For Indigenous populations, the U.S. Public Health Service and the Indian Health Services must increase their recognition and prevention outreaches for their constituency. For the military family system, further refinement and more intensive screening is called for. For families who have already experienced a suicide, access to counseling and mental health services may be limited for some, based on demographic and other factors.

Summary

Suicide is a major health issue worldwide, claiming the lives of far too many people, especially vulnerable youth (WHO, 2019). The variables that coalesce and combine to create the perfect—or imperfect—storm in fostering circumstances allowing suicidal behavior may never be quantified. However, it is possible to shed light on some of the contributory factors with the objective of recognizing and preventing future suicides. To this end, I examined a number of contributory conditions and factors in suicidality in this literature review. I focused this study on gaining deeper insights into the lives of those affected by the suicide of a loved one, with the

goal of ascertaining preventative measures going forward. To this end, I focused on the disproportionately high rate of suicide among military family populations.

In this review, I synthesized findings regarding suicide exposure in military veterans, service members, their families, and military systems, with an eye toward postvention and preventing further suicidal behavior through proactive trauma-informed interventions. Clements-Nolle et al. (2021) highlighted the need for trauma-informed approaches to mental health promotion in military families, especially with identified vulnerabilities as modifiers. Risk factors and preexisting comorbidities, as well as supportive factors, need to be considered in moving forward with efforts to better serve the military family system with its particular set of circumstances and peculiarities, remembering that the rates of depression, anxiety, and suicide are higher in this specific subset of the population.

A closer examination of ACEs leading to increased stressful and traumatic childhood events is necessary in the military family system, given the higher incidence of abuse, neglect, and a range of household dysfunction such as witnessing domestic violence or parental substance abuse as well as the periodic upheaval and added stressors of deployment. Wadsworth et al. (2016) found that internal positive self-appraisal, positive personal traits, zeal for living, and good coping skills helped to insulate the children and adolescents in military families from suicidal ideation and behavior. External factors such as social support, nurturing familial buffering and support, and an inclusive environment also mediate depressive and suicidal symptoms in a positive way, taking into consideration age, sex/gender, and indigenous identity as important contributors to resilience among youth (Shahram et al., 2021). Ungar (2013) answered questions about the extent to which transformative adult/youth partnerships could impact the most marginalized youth, such as those in military families, and noted positive results

as evidenced by a decrease in depressive and suicidal symptoms in those studied who had strong relationships as opposed to those who did not.

Findings in Shahram et al. (2021) indicated and validated that fostering resilience works as a primary suicide prevention factor among youth, but they offered little explanation for how these factors may work to protect youth from suicidality. Continued research in this area requires a focus on how to promote resilience at the community and systems levels. Overall, a more thorough emphasis on all factors collected and weighed as influencers of suicidal behavior is called for.

In Chapter Three, I discuss the methodology used for this study. I also include information on the participants, my role as the researcher, data collection, and ethical considerations. This chapter outlines how the study was organized, constructed, and conducted.

Chapter Three: Methods

Overview

Though suicide has long existed in the military services, suicide rates have steadily and dramatically increased in all services during the recently ended wars in Afghanistan, Iraq, and other parts of the Middle East and Central Asia (Harrington-LaMorie et al., 2018). The suicide rate among active duty and reserve components is nearly double that of the civilian counterparts, even factoring in gender (as the military is majority male and males have a higher rate of suicide) and age. Significantly, and surprisingly, the suicide rates for nondeployed personnel increased even more than for those deployed (Schoenbaum et al., 2014). Non-military-associated suicide rates also show an uneven distribution among populations, with a very high rate among North American Indigenous people and non-Hispanic Whites (Beaudoin et al., 2018). Causative factors for uneven suicide rates among various groups remain unclear. Suicidality is frequently associated with seasons and times of day and year (Shapiro, 2019).

The present study was a hermeneutic phenomenological investigation focusing on the experiences of those who have survived the suicide of a close family member. Two groups were examined: military-affiliated family members and civilian family members. Differences as well as similarities were examined and explored through in-depth personal interviews in which I gathered data on the participants' unique lived experiences.

The purpose was to discern possible markers, influences, and differences that may contribute to higher suicide rates among military members and families than in the general population. This information was sought from the study participants' in-depth disclosures and descriptions of experiences. Philosophers have postulated that a true understanding of life can be accessed by examining an individual's life experiences (Byrne, 2001). Richer and deeper insights

can be obtained through phenomenological interviews and observations (Barrett & Twycross, 2018). I explored and examined the lived experiences of families who have experienced a suicide and how the trauma affected them. Narrative data were collected and analyzed to understand the essentials of the trauma and give meaning to personal experiences brought about by the stressor.

Chapter Three details the methodology used to conduct the present study. The chapter includes discussions on the study design, research approach, questions asked, and the venues or settings used. The chapter also includes a description of virtual formats, enumerates and describes participant procedures that were followed, the researcher's role, data collection means, interviews with questions asked, data analysis, trustworthiness information, credibility, confirmability, dependability, transferability, and ethical considerations.

Design

To more deeply appreciate the individual's struggle following the suicide of a loved one, I chose a qualitative approach; specifically, experiential phenomenological methodology. This qualitative approach delves deeper into the why and the how, beyond the simpler where and when and how often examined in quantitative studies (Dixon-Woods et al., 2005). Philosophically, narrative formats can demonstrate how people manage their grief and go on with their lives after a trauma, thus revealing a belief and resiliency underlying the data (Brechlin & Myers, 2015).

There are subtle differences between purely descriptive and interpretive phenomenological research approaches (Matua & Van Der Wal, 2015). It was my goal to use hermeneutical analysis to interpret the data gathered for this study. Merriam and Tisdell (2015) stated that examining an experience in-depth in order to fully comprehend it is more crucial than merely looking at outcomes.

The work of Hegel, Kant, Brentano, Husserl, and Heidegger shaped phenomenological inquiry (Dowling, 2007). From their philosophical standpoints, deeper knowledge of a situation could be best obtained and approached through an in-depth examination through the eyes of persons affected by a situation. The present study was predominantly qualitative and used phenomenological experiences of survivors of suicides in the form of interviews and observations of family members of persons who died by suicide. The optimal means of capturing these data was through in-depth interviews of family members who experienced the suicide of a loved one, some selected for their military association, using consensual, intrinsic case studies.

I selected transcendental phenomenology methodology to best explore, describe, analyze, and interpret data. I made all efforts to achieve the fullness and richness as well as the depth and breadth of the related experience to approximate the participant's traumatic experience most closely. To obtain this transcendental purity, I had to minimize any preconceived notions about the experience. To this end, I used hermeneutic interpretive approaches to look closely at the contextual aspects of the participants' lived experiences in order to gain the optimal depth and uniqueness of experience in each family member.

The literature reviewed for this study both informed it and supported it. Ohlman et al. (2014) and O'Neill et al. (2020) examined students exposed to suicide by close friends, employing qualitative frameworks to reveal deeply held feelings of loss and vulnerability, interpreting responses, and fostering postvention and prevention strategies. Qualitative phenomenology allows for a deeper understanding of participant experiences, beyond superficial glimpses (Adams & van Manen, 2019). Employing phenomenology in this study afforded the opportunity to explore how a traumatic event of enormous magnitude affected the study participants as reflected in their lived experiences of these events. This approach also facilitated

a deeper understanding of what circumstances may be seen as predictors of suicidal ideation and behavior.

Research Questions

I focused on gaining deeper insights into the lives of those affected by the suicide of a loved one, with the end goal of ascertaining and identifying prevention and postvention strategies going forward. To this end, the research questions guiding this study were as follows:

RQ1: What insights can be gained from suicide family survivors that can contribute to the understanding of familial factors?

RQ2: What markers may be present in the military family system that may be absent in the civilian family, as the suicide rate is significantly higher in the military family system?

RQ3: What can be learned from the suicide family survivors that can inform efforts in possible prevention and postvention strategies?

RQ4: What can be learned about relationships with the decedents that will inform the understanding of survivor guilt, feelings of having failed, and the duration of the grief process?

Settings

The topic of a loved one's suicide is particularly difficult and stressful and required that privacy safeguards be in place for interviewing the study participants. The study settings, therefore, were virtual via Microsoft Teams, an internet-based videoconferencing platform, or face-to-face in participant homes if they were more comfortable there. In both settings, participants were in private areas where they could comfortably and privately express their deepest feelings regarding the suicidal exposure. Six interviews were conducted via video

platform; four were face-to-face. I conducted one practice session by video with the first participant. It went well, and the other interviews were conducted without issues.

When conducted in person at the participant's home, all involved in the interview (each participant, due to the sensitive nature of the lived experience, the danger of triggering suicidal thoughts, and the emotional level expected, was asked to have a support person nearby) wore appropriate protective gear, usually an approved mask, as required by state and local regulations during the COVID-19 pandemic. These regulations, while continuously changing and being refined, were respected regarding the venues and contact with individuals at their comfort level. Additional information was obtained through email and telephone as appropriate.

Participants

Ten participants were purposefully chosen for their close relationship with a family member who died by suicide. A list of participants was obtained from a facilitator of a suicide support group, who casually asked if anyone wanted to take part in a survey on suicidality. The organization had nothing to do with the survey. Individuals who contacted me were screened for appropriateness. Some participants were affiliated with the U.S. military as service members, spouses, children, or other persons who may fit the definition of a military family member. Liberty University institutional review board (IRB) approval was obtained (see Appendix A for this approval), and the participants were carefully approached, written approval obtained, and then interviewed.

Inclusion criteria were being a close family member to one who died by suicide within the last 10 years prior to this study and being over 18 years of age. Exclusion criteria were severe depression, high anxiety levels, or not being able to endure an interview due to instability. At the onset of the study preparation, 18 people were questioned, but only 15 satisfied the inclusion

criteria. Of them, five could not complete the interviews for a number of reasons. Two feared they might become too emotionally labile and had to withdraw. One did not respond after the initial email. One dropped out, stating that it may become too stressful, and another was going on vacation and would be unable to complete even a video interview. This resulted in a final total of 10 participants. Five had a military affiliation; the other five did not. All participants were given pseudonyms.

Procedures

The processes delineated in the Liberty University *Dissertation Handbook* were followed in this study to ensure compliance with these processes and to guarantee participant safety, security, and anonymity. Specific steps were followed as outlined in the request for study approval submitted to Liberty University's IRB. Prior to the interviews, the participants were informed of all potential data uses in accordance with IRB regulations, Health Insurance Portability and Accountability Act (HIPAA) compliance measures, and full utilization of informed consent measures (see Appendix B for the informed consent form). I administered the questions. The participants received the questions prior to their interviews.

All interviews were transcribed with the signed permission of the participants. All participants could choose how they wanted to be interviewed: telephone, email, video, or face-to-face in their home. No participants opted for telephone or email (though follow-up was sometimes through these methods). The participants needed to provide a safe, quiet, private, and disturbance-free venue. Careful consideration of the security, safety, and privacy of the venue was ascertained before beginning the questioning. Six interviews were conducted virtually by video platform; four face-to-face. I was the sole interviewer, so additional training was not needed.

For video interviews, the interviewee had a copy of the questions to refer to beforehand. I took notes during the interviews to reflect subtle voice inflection and other cues as to the interviewee's mental and emotional status. When the interview was in person, I recorded it with a tape recorder.

Body movements and physiological signs of distress were observed as well. The Subjective Units of Distress Scale (SUDS; see Appendix C) was employed to gauge the level of stress the interviewee was experiencing, reflecting guidance in Hope et al. (2019). The SUDS is a scale from 0 to 10 where 0 indicates no or almost no impact of repeated exposure to overwhelming emotions and 10 indicates maximum impact of repeated exposure. I explained how this tool would be used in simple terms to the participants and conducted spot checks during the interviews, asking "How do you feel now on a scale of 0 to 10, with 10 being the most severe anxiety and stress and 0 no distress?" If levels went beyond 7, indicating very anxious, or distressed, interfering with functioning, with physiological signs presenting such as shaking, sweating, or heavy breathing (Hope et al., 2019), I planned to pause or possibly terminate the interview while the participant de-stressed or received assistance. No such situation occurred.

The Researcher's Role

As the lead element and orchestrator of the study, I assumed responsibility for objectively obtaining information from the participants while being answerable to the readership, peers, colleagues, and myself. I was first and foremost aware of the need to protect the vulnerability of the responders, who have often been very deeply traumatized by a suicide close to them. Retraumatization was carefully avoided. Obtaining richness of experiential content from each person interviewed while maintaining participant anonymity was a daunting process.

As all humans are flawed, rigorous scientific discipline was needed to ensure study validity. Researchers assume a responsible role and are expected to report objectively, thoroughly, meticulously, and scrupulously, enhancing the validity of a study (Schreier, 2014). Avoiding overly applying personal interpretation is somewhat difficult, as noted by Matua and Van Der Wal (2015). I strove for the purest form of hermeneutical phenomenological research in describing the obtained data. Perceptions were influenced by several variables, such as the participants' spoken words, data obtained through observing subtle mannerisms and body language, and the participants' attitudes. I strove to minimize any preconceptions I harbored.

Dowling (2007) and van Manen (2011) posited that phenomenological studies morph into hermeneutic studies when more interpretive methods are applied. A disciplined and valid study must be substantiated and must meet the rigors of robust peer review. All data must be correctly and ethically obtained, categorized, safeguarded, and scrutinized through educated, science-oriented, fair, and unbiased approaches. In employing phenomenological hermeneutic approaches, researchers interpret the data, always risking the possibility of bias, error, misinterpretation, and misuse of data. My goal was to minimize these possibilities.

I am a stakeholder in the suicide education and prevention realm primarily due to my having experienced the loss of a daughter to suicide, thus the urgency and immediacy in conducting this study were born of a close comradery with the participants, although they were not known to me. I believe it is possible to affect families who have a family member contemplating suicide and perhaps help them take measures to prevent it. Many tools and approaches are already available; connecting families with these tools and facilitating access is a paramount goal (Andriessen et al., 2019). A list of resources for suicide survivors is found in Appendix D.

As a seasoned and experienced registered nurse in mental health and suicide prevention, I felt I was uniquely poised to respectfully and carefully approach individuals who suffered suicide loss in their families to assess their willingness to participate in a study. Additionally, my interviewing skills have been honed over a period of years. Gathering data and then interpreting their value is a learned scientific discipline that has been practiced and mastered through decades of patient contact and interaction (Adams & van Manen, 2019).

Data Collection

Existential data informed by the participants' life experiences were used in this study. For the largest portion of this study, and in alignment with qualitative methods of information gathering, data were collected through personal information obtained from the participants using open-ended questions to encourage a deeper exploration of experienced feelings. Field notes were also used to enrich the depth of information gathered.

The participant's demographic data and data that demonstrated the link between the decedent and the participating interviewee were collected. These data were crucial in making an assessment and in ascertaining a relationship between the participant and the decedent to obtain further experiential information that could shed light on emotions felt by survivors of suicide thus validating the survey. Pseudonyms and other measures were used to guarantee participant privacy.

Interviews

The process of contacting prospective participants began after IRB approval. A letter (see Appendix E) was sent to the prospective participants, along with a consent form (see Appendix B). All participants were asked to review, sign, and return the consent forms prior to their interviews. All complied.

I developed a semistructured interview format with open-ended questions to allow interviewees to freely express subtle and nuanced aspects of their experience and to search more deeply into the phenomenon experienced. Full disclosure about data collecting and methods was provided to the study participants, in accordance with IRB requirements. During the interviews, if any participant displayed signs of increased distress, suicidal ideation, or any other retraumatization, the session would have been halted and arrangements made for referral to help as indicated; no sessions needed to be halted. Crisis line information was also provided as well as a resource list for suicide survivors (see Appendix D for this information).

Directly interviewing survivors of familial suicide afforded the most straightforward method of obtaining richly detailed data informing our dissertation questions. The questions were tailored toward the study's research questions, plus the specific characteristics of the interviewed person. The participants filled out demographic questions as part of the survey. Demographic data helped to establish a relationship to the decedent for purposes of comparison and validity, as noted in Patton (2015), and whether the person was a part of a military family system. All data were locked and accessible only to me.

The questions started with an explanation of the reasons for asking these questions, followed by several questions asking for demographic data. The survey began with a preamble prior to the questions, as shown in the following.

Dear friend and survivor, I thank you for giving of yourself in participating in this important survey which seeks nothing more than to help shed light on the circumstances surrounding suicides and the adjustments made by loving family members of the person who has died. By sharing your deep feelings, others who have experienced similar traumas may find new insight, hope, and a trust in God who is the Father of us all. Please know that your words will be

treated with the utmost respect and dignity, and that your personal information will be carefully kept in confidence, with fictitious names and geographical locations implemented. Please know, too, that if at any time you feel overwhelmed and would like to pause, or end the interview, that will be graciously respected. Information for support groups, online sites, telephone numbers, and emergency services are provided for you. The information is obtained for the greater glory of God, and for the solace and understanding of His ever-searching people on earth.

"Blessed are they that mourn, for they shall be comforted" (Luke 6:23)

Demographics: 1. Your age at the time of the suicide_____. 2. Your age now_____. 3. The age of the person who died by suicide_____. 4. Your gender_____. 5. The gender of the decedent_____. 6. Relationship to you_____. 7. Was your loved one part of a military family_____?

1. Please introduce yourself to me, as if we just met one another (remember, names and identifiers will be changed, and identities strictly confidential).
2. Please walk me through your daily life before the suicide.
3. What was your daily routine after the suicide?
4. How has your daily life changed as a result of the suicide?
5. Is there something else you would like to add?
6. When comparing your stress level, on a scale from 1 to 10, how would you describe your average daily stress level before the suicide? (10 most stress possible, 0 no stress at all).
7. When comparing your stress level, on a scale from 1 to 10, how would you describe your average daily stress level after the suicide?
8. What aspects of daily life have been most affected by the suicide?

9. What vulnerabilities did you note in this person?
10. What strengths did you notice in this person?
11. Was this person able to confide in another?
12. Was this person buffered or supported by parents or adult role models?
13. On a scale of one to ten, one being the lowest, how much support did this person receive from a parent or caregiver? How much did he/she accept?
14. What do you see as potential reasons for the deceased to have taken his/her life?
15. As you have had time to think about the death of your loved one, what do you see as the greatest contributory factor(s) in causing this suicide?
16. As you have had time to think about the death of your loved one, what do you see as the biggest factors which might have prevented this suicide? Do you feel that something could have been done to prevent this suicide?
17. Do you think that this suicide has increased the risk of others for suicide? In what way?
18. Which protective factors do you feel are most important in preventing suicide?
19. To your knowledge, was this loved one spiritual or religious, and to what extent?
20. Are there any other insights you have developed since this suicide that you think may shed light on how to prevent further suicides?
21. If your loved one who died was part of a military family, were there deployments or other military-specific factors (frequent moving, changing schools) which you think may have contributed to the person's suicide?

Questions 1 through 8 dealt with interviewee changes in function following the suicide. The first question further established identity by asking participants to introduce themselves to me. Questions 2 through 4 related to the participant's subjective activities of daily living before

and after the suicide, while Question 5, which asked if there was anything participants wanted to add regarding their daily lives, allowed for creative thinking on the part of the participant, following guidance in Patton (2015). These questions were designed to develop a sense of how a loved one's suicide can alter one's own life.

Questions 6 and 7 asked the participants to use introspection to assess their distress level, using the SUDS model. This afforded both information to me and insights for the participants in gauging their own coping skills before and after the suicide. Question 8 asked participants to reflect on their lives in a qualitative manner, focusing on the depth of change in their daily routine, as suggested by findings in Sisask and Kolves (2018)

Questions 9 through 13 addressed factors that might have increased or decreased the risk of suicide in the decedent. These questions could be slightly altered, but for the sake of later comparisons, remained similar for each participant. The questions were open ended, nonthreatening, and intended to uncover aspects of how the suicide has changed the family.

Questions 9 and 10 asked participants for their perspectives on the decedent's strengths and weaknesses. This information allowed me to glean insights into the decedent's life, with the purpose of later comparisons to add to preventive incentives in the future. Questions 11 through 13 sought information on the perceived depth of support that participants felt the decedents had with significant others.

Question 14 asked what the participants felt were the reasons for the suicide, with a maximum opportunity for participants to verbalize their thoughts. Questions 15 and 16 asked participants to probe their memories and thoughts about what might have caused the suicide and what might have been done to prevent it. There was great latitude here for conjecture in order to

add richness to the study in inviting nuances of experience and interpretation of the traumatic event.

Questions 17 and 18 asked participants for their thoughts on further suicides and prevention and were informed by findings in Andriessen et al. (2019) and O'Neill et al. (2020). Information obtained here was sensitive, and in one case I had to suggest support resources for an interviewee. Although available as resources, no mental health professionals were needed.

Question 19 examined the presence and depth of the decedent's religiosity or spirituality. To many people, religion and spirituality are difficult to tease apart and are viewed as one and the same (Muehlhausen, 2021). Many turn to religion in the aftermath of a suicide.

Question 20 was very wide open to allow participants maximum latitude to share their insights into the circumstances surrounding the suicide and prevention of further suicides, as suggested in Roy et al. (2007). This afforded participants the chance to control the narrative in that they could add any pertinent information about their individual life experiences, which often adds an increased layer of richness, imparting valuable information (Patton, 2015). Thus, this extra insight enriched the phenomenological discourse, which might otherwise have been curtailed with structured questions; the person affected by the trauma got the last word.

Question 21 asked participants for their subjective interpretation of how the military milieu, including deployment, may have affected the deceased, reflecting findings in Messecar (2017) and O'Neal (2018). This question was only asked if the decedent was part of a military family system. This question was important for differentiating between stressors in the military family system as opposed to the civilian family, as identified in Wadsworth (2016) and Ruocco et al. (2021). The respondent may or may not have been a part of a military family system.

Observations

Observation in this study entailed written anecdotal notes on participant demeanor, body language, affect, ability to articulate, comfort, and ability to proceed. Video recording was used and approved by the interviewees. Direct observations were facilitated in virtual and in-person sessions. Observations were descriptive and reflective, adding to participant-subjective data and applied to the interviews themselves.

Data Analysis

I wrote the transcripts and made the recordings during individual interview sessions. Notes were later examined in detail for pertinent information to more thoroughly assess the nuances of meaning as well as to strengthen the validity of the dissertation study. Data obtained such as written or recorded information were organized, archived, and secured for review and interpretation. Email information was reviewed and added as needed. The data obtained revealed nuances that shed light on some of the subtleties that might prove useful in discerning causal markers or factors leading to a higher rate of suicide in military families.

Data were entered into a confidential, password-protected Excel spreadsheet with specific segments for key phrases, variables, commonalities, differences, effects, emotional responses, suicidal ideation, insightful responses, and risk determinants. Responses were then analyzed in a hermeneutical fashion for content and for nuances of experience and later for similarity and uniqueness of individual experience for comparison. All data were secured in a protected file.

I developed two other tools for analysis. One categorized several factors that participants may have perceived regarding the decedent and also what participants may have viewed as their own relationship to the decedent. See Appendix F for this tool. The other contained several data variable factor categories for comparing participant-perceived guilt, disconnection, hopelessness,

anger, drug use, buffering, religious participation, and other factors. These data are shown in the tables available in Chapter Four.

I analyzed the data using a constant comparative mode by synthesizing comments into themes and categories, following guidance in Merriam (2015). I then interpreted the data through a suicide prevention lens to discern variables that may coalesce into suicidal behavior. Each participant was later asked to confirm the data compiled for accuracy and validity by being given a chance to read and approve the script for accuracy. Member checking was also used to ascertain validity and trustworthiness.

Trustworthiness

In qualitative studies, trustworthiness is usually comprised of credibility, dependability, confirmability, and transferability (Elo et al., 2014). Trustworthiness was established based upon the telling of the personal lived experiences of participants as well as a review of pertinent literature and an accurate retelling of the experiences through accurate evaluation methods (Patton, 2015).

Credibility

Credibility refers to the extent to which the study is believable (Houghton et al., 2013). Credibility is predicated on the researcher having a clear understanding of the phenomena being explored. Similarly, triangulation involves the researcher collecting data through interviews, and having the data peer-reviewed, then confirming data points with the participants. Thus, interviewees were allowed to review what I had written about their expressions and input. Verification such as this contributes to the credibility of the study (Houghton et al., 2013).

Dependability and Confirmability

Dependability refers to the stability and the reliability of the data collected. Confirmability is closely linked to the dependability and accuracy of data. In order to reduce potential researcher bias, I made careful notes and recordings. Reviews were conducted to ensure I accurately represented the participants' recollections and input.

Transferability

A study is deemed transferrable when it can be applied to similar studies and experiences and maintain its meaning (Curtin & Fossey, 2007). I documented the data points and research methods and presented the findings in a precise manner which may be found in similar studies.

Ethical Considerations

Far from a forensic study or analysis of a death examining facts, hard evidence, and quantitative evidence, this qualitative experiential study of families in deep pain, having experienced one of the worst possible traumas, was designed to delve deeply but respectfully into the phenomenological experiences of the survivors of suicide. As such, and in light of the extremely sensitive and delicate feelings involved in the study of familial suicidality and its effects on family members, I took careful, respectful, and studious precautions to protect the feelings, sensitivities, privacy, and anonymity of the study participants. Potential risk to study participants might include emotional or psychological distress (McCosker et al., 2001).

The selected participants were informed of the study intent and purpose and given the option of discontinuing participation in the study if necessary. Approval was obtained from the IRB, and each participant signed informed consent forms. Their identities were protected by assigning pseudonyms and by removing all possible identifying information, including geographic locations, from the transcripts and the discussion of results in Chapter Four.

Utilizing SUDS, I maintained awareness and vigilance in watching for signs that the participants remained comfortable during their interviews. If a participant demonstrated signs of impending emotional crisis, I would have prepared to end the session, tend to the participant, and seek higher levels of care as needed. Information and crisis line numbers were provided in case the participants experienced increased emotional distress.

Data were obtained with the participants' written permission and stored safely and securely. All electronic data are password protected. All written documents generated for this study were secured in a private, locked room for the duration of this study. Electronic data were locked in a secure, password-protected file. Only I can access all documents and data. There is only one file for each participant, and no copies were made. All documents and data related to this study will be securely stored for 5 years, after which they will be destroyed.

Summary

Chapter Three detailed how the present study was conceptualized, designed, and conducted. The lived experiences of 10 participants, chosen for their close relationship with a family member who had died by suicide, were explored in this phenomenological study. Using a qualitative approach—specifically, phenomenology—afforded a more in-depth examination of what the survivors actually felt on a visceral level through using open-ended questioning, which afforded maximum flexibility and discerning of nuances of meaning and expression.

Data from military families were compared and contrasted with that of nonmilitary families to extrapolate potential differences that have might shed light on the higher prevalence of suicidality in the military and veteran milieu. Efforts were made to use objective rather than subjective factors on my part. I employed rigorous strategies to maintain the scientific method and prevent the excessive use of opinion, bias, prejudice, and preconceived ideas, following

guidance in Matua and Van der Wal (2015). Analysis included examining differences between suicide in military families versus nonmilitary families for key elements that may shed light on the uneven distribution of suicidality in the population. The data were interpreted objectively to determine the best models of coping in the postvention treatment of families experiencing suicide and to extrapolate some ideas on how to better inform suicide prevention strategies.

Confirmability, trustworthiness, credibility, and dependability are all factors important to the external validity of any study, and were all addressed in the methodology used in this study. The chosen subject matter was sensitive and personal for the participants and could have been very stressful. Respect and patience were paramount considerations for the participants, who graciously agreed to share their very private and very emotional experiences. Great care was taken to safeguard the identities of the participants and the decedents. For the most part, suicide methods were only inferred to avoid retraumatizing participants and readers. There were a few cases where the participant volunteered information regarding methods of suicide for informative and socially responsible reasons, but no effort was made to discuss or analyze the means of the suicides.

Chapter Four: Findings

Overview

The purpose of this study was to obtain a rich, nuanced depth of understanding of the experiences of 10 individuals who lost a close family member to suicide and to compare and contrast experiences, both civilian and military, with the objective of gaining insights into possible causes, approaches to grief resolution, and possible preventive mechanisms. The purpose of this chapter is to report the results of the analyzed study data. Findings are presented in the context of individual expression and experience based on responses to posed questions and additional information given by the 10 participants in the study on suicidality. Ten participants were interviewed, yielding rich descriptions of their individual experiences. Phenomenological occurrences and commonalities were explored both individually and thematically, followed by a summary. Tables and a figure are included to emphasize data points.

Participants

In qualitative studies, the researcher strives to be cognizant of the differences between interpretations and mere observations of revealed phenomena. To some extent, however, data will be interpreted by the researcher in the most objective way possible (Patton, 2015). The findings in this study reflect the phenomenological input from 10 individuals. At the onset of study preparation, 18 people were questioned, but only 15 satisfied the inclusion criteria; that is, were close family members of a person who had died by suicide and were 18 years of age or older. Of the 15 who met the inclusion criteria, five were unable to complete the interviews for a number of reasons. Two feared they might become too emotionally labile and had to withdraw. One did not respond after the initial email. One dropped out, stating that it may become too stressful. Another was going on vacation and would be unable to complete the interview.

Of the 10 individuals finally selected, each was over 18 years of age, was a close family member of one who died by suicide, was able and willing to complete the study, was deemed emotionally stable to undergo an interview, and had the time and desire to participate in the study. Five of the 10 had military affiliations that would prompt a positive response to Question 21 and warrant additional expression, which might add to the data points regarding contrasts in resiliency and buffering between military and civilian populations. Each was then invited to a scheduled interview.

Of the 10, four were interviewed in person at their own homes and six using the Microsoft Teams video platform. In each case, the utmost respect for the participant's safety, dignity, and emotional well-being was a paramount consideration. I maintained an unbiased, open, ethical, and objective approach throughout. Each virtual interview was recorded to include video and audio; each in-person interview was recorded with an audio tape recorder. All recordings were made with the approval of each individual participant and were subsequently reviewed for nuances after the end of the interview. All data remain in a secure location accessible only by me.

A few of the respondents felt comfortable with some of the questions but not all, answering only the questions they were comfortable with. All participants were advised that they could stop the interview at any time and skip the questions they were uncomfortable answering. Their responses formed a rich tapestry of nuances of feeling, expounding on the aspects they were comfortable with.

In one case, I reached out to a participant who had disclosed past suicidal attempts of her own, ensuring that she had resources for support, including emergency contacts, and that she was not having current suicidal thoughts. She did seek counseling and improved by her own report.

All study participants had their own stories regarding the loved one who died from suicide. While I made efforts to distinguish commonalities related to each, I recognized the importance of relaying individual stories for the depth of feeling and the shades of experience, each with its own unique characteristics.

Participant 1: Scott

Scott served in the U.S. Army infantry for several years, training soldiers for combat deployments. Scott loved the Army but lost his sister to suicide shortly after he was honorably discharged. He was 40 years of age at the time of the suicide; his sister was 30. She had enlisted in the Army herself but was discharged early due to her asthma. As she was discharged before finishing basic training, she was not eligible for care at the VA Medical Center. Her failure to remain in the Army was seen by Scott as contributory to her suicide, as her already low self-esteem decreased further at this point. Her biological mother died early from a drug overdose, and she felt abandoned by her stepmother as well. When a relative compared her to her biological mother she became very upset, crying "No, I am *nothing* like her!" She was described as spiritual but not overly religious, though religion was somewhat important for her.

Scott noted that his sister had been on an increasingly self-destructive path for some years, using recreational drugs. This pattern increased after the death of her father, which Scott cited as one of the main reasons for her suicide, as she was very close to her father and dependent upon him for buffering support. She and her father shared many adventures and retained a close bond as long as she was alive. Her father made her wedding an elaborate and memorable event, which was a milestone in the family's history. Scott followed suit after her death in ensuring that his sister had a dignified and respectful wake, visitation, funeral mass, and inurnment.

Scott described his sister as very intelligent, emotionally available to others, loving, and expressive. She was a quick learner, with toughness and athletic ability. He reported that she limited herself by not confiding in others, even when they offered support, which he felt may have contributed to her death. On a scale of 1 to 10 measuring buffering, with 10 being the greatest and 1 being the least, Scott felt that his sister was afforded about a 7 but only accepted about a 4. She often did not respond to the support offered.

Scott felt that his sister's perception of decline in her looks, as she was noted to be physically very attractive, as well as aging, dental problems, and loneliness contributed to her suicide. Other factors Scott noted in his sister were despair, shame, remorse, hopelessness, confusion, and guilt. Scott stated that his sister had several sources of support available but did not adequately use them. He felt that if she had accepted help and corrections, she may be alive today.

Scott felt that his sister's suicide may influence her children, who still have unanswered questions, and that these doubts and fears could reduce their resiliency to further life stressors of varying severity. Scott felt that intervention is needed for her surviving children and has recommended such to the children's custodial father, who lives with them in Iowa. The father has proceeded to seek counseling for the surviving family.

The protective factors that Scott felt were most important were support, finances, work ethic, resiliency, and treatment. Scott felt that more could have been done by all her friends, family, and his sister to prevent her suicide. Regarding prevention of further suicides, Scott said that people should learn how to deal with uncomfortable situations with a "spirit of humility, faith, open-mindedness, and willingness to grow emotionally, psychologically, and spiritually."

As a therapist himself, Scott noted that after his sister's suicide he experienced secondary trauma and countertransference at times when listening to clients who struggled with suicidality or expressed suicidal ideation. His stress level increased from an average of 5 on a scale of 1:10 to 7. His life changed in the aftermath of the suicide, with his engaging in risky behavior and eventually becoming divorced. This hypersexual activity gradually tapered off over the years.

Scott has been able to surmount many obstacles to achieve his goal of becoming a licensed substance abuse and mental health therapy professional. Since the suicide, Scott often has had to amend his own sessions as a self-care measure in order to remain fully functional in his profession. Scott has relied on his Catholic faith to help him through his grief process and has regained most of his previous enjoyment of life, though he still mourns for his beloved sister.

Participant 2: Bill

Bill lost his Marine Corps veteran son, Liam, to suicide when he was 57 years of age and his son was 29. They did not live together, but they maintained a close father–son relationship, meeting often. Liam had been diagnosed with PTSD and had sustained a traumatic brain injury while serving in the Marines. Bill described Liam as struggling with binge drinking and dependence on sleeping pills after leaving the Marine Corps. There were also early circumstances such as premature birth and fetal alcohol syndrome that Bill felt manifested in later life for Liam, compromising his executive functions. Despite these challenges, Liam did well in the Marine Corps. Bill felt that all of these factors were contributory to Liam's death.

While Liam was deployed overseas, his wife got pregnant from another man, which devastated Liam. The wife wanted a divorce and child custody payments for both children, only one of which was his. This led Liam to further detach and use alcohol.

Bill described Liam as compassionate, “wickedly book smart,” and being able to express himself far more easily in writing than in speaking. He never gave up on any challenge and was able to persist in the Marine Corps despite difficulties. Sadly, Liam did not open up to Bill about his drinking after discharge, fearing that his dad would push to help him gain sobriety. He felt that he needed his father’s approval badly, and therefore did not confide in Bill. Liam told Bill that he was his hero, and he looked up to him as a role model.

Liam had buffering support from his church, family, and friends as well as from Bill. Bill felt he afforded support to his son at a level of 8 out of 10, while Liam’s grandfather offered support at a level of 9 out of 10. As people saw him in need and offered support, Liam frequently shut them down by stoically stating, “I am a Marine.”

Bill felt that his son was feeling overwhelmed, without a job and needing to pay child support and other expenses. Spiraling downward, he had lost his driver’s license as well and resisted going into a rehab program. Liam received support from the VA, and had “a lot of love around him,” but may have been deeply depressed. With high levels of alcohol and sleeping pills on board, he took his life one day. Bill felt that the main contributing component was the fetal alcohol syndrome Liam was born with, which, according to Bill’s research, often makes men severely depressed when drinking alcohol.

The suicide left Bill devastated, with a self-reported stress level of 10 out of 10. He remained home for the first 10 days following the suicide, making trips to the gym to exercise as advised by others. He was told that exercise and eating right would help him deal with his loss. The weeks after the trauma were a blur, and he struggled daily. Before the suicide, Bill’s stress level ran at about 5 out of 10. Immediately after the suicide it was about a 10; he noted it at about

a 3 at the time of his interview. Though he still cries nearly every day, there is “healing in the tears now” as the struggle goes on.

Bill is a Christian pastor who shares his ministry with others in many ways, including doing podcasts on the subject of men struggling with loss and finding strength through sharing while trying to build resiliency. Bill feels that the most salient points in prevention may be using counseling, monitoring, and love. His son was a believer in Jesus Christ and was committed to Christianity. On the last day they were together, Bill and Liam spoke of paradise and the afterlife. In retrospect, given the benefit of what Bill calls hindsight, he feels he should have asked his son if he was considering suicide.

Life has changed for Bill’s family, with some members no longer taking part in singalongs, for instance. After 2 years, Bill has largely regained his previous routine, but it is accompanied by an ever-present sorrow he described as “a deep sadness.” From this experience, Bill has developed the ability to empathize with the pain of others and realize how little control he has. His Christian worldview reinforces the futility of self-blaming for him and allows him to let go to some extent, acknowledging that Christ is in control. God has shown him that all he has to do is “get through one day—sometimes one moment or one task.” This strong commitment to God continues to help him cope.

Bill has many regrets, and like so many others who have lost a child to suicide, has a litany of “could-have,” “should-have,” and “would-have” references, but confided that “only God has delivered me from the guilt and anguish.” Bill engages in proactive and inspiring outreaches to other men who have experienced loss, leading them in Christian brotherhood and comradery.

Participant 3: Sue

Sue lost her son to suicide after he had made multiple suicide attempts through the years. She also shared some painful memories of her own attempts at suicide, which she felt enabled her to more fully appreciate the thoughts going through the mind of those who die by suicide. None of her children were ever aware of these attempts, as she felt that she needed to protect her family.

Sue's son often talked about suicidal ideation and intent and had made previous attempts before he finally completed suicide at age 34 years. She was 62 years of age at the time. She was able to intervene in a previous serious attempt with pills, getting him the help he needed. She made frequent interventions and often instituted the Baker Act, an involuntary temporary court-ordered treatment mechanism. Her son was in multiple treatment centers several times. He had three young children with his girlfriend, who kicked him out of the house and cheated on him. By report, his alcohol usage played a big part in this. Sue felt that he "was dying every day" from being worn down by multiple severe stressors.

Sue struggled with a plethora of feelings regarding what she could have or should have done, even though she had helped often and always made herself available, sometimes to the detriment of her own life. Sue misses her son every day and feels guilty about not being able to stop him from suicide, though she was in daily contact with him and had intervened on multiple occasions.

Sue reported that her son spoke constantly of suicide and was forced into treatment multiple times for alcohol abuse and suicidal ideation. He was encouraged to seek counseling, which he did at times with mixed results, none lasting long. A friend of Sue's has told her that

she needs to move on and start to do things to take care of herself or she will remain in limbo forever.

Some of Sue's other family members have had to leave jobs where they were in contact with suicidal individuals. The similarities to the suicide they experienced in their relatives proved too stressful. Sue has been unable to speak of her feelings, even to other family members. Those family members, too, are unable to speak of the trauma. One family member expressed that he felt Sue's son was being selfish by taking his life, which upset Sue since she does not believe that the act of suicide is selfish but rather done out of desperation.

I encouraged Sue to seek counseling and attend groups such as SOS (Survivors of Suicide), Compassionate Friends, and others. I gave her the same list of resources that was provided to all other participants in this study (Appendix D). She acknowledged these resources and accepted encouragement. Sue has made progress in her grief process, recognizing the need for preventing suicide in others and the vulnerabilities of family members and friends.

Participant 4: Aaron

Aaron lost his wife to suicide after a long history of depression, often treated with medication, and at times with electroconvulsive therapy. Despite years of treatment, she finally succumbed to her depression, leaving a suicide note apologizing for her action. She had struggled and attempted suicide in the past but was showing signs of improvement just before the suicide. Aaron observed that, as often happens, people who have made a decision to take their life reach a level of relative peace and tranquility and are able to appear happy and content during the period immediately before completing suicide. Aaron reported that his spouse had very low self-esteem and was depressed and anxious but could often manage in social gatherings.

Aaron spent increasingly more time with his wife over the last 4 years of her life. Her parents, whom she held in high esteem, died, and she had required more close observation and occasional hospitalization. They sought different medications and changed psychiatrists several times. While she functioned fairly well in limited social venues, she required more attention, with Aaron eventually becoming her 24-hr caregiver.

Aaron's wife confided in him, but he feels she did not confide in her doctors for fear that they would invoke the Baker Act, involuntarily sending her to a mental health facility. Despite Aaron providing a very high level of buffering support to his wife, she succumbed to depression, seeing no other way out of the misery it inflicted upon her. Aaron's stress level increased from 8 out of 10 to 10 out of 10 following his spouse's suicide; he now feels that he is back to almost normal emotionally.

Aaron was the first to find his spouse after her awful suicide and remained in a shock-like state for a whole year afterward, holding on to the image. He described being in a "dense fog" and feeling "empty" for several months. He felt guilty for not being able to see what was coming. After the early days, he was able to survive being alone with encouragement and socialization with friends and with therapy.

Aaron's confusion and emptiness were relieved to an extent by meeting another person who had lost her husband as well. Though the circumstances were different, there was a connection that proved comforting and eventually enabled Aaron to find new meaning and to move forward. Notably, he was able to accept that his wife is not coming back.

Noting in retrospect that a person who decides to take their life experiences a period of calmness, even happiness, before acting, Aaron wishes he had had this insight so that he may

have intervened to prevent the suicide. He feels that he would have been more vigilant and less hopeful armed with this knowledge.

Aaron was diagnosed with a chronic degenerative and debilitating disease, which he feels, based on his research, may have been triggered or activated in part by the emotional trauma of his experience, or at least was a contributing factor for him. Starting over has proven a daunting task, but Aaron is determined to regain his physical strength as much as possible given his diagnosis.

Aaron was perplexed that his wife could have passed a screening to buy a weapon given her history of having been in a mental health facility involuntarily for an earlier suicide attempt. He feels that more stringent rules relating to background checks purchasing guns might have prevented her purchase and perhaps her eventual suicide, but has nearly accepted that if she was determined, she would have found another, slower way to complete suicide.

Participant 5: Travis

Travis's stepsister died by suicide when he was just 21 and she was 27 years of age, leaving behind a young child. Travis related his experience:

> Before her death, I felt invincible. After, I felt shock and disbelief, as she had more life than anyone. I felt diminished. This was one of the hardest things ever. I was taking life for granted, but this would be a reality check on my existence. I understood the concept of loss for the first time. I was an abuse victim but had never lost a loved one. I felt deep sorrow, grieving for someone other than myself now. I felt the pain I never felt before. After, I became self-aware and tried to see people for their strengths and better qualities. She did not want to disappoint anyone, she opened up and ignored the possibility that

> those around her could be toxic; she saw only the good in people, which would eventually lead to her downfall.

When asked about what strengths he saw in his stepsister, Travis replied:

> She was like a free spirit, she ignored social norms, she lived on the edge, she loved snakes and reptiles. She wanted people to feel loved. She was headstrong, honest, and unconditionally loving, and she helped those suffering over herself. I saw her strength and wanted to be like her. I looked up to her; she confided in me and helped me when I was depressed. She often said that she felt like a black sheep.

When asked about buffering support offered, Travis replied,

> She felt alone and felt ugly, as first the father of her child, and then another guy whom she took in and tried to help belittled her, but she loved her parents. She would feel alone in a room full of people. She felt completely alone, she would take comments to heart, and lived with a monster who she felt sorry for and allowed to stay in her apartment. The abuse took its toll. She was an empath, and felt what others were feeling; if she had not met these people she might still be here. They took advantage of her.

Travis also related that his stepsister believed in God and in heaven and often went to the Catholic cemetery, where she felt at peace close to her grandparents who were buried there.

I asked Travis if he thought this suicide increased the risk of others for suicide, and in what way. He relayed how he worried for years about her parents, who were in deep grief that persisted for many years and still is visible to him. He also offered these thoughts:

> My best advice is to let those who are important to you know that they are loved; don't wait! They may smile but are hiding fears. They don't want to be a burden. Let them know they matter, even if they look happy, they may be faking it and hiding their

depression. Her father's deployments may not have been bad for her, she viewed him as a gentle giant and spoke highly of him. She had a special bond with her father. In the end, she went from rescuing animals to rescuing men. This would eventually destroy her.

Travis recalled that his stress level increased tremendously after his stepsister's death, and that it would be years until he returned to his base level (from 4 out of 10 before the suicide to 8 out of 10 after, then returning to 4 out of 10 two years later). Travis felt his stepsister was offered support at a level of 10 out of 10, but still had low self-esteem and did not believe she was good enough. For the biggest factors leading to her suicide, Travis cited the relentless abuse from the father of her child and another man, adding, "Depression told her she was alone. I also have felt a lot of the abuse she felt when I was growing up."

Asked about insights that may shed light on preventing further suicides, Travis stated, "Let those who are important to you know how you feel. Always reach out, be available, and offer support." Travis recalled his own childhood experiences with sexual, physical, and emotional abuse, and feels that these traumas have made him more compassionate and able to extend loving support and understanding to others who have experienced abuse.

Participant 6: John

John lost his daughter to suicide when she was 28 years old. They were a military family who had moved multiple times during John's military career, first to California, then to Idaho, Europe, and Nevada. John had three deployments when his four children were young, often taking him out of the family scene. John feels these deployments caused stress in his children, which would prove toxic in the case of his daughter, who had developmental trouble while he was away. He believes factors in the military family system played a role in his daughter's

eventual suicide due to frequent moves, loss of connectedness, confusion, lack of surety, and general turmoil in the family.

John was called to active duty shortly after September 11, 2001, following the attacks on the World Trade Center and the Pentagon. He recalled that

> Disruption of family life kept the children in a state of chaos, especially as they feared for their father's safety in Afghanistan. At the same time, they had to deal with their own development during school years, with the stressors there. They had to do this now with one parent.

John related that on the night before leaving for deployment, he "took the kids to a drive-in movie to see *Apocalypse Now*—what was I thinking?" He felt guilt about increasing their level of fear and distress.

Religion played an important role for John, who encouraged all the children to go to church each Sunday and ensured each was baptized and received Holy Communion and Confirmation through the auspices of the Roman Catholic Church. With the first deployment, John returned to find that no one had gone to church in the entire 6 months he was absent. From that day on, he was never able to get his children back into church. Each had their own television and computer and retreated to their own rooms. The cohesive family unit was altered and unretrievable despite how he struggled to regain lost ground. He feels that the absence has a lot to do with the fragmentation of family life and was perhaps a contributing factor in his daughter's suicide. He felt that his wife did the best she could as the only parent of four children for that period of time.

John's daughter had difficulty in school since being identified as having attention deficit disorder, for which she took medication. John felt that this medication may have instilled in her

the idea that there was something wrong with her and that she could only function with a medication, which may later have led to drug usage.

John's daughter eventually had a child with an abusive man who did not marry her but berated her and physically abused her. She lacked self-esteem and did not report the abuse. She would later share custody with the child, which forced her to drive long distances every 2 weeks per the sharing agreement. She tried different jobs and was unemployed at the time of her suicide. It is suspected that the child's father and another man she felt sorry for and had taken in were accomplices in the suicide. She left a lengthy note that expressed sorrow, regret, concern for her child, and hopes that he would be all right. John has never fully accepted her death and continues to try and see his daughter's child, which is not allowed by the father.

John's stress level was about 4 or 5 out of 10 before the suicide, and reached 10 for weeks after the suicide, eventually returning to about 5 or 6 at the time of his interview. The devastation of his daughter's suicide has never left him, as he talks about "the life after the death," meaning his current life following his daughter's death. John stated, "Now the life is different, we are sadder and more introspective. We wrestle with guilt and what we missed, what we should have and could have done." John further related,

> Every missed opportunity is now a sad sentinel reminding us of what we neglected to do. We have redoubled our efforts with the other kids, maybe to the point of suffocating them. I really think we have to "model joy" for the other kids, as one therapist told us. I have written this phrase and placed it above my desk to remind me of that. It is hard to model something you cannot feel. Still, we make great efforts to celebrate our children and their lives and tribulations and successes.

Like so many parents who have lost a child to suicide, John struggles with regret, guilt, overwhelming sadness, and longing. He attends counseling sessions and support groups, searching for what he called "that elusive solace that comes only from God's grace." He has accepted that losing a child to suicide is a lifelong struggle punctuated by moments of relief and happiness. For John, experiencing PTSD, the future is tinged with fear that "just when everything is going well, even great, something terrible is about to happen." John continues to help others in their struggles after the suicide of a family member.

Participant 7: Nicki

Nicki struggled while her husband was deployed on several occasions in support of the wars in Afghanistan and Iraq. She lost her son, Blake, to suicide when he was 23 years of age, just after her husband returned from another deployment. During this and previous deployments, Nicki felt alone and isolated, taking on the responsibilities of both mother and father, keeping the family together and safe while simultaneously worrying "all day and all night" about whether her husband would make it back alive.

Living in a small Nebraska town away from any military bases, she felt disconnected and isolated. Blake had friends that Nicki did not approve of and thought would lead him into bad behaviors. Nicki could see Blake spiraling out of control after having fathered a child and not being married to or living with the child's mother. There was a shared custody ruling that favored the mother and added to Blake's stressors. He was often unemployed and had on one occasion tried to enlist in the military, but without success due to an old leg injury that left Blake with a deficit in his gait. According to Nicki, this physical disability, which made it difficult to walk without a limp, would negatively affect Blake's self-esteem, making him feel that he was "not as good" as other men.

Nicki tried to provide loving, comforting support to Blake and her other child, but often found herself fighting with Blake over his choices, leading to conflict that made the family situation more dysfunctional. Several attempts at counseling were made over the years, but none were followed up on, as the family continued to fragment.

Nicki stated, “Cherish each of your children every day, for we don’t know how long we have them.” She still struggles with her own suicidal thoughts but has sought professional help. She does flower arrangements and arts and crafts with symbolism regarding heaven and the afterlife. She also looks for signs such as butterflies and rainbows, which make her feel more connected to her son.

Nicki feels that her son was disconnected, overwhelmed, depressed, and eventually hopeless, though these insights became more acute after his death. She regrets not having seen the significance of his sadness, as she concentrated on criticizing his behavior. By her own acknowledgment, she has also assumed a lot of guilt.

Nicki frequently seeks the insights she feels are offered by mediums and clairvoyants, hoping to somehow communicate with her son. Like other parents of children who have died by suicide, Nicki laments and endlessly seeks solace from extrinsic sources, trying multiple means of finding succor. Nicki described her stress level after the suicide as 10 out of 10 but stated that it had decreased to about a 6 at the time of this study.

Participant 8: Melvin

Melvin was in his upper 70s when his daughter took her life at age 41 years. She left behind Melvin’s grandson, Joshua, who had been living with her. Melvin and his wife became custodial caregivers when their daughter died by suicide, but they were unable to care for him due to their age, their own physical limitations, and the boy’s developmental issues. Joshua is a

loving and gentle person, which made their decision to have him stay in a facility even more difficult. Unable to care for him, they decided upon a home for developmentally disabled individuals in a local facility for their ethnic group.

Because of cognitive impairment, Melvin's grandson could not comprehend that his mother was dead and would also need maximum assistance with activities of daily living. Melvin and his wife knew they could not provide this kind of care for Joshua. They made the tough decision, resolving to visit him frequently and to try to help him understand what happened to his mother. Though they felt they had made the right decision, with approval and encouragement from friends and other relatives, they struggle with guilt to this day. Their religious and ethnic tradition (Judaism) emphasizes close and loving support for all family members. They often have nightmares, waking up panting and sweating, and continue to question their decision. Whenever possible, Melvin and his wife visit Joshua at the facility and make special celebrations on their religious holidays, though they perceived that religion was not very important to their deceased daughter.

Melvin reflected on his daughter's years of mental health issues, substance abuse struggles, and numerous suicide gestures and attempts, noting that she became increasingly desperate. Her problems began in grade school and had increased throughout high school and later life. She would frequently stay out all night and engage in risky behavior. She developed an alcohol and drug problem, leading to arrests and jail time. Reluctant to accept help or to go into inpatient rehab, she spiraled down in the later years, causing great stress for Melvin and his wife, who felt that they had to intervene for the sake of their grandchild.

Melvin's daughter rapidly went through funds and became physically and emotionally abusive to Joshua and others at times. In her abusive cycle, she would feel remorse, guilt, and

sorrow after sobering up. Her life had become out of control. She became increasingly unable to cope and was certainly incapable of caring for her special needs son.

Melvin wrestles with guilt over having had thoughts of relief after his daughter's death and the decision to have Joshua admitted to a care facility. He has needed frequent affirmations that his decision was the best one for all concerned and that his daughter is at peace. His eschatological process does not view an afterlife in the same way as most Christians perceive it, leading him to ponder death and perhaps undergo a different bereavement process for himself and his spouse. An exacerbating factor is grandson Joshua's inability to comprehend what is happening.

One of the most salient and disturbing factors for Melvin is his knowledge that his grandson will likely outlive him and his spouse and that Joshua will once again have to grieve without understanding why his loved ones have gone away. Melvin feels that there will be no one to really love Joshua the way they have. Overcome with guilt, they do as much as they can to raise awareness of the effects of suicide on family members and continue to attend support groups such as Survivors of Suicide.

Melvin and his wife struggle with doubts, question their actions, and cross-examine all their interactions with their daughter in a seemingly endless gauntlet of would-have and could-have cognitions—a familiar theme for parents of those who have died by suicide. Melvin still seeks the important validation and comfort that he derives from support groups and his Jewish spiritual constructs.

Participant 9: James

James was 41 years of age when he lost his only son, Jake, who was 22 years of age. James found Jake, and struggles with the memories of finding his beloved son dead by his own

hand in a horrific scenario. Though years have passed, James and his wife continue to struggle with feelings such as wishing they had seen the signs coming, wishing they had spent more time with Jake, and feeling they could have altered his path and prevented the suicide.

Unlike many others who have died by suicide, Jake seemed very happy and did not have any particular or noticeable problems. James feels there were no signs, which increases his angst, as he thinks there must have been some indicators but that he and wife never picked up on them. They live riddled with guilt feelings as father and mother of their only male child. They recite the would-have, could-have, should-have mantra that permeates their waking hours. The fact that they had only one son torments James as he ruminates about lost opportunities of spending time with Jake.

James and his wife seek to comfort and protect each other. James shelters his wife from the awful details of the death, and his wife tries to keep James from succumbing to his own demons. They are both Orthodox Christians and obtain some comfort from their closeness to God. Like many who lose a child, they have questioned God, displayed anger at Him, and eventually sought His comfort. For several years, they blamed God for the tragedy and sought counseling and support groups, which were of some use to them.

A further stressor for James is that he adopted Jake, his wife's child, when Jake was 2 years old. He struggles with fears that he may not have applied the same constant loving support to him that he applied to his daughters. He stated that he often feels like a failure, having lost a child. He feels that "A father's primary role is to protect his family; I have failed miserably. Whatever I did or failed to do has resulted in my child's death." James has struggled to overcome these thoughts and attends support groups that help, but he cannot listen to "others relate the gory

details of a suicide" as it retraumatizes him. On several occasions, he had to leave the room when a group member would describe something that he found triggering.

James's lack of forewarning about problems with Jake has led to an ongoing quest for understanding. Though James and his wife had a "close and open relationship" with Jake, and he expressed no signs of depression, nor did he share that there were problems, the couple feels that they obviously missed something crucial. As parents, they cling to their devastation, blaming themselves for not having "seen it coming."

Life has changed drastically for James and his wife since his son's suicide, with stress levels in the range of 7 out of 10 at times, and never being able to fully relax. James recalls wearing dark colors and thinking dark thoughts for many years after Jake's suicide, still unable to fully process the horrors. James has recently stopped going to support groups and tries to bury his feelings in his work.

Participant 10: Marina

Marina was returning from a vacation out west a few years ago. Upon landing at her local airport, she felt lucky that the flight was fairly smooth, as they had experienced significant turbulence on other recent flights. As they landed and pulled up to the tarmac, the lights went on, with the seat belt sign turned off, as people began to get out of their seats and reach for overhead and underfoot baggage. Suddenly, a flight attendant announced that all passengers should take their seats, as there were two individuals who needed to be escorted off the plane. As most people resumed sitting, an attendant came up to Marina and her husband and asked if they would kindly follow to deplane first. Jokingly, Marina's husband said, "Oops, it must be those traffic tickets I didn't pay."

The light-hearted feeling would soon dissipate as it appeared increasingly serious, and the attendants would not answer Marina and her husband's questions of "What happened, what's going on?" Marina and her husband followed the escort into the terminal as they pondered what it could be. The first thought was that perhaps her elderly father passed away, which would not have been totally unexpected.

The truth was far worse as they noted one of their sons was waiting, alone, on the other side of the partition. He gave them the news that their other son had taken his life while they were away. Marina remembers little other than collapsing and screaming while she was scooped up in a wheelchair and escorted out of the terminal. Her husband had to drive as there was no other way. It was a surreal, nightmarish scenario, one that would stay with them for many years to come. This would mark the beginning of a struggle still going on for the surviving family.

Marina's son left behind a child who spent most of his time with her. After the suicide, the child's mother got full custody and refuses to allow Marina and her husband to see their grandchild, causing further distress. Marina and her husband are Catholic. She attends weekly Mass and prays. Her husband does not, feeling that he can deal with spirituality on his own.

Like many others, Marina never expected the suicide to occur. She feels that if she had any inkling, she could have done something to prevent it. She and her husband continuously try to piece it all together but still live with sadness and regret. Unlike the other participants, Marina did not see her son as disconnected, hopeless, depressed, or lonely, but admits that he must have been overwhelmed, though he did not show it and she did not see it.

Results: Phenomenological Descriptors

Data collected were analyzed using a constant comparative mode by synthesizing comments into categories, as described by Merriam (2015), and then interpreting through a

suicide prevention lens to discern findings that shed light on some of the variables that might coalesce into suicidal behavior. The participants answered open-ended questions about their own reactions and feelings as well as their observations of the decedent. I used member checking by having the participants review the transcripts to ascertain validity and trustworthiness prior to analysis.

Perhaps it is human nature—and it was surely my goal—to seek commonalities in a population with similar experiences. The phenomenological qualitative process, however, calls for a more thorough and in-depth investigation of the individual's personal experiences and unique responses to a traumatic event. In interviewing members of this population, some common themes emerged that were worthwhile discussing and related to the research questions. A major purpose of this study was to compare and contrast experiences in military-affiliated families with civilian families.

Theme 1: Familial Factors Affecting the Grief Process

A common theme often found among families who have experienced a suicide is a feeling of regret manifested by rumination and prolonged pursuit of looking for reasons and opportunities to overturn the suicide; that is, undo it by proving the impossibility thereof. Some endlessly research prevention methods. In some circles, this is referred to as denial.

Each study participant revealed factors that affect how they view the death and mourn the loss of a loved one who dies by suicide, each mourning for an unpredicted period of time. John stated,

> To this day, I can't write the word suicide without misspelling it, even 6 years after the event! Maybe by leaving a letter out, it is not completed; I don't know, I don't do it on purpose. I don't get it, it's crazy, but it keeps happening.

This statement illustrates a Kubler-Ross assertion that denial can reemerge years later as the cycle continues in a nonlinear manner (Yanke, 2019). Acceptance may be obtained intellectually but perhaps not as fully accepted emotionally and spiritually. A healthy, cathartic variant of this theme may be a person delving into school, sports, art, or poetry in an effort, consciously or otherwise, to address the longing and search for a surcease of sorrow that may contribute to a healing process.

Recurring dreams are common for many survivors, which can be both a blessing and a sad reminder. John has had multiple dreams of his daughter, Mary, as many as 10 dreams in the 7 years since her death. While most were concentrated in the first couple of years, he continues to experience them, the latest being during this study. John described the experience as such:

> I thought sure I was awake, coming out of the bedroom and seeing a figure standing by the table in the dinette with another woman. She was tall and slender, wearing a neck brace, and I thought, hopefully, "Is that Mary? Can it be her?" Oh God, yes, it was her, she was with us this day right after the party yesterday, in the same place, for her cousin's birthday.
>
> I went over to her in adoration, we were smiling at each other. I held her hand; it was so tiny and cold. I wouldn't let go. Time was frozen in a reality just as sure as the awake reality. We spent time together, just we two, smiling and peaceful. I kept saying "No, I won't let go. Don't go!" She was smiling; we were hugging. It was as real as real could be.
>
> I then started to become increasingly desperate until she suddenly disappeared, while I was pleading with her not to go. I was waking, screaming "I won't let go." As I

awoke, the dog heard my cries and tried to come to me. The cat, who is afraid of the dog, attacked the dog. My wife awoke, startled, and yelled out; back to reality.

For those moments, which could have been seconds but could have been hours, I was with Mary again. Is this something God provides for us, a piece of succor, a little solace, another sweet chance to see our loved one? Grief has a terrible lifelong grip on us.

Mixed emotions and conflicting feelings complicate the grief process for suicide survivors (Harrington-LaMorie et al., 2018). Some grief processes can last for years, some for a lifetime, with multiple mediating factors involved such as closeness to the loved one, parental relationship, guilt feelings, regrets, and a myriad of human feelings and emotions.

The present study's findings indicated that all participants acknowledged offering support to their loved ones who died by suicide but also noted that the support was only partially accepted. Eight participants felt the decedent was disconnected, but only five had asked for help. Six participants felt that drugs were involved, and five saw alcohol as a factor. See Figure 1 for more detail on these factors, broken down by military versus civilian participants. Mean religiosity level was 2.8 on a scale of 1 to 5, with 1 being the lowest and 5 being the highest (see Table 1). No strong causal or buffering relationship between religion and suicide was noted in this study.

Figure 1

*Frequencies of Reports of Perceived Mediating Factors, Military (*n = *5) Versus Civilian (*n = *5)*

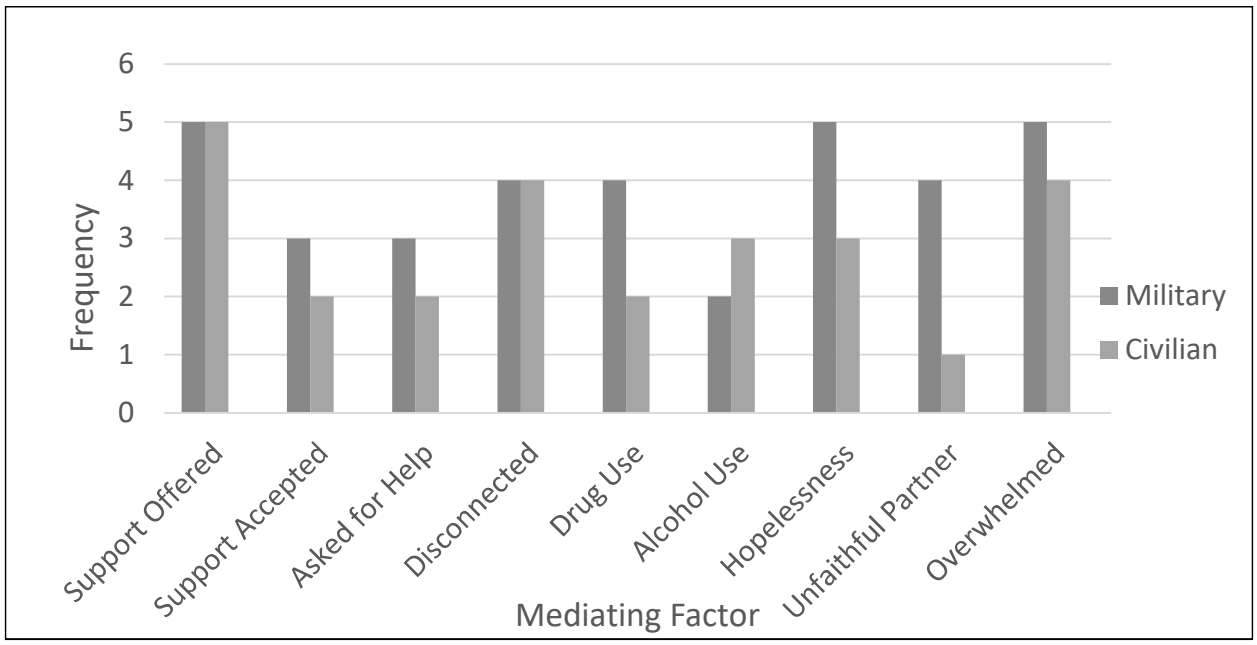

Table 1

Participants' Perceptions of Decedents' Religiosity/Spirituality Level

Participant	Scale score
Scott	2
James	3
Marina	5
Nicki	2
John	4
Travis	3
Aaron	2
Sue	2
Bill	4
Melvin	1

Note. Scores on a scale of 1 to 5: 1 = least religious/spiritual, 5 = most religious/spiritual

Both the military-affiliated and civilian participants felt that all their loved ones who died had received buffering support at an equal rate, but the military-affiliated group felt that this support was only used in 60% of the cases while the civilian group endorsed 40% of the time. Drug use was confirmed in 80% of the military-affiliated group but only 40% in the civilian group, and alcohol use was 40% among military and 60% among civilians. Unfaithfulness was acknowledged in 80% of the military-affiliated group but only 20% of the civilian group. All the military-affiliated participants saw hopelessness and overwhelmed feelings in their loved ones who died (100%), contrasted with 60% (hopelessness) and 80% (overwhelmed) among the civilian group. Both the military-affiliated participants and the civilian participants noted that 80% of their loved ones felt disconnected. 60% of the military and 40% of the civilians noted that their loved ones asked for help.

Theme 2: Military Peculiarities as Suicide Risks

The five military-affiliated participants shared vast commonalities with the five civilian survivors. There were, however, some distinct differences. Discontinuity and disconnection often characteristic of the military family system manifest in many issues more common to these families than to the population at large.

Four military-affiliated survivors spoke of the added strain on their loved ones, who had fragmented social contacts due to frequent moves. Particularly at risk were children or adolescents who did not have strong social connections and then experienced the parent deploying. Deployment for prolonged periods is another hallmark of the military family system. The deployed member may be in a distant location overseas while their spouse or partner remains at home.

In the case of John, his family cohesiveness diminished while he was deployed and unavailable, leaving him floundering and his family distanced. Reintegration was difficult, as he stated:

> No matter how I tried, I was no longer the dad that my kids needed, but just in a supporting role; nice to have around but expendable. I lost my role and never really regained it, though I would try forever to.

This loss of connectedness led to infidelity on John's part, which he cited as a possible contributory factor in his child's suicide.

Unfaithfulness is not uncommon in the military: four of the five military-connected participants in this study reported it. It creates further stressors for the family system. Bill's son who died by suicide, for example, had a spouse who was unfaithful during a military deployment overseas. This proved devastating to his already fragile self-esteem, which Bill saw as a factor contributing to his son's eventual suicide.

Theme 3: Possible Contributory Factors

Aaron recalled the "dark, sad, confused, frightening time" immediately following the suicide. He felt that if only he had foreseen what might be coming, he could have intervened and prevented the suicide. He ruminated on thoughts that he missed clues that might have been important.

Many people who experience the suicide of a loved one blame God, saying things such as "If God is all-powerful, why can He allow this?" or "What kind of God can ignore this kind of suffering in our loved ones?" Blaming God acknowledges that the person believes there is a God, so that perhaps a meaningful dialogue may begin between the bereaved and God as the person

envisions Him. Melvin laconically noted, “Earth is all I know, yet I am told we will reunite in heaven. How can I know this for certain?”

Possible preventive strategies offered by participants included closer relationships, being connected, looking for signs of suicidal intent even when the person seems fine, asking about suicidal thoughts, helping family members financially, offering real help including counseling and treatment, and being a sponsor or advocate who is willing to be there for the person at risk.

As shown in Table 1, most of the participants affirmed that their loved ones had a spiritual or religious base, which may have been a source of comfort. However, no clear evidence was forthcoming on the role of religion in the decision to complete the suicide. The importance of religion or spirituality found in this study ranges from a small amount to a great deal. For many of the participants who survived the suicide of a loved one, however, religion played a part in their healing.

Table 2 shows the frequencies of participants endorsing various perceptions of the decedents’ demeanor. Only one participant expressed the idea that the suicide was selfish (10%), while 50% felt the person was angry, 70% felt that the person felt guilty, 50% felt that the person was lonely, and 60% felt that their loved one seemed disconnected. Of those surveyed, 90% felt that the person was overwhelmed and confused, and 80% thought they were feeling hopeless before the suicide. Depression was seen as a factor in eight of the suicides, with recklessness in four and loneliness or anger in five.

Table 2

Participants' Perceptions of Decedents' Demeanor

Demeanor	No. of participants endorsing
Guilty	7
Angry	5
Confused	9
Lonely	5
Selfish	1
Depressed	8
Overwhelmed	9
Disconnected	6
Hopeless	8
Reckless	4

Theme 4: Relationship and Guilt

Survivors of familial suicide often struggle with feelings of blame, shame, guilt, and a sense of having failed or fallen short of preventing the suicide. The present study's participants demonstrated a wide array of feelings, reactions, and even fixations on the nature of the death and their own perceived role in its occurrence. Parents, particularly, take on an unending litany of guilt feelings for not having seen the action coming or not having been able to somehow prevent it. Many report an increase in stress in their lives following the suicide that takes years to dissipate. Most move forward, albeit often slowly. Many are affected to the point of their own lives being changed in negative ways for prolonged periods of time. Some never recover.

In the present study, seven participants had feelings of guilt, while eight felt they could have done more or should have done something differently. Five participants felt that they were unavailable, while three felt they were partially to blame. Of those who were a parent of the

decedent, the rate of feeling that they were somehow to blame was higher (90%). All participants felt that they failed to recognize or prevent the suicide.

Scott, for example, underwent a change in behavior that led to some consequences that he did not foresee. His actions resulted in serious relationship problems and an end to his marriage. Other participants experienced similar changes, perhaps in reaction to the suicide loss. Several parents endorsed having been negligent in providing a strong religious model for their child and feeling remorse. One participant felt guilty for not having foreseen what his spouse planned. He felt that recognizing a planned suicide could have resulted in his intervention and perhaps prevention of the suicide. Absent any warning signs, he still felt somehow remiss. Grief can be all-consuming.

Parents often seek absolution or exculpation to ensure themselves that their own actions or inactions were not contributory to their child's death. Some participant parents imagine, whether real or not, that they were unavailable or not fully available and that if they were, their son or daughter would not have died by suicide. Nicki still mourns for her son, who died by suicide 9 years ago, and despite bouts of counseling and sessions with suicide support groups through the years, still wrestles with residual guilt feelings. She has good days intermingled with bad days, where she ruminates over could-have, would-have, and should-have cognitions, leading to decreased self-esteem and depression. She has had suicidal ideation on a number of occasions and has even attempted suicide.

James and his wife endlessly ruminate over possible missed opportunities despite the fact that there were no external clues provided by the decedent that he was in peril. They feel the same burdensome weight of guilt that others who were aware of difficulties experienced, not

letting themselves off the hook. For some, the feeling remains that parents should protect their children at all costs and at all times. Some parents take on the yoke of guilt for a lifetime.

Theme 5: Intrinsic Factors Versus Extrinsic Factors in Resiliency

Much has been discussed about intrinsic resiliency factors in individuals that may afford them the ability to better cope with traumatic stressors. Multifaceted resiliency factors include the ability to withstand stressors and develop defenses. Many stressors are considered a normal part of growth and development that occur in all people in their lifetimes. Certainly, some people are subjected to more severe and even toxic stressors than others.

The most meaningful factors in resiliency are the severity of the stressor or trauma and the degree of loving, buffering support on a continuous basis. For instance, a child who experiences mild separation from the parent, some sickness, problems in school, and other stressors that may be considered a normal part of growing up may find it easy to develop coping skills. The process will be easier in the presence of a loving and supportive family. The same child experiencing the same stressors may have a harder time when their family is distant, non-supportive, inconsistent, or even abusive.

Three participants endorsed their loved ones having been bullied. Five identified their loved ones having had ACEs. Bill felt that being bullied in school was a major factor in his son's suicide. Three participants acknowledged that the ACE could have been contributory to the eventual suicide. Four participants stated that their loved ones had made previous suicide attempts. Six participants felt their loved one asked for help, and all acknowledged giving buffering support, but only seven participants noted acceptance of support on the decedent's part.

Table 3

Participants' Perceived Mediating Factors for Decedents

Mediating factor	No. of participants endorsing
Adverse childhood experiences (ACEs)	5
Confused	9
Previous attempts	4
Support present	10
Support accepted	7
Asked for help	6
Was angry	5
Disconnected	6

Freytes et al. (2017) examined post-deployment integration and rebonding as resiliency factors in the military family. Findings in the present study underscore the importance of continuing to advance the current knowledge base about the long-term impact of deployment on veterans and their families, especially factors that contribute to positive post-deployment family functioning. Additional empirical studies are needed to provide a more in-depth understanding of the long-term post-deployment reintegration experiences of veterans and their families (Wadsworth et al., 2016).

Theme 6: Influential Suicide

At-risk adolescent populations are particularly sensitive to peers, social media, and television and cinema influences. Influential suicide implies that external factors act upon internal belief systems in such a way as to lower the protective threshold that prevents a person from self-destructing (Ivey-Stephenson et al., 2020). An already vulnerable person may be exposed to a last-straw stressor that overwhelms and overrides the erstwhile protective mechanisms, allowing the more spontaneous part of the brain to acquiesce to suicide.

Much literature addresses the subject of suicide from a myriad of approaches and through multiple lenses but falls short of exposing core reasons for suicide among youth and adolescents. In the current study, Scott felt that his sister's suicide, leaving behind four children, could result in further suicide attempts as these children have a number of unanswered questions, and that "these doubts and fears could reduce their resiliency to further life stressors of varying severity."

Regarding whom might be at risk for suicide, Hom et al. (2018) posited that military personnel who have been exposed to a suicide are at greater risk for suicide themselves. Accordingly, greater closeness to the decedent implies greater risk. The present study's findings complement other empirical evidence that suicide rates are higher in military populations, supporting further investigation efforts.

Bullying and intimidation affect adolescents and adults through social media and at school. Ferráns and Selman (2014) explored how school attitudes and rules create school cultures of tolerance and certain climates, which affect students' perception of what is allowed. Some children are more likely to be bullied when there is a loose control of the school environment. As shown in Table 3, five study participants mentioned that their loved ones who died by suicide had experienced ACEs.

Summary of Findings

Discussion

Bereavement in suicide is often compounded by multiple influencing issues, with prolonged grief often found in families. The added trauma of the specific means of death can result in family members reeling in painful sadness and depression for many years, long beyond what might be expected to be the length of time predicted or anticipated for the normal grieving process. Harrington-LaMorie et al. (2018) discussed the added elements of shame, stigma, guilt,

and the perception of preventability often surrounding a suicide. These factors entered into the lexicon and the real feelings of the families interviewed for the present study, as they struggle with the "what if," the "would have" and the "could have" that entrap them in a seemingly endless cycle of self-blame and regret.

A common thread among survivors of familial suicide is the feeling of deep regret, longing, and a sense of having missed out on opportunities to improve relationships. Looking at the variables delineated in the present study, many survivors can recognize missed opportunities to have made changes to alter the outcome. Pondering and ruminating may last years and lead to adverse health issues. Feelings of guilt and inadequacy on the survivor's part were particularly noted among those who lost children to suicide. Nicki said that mourning the loss of a child by suicide is a lifelong process and that the surviving father or mother must manage the myriad of emerging feelings such as guilt, feelings of inadequacy regarding closeness and nurturing, and having missed opportunities to help their child. Languishing over details of the death is a hallmark of the grieving process that the parent endures and can last far longer than models predicted by experts. Some participant parents in the present study imagine, whether real or not, that they were unavailable or not fully available and that if they were, their son or daughter would not have died by suicide.

Of the participants, 30% felt that they were partially to blame for the suicide, while 80% said they could have done more or should have helped more to prevent it. Some 50% of the respondents felt that they were partially unavailable to their loved one, and 70% endorsed feelings of guilt on their own part. All participants felt that they had failed to recognize a pending suicide but, encouragingly, 70% felt that they would be able to recognize a potential suicide in the future and take action to prevent it.

Implications for Families

Families who experience the suicide of one of their members are never prepared for the life-altering effects that emerge. The full gamut of denial, anger, bargaining, depression, and acceptance first outlined by Kubler-Ross (Yanke, 2019) are experienced, plus many more undefined and not easily understood emotions. The emotions are not felt in any predictable linear mode, but rather as spontaneously occurring feelings that may overwhelm at any given time and may proceed in any random order. The family survivors of suicide are pulled into a surreal existence marked by constant attempts to piece together the events in an often-futile attempt to comprehend the incomprehensible.

The period immediately following the suicide is marked by disbelief, punctuated by thoughts aimed at undoing or negotiating the events after the fact, in a vain attempt to prevent the death after it has occurred. These attempts are more a wishful appeal to God or to the person who died to tell the survivors that it really was a bad dream from which they will wake up relieved; this wish is never granted, as it is and remains unrealistic. While feeling these thoughts and experiencing these emotions, the survivors are not living in a delusional state, but rather forcing prayerful, wishful, willful thinking to try and undo that which cannot be undone. This pattern may continue for months, years, or a lifetime at different levels of intensity (Peterson et al., 2020). During this time, postvention is most essential and can be life-saving.

For military families, closer communications such as using video interface when possible may contribute to togetherness. Interventions such as the TAPS program for military people (Ruocco et al., 2021), and similar postsuicide civilian interventions by skilled therapists and counselors are crucial, as is connectedness; 60% felt that their loved one was disconnected.

Summary

To summarize, 10 people participated in this study sharing intimate details of loss of a loved one to suicide, each from different ethnic and religious backgrounds and experiences. They were mothers, fathers, brothers, and sisters. Each related poignant and personal details, expressing deeply felt passions regarding the lives of their loved ones who died by suicide, revealing carefully and systematically thought-out ideas about the strengths and weaknesses of their lost family member, having ruminated for years on what could have been done differently, what was missed, what factors played into the suicide, and how they could or should have intervened to possibly prevent the tragedy.

There were varying degrees of religiosity and spiritualism perceived in the decedents by the participants, with varying amounts of importance perceived in the decedent's life. Outcomes indicated little difference. Participants most often turned to God after the event.

Table 4

Participants' Perceptions of Their Own Roles (n=10)

Self-assessment	No. of participants endorsing
Feel guilt	7
Should have helped more	8
Failed to recognize	10
Partially caused	3
Was unavailable	5
Could have done more	8
May be able to prevent more suicides	7

Chapter Five: Conclusion

Overview

This study focused on military-related and civilian families who have survived the suicide of a family member and who have developed insights and coping and resiliency skills along the journey. This chapter consists of an overview, a summary of the findings, a discussion of the findings and implications in relation to the relevant literature, implications for the study, an outline of delimitations and limitations, and recommendations for further research.

Summary of Findings

Findings for Research Question 1

Research Question 1 was, What insights can be gained from suicide family survivors that can contribute to the understanding of familial factors? I found multiple factors in the literature I reviewed for this study that help to answer the first question to differing extents. In addition, several deductive themes emerged from the interviews with the 10 study participants. Each participant interview revealed some points that may increase knowledge of the phenomena of suicide as it affects close family survivors.

Insights offered by survivors of familial suicide are often poignant and painful recollections and ruminations about what was done wrong or what was missed. Too often, grieving family members never fully resolve their sorrow. In extreme cases, affected mourners may obsess over the loss to the exclusion of applying feelings to other people as they ponder and languish over the death. They may thus become unavailable to others, isolated in their own sphere of sorrow.

The themes that emerged in the study that are germane to this question are Theme 1, familial factors affecting the grief process; Theme 3, possible prevention and postvention

strategies; Theme 4, relationships and guilt; Theme 5 extrinsic and intrinsic factors in resiliency, and Theme 6, influential suicide. A child or adolescent may be endowed with inner strengths and may be better able to navigate a stressful environment. Extrinsic factors such as support, love, buffering, and continuity are important for all, but particularly for those who are subjected to severe stressors such as the death of a loved one; divorce of parents; physical, sexual, and emotional abuse; or witnessing parental drug use or neglect. The fortunate child or adolescent has inner strength and outer support. Others have poor intrinsic strengths and poor extrinsic supportive factors. The majority fall somewhere in between. Loving, buffering support works well when accompanied by consistency and sincerity.

Findings for Research Question 2

Research Question 2 was, What markers may be present in the military family system that may be absent in the civilian family, as the suicide rate is significantly higher in the military family system? Findings related to this question were found in all themes, particularly in Theme 2, military peculiarities as suicide risks. The five members of military-affiliated families in the present study responded in several characteristic ways. The military family system is intrinsically devoid of some of the factors most cherished in raising families, including the stability and feelings of security that come with settling into a specific venue.

Relationship formation is compromised when children or adolescents cannot fully connect, as they are painfully aware that social constructs are temporary. Building friendships is challenged by the disruption that is characteristic of the military family system. The family can expect to be reassigned to another base or post every 3 years, far from the friends they have just made. The added stressors extant in the military family system subject vulnerable family members to additional and more severe stressors than found among their civilian counterparts.

Uprooting every 3 or 4 years is standard for military families and is especially hard on school-age children. This absence of stability versus remaining in one school for many years has been cited as a major problem in the military family milieu. Several of the military-related families in the present study experienced separation from family members that may have contributed to their lack of feeling connected and eventually spiraling into a sense of hopelessness.

Clements-Nolle et al. (2021) studied the mediating role of ACEs as they relate to suicidality among military-dependent children. The trauma of the parent's deployment itself, plus other stressors, combine to increase the risk of mental health issues, including depression, anxiety, and suicidal ideation and behavior, contributing to the higher instance of suicide in the military family system population. Military deployments often lead to trauma, both in the war zone and on the home front. Suicidal behavior is one of the most extreme traumatic events that may occur in the family system at home either when a parent is deployed or after.

Deployments are stressful for all family members—the military member as well as the spouse and children—despite careful preparations for the event. Marginalized and powerless, the children of the military member often feel vulnerable and may experience a higher level of depression, anxiety, and thoughts of suicide. Of note, military children often have a heightened sense of what the parents are feeling about the separation and often act accordingly. In the absence of the deployed parent, children and adolescents often experience a range of traumatic stressors. Two of the present study's participants experienced the suicide of a dependent child after a military deployment.

Findings for Research Question 3

Research Question 3 was, What can be learned from the suicide family survivors that can inform efforts in possible prevention and postvention strategies? Several insights into preventive strategies emerged from the interviews. The relevant themes are Theme 3, possible prevention and postvention factors, and Theme 5, extrinsic and intrinsic factors in resilience. One tactic mentioned in several interviews calls for an increase in resilience through a closer relationship with God, whether in church or in less formal settings. Another was reinforcing the need for one-on-one meaningful and sustained relationships between a person with suicidal ideation and a father or mother figure.

Asking the person if they are considering suicide will not, as some believe, trigger the person to do so but rather open up an avenue of dialogue that may be useful in prevention. The person who admits to suicidal ideation can receive timely help.

Findings for Research Question 4

Research Question 4 was, What can be learned about relationships with the decedents that will inform the understanding of survivor guilt, feelings of having failed, and the duration of the grief process? All the themes identified in this study are pertinent in answering this question, but particularly Theme 1, familial factors, and Theme 4, relationships and guilt. The grieving process has been shown not to follow any predicted linear route. In the present study, several respondents whose adult children died by suicide demonstrated indicators of a prolonged grieving process, sometimes more than a decade, marked by feelings of guilt or having fallen short of providing more meaningful closeness or connectedness, while participants who were not parents normally reported a significantly shorter grief period. Thus, the specific relationship to

the decedent played a measurable role in both the severity and longevity of the grief process overall.

Other participants reported a feeling of having not been there for a brother or sister, precipitating a feeling of guilt and remorse for not having done more. Nearly all participants had at least a cursory feeling, some lasting longer than others, that something they did, or failed to do, impacted the loved one's death. Almost all participants self-examined their own actions vis-à-vis their effect upon the loved one who died by suicide and their sensed or observed potential roles as causative factors.

Discussion

Broadly, the present study's results are consistent with multiple studies in the current empirical literature. The results confirm and corroborate other qualitative and quantitative evidence-based studies. Suicidality has been studied with a myriad of foci and approaches, many of them qualitative. Consistent themes revealed in this study reflect and validate previous recurring themes in the literature: Many people who lose family members to suicide experience a profound sadness about the loss but often a sense of partial responsibility for the loss. The degree of closeness to the decedent is a factor in determining the level and depth of guilt; that is, the closer the relationship, the stronger the sense that what the participant did or failed to do influenced the decision of their loved one to die by suicide.

That the parents of a person who died by suicide are often the most affected by feelings of remorse and self-rapprochement can be extrapolated from this study's findings and from the literature reviewed for this study. Those closest to the person, especially parents of the loved one who died, consistently endorsed feelings of guilt and responsibility for at least some aspects of

the death. The participants who were interviewed in person may have been able to reach a deeper level of expression that may have been slightly decreased by virtual video contact.

Feelings of guilt to varying degrees were revealed by many participants and are consistent with other evidence-based studies on survivors of familial suicide. One of the main goals of postvention therapy is to assuage feelings of guilt, responsibility, and neglect on the survivor's part. One participant disclosed that his therapist assured him that if there was no gun, then the decedent would have found another means to complete the suicide, and that the person would have died quickly by using a weapon. For some, this type of knowledge can mitigate their feelings of having somehow been partly responsible for the death.

This study's findings extend the conversations in earlier research and previous studies. ACEs, including toxic stressors in the context of a lack of parental buffering, can strongly influence suicidality in children and adolescents (USDHHS, 2020). Prolonged exposure to stressors, the severity of the stressors, and the presence or absence of essential nurturing and buffering support are crucial determinants of resiliency development. Stressors are an expected part of development, but more severe stressors require a greater degree of resiliency, buffering, and support (Shahram et al., 2021). Continued research in this area requires a focus on how to promote resilience at the community and systems levels.

ACEs are stressful or traumatic childhood events that include neglect, physical or sexual abuse, and general dysfunction including witnessing domestic violence or parental substance abuse. Research by Clements-Nolle et al. (2021) showed that adolescents in military families have higher rates of suicidal behaviors compared to their nonmilitary peers. This higher rate of suicide is typically attributed to military-specific stressors, but exposure to ACEs may also play a role. Studies have shown that adolescents in military families have higher rates of suicidal

behaviors compared to their nonmilitary peers. Suicidal behaviors among students in military families are typically attributed to military-specific stressors such as the deployment of a parent (Chandra et al., 2011).

Implications

Theoretical Implications

> Blessed are they that mourn, for they shall be comforted.
>
> —Luke 6:23, KJV

Christian perspectives informed this study of suicidality and the grief process for many. Spirituality and religion play a prominent role in the healing process for families who sustain a suicide loss, especially if they had a spiritual connection in the past. Blaming God is a common reaction for many survivors, well documented in the literature and in this study. Anger at God is usually followed by seeking comfort from Him. Blaming God indicates belief therein and often opens a pathway for healing when the survivor is open to it. Acknowledging God, even as they blame Him, can be a springboard for families to start the healing process. For military members, Christian-focused therapy is available for combat-related loss (Adsit, 2015).

Through feedback from participants, 60% felt that their loved ones were disconnected. The VA (2021) posited that lack of connectedness is a potential risk factor for suicide. Baumeister (1990) theorized that many people take their lives to avoid severe distress, turmoil, and pain. Findings in the present study indicated that the participants perceived that their loved ones felt hopeless (80%), guilty (60%), confused (90%), or overwhelmed (90%). The current study also underscores theories of Keefner and Stenvig (2020) that there are multiple causes, reasons, and factors involved in suicide rather than a small number of causative factors.

Learning about risk factors, even after the suicide, can inform survivors in building strategies for surviving, and perhaps preventing further suicides. Similarly, Judaism, Islam, Buddhism, Hinduism, and other faiths offer support to people experiencing the suicide of a close family member or friend. Eschatological viewpoints and expressions vary but focus on the survivors, as turning to God for comfort after a loss appears to hold universal application (Tan, 2011).

Postvention refers to the interventions after a suicide has occurred and focuses on fostering and promoting healing in the family system. Jordan (2017) posited further that postvention is prevention; that is, treating survivors of familial suicide can contribute to decreasing further suicides in affected families and friends of a decedent. Many of the present study's participants used art, music, and drama therapy on their road to recovery, reinforcing therapeutic, diagnostic, and preventative studies conducted in Korea and Italy. Kim and Woo (2014) studied the use of art for both diagnostic and therapeutic purposes, while in Italy, Testoni et al. (2018) found that dramatic reenactment with students participating helped adolescents bring out their feelings about mortality and suicide, and enabled them to discuss their feelings.

Empirical Implications

There is a statistically higher rate of suicide among military members and families than in the general population (Clements-Nolle et al., 2021; Hajal et al., 2020). The present study's findings suggest that added stressors found in the military family system such as frequent moving, long deployments, propensity for unfaithfulness, and familial disconnection contribute to the almost double rate of suicide when compared to civilian populations (Wadsworth et al., 2016). Findings in the current study corroborate evidence-based literature by O'Neal et al. (2018) and Peterson et al. (2020).

The current study complements some empirical literature findings that social media can play a role in influencing suicides. Television, movies, and literature can likewise strongly influence a vulnerable or immature mind and reinforce negative cognitions. Several of the present study's participants related that their loved ones had decreased self-esteem, often associated with others leveling criticism at them. Adolescents who are already doubting their self-image, their purpose, and their meaning in life are particularly susceptible to strong extrinsic influences. A simple post on social media can be met with a myriad of negative, hurtful, and mean-spirited replies, often anonymous, from others, which may unduly affect the individual who posted. Military families are at increased risk as they may spend long hours on social media in the absence of parental supervision (Harrington-LaMorie, 2018).

Practical Implications

Various therapies are available for ameliorating guilt and improving the quality of life for close family members of people who have died by suicide. Cognitive-behavioral therapy focuses on replacing negative thoughts and beliefs by challenging the person to form new healthier cognitions. Prolonged exposure therapy exposes the participant to a restating of the trauma in a safe and supervised environment, recording their own recollection of the trauma for later repeated playback. Through a guided desensitization process, the participant may gradually be able to relax and better cope with their trauma (Steenkamp et al., 2019).

Delimitations and Limitations

The current study was a purposeful examination of only a handful of participants (10), which limits its scope and validity. This study was not meant to be a comprehensive examination of suicidality but rather an additive phenomenological study of emotions, feelings, and strategies of survival found in family members who are enduring the suicide of a loved one, one of the

most horrific traumas that can befall a person. In combination with multiple sources of evidence-based findings, I sought to enrich and add to the depth of understanding of the phenomenological experiences of those closest to a person who died by suicide.

I deliberately excluded individuals under age 18 years and those who have not experienced the death of a close family member to suicide. I felt that persons under 18 years of age may have more difficulty expressing their feelings about a suicide loss and may actually be retraumatized by the experience. It is assumed that age maturity adds a dimension of understanding and the ability to better cope. I acknowledged that the actual age of 18 is an artificial construct, but a convenient one most often used legally to define an adult person. Interviewing adults was appropriate for this study's purposes. I also focused on the experiences of those who lost a family member to suicide, not friends or acquaintances.

This study encompassed a sample of the phenomenological experiences of 10 people who lost a family member to suicide. A small sample narrows the research validity, but close examination affords a depth of investigation that can reveal nuances of phenomenological experience. I hope that this depth of study revealed something new to add to the literature on suicidality.

Other potential limitations included the reliance on information gathered from participants who may be emotionally compromised and a sample that did not represent a wide array of ethnicities. Most participants were located in the southeastern United States, but their stories often encompassed a wider geographic selection, including influences from countries in Southwest and Central Asia, Europe, and elsewhere. Interviews conducted virtually may have lacked some of the full experience of nuance in those conducted face-to-face.

Recommendations for Future Research

The study of suicidality has amassed a broad amount of research, discussion, and findings on suicide's impact on survivors. Still, the close examination of the grieving process and postvention in families, especially military-connected families, can be expanded both in breadth and depth to further enlighten and inform the nuances of experiences, all with the end goal of ameliorating this grief and assisting survivors toward healthy adjustment and bereavement behaviors. Insights enabling awareness and modes of prevention are also sought.

The military family is particularly vulnerable to suicide, with an occurrence twice that of the U.S. population in general. In North America, however, the incidence of suicide is much higher among Native Americans, Alaskan Natives, and Indigenous and First Nation peoples of Canada (Government of Canada, 2021; WHO, 2019). While studies of suicide among military people are fairly extensive, more research is called for among Indigenous populations. One approach would be gathering longitudinal data on Native American and First Nation populations that could help to broaden mental health care access, decrease substance abuse, and decrease the high suicide rate. Intrinsic, extrinsic, and cultural factors must be examined in depth to understand influences and establish strategies for prevention.

Additional factors warranting closer examination in suicidality are severe or chronic pain, age-related decline, chronic degenerative disease diagnoses, death of other significant people, isolation, and loneliness. LGBTQ+ populations have a higher rate of suicide when compared to other groups (Hatzenbuehler, 2011; Woodruff et al., 2018) and should be further studied (Ohlman et al., 2014; WHO, 2019). Research on COVID-19's social isolation effects on suicidal ideation and behaviors would be timely and valuable.

Interviews regarding depressive symptoms and potential suicidality in promoting efficacious strategies in suicide prevention and postvention should be encouraged to further confirm the validity of scores accumulated through the various screening measures. Of the short screening measures, the Depressive Symptom Index Suicidality Subscale, the Suicidal Behaviors Questionnaire-Revised, and the Suicidal Ideation Attributes Scale seem the most promising for individual family studies. Further research is needed to assess the performance of these measures and their implications for trauma-informed military family system-focused strategies. Interviews afford the chance to stratify as well as quantify the severity of the stressors in a forward-looking, postventional manner, estimating and calibrating the chances of suicidal ideation and behavior, providing counselors the golden opportunity to plan accordingly to serve military family dynamics. Validity can be expanded with a larger number of studies.

Summary

If there were one word that most succinctly summed up the feelings among the family survivors who participated in the present study on how to prevent suicide, it was connectedness. Suicide is so unforgiving, so final, so irreversible, and so horrific that loved ones undergo a radical change in their lives. Those who survive the suicide of a loved one might feel that, in retrospect, they should have acted differently in a plethora of ways, subjecting themselves all too often to an endless litany of regrets, of mea culpas. Those who developed, nurtured, and sustained a relationship characterized by consistent trust and a feeling of belonging may have been the most likely to develop the resiliency needed to be more refractory to suicidal behaviors.

Some of the commonalities felt by both civilian and military-related family members surveyed included the perception that the person who died by suicide experienced guilt and loneliness. Many were perceived to have felt a sense of hopelessness, were overwhelmed,

disconnected, and often depressed. Feelings of pain, guilt, regret, and longing are also firmly embedded in those who have lost a loved one to suicide, perhaps most agonizingly so in parents who have lost a child.

Prolonged grief can be debilitating and progressively destructive in many ways, including changes in sleeping and eating habits, engaging in risky behaviors, self-neglect or neglect of others, inability to concentrate, physical illness, and even suicidal behavior. For some, the trauma leads to a prolonged process akin to PTSD and may last until treatment is sought.

The good news is that there are multiple alternatives to employ for healing. Current therapeutic interventions focus increasingly on replacing negative, self-blaming thoughts with more positive cognitions. Thus, many options and combinations of therapies are available to tailor to the individual needs. Many who have experienced the suicide of a loved one are availing themselves of these options, overcoming the erstwhile negative stigmas attached to mental health interventions; much of this progress is perhaps attributable to outreaches in the mental health sector and evidence-based research.

Families and individuals who face the aftermath of suicide in a loved one are often at risk for prolonged, even lifelong, grieving processes, with accompanying life interruption and dysfunction. Indeed, the TAPS approach previously discussed remains one of the foremost intervention tools in guiding and assisting military families dealing with the often-prolonged grief process that is part and parcel of many deaths by suicide. These great efforts notwithstanding, the extant support for military reserve families falls short of that offered to active duty families. Reservists and their families are separated geographically and therefore socially and emotionally from the base or post with which they are connected. This disconnection can and does have a profound impact on the support available and the quality,

quantity, and length of the healing services provided. Studies suggest that prolonged and complicated grief is more prevalent among reservist families. Reintegration of the deployed military member can be a daunting task (Messecar, 2017), but help is available through military bases, the VA, and private counselors.

Self-care strategies are an important aspect of postvention and the bereavement processes going forward as well. Informal support, including groups, is crucial in the healing process for survivors of suicide and can be found online through various search engines. Typing key phrases into a search engine such as *help for suicide survivors* or *suicide support groups* can lead to a plethora of information and resources for local or online assistance. Apps are available for mental health self-assessment and therapy. Self-care is also an important consideration among researchers, therapists, counselors, and providers, who often place themselves in vicarious positions and can be traumatized or experience countertransference. Spiritual and vicarious trauma can adversely affect clinicians and researchers (Muehlhausen, 2021).

Shakespeare's Hamlet profoundly pondered "To be, or not to be—that is the question! Whether 'tis nobler in the mind to suffer the slings and arrows of outrageous fortune, or to take arms against a sea of troubles, and by opposing, end them . . . " (Shakespeare, 2016/1599, 3.1.63–67). As Hamlet contemplates suicide, he examines the spiritual and eschatological aspects and decides not to proceed fearing "in that sleep of death what dreams may come when we have shuffled off this mortal coil must give us pause . . ." (Shakespeare, 2016/1599, 3.1.73–75).

Many loved ones leave notes written while they were contemplating or completing suicide. Many are in questionable frames of mind and often impaired by substances, prescribed or otherwise. Profundity is not lacking in many of these notes, describing in poignant, often

grueling detail some of the reasons that led to their decision. Those who read these notes are forever changed. The life before is no more. Most often these notes are not full of hate, anger, bitterness, or blame but instead reflect hopelessness, remorse, sorrow, longing, and sharing of forgiveness. The person who reads these notes should ideally have support from another buffering individual due to the often serious and potentially psychologically harmful content that may be present.

Close and supportive relationships are crucial factors in mitigating the effects of potentially toxic stressors. Connectedness, support, purposefulness, and constancy appear to be the essential cornerstones that are most useful in keeping people meaningfully engaged, contributing to resiliency, and perhaps buffering against suicide. People who remain engaged with significant friends, family, or coworkers are more likely to use coping mechanisms that may stop them from contemplating suicide.

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Appendix A: Institutional Review Board Approval

LIBERTY UNIVERSITY

INSTITUTIONAL REVIEW BOARD

June 23, 2022

Ken Dempsey
Mollie Boyd

Re: IRB Exemption - IRB-FY21-22-1045 Resiliency and Buffering Contrasts Between Military and Civilian Families as Factors in Suicidality

Dear Ken Dempsey, Mollie Boyd,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2. (iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by 546.1 1 1 (a)(7).

Your stamped consent form(s) and final versions of your study documents can be found under the attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Appendix B: Informed Consent

Title of the Project: Resiliency and Buffering Contrasts between Military and Civilian Families as Factors in Suicidality
Principal Investigator: Kenneth Earl Dempsey, RN, MED, Doctoral Candidate at Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate you must be 18 years of age or older and have lost a close family member to suicide. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of this study is to try and identify factors which may contribute to suicide, with the hope of furthering prevention as well as caring for the survivors of suicide. This study hopes to recognize indicators that a person is contemplating suicide in order to further knowledge of prevention.

What will happen if you take part in this study?

If you agree to this study, I will ask you to do the following:

1. Participate in a video-recorded interview, either in person or via Zoom. The interview should take about an hour. Remember you are welcome to stop at any time. You also have the option to respond to the questions via email if that is what you would prefer.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from participating in this study; however, participants may gain some insight from this study.

Benefits to society include increased knowledge from this important study on suicide, which is one of the leading causes of death.

What risks might you experience from being in this study?

The risks involved in this study are expected to be minimal, possibly making you upset about recalling sad and unpleasant memories, but these risks are equal to those you would encounter in everyday life. The study may be terminated at any time by the participant or the researcher. If you were to reveal suicidal intention in yourself, the researcher will help, and is required to report this to the Suicide Crisis Line for assistance.

How will personal information be protected?

The records of this study will be kept private. Information published will not include any information that will make it possible to identify you or your loved one. Any shared data will not include identifiers. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential through the use of pseudonyms.
- Interviews will be conducted in secure areas where others cannot easily overhear or video the conversation.
- Data will be kept in a secure, password protected file accessible only to the researcher. Hard copy data will be stored in a locked drawer. After three years, all records will be deleted or erased, and any hard copy data will be shredded.
- The data obtained will only be used to further the cause of suicide prevention and postvention, and never used for profit.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address or phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in the study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Kenneth E. Dempsey. You may ask any questions you have now. If you have any questions later, **you are encouraged** to contact him at 561-707-7936 or email [redacted] You may also contact the researcher's faculty sponsor, Dr. Mollie Boyd, at [redacted]

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to video-record me as part of my participation in this study.

_____

Printed Subject Name

_____ Signature

& Date

Appendix C: Subjective Units of Distress Scale (SUDS)

(The following chart describes each level of distress on the 10-point scale)

0 – The absence of any distress. Feeling calm and totally relaxed.

1 – Neutral feeling or just OK, not as relaxed as could be.

2 – A mild irritation. The first awareness of tension or vague stress.

3 – Increased discomfort, unpleasant, but in control.

4 – Noticeable discomfort or distress, perhaps agitation, but tolerable.

5 – Discomfort is very uncomfortable, but I can stand it.

6 – Discomfort worsens and affects my life.

7 – Discomfort is severe and emotional pain interferes with life.

8 – Discomfort increases and it is in my thoughts constantly.

9 – Discomfort is nearly intolerable.

10 -Discomfort is extreme and the worst imaginable. I feel panicky and overwhelmed.

From Wolpe, J. (1969). *The practice of behavioral therapy*. Pergamon Press.

Appendix D: Resources for Those Affected by Suicide

1-800-273-TALK (8255) (Veterans, press 1) www.suicidepreventionlifeline.org

American Foundation for Suicide Prevention. www.afsp.org

Crisis Hotline: National Suicide Prevention Lifeline Network 24/7

Crisis Line: 988

Crisis Text Line: Text TALK to 741-741 to text with a trained crisis counselor

Dougy Center – The National Center for Grieving Children and Families

How to Talk to a Child about a Suicide Attempt in Your Family (Rocky Mountain MIRECC)

Jason Foundation

Man Therapy

Mental Health America

My3 App

National Action Alliance for Suicide Prevention

National Organization for People of Color Against Suicide

National Suicide Prevention Lifeline

National Teen Dating Abuse Helpline 1-866-331-9474

Now Matters Now

RAINN National Sexual Assault Hotline 1-800-656-HOPE (4673)

SAMHSA Treatment Referral Hotline (Substance Abuse) 1-800-662-HELP (4357)

TAPS.org/suicidepostvention

The Trevor Project - LGBTQ+ 1-866-488-7386

Veterans Crisis Line: Send a text to 838255

Appendix E: Letter to Participants

Dear Support Group Member,

As a student in the School of Behavioral Sciences at Liberty University, Lynchburg, Virginia, I am conducting research to better understand the experiences of those who have had a loved one die by suicide. The purpose of my research is to gain insight into factors that may be present in family relationships in military or civilian families that can help us understand suicide, and I am writing to invite eligible participants to join my study.

Participants must be 18 years of age or older and have lost a close family member to suicide. Participants, if willing, will be asked to complete a video-recorded interview about their experience. Participants will also have the option to respond to the questions via email if that is what they would prefer. This should take approximately one hour. Names and other identifying information will be requested as part of the study, but the information will remain confidential.

To participate, please email me at k[redacted] to confirm your eligibility. If you meet my study criteria, we can then arrange a time to meet at your home, or meet by video platform such as Zoom, or conduct the interview by email.

A consent document will be emailed to you if you are eligible to participate. The consent document contains additional information about my research and will require your signature. If you choose to participate, you will need to sign the consent document and return it to me prior to the interview. You may download and sign, then upload to me at [redacted], or mail it to me at the following address:

Kenneth Dempsey

[redacted]

[redacted]

Sincerely and appreciatively,

Kenneth Earl Dempsey

Kenneth Earl Dempsey

RN, EdD

[redacted]

[redacted]

I would like to add that I deeply appreciate the trauma that you must be going through over your loss and respect this immensely. Though I cannot say I know how you feel, I can say that I too am experiencing the prolonged grieving process which characterizes suicide loss in a loved one, as I have lost my daughter to suicide. My background is as a Registered Nurse, most recently in Mental Health and Behavioral Sciences. My family and I continue to support each other through the years in coping with our loss in a healthy manner as much as is possible.

I have reached out to several people who have this loss in common in the hopes of gathering information that can help all of us. All the information will be strictly confidential, and names, addresses, or identifying circumstances will not be shared or used. My sincere hope is that families will share their thoughts, feelings, difficulties, hope, and insights to the betterment of us all. I hope you can find a way to anonymously share your experiences, sorrows, and encouragement with other survivors through participating in this work. I have attached a list of resources that may be helpful.

I close by offering my prayers for your family and your loved one, in the knowledge that our great God will somehow provide the solace we are so deeply in need of. God bless you.

Appendix F: Survivor's Perceptions Regarding Decedent and Self

Survivor perception about decedent	1 Scott	2 Bill	3 Sue	4 Aaron	5 Travis	6 John	7 Nicki	8 Melvin	9 James	10 Marina
Decedent felt guilt	Y	Y			Y	Y	Y	Y		
Hopeless	Y	Y	Y	Y	Y	Y	Y	Y		
Disconnected	Y		Y	Y	Y	Y	Y			
Overwhelmed	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Depressed	Y	Y	Y	Y	Y	Y	Y	Y		
Was selfish								Y		
Previous attempts	Y		Y	Y				Y		
Unfaithful partner		Y	Y		Y	Y	Y			
Lonely	Y		Y		Y	Y	Y			
Confused	Y	Y	Y		Y	Y	Y	Y	Y	Y
Anger issues			Y		Y	Y	Y			Y
Drug use	Y	Y	Y		Y	Y		Y		
Alcohol use	Y	Y	Y					Y		Y
Adverse childhood experience	Y		Y		Y	Y	Y			
Buffers or support	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Used supports		Y				Y	Y		Y	Y
Asked for help			Y	Y	Y	Y	Y			
Religion significant (1 slight, 5 a lot)	2	4	2	2	3	3	2	1	3	5
Survivor feelings about self										
Guilt	Y	Y		Y		Y	Y	Y	Y	
Should have helped	Y	Y	Y	Y	Y	Y	Y		Y	
Failed to recognize	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Caused partially	Y					Y	Y			
Was unavailable	Y					Y	Y	Y	Y	
Could have done more	Y	Y	Y	Y		Y	Y		Y	Y
Able to prevent more suicides	Y	Y			Y	Y	Y	Y	Y	
Gender of decedent	F	M	M	F	F	F	F	F	M	M
Age of decedent	30	29	37	73	28	27	28	41	23	31