2013

Examining the benefits and detriments of being a member of an active postvention team for survivors of suicide

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EXAMINING THE BENEFITS AND DETRIMENTS OF BEING A MEMBER OF AN ACTIVE POSTVENTION TEAM FOR SURVIVORS OF SUICIDE

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The School of Human Resource Education
And Workforce Development

by

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May 2013

ACKNOWLEDGEMENTS

I would like to thank a number of people for their love and support throughout my graduate school experience, especially while conducting and writing my dissertation research. First and foremost, I would like to thank my mother for her endless support. Thank you for never giving up on me, constantly believing in me, and always encouraging me to accomplish my goals. You have always been a great role model and I wouldn't be where I am today without your love and guidance. To my other family members, Dad, Denise, Willy Wade, Jeffrey, Brandon, Ashley, Ava, and Jordan; thank you for all of your continuous support during this time.

To my greatest friend, Melissa, thank you for being the one I could call to have fun and procrastinate with when I was overwhelmed with my work. Although you and Melanie never thought I actually did work, I wrote this entire document. To my student colleagues who also went through this process, Shannon, Regina, and Missy, it was great having you to commiserate with on a daily basis. I'm so glad that we were able to take this journey together.

Kevin, there aren't enough wonderful words to describe how much your daily love and support meant to me. Not only am I grateful for the continuous support and love, but the day-to-day acts of kindness like washing the dishes and taking care of the pups meant the world to me. I am also appreciative of your patience when I spent late nights in class or weekends at coffee shops. Most of all, I am thankful for the fun times we were able to have when I wasn't working on my dissertation research. Although many people may not think to thank their furry friends, my two dogs, Addy and Ellie who always brought a smile to my face when I came home after a long day at school.

Finally, I wish to acknowledge the members of my graduate faculty committee. I owe special thanks to Dr. Burnett for his continuous effort to support suicidology research in the

Department of Human Resource Education. You have showed continuous interest in my research from the first meeting I had with you about the doctoral program and it is much appreciated. Dr. Verma, I admire your knowledge about leadership development and appreciate the support I received from you through my general exam and the support you have provided throughout my dissertation research. I am grateful to have a Dean's Representative, Dr. Gouvier, who offered a unique perspective on my research and allowed me the chance to look at it in a different way. The greatest thanks are offered to Dr. Machtmes for the immense support and encouragement that you provided throughout this entire process. Your guidance was instrumental in my success. I also want to thank Dr. Margo Abadie, my mentor, professor, colleague, and friend. I have learned so many things from you that have contributed to the person and social worker that I am today. Thank you for being a wonderful mentor and being a constant source of encouragement and support.

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ABSTRACT

The purpose of this phenomenological qualitative research study was to examine in great detail the experiences of members of an active postvention team for survivors of suicide. This team is referred to as the Local Outreach to Suicide Survivors (LOSS) team in Baton Rouge, Louisiana. This study also assesses potential benefits and detriments of being an active member of this team.

In this phenomenological research study, seven participants meeting the following criteria were interviewed: 1) Participant is a survivor of suicide 2) Participant's loss by suicide was at least one year prior to the beginning of this study 3) Participant is/was a member of the Baton Rouge, Louisiana Local Outreach to Suicide Survivors (LOSS) team within two years from the beginning date of the research study 4) Participant is/was an active member of the Baton Rouge, LOSS team for at least one year. The modified version of van Kaam's methods for organization, analysis, and synthesis of data presented in Moustakas (1994) was used.

The participants in this research study clearly indicated that the active postvention services of the LOSS team were an essential part of their grieving and healing process and enabled them to continue to live their lives. These individuals truly believe that without the survivors of suicide support group and the LOSS team, they would not be where they are today. These individuals strongly believe in the importance of providing newly bereaved survivors of suicide with an instillation of hope. This is one of the many reasons why they continue their volunteer efforts. Although few detriments to being a member of the LOSS team were introduced, there are safeguards in place for each of them to ensure the mental stability of the LOSS team members.

CHAPTER ONE
INTRODUCTION

Rationale

According to the Center for Disease Control (2011), one person that lives in the United States of America dies by suicide every 15 minutes. As the 11th leading cause of death in the United States (Center for Disease Control [CDC], 2010), suicide is a very serious issue. The American Association of Suicidology ([AAS], 2012e) estimates that for every death by suicide, there are at least 6 "survivors" left behind. Therefore, every 15 minutes, there are at least 90 people who are affected by the death of a loved one's suicide. The CDC (2011) estimated that nearly 2.9 million individuals in the United States between the ages of 18 and 29 had thoughts of suicide at some point in the year 2007. This statistic clearly shows that suicide is a serious issue in the United States.

Often times, those left behind are forgotten. It is important to have suicide postvention services available for individuals who have recently lost a loved one to suicide. These individuals are called survivors of suicide (AAS, 2012). This term can be confusing to individuals who have not experienced this type of loss. The National Alliance of Mental Health explains why this term is used in the following quote,

> because mourning a death by suicide is a much more intense and confusing process than mourning a death from natural causes. Words are completely inadequate to describe the raw, painful emotions of confusion, guilt, possible anger and depression, but accepting them as part of the grieving process is essential (National Alliance on Mental Illness ([NAMI], 2012, para. 1).

Individuals who lose a loved one to suicide are often left to work through this complicated and unique type of grief on their own.

Vessier-Batchen and Douglas (2006) explain complicated grief as a more complex and enduring and type of grief that is associated with lasting mental health problems. Mental health problems such as depression, anxiety, and post-traumatic stress disorder are common amongst survivors of suicide, especially those who do not seek help (Vessier-Batchen & Douglas, 2006). Help for survivors of suicide can be found in the form of individual therapy, group therapy, outreach efforts, and other non-traditional forms.

Shneidman (1972) introduced "postvention as prevention for the next generation" when he was asked to write the preface in Al Cain's book titled *Survivors of Suicide*. After the concept of active postvention was well received at the 1997 annual conference of the American Association of Suicidology, Campbell developed an active postvention model where a team of survivors of suicide would respond to a death by suicide (Campbell, 2001). This team of paraprofessional survivors of suicide respond as close to the time of death as possible to help the newly bereaved (Campbell, 2001). While serving as Executive Director of the Baton Rouge Crisis Intervention Center, Campbell developed the Local Outreach to Suicide Survivors (LOSS) team, which employs the active postvention model. An active postvention model is defined by Campbell (2001) as "a concept where responders who are prepared to assist the newly bereaved go to the scene of a suicide and begin to work with the survivors as close to the time of death as possible" (p. 6).

The first LOSS team was comprised of a group of mental health clinicians and paraprofessionals. Each of the paraprofessionals had a loved one die by suicide. The team members received an extensive amount of training prior to beginning their active postvention volunteer work. They were trained in crisis intervention, critical incidence stress debriefing,

crime scene etiquette, and facilitating survivor grief recovery amongst other things (Campbell, 2001). Eight of the 12 members of the team were survivors of suicide and four were mental health clinicians. The eight survivors of suicide traveled to a crisis center in Atlanta, Georgia for additional training in active listening and strategies for working with newly bereaved survivors of suicide (Campbell, 2001). Campbell (2001) administered the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI-II), and the Hayes-Jackson Bereavement Inventory (HJBI) every 60 days to monitor the mental health of the team.

In his early research, Campbell compared two groups of survivors of suicide. The first group consisted of 50 survivors of suicide who received an active postvention model, in the form of the LOSS team, and the comparison group consisting of 76 survivors of suicide who received a passive postvention model in which the survivors of suicide learned of the services, sought them out, and requested assistance in dealing with the aftermath of a suicide (Campbell, 2001). These individuals all sought treatment at the Baton Rouge Crisis Intervention Center during the 1999 and 2000 calendar years. Campbell (2001) measured the amount of time that elapsed between the death of their loved one by suicide and the time that the individual sought treatment for their loss at this particular crisis intervention center. Campbell (2001) used the LOSS team to execute his active postvention model.

In his research, Campbell (2001) concluded that survivors of suicide in the control group who experienced a passive postvention model, took an average of 4.5 years to request mental health services to address the aftermath of their loved one's suicide. The experimental group which was exposed to an active postvention model in the form of the LOSS team visiting their homes took an average of 39 days before seeking out mental health services for their loss of a loved one to suicide (Campbell, 2001).

Since this study, Cerel and Campbell (2008) used the archival data that was collected at the Baton Rogue Crisis Intervention Center from 1999 through 2005 for survivors of suicide who presented for treatment. The comparison between survivors of suicide who received an active postvention model and those who received a passive postvention model solidified Campbell's research in 2001. Those who received a passive postvention model presented for treatment within an average of 97 days while those who received an active postvention model presented for treatment within an average of 39 days of the suicide (Cerel & Campbell, 2008).

LOSS teams such as the one in Baton Rouge, Louisiana, are great examples of active postvention services that are available to survivors of suicide. Survivors of suicide are two to ten times more likely to take their own life compared to the general population (Kim et al., 2005; Mitchell, Kim, Prigerson, & Mortimer, 2005; Runeson & Åsberg, 2003). Postvention services are essential for individuals who are working through the complicated grief process associated with suicide. In fact, the need for these types of services has been recognized worldwide (Anglicare, 2012; Cerel & Campbell, 2008; Culver, 2012; Nebraska LOSS Team Local Outreach to Suicide Survivors, 2012; Suicide Prevention Task Force of Union County, Ohio, 2011).

Programs modeled after the LOSS team and Campbell's active postvention model have developed throughout the United States of America and other countries such as Australia and Singapore (Cerel & Campbell, 2008). In West Australia, an organization named Anglicare developed an active postvention outreach service, called ARBOR (Anglicare, 2012). This outreach was developed to assist those individuals who have lost a loved one to suicide as close to the time of death as possible. There are currently LOSS teams in the United States in states such as Texas, Nebraska, and Ohio (Culver, 2012; Nebraska LOSS Team Local Outreach to

Suicide Survivors, 2012; Suicide Prevention Task Force of Union County, Ohio, 2011).

Purpose Statement

The primary purpose of this phenomenological study is to examine the experiences of those members of the LOSS team in Baton Rouge, Louisiana. The secondary purpose of this study is to assess the potential benefits and detriments of being an active member of this team. This study is of great importance to the population of survivors of suicide because the benefits and detriments of being on a team such as the LOSS team have yet to be researched and the concept of an active postvention model is still quite new to the field of suicidology.

Research Questions

The following research questions guided this study:

1. Why did the members of the LOSS team choose to become part of this group?

2. What are the experiences of the members of the Local Outreach to Suicide Survivors team?

3. What are the benefits and detriments of being a member of the Local Outreach to Suicide Survivors team?

Significance of Study

With the large number of survivors of suicide that are left behind when an individual dies by suicide, services for this population are in high demand. The literature confirms that survivors of suicide experience a unique and complicated type of grief and need postvention services (Campbell, 2001; NAMI, 2012). After Campbell (2001) created the active postvention model, the LOSS team was created in Baton Rouge, Louisiana to execute this model. The

original Baton Rouge LOSS team currently functions through a partnership with the Baton Rouge Crisis Intervention Center and the East Baton Rouge Parish Coroner's office. Active postvention services such as the LOSS teams are popping up worldwide and each one operates differently. Best practice guidelines need to be established for this type of work, but it is difficult to do this without fully understanding the experiences of the volunteers.

Extensive research was conducted prior to the inception of the original LOSS team. Campbell (2001) collected data from clients at the Baton Rouge Crisis Intervention Center who presented for treatment due to the death of a loved one by suicide. This data was collected in 1999 and continued until 2005. However, there is limited research examining the experiences of an individual who is a member of a group that implements an active postvention model. Since the inception of the LOSS team in 1998, the active postvention model has been used globally to create similar postvention services to survivors of suicide. Nonetheless, there has yet to be research that has spoken to the survivors of suicide who are participating in this volunteer opportunity. While studies have shown the effects of an active postvention model in regard to getting the survivors of suicide to seek help for their loss, no one has gathered personal experiences from the survivors of suicide to get their perspective on the work that they do first hand and how it has affected their lives.

There is a great need for qualitative research in this field to establish the benefits and detriments of being a LOSS team member and to give insight to the experiences that these individuals have. Without knowing this information, improvements cannot be made to the existing model and there is the possibility that these experiences could be detrimental to the mental health of those individuals serving on the LOSS team. A phenomenological study of this nature will provide qualitative research to examine in great detail the experiences of those

members of the LOSS team in Baton Rouge, Louisiana.

Definition of Terms

This section includes definitions of terms that will be used in this study. These terms are defined according to their relevance to this particular study.

Active Postvention Model (APM): A concept where responders who are prepared to assist the newly bereaved go to the scene of a suicide and begin to work with the survivors as close to the time of death as possible (Campbell, 2001)

Completed Suicide: Any suicide attempt that results in death. (American Association of Suicidology, 2009)

Complicated Grief: A debilitating syndrome that is comprised of symptoms that interfere with adaptation and reengagement in life after bereavement, and that result in persistence of acute grief. (Simon, 2012)

Passive Postvention: A concept where survivors of suicide learn of the services and seek them by contacting the resources and requesting assistance in dealing with the aftermath of a suicide (Campbell, 2001)

Postvention: Providing care for those impacted by suicide regardless of familial relationship to the deceased. Postvention is delivered to the survivors in an organized fashion by trained responders in an active or passive approach. (Campbell, 2001)

Spirituality: Associated with personal beliefs and inner-paths

Religion: Associated with membership in a public place of organized worship

Suicide: The act or an instance of taking one's own life voluntarily and intentionally (Merriam-Webster, 2011)

Suicide Attempt: Any act of self-harm in which the intent is to die regardless of the outcome. (American Association of Suicidology, 2009)

Suicide Postvention: The provision of crisis intervention, support and assistance for those affected by a completed suicide. (American Association of Suicidology, 2009)

Suicidology: The study of suicide and suicide prevention. (Merriam-Webster, 2011)

Survivor of Suicide: The friends and family members who are affected by their loved one's completed suicide. (American Association of Suicidology, 2009)

Survivors of Suicide (SOS) Support Group: A support group that meets every Tuesday night at the Baton Rouge Crisis Intervention Center. Clinicians as well as volunteer paraprofessionals who are survivors of suicide run this group. (Campbell, 2001)

CHAPTER TWO
REVIEW OF LITERATURE

Brief History of Suicidology

Émile Durkheim is known as a founding father of modern sociology. In 1897, he published his book *Le Suicide* in which he defined suicide as, "applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result" (Durkheim, 1897, p. 44). Not only did Durkheim define suicide, but he also distinguished four subtypes of suicide: egoistic suicide, altruistic suicide, anomic suicide, and fatalistic suicide (Durkheim, 1897). Durkheim (1897) was the first to look at suicide in a scientific way by comparing suicide statistics of individuals by gender, religion, method, and age.

Over a century later, Edwin Shneidman became known as a father of contemporary suicidology (Leenaars, 2010). Shneidman began his career as a clinical psychologist at the Veteran's Association when, in 1949, he was led to a vault of suicide letters at the Coroner's office (Leenaars, 2010). This is what initially sparked his interest in suicide and guided him toward his work and research in suicidology (Leenaars, 2010). Shneidman's contributions to the field of suicidology can be categorized into the five following areas: "definitional and theoretical, suicide notes, administrative and programmatic, clinical and community, psychological autopsy and postvention" (Leenaars, 2010, p. 5).

Shneidman made numerous definitional and theoretical contributions to the field of suicidology. As Durkheim did in 1897, Shneidman redefined suicide. In 1973, Shneidman was asked to write a paper for the *Encyclopedia Britannica* on suicide (Leenaars, 2010). Shneidman considered his entry on suicide in the *Encyclopedia Britannica* to be one of his most important works (Leenaars, 2010). An excerpt from his entry is as follows:

> Suicide is not a disease (although there are those who think so); it is not, in the view of the most detached observers, an immorality (although, as noted below, it has often been so treated in Western and other cultures); and, finally, it is unlikely that any one theory will ever explain phenomena as varied and as complicated as human self-destructive behaviors. In general, it is probably accurate to say that suicide always involves an individual's tortured and tunneled logic in a state of inner-felt, intolerable emotion. In addition, this mixture of constricted thinking and unbearable anguish is infused with that individual's conscious and unconscious psychodynamics (of hate, dependency, hope, etc.), playing themselves out within a social and cultural context, which itself imposes various degrees of restraint on, or facilitations of, the suicidal act. (Shneidman, 1973, p. 383)

In 1955, Shneidman, along with two colleagues, opened the Los Angeles Suicide Prevention Center (Leenaars, 2010). This organization was the first of its kind and has become a model for suicide prevention and crisis centers worldwide (Leenaars, 2010). After this contribution to the community, Shneidman continued his work in suicide prevention by writing the first suicide prevention program guidelines in 1967 (Leenaars, 2010). Soon after, Shneidman formed the AAS in 1968, a national not-for-profit organization that aims to understand and prevent suicide (AAS, 2012g). Shneidman's administrative and programmatic contributions to the field of suicidology were the beginning of what the field has become today.

Aside from his theoretical, definitional, administrative, and programmatic contributions, Shneidman also had a clinical role in the field of suicidology (Leenaars, 2010). Shneidman worked with suicidal patients on a regular basis in his clinical practice in an effort to lessen the number of suicides in his community (Leenaars, 2010). Shneidman published several scholarly articles and books on the topics of psychotherapy with suicidal patients, clues to suicidal behavior, and how to prevent suicide (Leenaars, 2010). Along with his writings and clinical work with patients, Shneidman continued to open new doors in the field of suicidology.

With the help of several colleagues from the Los Angeles Suicide Prevention Center, Shneidman identified the need for investigations into the modes of equivocal deaths and introduced the concept of a psychological autopsy (Leenaars, 2010). A psychological autopsy is

a retrospective investigation into the life of the decedent, which helps to determine the mode of death: homicide, suicide, accidental, etc. (Shneidman, 1994). This investigation is done by collecting police and medical reports, interviewing those close to the decedent and collecting any other pertinent information (Shneidman, 1994). By gathering this information, the investigator can create a timeline of the decedent's last days of life and their intentions at the time of death (Shneidman, 1994).

A final contribution that Shneidman made to the field of suicidology was coining the term *postvention* to define services provided to a survivor of suicide after a death by suicide. Shneidman recognized the fact that services were being provided after a suicide, just like preventative measures were being taken to prevent suicides (Leenaars, 2010). The terms prevention and intervention were already in existence and Shneidman made an addition by coining a unique term and identifying eight principles for postvention services (Leenaars, 2010; Shneidman, 1975).

In one lifetime, Shneidman laid a tremendous foundation for the field of suicidology. His accomplishments included starting the first suicide prevention center, first national suicidology organization, and developing concepts such as psychological autopsies and postvention services (Leenaars, 2010). However, these are only a few of his many triumphs. In his review of Shneidman's accomplishments, Leenaars (2010) recognizes that Shneidman's "works are windows to the suicidal mind" (p. 17) and they aim toward an effort to be more effective in preventing unnecessary deaths.

Theoretical Framework: Postvention as Prevention

The theory of postvention as prevention for future generations is the framework for this research study and will be discussed throughout the chapter. Shneidman (1972) proposed that

providing postvention services to survivors of suicide not only assists them through the grieving process, but also serves as prevention for future generations. Survivors of suicide are 2 to 10 times more likely to take their own life compared to members of the general population (Kim et al., 2005; Mitchell et al., 2005; Runeson & Åsberg, 2003). The complicated grief that these survivors experience including feelings of guilt, shame, and embarrassment along with the stigma attached to suicide are contributory factors to their suicidal ideation (Jackson, 2003; Mitchell et al., 2005; Simon, 2012). Campbell (1997) said "the long-term consequences of suicide may be averted if the problems of access for survivors to services and awareness of resources is overcome." (p. 336).

The literature reveals that survivors of suicide are at a greater risk for taking their own life than the general population (Kim et al., 2005; Mitchell, et al., 2005; Runeson & Åsberg, 2003). Runeson, and Åsberg (2003) concluded that individuals whose family member died by suicide were twice as likely to take their own life in comparison to a control group. In a similar study, Kim et al. (2005), explained that "relatives of suicide completers were over 10 times more likely than relatives of comparison subjects to attempt or complete suicide after the authors controlled for psychopathology" (p. 1017). In another study, Mitchell et al. (2005) concluded that "complicated grief was associated with a 9.68 times greater likelihood of suicidal ideation after controlling for depression" (p. 498) in survivors of suicide.

Themes of guilt, shame, and depression for survivors of suicide are common throughout the literature (Jackson, 2003; Jordan & McIntosh, 2011). "A suicide survivor's grief, stigma, shame, isolation, and self-blame result in a state of heightened stress" (Aguirre & Slater, 2010, p. 531). This high level of stress can turn into psychache, a common trigger for suicide (Aguirre & Slater, 2010). Active postvention as an element of prevention to survivors of suicide will link

them to postvention services in their community. Current research (Campbell, 2001) explains that survivors of suicide who receive active postvention services present for help sooner than those who do not receive active postvention services. This review of the literature will give an overview of suicide including statistics and demographics, a look into survivors of suicide and the complicated grief they experience, and postvention services available to survivors of suicide.

Suicide: The Big Picture

In a recent report, the AAS (2012a) noted that there were over 36,000 suicides in the United States in 2009. This number is shockingly high, but is also an underestimate (AAS, 2012a; Bertolote & Fleischmann, 2002; Claassen et al., 2010). A death by suicide cannot be a ruled a suicide without unreasonable doubt (Bertolote & Fleischmann, 2002). In an annual report of suicide statistics in the United States, AAS (2012e) reported "although there are no official national statistics on attempted suicide (e.g., non-fatal actions) it is generally estimated that there are 25 attempts for each death by suicide" (p. 2).

Bertolote and Fleischmann (2002) explain that in order for a death to be considered a suicide, the death certificate must say that suicide is the cause of death. These death certificates are signed "by legally authorized personnel, usually doctors and, to a lesser extent, police officers" (Bertolote & Fleischmann, 2002, p. 181). Officials may be hesitant to rule the death a suicide due to cultural or religious attitudes toward suicide in a particular geographical area (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Research shows that suicide may be underreported by between 20% and 100% in some areas (Bertolote & Fleischmann, 2002). Claassen et al. (2010) explain that suicide rates are underreported locally and nationally. They suggest that true suicide rates are "always higher than the officially reported rate" (Claassen, 2010, p. 194). Suicide ranks as the third leading cause of death for individuals between the ages

of 15 and 24 only behind accidents and homicides (AAS, 2012e). Many of these accidents and even homicides may have actually been suicides, but there may not have been enough evidence to rule the death a suicide.

Suicide affects a large number of people in our country and is a huge public health issue. By being familiar with the risk factors associated with suicide, a community can become more aware and alert to this issue which affects all communities in some way, shape, or form. In an effort to provide awareness and insight into the suicidal mind, risk factors for suicide and demographics of individuals who take their life will be explained.

Risk Factors of Suicide

There are many risk factors associated with suicide. The AAS (2012c) classifies these risk factors into two groups: chronic risk factors and acute risk factors. AAS (2012c) defines chronic factors as those factors that will increase one's risk for suicide over their lifetime if they are present and acute factors are defined as those factors that will increase one's risk for suicide in the near future if they are present.

Chronic risk factors can be broken down into perpetuating risk factors and predisposing/potentially modifiable risk factors. Included in the perpetuating risk factors are elements such as demographics, history of parent's behaviors, and history of individual's behaviors. Some of the demographics that put individuals at higher risk are Caucasian or American Indian ethnicity, male gender, and older age (AAS, 2012c). Those individuals who are separated, divorced, or widowed also fall into this category (AAS, 2012c). Individuals with a history of suicide attempts, self-harming behavior, trauma or abuse, psychiatric hospitalization, frequent mobility violent behaviors, and/or impulsive/reckless behaviors also fall into the category of having perpetuating, chronic factors (AAS, 2012c).

Those factors that are in the predisposing/potentially modifiable, chronic category include factors such as medical diagnoses that include brain injuries, certain psychiatric diagnoses, and personality disorders (AAS, 2012c). Some other factors that fall into this category are individuals that are a survivor of suicide, individuals with low self-esteem, individuals who smoke, and individuals who are unsure of their sexual orientation along with a few other factors (AAS, 2012c).

There are many acute factors associated with risk for suicide. Many of these factors are events or significant life changes that have recently occurred such as a recent divorce, recent suicide attempt, recent release from a psychiatric hospital, and/or a recent diagnosis of a terminal condition (AAS, 2012c). Other factors in this category include, but are not limited to, current self-harming behavior, anger, insomnia, feelings of hopelessness, and/or feelings of helplessness (AAS, 2012c).

The AAS (2012c) also includes contributory risk factors and precipitating or triggering stimuli. Contributory risk factors include owning a firearm, unemployment, and stress among other things (AAS, 2012c). Precipitating or triggering stimuli are considered to be events that cause or threaten legal problems or certain feelings such as shame, guilt, or humiliation (AAS, 2012c).

Demographic Patterns

Gender. In 2007, there were more than 34,000 deaths by suicide in the United States (Center for Disease Control [CDC], 2010). By 2009, this number increased to more than 36,000 deaths by suicide (McIntosh, 2012c). Although men complete suicide at a higher rate than women, the latter attempts suicide at a much higher rate (AAS, 2012e). Men in the United States actually complete suicide at a rate four times that of women (CDC, 2010). This statistic even

holds true for youth between the ages of 10 and 24 where male youth complete suicide four times more frequently than their female counterpart (National Center for the Prevention of Youth Suicide [NCPYS], 2012). As individuals get older, males complete suicide at a much higher rate than females (AAS, 2012a). In 2009, "84.4% of elderly suicide were male; the rate of suicides in late life was 5.4 times greater than for female suicides" (AAS, 2012a, p. 1). As the seventh leading cause of death for males and the fifteenth leading cause of death for females, suicide is a serious public health issue (CDC, 2010).

Age. In 2009, 4,630 youth between the ages of 10 and 24 died by suicide (NCPYS, 2012). Although there was a large spike in suicide rates for 15 and 24 year olds between the 1950's and 1970's of nearly 200%, suicide rates for this age of individuals has stabilized over the past thirty years and has even decreased recently (AAS, 2012e). However, suicide is still the third leading cause of death for individuals between 15-24 years of age only behind accidents and homicides (CDC, 2010).

Suicide rates are highest among elderly individuals age 80 and over (AAS, 2012e). Rates for this age group are nearly 50% higher than the national average (AAS, 2012e) accounting for 15.9% of the suicides in 2009 (AAS, 2012a). Elderly, white males are at the highest risk for suicide, especially those over the age of 85 with a suicide rate of 45.6 per 100,000 (AAS, 2012a). After the age of 60, the suicide rate for women tends to decline (AAS, 2012a). This elderly population of individuals attempts suicide at a much lower rate than other age groups, (1 suicide per 100-200 attempts) but this population's completion rate is 1 suicide per every 4 attempts (AAS, 2012a).

Race and Ethnicity. AAS (2012e) reports that Caucasians have a much higher rate of completed suicides than African Americans. Suicide is the second leading cause of death for

American Indians and Alaska Natives that are between the ages of 15 and 34 years old, which is 1.8 times higher than the national average for this particular age group (CDC, 2010). Suicide was also the third leading cause of death for Hispanic individuals between the ages of 15 and 34 years old (AAS, 2012b). Although suicide ranks high among the leading cause of death for many Hispanic individuals, this population has a much lower suicide rate than Non-Hispanics of all age groups (AAS, 2012b).

Methods Used for Death by Suicide

The method chosen to take one's life is a major factor in determining the lethality of a suicide attempt (Krug et al., 2002). In the United States, firearms have remained the most common method for completing suicide (AAS, 2012e). Almost two thirds of all individuals who die by suicide in the United States use a firearm as their method (Krug et al., 2002). When broken down by gender, males follow the norm with firearms being used most frequently while females tend to use poison the most with firearms following behind as the second most used method (AAS, 2012e). In the World Report on Violence and Health, Krug et al. (2002) explained that elderly people are more determined to die and therefore use a more lethal method to take their life.

When considering Shneidman's (1972) theory of postvention as prevention for the next generation, it is important to understand the aforementioned risk factors associated with suicide and the demographics of the individuals who die by suicide. Over 36,000 people in the United States took their own life in the year 2009 and so many more people were affected by the aftermath (AAS, 2012a). Research shows that survivors of suicide are at a greater risk to take their own life; therefore it is necessary to have a greater understanding of this population (Kim et al., 2005; Runeson, & Åsberg, 2003).

Survivors of Suicide: Who Are They?

The term "survivor of suicide" has often been referred to as a confusing term (Carmean, 2007). Laypersons, as well as mental health professionals, misconstrue the meaning of this term. One of the reasons for this is because many individuals think that a survivor of suicide is an individual who has attempted suicide, but did not die as a result of their attempt. However, a person who has attempted suicide and lives is a suicide attempt survivor (AAS, 2012d). The fact that there is such confusion and controversy over the terminology used to identify this population shows just how little awareness there is of their existence despite the extreme number of individuals that are affected (Carmean, 2007).

The varying definitions of *survivor of suicide* contribute to the ambiguity of the term and the qualifications for who falls into that category. A survivor of suicide is defined by AAS (2012f) as "a family member or friend of a person who died by suicide" (p. 1). This definition is straightforward, but says nothing about the nature of the relationship to the deceased who died by suicide or how they were affected by the death. Andriessen (2009) says, "A survivor is usually regarded as a person who has lost a significant other (or a loved one) by suicide, and whose life is changed because of the loss" (p. 43). In this definition, Andriessen (2009) explains that the person's life was affected by the death by suicide. However, Jordan and McIntosh (2011) define a survivor of suicide as "someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person" (p. 7). Jordan and McIntosh (2011) seem to focus even more on how the individual is affected after the death by suicide, but do not explain the nature of their relationship with the individual who died by suicide. By using the term "exposure," the researchers may be referring to an individual who found the body of someone who died by suicide. Individuals who

discover the body of someone who dies by suicide may be someone such as a maid at a hotel, a police officer, or person who just happens to be walking by the scene of the suicide (Campbell, 2001). The variety of definitions contributes to the confusion surrounding the term *survivor of suicide*.

In addition to confusing terminology, there is also an unclear picture of the number of people who are survivors of suicide. In 1969, Shneidman published his book *On the Nature of Suicide* and estimated that there were at least 6 survivors of suicide per suicide. Although this number was published over 40 years ago, it is still used today as the "go to" number for how many survivors of suicide are left behind. AAS (2012f) reports that with at least 6 survivors left behind for every one suicide, there were at least 6 million survivors of suicide in the past 25 years. Shneidman (1969) quotes "for each committed suicide there are an estimated half dozen survivor-victims whose lives are there-after benighted by that event" (p. 22), but there is no empirical data to back this up. Jordan and McIntosh (2011) explain, "this figure has now been so widely quoted that it is sometimes repeated as an established fact when in reality, it was only an educated guess by a pioneer in the field" (p. 10). Linn-Gust (2004) interviewed Shneidman and asked him how he came to his number of six survivors per suicide death and he explained that it was merely a guestimate.

Since Shneidman's initial estimate of the number of survivors of suicide per suicide death, there have been few studies that have tried to derive more empirically based results. In 2001, Campbell estimated that there are at least 24 different survivor relationships per suicide. These relationships include wife, mother, sister, brother, father, daughter, friend, husband, son, girlfriend, uncle, son-in-law, stepfather, brother-in-law, aunt, niece, grandson, daughter-in-law, boyfriend, sister-in-law, step-daughter, step-mother, cousin, and fiancé to the deceased

(Campbell, 2001). Although an individual will not have all 24 of these relationships, it would not be unrealistic to suggest that an individual could have more than 6 survivors per suicide, especially since there may be multiple individuals for each relationship such as friend, cousin, son or daughter.

In 2011, Berman published the article *Estimating the Population of Survivors of Suicide: Seeking an Evidence Base*. In this article, Berman explored the fact that there was no evidence base for Shneidman's original estimate of the number of survivors of suicide per death by suicide. He also explained the difficulty in defining who falls into the category of being a survivor of suicide as there are so many definitions of this term (Berman, 2011). Berman mailed surveys to 187 individuals who were registered as survivors of suicide with the American Association of Suicidology and to 66 group leaders of survivors of suicide support groups that were registered with the same association (Berman, 2011). Berman's intention was to acquire a better idea of the number of survivors of suicide per suicide death (Berman, 2011).

Berman (2011) identifies the limitations of his study as follows: 1) survivor-respondents may not be representative of the population since they self-identified as survivors of suicide 2) the sample size is small and one from convenience populations and 3) the sample does not include people who are homeless and/or alone and die by suicide. Although Berman (2011) explains the limitations of his study, his research gives the field of suicidology greater insight into the number of survivors of suicide per death by suicide. Berman (2011) broke down survivors into four different categories: family survivors (immediate family), extended family survivors, friend survivors, and coworker/classmate survivors. Berman (2011) noted that "all results were calculated as medians since a few reported estimates were sufficiently extreme to bias use of means to assess and report overall central tendencies" (p. 112). The median number

of survivors of suicide in the family category was 5.13 where n=142 (Berman, 2011). This number is close to Shneidman's original estimate of six survivors of suicide per death by suicide. The median number of extended family survivors was 14.5, friend survivors was 19.85, and coworker/classmate survivors was 19.67 (Berman, 2011). When broken down by age, younger people who died by suicide showed to have less immediate family members and larger extended family members where older people who died by suicide had the opposite (Berman, 2011). When taking into account extended family, friends, and coworkers/classmates in addition to immediate family members, the number of survivors of suicide per suicide death increases dramatically.

Complicated Grief and Stigma

In Shneidman's early career, he wrote that there were two different types of grief: grief that people experienced when they lost a loved one to cancer, heart disease, an accident, or disaster and the type of grief that one experienced when their loved one died by suicide (Shneidman, 1972). Survivors of suicide often identify the type of grief that they experience as a complicated and unique type of grief (Jackson, 2003; Mitchell et al., 2005). Complicated grief has become a widely recognized term and many researchers and mental health professionals are advocating for this to become a diagnosis in the new Diagnostic and Statistical Manual of Mental Disorders 5 (Simon, 2012; Shear et al., 2011).

Simon (2012) explains that there is a difference between the natural, acute grief following a death and complicated grief that can occur when someone loses an individual that they have a close relationship with. She explains that this can be one of the greatest stressors in a person's life and that "complicated grief may be conceptualized as a post-loss stress disorder" (Simon, 2012, p. 544). Simon (2012) defines complicated grief as "a debilitating syndrome that is

comprised of symptoms that interfere with adaptation and reengagement in life after bereavement, and that result in persistence of acute grief" (p. 541). Simon (2012) lists the following as typical symptoms associated with complicated grief:

Table 1. Typical CG symptoms

1. Persistent intense yearning or longing for the person who died.
2. Frequent intense feelings of loneliness.
3. Feeling that life is empty or meaningless without the person who died.
4. Wish to die in order to find the person or because life is unbearable without them.
5. Thoughts or images of the person regularly intrude on usual activities or interfere with functioning.
6. Frequent troubling rumination about something related to the loss.
7. Recurrent feeling of disbelief or inability to fully comprehend the finality of the loss.
8. Persistent feeling of being shocked, stunned, dazed, or emotionally numb since the death.
9. Recurrent feelings of anger or bitterness related to the death.
10. Persistent difficulty trusting or caring about other people.
11. Frequently experiencing pain or other symptoms that the deceased person had, or hearing the voice, or seeing the deceased person.
12. Intense emotional or physiological reactivity to reminders of the loss.
13. Excessive avoidance of reminders of the loss.
14. Excessive proximity seeking, frequent impulse to see, touch, hear, or smell things to feel close to the person who died.

Note. Reprinted from "Is complicated grief a post-loss stress disorder?" by N. Simon, 2012, Depression and Anxiety, 29, p. 542.

Many of these symptoms are listed in the suggested addition to the upcoming edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for *Persistent Complex Bereavement-Related Disorder* (American Psychiatric Association, 2012). In a recent study, Mitchell, Gale, Garand, and Wesner (2003) explain "the sudden, often violent, unnatural death of an individual is frequently conceptualized as a stressful life event with negative mental health outcomes among bereaved survivors" (p. 91). The diagnosis of *Persistent Complex Bereavement-Related Disorder* that is being proposed by the American Psychiatric Association (2012) to be included in the new edition of the DSM is being recommended because of the recent research in prolonged grief, complicated grief and other studies that explain the negative mental health outcomes that Mitchell et al. (2003) explained in their study.

The grief associated with suicide is often referred to as complicated grief. One of the many reasons this may be true is because of the stigma associated with suicide. The AAS (2012f) states,

> The loss of a loved one by suicide is often shocking, painful and unexpected. The grief that ensues can be intense, complex, and long term. Grief work is an extremely individual and unique process; each person will experience it in their own way and at their own pace (p. 1).

Since there is such a strong stigma attached to suicide, it is common for people not to know how to offer condolences when someone has died by suicide (AAS, 2012f; Jackson, 2003). This can make the grieving process especially difficult and complicated to the survivors of suicide and leave them feeling lonely and confused (AAS, 2012f; Jackson, 2003). For those individuals who do offer compassion, it is sometimes accompanied with blame, judgment or exclusion (Jackson, 2003).

Aside from the normal feelings associated with grief, survivors of suicide experience a unique set of emotions which may come from the fact that their loved one chose to die (AAS,

2012f; Jackson, 2003). The fact that they chose to die is one of the reasons that this grieving process is so complicated. Survivors of suicide often ask themselves why their loved one killed themselves (AAS, 2012f). They often times wonder if they did something to contribute to this outcome or if there was something they could have done to prevent it (AAS, 2012f).

AAS (2012f) considers the following to be common emotions that survivors of suicide experience: "shock, denial, pain, guilt, anger, shame, despair, disbelief, hopelessness, stress, sadness, numbness, rejection, loneliness, abandonment, confusion, self-blame, anxiety, helplessness, and depression" (p. 1). Although some of these emotions are common with any type of grief, some of them are specific to suicidal grief and can be overwhelming, but are a natural part of the grieving process (AAS, 2012f). However, there has been much controversy over the empirical basis for the belief that survivors of suicide grieve differently than an individual grieving another type of death (Sveen & Walby, 2008).

Although the grieving process for those survivors of suicide may be a long and grueling process, a recent study shows that there is no difference between the grief experienced by those who lost a loved one to suicide and those who lost a loved one to another type of death (Sveen & Walby, 2008). Sveen and Walby (2008) conducted a qualitative study and found that there were no differences in the two groups in the areas of "general mental health, depression, PTSD symptoms, anxiety, and suicidal behavior" (p. 13), when it came to them grieving the death of a loved one. However, the overall level of grief experienced varied depending on the specific instrument that was used to measure the grief (Sveen & Walby, 2008). When examining specific symptoms of grief, **"**suicide survivors report higher levels of rejection, shame, stigma, need for concealing the cause of death, and blaming than all other survivor groups" (Sveen & Walby, 2008, p. 13).

The complicated type of grief that is experienced by survivors of suicide along with the stigma attached to suicide can make it difficult for survivors of suicide to seek help and in some cases leads to suicidal ideation. Shneidman (1972) proposed the term postvention referring to services provided to survivors of suicide after a suicide. Since survivors of suicide are at a greater risk for taking their own life, it is important to have these types of services available. Providing postvention services to survivors of suicide not only helps them through the immediate crisis associated with a death by suicide, but also serves as prevention for future generations.

Postvention Services

As Shneidman (1972) noted when he coined the term *postvention*, there have always been services provided to people who were grieving. Shneidman (1972) gave these services a name referring to them as postvention services. Shneidman referred to prevention, intervention, and postvention as a process similar to immunization, treatment, and rehabilitation (Shneidman, 1975). In his book *On the Nature of Suicide* (1969), he wrote,

> I have proposed the term *postvention* to label activities which occur after a suicidal event. These postventitive efforts can be of two types: (a) working with an individual after he has made a suicide attempt-with the obvious goals of decreasing the probability of any subsequent attempt and of mollifying the consequences of the recent attempt; and (b) working with the survivor-victims of a committed suicide to help them with their anguish, guilt, anger, shame, and perplexity. (p. 21)

Part b of Shneidman's definition listed above more closely reflects what postvention means today (Andriessen, 2009). Andriessen and Krysinska (2012) provide a more current definition of the term *postvention* as "support for families and communities after a suicide" (p. 24). This type of support can come in the form of survivors of suicide support groups, on-line resources and literature, and active postvention amongst other things (McMenamy, Jordan, & Mitchell, 2008).

In a pilot study, McMenamy et al. (2008) explored the needs of survivors of suicide after a loss. When discussing the results of the study, McMenamy et al. (2008) used N to "represent the number of participants that utilized each type of resource" (p. 382) and used *n* to represent "the number of participants that reported moderate to high levels of helpfulness from each type of resource" (p. 382). Of those who talked to a survivor of suicide one-to-one, 100% (*n*/N=52/52) reported moderate to high levels of helpfulness (McMenamy, et al., 2008). Survivors of suicide support groups were moderate to highly helpful to 94% (*n*/N=50/53) of the individuals who utilized this resource compared to a general grief support group where only 27% (*n*/N=9/33) of the survivors of suicide found it to be helpful to utilize this type of resource (McMenamy, et al., 2008). Written resources were also found to be a significant help for the survivors in this study where 72% (*n*/N=23/32) reported moderate to high levels of helpfulness using internet websites and 85% (*n*/N=45/53) found books on suicide and grief to have a moderate to high level of helpfulness (McMenamy, et al., 2008). Although these individuals found these resources to be helpful, 38% of the participants had a moderate to high level of difficulty finding these support resources (McMenamy, et al., 2008).

McMenamy et al. (2008) identify many types of postvention services and which ones are most helpful to survivors of suicide. Among the more popular postvention services that McMenamy et al. (2008) identify are on-line resources and literature, survivor of suicide support groups, and one-to-one conversations with other survivors of suicide. Each of these types of postvention services for survivors of suicide will be discussed with an emphasis on one-to-one conversations with a survivor of suicide. This emphasis will come in the form of an active postvention model referred to as the LOSS team.

On-Line Resources and Literature. Krysinska and Andriessen (2010) explored the variety of online resources available to survivors of suicide and found nearly 273,000 hits on Google when searching for "bereaved by suicide" (p. 645). Within the 145 web sites found in their search, Krysinska and Andriessen (2010) discovered a wide array of information including personal websites, survivors of suicide support group web sites, crisis intervention center websites and more. Much of the content within the websites contained "information on suicide bereavement and suicide, referral information for people at risk of suicide and for people bereaved by suicide, resources (such as suggested reading, leaflets, and material for sale), and links to other relevant web sites" (Krysinska & Andriessen, 2010, p. 645).

Survivors of Suicide Support Group. Many survivors find that the best help comes from attending a support group for survivors of suicide where they can openly share their own story and their feelings with fellow survivors without pressure or fear of judgment and shame. Support groups can be a helpful source of guidance and understanding as well as a support in the healing process (AAS, 2012f, p. 2)

Survivors of suicide support groups have become a safe place for survivors of suicide to talk about suicide and their loss in a safe environment (American Foundation for Suicide Prevention [AFSP], n.d.). These types of support groups are the most common place where survivors can share their stories (AFSP, n.d.). Survivors of suicide support groups can be found all around the world and are either run by mental health professionals, peers, or a combination of the two (Jackson, 2003).

The survivors of suicide support group at the Baton Rouge Crisis Intervention Center "offers survivors a safe place where they can share their feelings, thoughts, and memories about the person they lost to suicide" (Baton Rouge Crisis Intervention Center [BRCIC], 2012c). As

one of the postvention services offered for survivors of suicide, this support group offers survivors of suicide a place to safely grieve. In 2011, BRCIC had 87 survivors of suicide come in to the center for an intake to join the survivors of suicide support group (BRCIC, 2012b). Of the 87 intakes that were completed, 74 new members joined the group (BRCIC, 2012b). When continuing members from previous years were included, the survivors of suicide support group had 98 total group members throughout the year (BRCIC, 2012b).

One of the goals of the LOSS team is to get the newly bereaved survivors of suicide to the Baton Rouge Crisis Intervention Center to attend the survivors of suicide support group (Campbell, 2001). Of the 87 intakes that were completed in 2011, many came from the 28 LOSS team activations that year (BRCIC, 2012b). When looking for new recruits for the LOSS team, the coordinator first looks to the members of the survivors of suicide support group. Some of the individuals who are now members of the LOSS team have even come full circle after receiving a LOSS call for their loss, attending the survivors of suicide support group, and now being an active member of the LOSS team.

Active Postvention

Identifying the Need. In Campbell's early research, he compared a group of 50 survivors of suicide who received an active postvention model to another group of 76 survivors of suicide who received a passive postvention model (Campbell, 2001). These individuals all sought treatment at the Baton Rouge Crisis Intervention Center during the 1999 and 2000 calendar years. Campbell (2001) measured the amount of time that elapsed between the death of their loved one by suicide and the time that the individual sought treatment for their loss at this particular crisis intervention center. Campbell (2001) used the LOSS team to execute his active postvention model.

In his research, Campbell (2001) concluded that survivors of suicide who experienced a passive postvention model, the control group, took an average of 4.5 years to request mental health services to address the aftermath of their loved one's suicide. The experimental group that was exposed to an active postvention model in the form of the LOSS team visiting their homes took an average of 39 days before seeking out mental health services for their loss of a loved one to suicide (Campbell, 2001).

Since this study, Cerel and Campbell (2008) used the archival data that was collected at the Baton Rogue Crisis Intervention Center from 1999 through 2005 for survivors of suicide who presented for treatment. The comparison between survivors of suicide who received an active postvention model and those who received a passive postvention model solidified Campbell's research in 2001. Those who received a passive postvention model presented for treatment within an average of 97 days while those who received an active postvention model presented for treatment within an average of 39 days of the suicide (Cerel & Campbell, 2008).

As previously mentioned, it is sometimes difficult for people who are not survivors of suicide to offer condolences to the newly bereaved and they are left feeling lonely and confused (AAS, 2012f). The survivor-to-survivor contact that is made when an active postvention model is employed is very helpful to the new survivors of suicide (Davis & Hinger, 2005). The presence of individuals who have gone through the same experience helps to give the newly bereaved survivors of suicide an instillation of hope. The members of the LOSS team share their stories with the newly bereaved individuals at the scene of every suicide as well as offer them resources that can help the newly bereaved get through this difficult time in their life. Having a LOSS team member to relate to when the newly bereaved is going through such a traumatic experience can help the individual to get through the tough time.

Inception of the LOSS Team. When speaking about active postvention services provided for survivors of suicide, Campbell (2001) said, "I envisioned an Active Postvention Model (APM) made up of a team of trained survivors who would go to the scenes of suicides to disseminate information about resources and be the instillation of hope for the newly bereaved." Shneidman (1972) introduced "postvention as prevention for the next generation." In November of 1997, Campbell took Shneidman's words to heart and created the first LOSS team (Campbell, 2001).

After the concept of active postvention was well received at the 1997 AAS annual conference, Campbell developed an active postvention model where survivors of suicide would go out to the scenes of suicide and help the newly bereaved as close to the time of death as possible (Campbell, 2001). Shneidman (1975) has previously discussed this idea when he wrote the eight principles of postvention and included beginning postvention work with survivors within the first 72 hours following a death, if possible. While Executive Director of the Baton Rouge Crisis Intervention Center, Campbell developed the LOSS team, which employed the active postvention model (Campbell, 2001).

The first LOSS team was comprised of twelve individuals who were mental health clinicians and/or survivors of suicide (Campbell, 2001). These survivors of suicide were considered to be "paraprofessionals" and were required to be at least one year out from their loss (Campbell, 2001). The team was extensively trained over the period of one year before they were ready to begin offering their postvention services to the community. They were trained in crisis intervention, critical incidence stress debriefing, crime scene etiquette, and facilitating survivor grief recovery amongst other things (Campbell, 2001). The eight survivors of suicide traveled to a crisis center in Atlanta, Georgia for additional training (Campbell, 2001). As part

of the early stages of the development and implementation of the LOSS team, the mental health of the team members was monitored. Campbell (2001) administered Beck's Inventory of Depression, Beck's Inventory of Anxiety, and the Hayes-Jackson Bereavement survey every 60 days to accomplish this task.

The first LOSS team began offering their services to the East Baton Rouge parish community in 1998 (Campbell, 2001). In conjunction with the local Coroner's Office, the LOSS team was notified every time there was a suicide in East Baton Rouge Parish. At the time, this was about once every eight days (Campbell & Lester, 1996). The LOSS team members that were on call would immediately go out to the scene of the suicide where they were introduced to the survivors of suicide on the scene by the Coroner's office investigator on-call. The LOSS team quickly became part of the group of first responders that were present at the scene of every suicide in East Baton Rouge parish. Other first responders looked forward to the attendance of LOSS team members for assistance in discussing such a sensitive matter (Campbell, Cataldie, McIntosh, & Millet, 2004).

Current LOSS Teams. Programs modeled after the LOSS team and Campbell's active postvention model have developed throughout the United States and other countries such as Australia and Singapore (Cerel & Campbell, 2008). In West Australia, an organization named Anglicare developed an active postvention outreach service that they call ARBOR (Anglicare, 2012). This outreach was developed to assist those individuals who have lost a loved one to suicide as close to the time of death as possible. There are currently LOSS teams in the United States in states such as Ohio, Texas, and Nebraska (Culver, 2012; McMenamy et al., 2008; Nebraska LOSS Team Local Outreach to Suicide Survivors, 2012; Suicide Prevention Task Force of Union County, Ohio, 2011).

LOSS teams such as the one in Baton Rouge, Louisiana, are great examples of active postvention services that are available to survivors of suicide The literature reveals that survivors of suicide are at a greater risk for dying by suicide than the general population (Kim et al., 2005; Mitchell et al., 2005; Runeson & Åsberg, 2003). Postvention services for individuals who are working through the complicated grief associated with suicide are essential in helping these individuals through the grieving process. In fact, the need for this type of service has been recognized worldwide.

This high number of deaths by suicide has left a great number of survivors of suicide behind to grieve the loss of their loved one. Survivors of suicide experience a complicated type of grief that leaves others feeling uncomfortable and sometimes unable to offer condolences (AAS, 2012f; Jackson, 2003; Simon, 2012). Survivors of suicide often seek help in many different forms (McMenamy, et al. 2008). Online resources and books are two ways that survivors of suicide search for answers (McMenamy et al., 2008). The most common type of help that is sought by survivors of suicide is that of a survivors of suicide support group (AAS, 2012f; McMenamy, et al. 2008).

Although active postvention models for survivors of suicide are not as common as passive postvention (support groups), active postvention is also meant to "reduce the isolation, stigma, and trauma often experienced after a death by suicide" (McMenamy, et al. 2008, p. 388). Active postvention models such as the LOSS team in Baton Rouge, Louisiana are there for survivors of suicide as close to the time of death as possible and aim to connect them with resources such as literature and survivors of suicide support groups (Campbell, 2001). The importance of teams such as the LOSS team has been recognized worldwide, but no one has researched the impact that this volunteer effort has on the members of the LOSS team.

CHAPTER THREE
METHODS

The purpose of this chapter is to describe qualitative research using a phenomenological method and to outline the process of a phenomenological study. The data collection preparation is explained including: conceptual model, guiding questions, researcher role, credibility, sampling strategy, confidentiality, informed consent, and discussion of a pilot study. The interview process that was used during data collection is also described with consideration of potential ethical dilemmas. Organization, analysis, and synthesizing the data are the final concepts explained in this chapter.

The primary purpose of this phenomenological study was to examine the experiences of those members of the Local Outreach to Suicide Survivors team in Baton Rouge, Louisiana. A secondary purpose of this study was to assess the potential benefits and detriments of being an active member of this team. This study is of great importance to the population of survivors of suicide since the benefits and detriments of being on a team such as the LOSS team has yet to be researched as the concept of an active postvention model is still quite new to the field of suicidology. This study was aimed at answering the following questions:

1. Why did the members of the Local Outreach to Suicide Survivors team choose to become part of this group?

2. What are the experiences of the members of the Local Outreach to Suicide Survivors team?

3. What are the benefits and detriments of being a member of the Local Outreach to Suicide Survivors team?

Qualitative Research

This research study used the "interactive and humanistic" (p. 8) qualitative research methods that Rossman and Rallis (2012) discussed in their text. The primary purpose of qualitative research is to learn and encompasses the following two key features: "the researcher is the means through which the study is conducted, and the purpose is to learn about some facet of the social world" (Rossman & Rallis, 2012, p. 5). Qualitative research is grounded in empiricism and is conducted in natural settings rather than laboratory settings (Rossman & Rallis, 2012). In qualitative research, the researcher uses a complex reasoning process that starts with a "well-thought-out" (p. 10) conceptual framework, but the researcher must be flexible and self-reflective throughout the research process recognizing that the conceptual framework may change and develop (Rossman & Rallis, 2012). Although the process of qualitative research is "labor intensive, time-consuming, frustrating, and challenging," (Rossman & Rallis, 2012, p. 11) the researcher is able to "learn about some aspect of the social world and generate new understandings that can then be used" (Rossman & Rallis, 2012, p. 4).

It is only over the past couple of decades that qualitative research is being used more frequently in the applied fields (Miles & Huberman, 1994). Qualitative research describes and interprets data whereas quantitative research predicts and measures data (Rossman & Rallis, 2012). Miles and Huberman (1994) explain that qualitative data are more often appealing to a reader than a summary of numbers and that qualitative data have a "quality of undeniability" (p. 1). There are several forms of qualitative research methods such as ethnography, case studies, and phenomenology (Miles & Huberman, 1994; Moustakas, 1994). A phenomenological qualitative research approach was used with this study.

Phenomenology and Phenomenological Method

The goal of using a phenomenological approach to qualitative research is to be able to determine what an experience meant to the person who had the experience (Moustakas, 1994). In other words, the researcher aims to understand the lived experiences of these individuals (Moustakas, 1994). When using a phenomenological approach, "the human scientist determines the underlying structures of an experience by interpreting the originally given descriptions of the situation in which the experience occurs" (Moustakas, 1994, p. 13). In phenomenology, "perception is regarded as the primary source of knowledge, the source that cannot be doubted" (Moustakas, 1994, p. 52).

Moustakas (1994) explained the process of conducting a phenomenological research study in terms of methods of preparation, methods of collecting data, and methods of organizing and analyzing data. Methods for preparation include: formulating the topic and question, defining terms, conducting a review of the professional and research literature, locating and selecting research participants. Also included in the preparation for collecting data is: informed consent, establishing confidentiality with participants, and developing the guiding questions for the interviews. Moustakas (1994) included engaging in the Epoche process prior to and sometimes during the interview as part of the method for data collection. This process includes setting aside prior knowledge about the subject matter, judgments, and biases (Moustakas, 1994). However, the key component of data collection is conducting the interviews with the participants in the study. Finally, after the data is collected, the researcher organizes, analyze, and synthesize the data.

Phenomenological Processes

Moustakas (1994) explained the importance of understanding the "nature, meanings, and essences" (p. 101) of the phenomenological process. This process consists of engaging in Epoche, phenomenological reduction, imaginative variation, and synthesis. These four aspects of the phenomenological processes were used in this research study to understand and derive meaning from the lived experiences of members of the LOSS team in Baton Rouge, Louisiana.

Epoche. In a phenomenological research study, the researcher serves as the instrument for data collection (Rossman & Rallis, 2012). When serving in this role, engaging in the Epoche process was extremely important. According to Moustakas (1994), the researcher should engage in the Epoche process prior to an interview so that " past associations, understandings, facts, and biases, are set aside and do not color or direct the interview" (p. 116). This process required the researcher to exclude any previous knowledge or experiences that might influence the way the interview was conducted (Moustakas, 1994). Moustakas (1994) explained that this process is not only a preparation for conducting an interview, but also an experience that allows the interviewer to see things, events, and people as if it were the first time. Moustakas (1994) also explained that the difficulty of this task sometimes requires researchers to continue the Epoche process throughout the duration of the interview. The researcher made every effort to reduce all "prejudgments, biases, and preconceived ideas" (Moustakas, 1994, p. 85) the researcher had toward this particular research, but it was impossible for them to be completely eliminated.

Phenomenological Reduction. Moustakas (1994) defined phenomenological reduction as "describing in textural language just what one sees, not only in terms of the external object but also the internal act of consciousness, the experience as such, the rhythm and relationship

between phenomenon and self" (p. 90). The steps of phenomenological reduction include bracketing, horizonalization, clustering the horizons into themes, and organizing the horizons and themes into a coherent textural description of the phenomenon (Moustakas, 1994). During the process of phenomenological reduction, the researcher repeatedly examined and described the data until she came to a conscious awareness and understanding of the meaning of the nature of the phenomenon (Moustakas, 1994).

Bracketing, the first step in phenomenological reduction, occurs when the focus of the research is placed in brackets (Moustakas, 1994). The focus becomes the topic and question while everything else is set aside (Moustakas, 1994). Horizonalization is another step in the process of phenomenological reduction that consists of initially treating all statements with equal value (Moustakas, 1994). After this occurs, irrelevant, repeated, or overlapping statements were removed form the data. The statements that are left over are considered to be the horizons or meaning units (Moustakas, 1994). The next step was to cluster these horizons by themes (Moustakas, 1994). Once the clusters of themes were determined, the researcher organized the horizons and themes into a coherent description of the phenomenon (Moustakas, 1994).

Imaginative Variation. The next step of the phenomenological research process is imaginative variation, which aims to "seek possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles, or functions," (Moustakas, 1994, p. 97). Through imaginative variation, the researcher developed structural descriptions that help the researcher to understand how the experience came into the lives of the participants (Moustakas, 1994). Through this process, the researcher learned that

"countless possibilities emerge that are intimately connected with the essences and meanings of an experience" (Moustakas, 1994, p. 99).

Synthesis. The final step of the phenomenological process includes the "intuitive integration of the fundamental textural and structural descriptions into a unified statement of the essences of the experience of the phenomenon as a whole" (Moustakas, 1994, p. 100). Essence refers to the quality that makes something what it is; and without this quality, it would not be the same. Essentially, the researcher develops a synthesis of the meanings and essences of the lived experiences of the participants (Moustakas, 1994).

Data Collection Preparation

Preparation for data collection can be a challenging experience (Moustakas, 1994). Formulating the topic and research questions are the first steps in this process. Next, a conceptual model must be developed (Moustakas, 1994). Other steps in this process include: creating guiding questions, establishing the researcher's role, reliability and validity, selecting participants, informed consent and confidentiality. Each of these preparations for data collection will be discussed in this section as well as a description of a pilot study.

Conceptual Model. Miles and Huberman (1994) explain that building a conceptual framework allows the researcher to "decide which variables are most important, which relationships are likely to be most meaningful, and, as a consequence what information should be collected and analyzed-at least at the outset" (p. 18). The conceptual model for this research study was designed from two sources: information revealed in the review of related literature and information regarding the purpose of the research study and what the researcher hopes to learn from the research study.

The conceptual model developed by the researcher represents what the review of literature revealed about survivors of suicide and the creation of the LOSS team as well as what the researcher hopes to find out about the experiences of the members of the LOSS team. Developing this conceptual model assisted the researcher in binding the research study. The researcher can ensure that the data collected is within the scope of the research study by binding the study within the limits of the conceptual framework. The boundaries created for this research study established what was and was not studied (Miles & Huberman, 1994).

The conceptual framework developed by the researcher starts with the population, survivors of suicide, that are the focus of this research study. An arrow leads from survivors of suicide to the creation of the LOSS team, which leads to the benefits, and detriments of being a member of the LOSS team. Figure 1 presents the conceptual framework used in this research study.

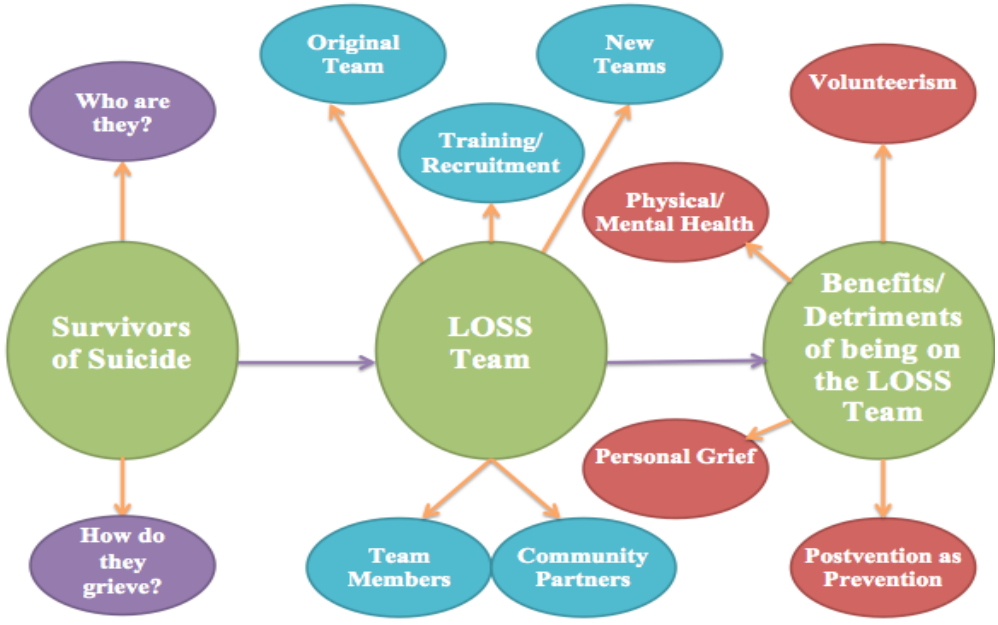

Figure 1. Conceptual Model: Experience of LOSS team members

Guiding Questions. The guiding questions in this phenomenological research study were used to assist in the primary goal of this study: to gain insight into the lived experiences of members of the LOSS team. The primary investigator developed the guiding questions based on the conceptual framework that was derived from the review of the related literature. Experts in the field were given the chance to provide the researcher with feedback and questions were modified prior to beginning the interviewing process. Further modifications were made after the first few interviews. The guiding questions are as follows:

1. Can you please tell me about the loved ones you've lost to suicide?
2. Did you get help after your loss (i.e. group, individual therapy)

   How long were you in treatment?

   Are you currently in any sort of treatment?

   How often do you go?
3. Have you ever been given a clinical diagnosis of depression?
4. How would you define depression?
5. Do you consider yourself spiritual?
6. Do you consider yourself a religious person?
7. How might spirituality/religion come into play at the scene of a suicide?
8. How did you first hear about the LOSS team?

   Why did you choose to become a member of the LOSS team?

   Are you involved in any other type of volunteer work?

   Did you know anybody already on the LOSS team?

9. Since you've been a member of the LOSS team, do you look at suicide in a different way?

   Do you read more literature about suicide?

10. Do you feel a sense of obligation for being a member of the LOSS team?

11. What do you tell yourself about why you are a member of the LOSS team?

12. Do you think you're changing anything by being a member of the LOSS team?

13. How much of your time do you spend dedicated to the LOSS team?

    How does that affect your family life?

    How does that affect your job?

    How does that affect any other volunteer work that you do?

    How does that affect your social life?

    Do you, your family, friends, or job ever get sick of it?

14. What are the benefits of you being a member of the LOSS team?

15. What are the detriments of you being a member of the LOSS team?

16. Do you ever feel emotionally overwhelmed with this volunteer work?

17. Do you take part in any type of debriefing after a LOSS call?

    What is the goal of debriefing?

    Are some scenes more difficult for you than others?

18. Do you ever think being a member of the LOSS team prevents you from moving forward in your life?

    Do you think it ever prevents you from getting involved in other activities?

19. Do you think people view it as being over your loss if you are asked to be on the LOSS team?
20. How long do you see yourself staying on the LOSS team?
21. Would you recommend that everyone who has lost a loved one to suicide become a member of the LOSS team? Why? Why not?
22. Do you think there should be term limits on the LOSS team?
23. Have you ever had any training in suicide prevention or intervention?
    What kind of training did you get prior to becoming a member of the LOSS team?
    In retrospect, would you change anything about the training process?
24. Why were you picked to be on the LOSS team over another person in the support group?
25. What would you look for when picking a new person to join the LOSS team?
26. If someone says to you that they've been asked to be on the LOSS team and they ask you if they should join, what would you tell them?

Researcher Role. As the primary investigator in this research study, it is important to explain how I came to know the participants, my relationship with the participants, and the potential researcher bias. The first year of my Master of Social Work program, I was assigned to the Baton Rouge Crisis Intervention Center as an intern. I completed 480 hours of service to this non-profit organization and within the internship functioned as a certified counselor on THE

Phone, a 24 hour crisis line, a co-facilitator in the Survivors of Suicide (SOS) support group, a co-facilitator of the Children's Bereavement group (CBG), and a volunteer with the LOSS team.

Upon completion of my internship requirements, I continued as a volunteer with all of the aforementioned programs. Shortly after the completion of my internship, I was asked to be a part-time staff member of the crisis center and function as a clinical co-facilitator for the Children's Bereavement Group. When the position as the Clinical Coordinator for the LOSS team became available, the executive director of the crisis center offered me the career opportunity. Currently, I hold the position of the LOSS team Clinical Coordinator at BRCIC. As the Clinical Coordinator, I am responsible for the daily functioning of the LOSS team which includes serving as the liaison between BRCIC and the Easton Baton Rouge Parish Coroner's office, debriefing with team members after they go out on calls, and keeping records and statistics of call-outs and clients served.

It must be noted that I have served as the Clinical Coordinator for this team since April 2009. Although not a personal one, I have had a relationship with each one of the participants in this study since that time. As the primary investigator for this study, it was extremely important to engage in the Epoche process throughout the entire research study. There is a great level of importance in setting aside information that the researcher already knew about the LOSS team and the individuals being interviewed. Being able to see these individuals and listen to their stories as if hearing and seeing them for the first time was essential. The peer debriefer and triangulating analyst for this research study played an important role in keeping the researcher's bias out of this study.

Credibility. Credibility is the confidence in the truth of the findings (Miles & Huberman, 1994). When considering credibility, Miles and Huberman (1994) asked if the findings make sense, if the findings are credible to the participants and the readers, and if the researcher has an authentic portrait of the phenomenon when determining if credibility is an issue. When conducting a research study, following certain standards will help the researcher to establish credibility and integrity within their study (Rossman & Rallis, 2012). Rossman and Rallis (2012) suggested the following five standards for establishing credibility: triangulation, being there, participant validation, using a critical friend, and using the community of practice.

In this research study, the researcher used triangulation to ensure that the data collected was robust, well developed, and comprehensive (Rossman & Rallis, 2012). Prolonged engagement or "being there" helps ensure that the researcher has a comprehensive view of the phenomenon by being present in the setting and with participants for a long period of time (Rossman & Rallis, 2012). The researcher's experience with the LOSS team helped establish this standard for credibility. Giving the participants a chance to review the transcript of their interview and make corrections and additions to the content confirmed participant validation (Rossman & Rallis, 2012). A critical friend or peer debriefer served as an "intellectual watchdog" and kept the researcher on track (Rossman & Rallis, 2012, p. 65). For this research study, Dr. Krisanna Machtmes, the chairperson of the researcher's dissertation committee, served as the peer debriefer. Finally, the researcher used the community of practice by engaging in discussion with people in the field of suicidology to share newly developed ideas (Rossman & Rallis, 2012).

Sampling Strategy. The sampling strategy used in this qualitative phenomenological research study was purposeful. Participants were selected based on meeting a certain set of

criteria. Randomness and quantity of participants was not as important as collecting comprehensive data and reaching a level of saturation in this research study. Therefore, a large sample size was not necessary and was not used. Rossman and Rallis (2012) explained that it is not uncommon in qualitative research, for saturation to occur around eight to ten participants. Saturation is the point in the research where the researcher is not receiving or hearing any new information (Rossman & Rallis, 2012). Saturation occurred in this research study after seven participants.

Moustakas (1994) explained that the essential criteria for participants in a phenomenological research study include: "the research participant has experienced the phenomenon, is intensely interested in understanding its nature and meanings, is willing to participate in a lengthy interview and possibly videotape the interview, and publish the data in a dissertation and other publications" (pg. 107). Keeping this in mind, the researcher selected participants for this study that fit the following criteria: 1) Participant was a survivor of suicide 2) Participant's loss by suicide was at least one year prior to the beginning of this study 3) Participant was a member of the Baton Rouge, Louisiana Local Outreach to Suicide Survivors (LOSS) team within two years from the beginning date of the research study and 4) Participant was an active member of the Baton Rouge, Louisiana Local Outreach to Suicide Survivors (LOSS) team for at least one year.

Having a professional relationship with the participants in the study made it easy for the researcher to ask potential participants if they were willing to take part in the research study. During a monthly LOSS team meeting, the researcher explained the upcoming qualitative phenomenological research study to the potential participants and expressed interest in their participation. LOSS team members were asked to sign a sheet of paper that was passed around

during the meeting to signify if they were willing to be a participant in the research study. All of the LOSS team members were told that participation in this research study was voluntary and there would not be any negative consequences if they chose not to participate in the study.

Informed Consent and Confidentiality. The Institutional Review Board (IRB) of Louisiana State University and A&M College approved application number E-3258 for this research study on March 21, 2012. Upon beginning the interview process, participants were reminded that participation in this research study was voluntary and that they have the right to refuse and withdraw from the study at any time. If any participants would have chosen to withdraw from the study, their interviews would have been discarded. Participants were also given a chance to ask any questions that they had about the research study after reading the consent form and prior to beginning the interview process.

Privacy and confidentiality concerns in this research study were taken very seriously. Participants were informed that although the results of this study may be published, no identifying information would be published and that their identity would remain confidential unless the researcher was legally compelled to release this information. The names of the participants did not appear on the transcripts or audio files. In order to maintain anonymity, participant's names were replaced with fictitious names in the transcriptions. All of the recorded interviews were kept on the researcher's laptop computer that requires a password for use and transcriptions were kept in a locked file cabinet in the home of the researcher.

Pilot Study. After approval from the researcher's committee, a pilot study of the guiding questions was used with the first interviewee (Emma). Following the first interview, the participant was asked for feedback as to the clarity of the questions and flow of the interview.

Emma's feedback was helpful and influenced some of the changes that were made to the guiding questions. Emma stated that the questions were clear and seemed to flow well. She also said that the questions were thought provoking and brought up topics that she had not thought about in the past.

Upon completing the interview, the researcher immediately transcribed the interview using a word processing program on a laptop computer. The researcher then reviewed the collected data with the peer debriefer. Together, the researcher and peer debriefer agreed upon the addition of the following three guiding questions: 1) "Why were you picked to be on the LOSS team over another person in the support group?" 2) "What would you look for when picking a new person to join the LOSS team?" and 3) "If someone says to you that they've been asked to be on the LOSS team and they ask you if they should join, what would you tell them?" Amendments were also made to several of the guiding questions including three additional questions.

Data Collection

In this phenomenological research study, the data collection process consisted of one-time, in-depth semi-structured interviews. It was important for the researcher to engage in the Epoche process throughout the entire data collection process.

Interview Process. In a phenomenological research study, a long interview is the most common method for data collection (Moustakas, 1994). This type of interview involves an "informal, interactive process and utilizes open-ended comments and questions" (Moustakas, 1994, p. 114). To create a relaxed environment for participants, interviews often begin with a social conversation or meditative activity (Moustakas, 1994). During the course of this research

study, all interviews were conducted face-to-face at the Traumatic Loss Building of the Baton Rouge Crisis Intervention Center. The interviews were scheduled over a period of one month at the convenience of the participants. These one-time, in-depth semi-structured interviews were all recorded using an audio recording device on the researcher's iPhone. The interviews lasted between forty-five minutes and one and one-half hour.

Prior to beginning each interview, the participants were asked to fill out a demographics questionnaire that included the following information: age, gender, marital status, highest level of education completed, race, and religious affiliation. Furthermore, the participants were informed that if they needed to take a break, they needed to let the researcher know and the interview would be paused. Following these housekeeping issues, the participants were given two copies of the consent form and a copy of the description of the research study. All participants signed both copies of the consent form. One copy was given to the participant to keep for their personal records and the other copy was turned over to the researcher for her records. Following this exchange, with the participant's consent, the recording device was turned on and questions regarding the consent form were discussed prior to beginning the interview questions.

Once each interview began, the researcher continuously engaged in the Epoche process and kept in mind her previous bracketing of the guiding questions. This was a difficult process due to the emotional stories that the participants were telling the researcher. It was important for the researcher to remember her role as the researcher and not as a social worker or the director of the LOSS team. Throughout the interview process, the researcher took notes including non-verbal observations and thoughts about the responses to questions that may lead to certain themes. After the conclusion of each interview, the researcher informed the participants of

several outlets to debrief if needed. The participants were encouraged to call The PHONE, a 24-hour crisis line, if they needed to talk after the interview. The participants were also told that they could contact the researcher if they thought of any additional information they wanted to add or if they wanted to further debrief after the interview.

At the researcher's earliest convenience, each of the interviews was transcribed. Each of the interviews was transcribed in a non-populated area using headphones to protect the anonymity of the participants. After transcribing each of the interviews, paper copies of the transcriptions were locked in a file cabinet at the researcher's home. To ensure the credibility of the transcriptions, the peer debriefer reviewed each transcription and transcribed two interviews chosen at random. The researcher's version of each transcription was compared to the peer debriefer's version of each transcription. The only wording differences found were in filler words such as "ah" and "uhm". After a discussion with the researcher the peer debriefer indicated 100% compatibility.

Ethical Dilemmas. All researchers are guided by a set of ethical principles (Moustakas, 1994). Due to the sensitive nature of this research study, every effort was made to keep the participants from experiencing harm. All participants were given a copy of the consent form prior to beginning the interview. The consent form was read out loud with each participant, stressing the potential risks they faced by participating in this research study and their right to refuse participation at any time. The participants were given ample time to review the consent form before starting the interview and had a chance to ask questions once the recording device was started. Due to the potential ethical dilemmas that can arise when recording interviews for a research study, the participants were informed of all of the measures that were taken in order to protect their confidentiality and anonymity. The participants were also informed that once the

interview was completed the researcher would transcribe the interview in a private location and it would be kept in a locked file cabinet.

Prior to the beginning of each interview, the participants were asked not to use other people's names in the interview. In cases where participants did use another person's name, fictitious names were assigned to the person they were speaking about. When writing the results section, the participant's anonymity was kept in mind and details that expose their identity were carefully considered before publication.

Participants were asked to discuss sensitive topics (e.g., suicide, death, etc.) during the interview and may have experienced negative emotions associated with the subject matter. Bäärnhielm and Ekblad (2002) stated, "data collection can be intrusive and invasive regarding sensitive experiences" (p. 469). The researcher was sure that the participants understood that they could withdraw from the research study at any time regardless of their reason for doing so. If at any point during the interview process a participant became noticeably upset by the subject matter, they were encouraged to take a break.

Bäärnhielm and Ekblad (2002) suggested that the role of a clinician as a researcher can be related to certain ethical issues. When a clinician serves as the researcher in a qualitative research study they may be put in the position to decide whether or not to intervene in clinical situations (Bäärnhielm & Ekblad, 2002). In order to avoid any ethical dilemmas, the participants were notified prior to the beginning of an interview that the researcher was also a social worker and abides by the National Association of Social Worker's (NASW) Code of Ethics. The participants were informed that the researcher/social worker is required by Louisiana reporting laws to report any cases of reported or suspected child/elder abuse or neglect (National Association of Social Workers ([NASW], 2012). If participants were to have mentioned any

suicidal ideation, the researcher/social worker would have assessed their risk and only broken confidentiality in the case that the participant was an immediate threat to himself or herself. One final step to ensure that there was no harm caused to the participants was to provide them with the phone number to The PHONE, a 24-hour crisis line in case they needed to talk after the interview had concluded.

Organization, Analysis, and Synthesis of Data

"Organization of data begins when the primary researcher places the transcribed interviews before him or her and studies the material through the methods and procedures of phenomenal analysis" (Moustakas, 1994, p. 118). Prior to beginning the processes of organizing, analyzing and synthesizing the data, the researcher needed to validate the accuracy of the transcripts and triangulate the data. In order to triangulate the data, the researcher used the participants, a peer debriefer, and a colleague from the community of practice as analysts for triangulation. Following the transcription of each interview, the participants were given a copy of the transcript with a chance to correct or add any information. Only one participant had any additions or changes to be made to their interview. The changes were made, the participant reviewed the changes, and then approved the transcript. Dr. Krisanna Machtmes, the peer debriefer and triangulating analyst met with the researcher regularly to discuss saturation of data and emerging themes. A colleague from the community of practice who has over twenty years of experience in the field of suicidology was also consulted when necessary.

The modified version of van Kaam's methods for analysis of data presented in Moustakas (1994) was used. The methods for organizing, analyzing, and synthesizing data were followed and are listed below:

1. Listing and Preliminary Grouping: List every expression relevant to the experience (Horizonalization)
2. Reduction and Elimination: To determine the Invariant Constituents: Test each expression for two requirements:

    a. Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it?

    b. Is it possible to abstract and label it? If so, it is a horizon of the experience. Expressions not meeting the above requirements are eliminated. Overlapping, repetitive, and vague expressions are also eliminated or presented in more exact descriptive terms. The horizons that remain are the invariant constituents of the experience.

3. Clustering and Thematizing the Invariant Constituents: Cluster the invariant constituents of the experience that are related into a thematic label. The clustered and labeled constituents are the core themes of the experience.
4. Final Identification of the Invariant Constituents and Themes by Application: Validation. Check the invariant constituents and their accompanying theme against the complete record of the research participant. (1) Are they expressed explicitly in the complete transcription? (2) Are they compatible if not explicitly expressed? (3) If they are not explicit or compatible, they are not relevant to the co-researcher's experience and should be deleted.
5. Using the relevant, validated invariant constituents and themes, construct for each co-researcher an Individual Textural Description of the experience. Include verbatim examples from the transcribed interview.
6. Construct for each co-researcher an Individual Structural Description of the experience based on the Individual Textural Description and Imaginative Variation.
7. Construct for each research participant a Textural-Structural Description of the meanings and essences of the experience, incorporating the invariant constituents and themes.

From the Individual Textural-Structural Descriptions, develop a Composite Description of the meanings and essences of the experience, representing the group as a whole. (Moustakas, 1994, p. 120-121)

CHAPTER FOUR
ORGANIZING, ANALYZING, AND SYNTHESIZING DATA

This chapter explains how the data were organized, analyzed, and synthesized according to van Kaam's method presented in Moustakas (1994). The chapter is organized as follows: Horizonalization, meaning units, themes, individual textural-structural descriptions, and composite textural-structural descriptions.

Horizonalization

Horizonalization was the first step in the process of phenomenological reduction. The researcher first looked at each of the seven verbatim transcripts in their original form. The researcher read each transcript carefully and treated all statements with equal value as recommended by Moustakas (1994). The researcher's peer debriefer also reviewed each of the seven verbatim transcripts. Each of the seven participants was given a chance to review their transcript and make any necessary corrections or additions in order to have the most accurate representation of their experiences. Since none of the participants had any additions or corrections to their transcripts, the researcher and peer debriefer considered the transcripts to be valid representations of their experiences. The researcher read through each of the seven transcripts numerous times over an extended period in order to gain a well-defined understanding of the experiences of each of the participants. Irrelevant, repeated, or overlapping statements are removed from the data and the statements that are left over are considered to be the horizons (Moustakas, 1994).

Meaning Units

Meaning units were classified for each of the horizonalized statements. The researcher first identified all meaning units in each transcript by reading and reflecting upon the verbatim responses from each participant. The meaning units from each transcript were compiled into a document with each participant's meaning units categorized under the corresponding guiding question. Equal weight was given to each response and all meaning units were kept in their original, verbatim form. Distracting phrases were deleted in order to present the meaningful data in a clear and concise manner. The first guiding question, "Can you please tell me about the loved ones you've lost to suicide?" was removed from the following meaning units to protect confidentiality.

1. Did you get help after your LOSS (i.e. group, individual therapy)

A. Group?

Emma: I did. I needed some help. It was pretty obvious to my dad… He kept saying, "you need to get some help," because basically I would call him and cry to him and to my husband and so he started calling around and I think Our Lady of the Lake hospital told him about the crisis center and then I called and came to group (the survivors of suicide support group), did my intake, and then started group probably within a month after she died.

Mel: A few weeks after… I say for about six years…Every Tuesday….Never missed…Very important…I highly recommend it. I've got so much out of group

Kevin: I came in for an intake and… I remember coming the first night, terrified. It was a room full of strangers, but in the introductions I'm thinking, damn, I'm not the only one this has happened to. These people have been through it too. It was the survivor's group.

Addy: With my child, I had never heard of the crisis center and actually, a man at the funeral home told me about it and gave me some information and I am not really a support group type of person… It's just I'm kind of private when I have something going on or I share it with my closest friends or family, but I knew this was not something I could do on my own… So probably within two weeks within my child's death, I called and came in for an intake… I told my ex-husband about it and he came. We both came to group. The SOS, survivors of suicide, that meets ever Tuesday night and I came for probably ten years and I became a facilitator which means I kind of lead a small group. And then I can't remember why, no reason to stop coming, I just started coming less often and stopped being a facilitator. I had a lot of other things going on and I was out of town a lot. I felt like I couldn't be as committed to it time wise as I should be and also I felt like there were other people who could take over and do more, a better job and, so, anyway. Now I'm a member of the LOSS team which goes out to suicides in the community to help the family with information and things that might help them to get through that.

Brandon: Not my uncle. After my child we went to the Grief Recovery Center…We went there from August until December and she wasn't doing us any good. She knew it and we knew it and she referred us to the Baton Rouge Crisis Intervention Center… My wife came right away... I came to the crisis center, did an intake, and then started to do group immediately and then I knew the first night I was in the group with others who had lost someone to suicide that I was in the right place.

Sheri: I think it was a couple of months, maybe three months… I don't have very good memory of time during that. I knew from the day he died, that Sunday that I was going to need help. I have two girls. I knew I could not explain suicide to them and I did not understand what was going. If I could not explain it to myself, how am I going to explain it to them or even try to help

them and to make sure we got through whatever we were going to have to go through and be mentally healthy on the other end. So, we needed some sort of help… At different times I saw a counselor at the crisis center. So, at different times, I got different kinds of counseling.

Ellie: I did. Someone from the LOSS team came to the scene and informed me of what was available and I think it was probably about a month or 6 weeks after that, that I actually made it into the center to have an intake and then I joined the survivors group, I think the next week.

B. Individual Therapy

Emma: No.

Mel: No.

Kevin: I went to her see her psychiatrist one time… This was after she died… So, no I didn't get any help.

Brandon: Well, my wife and I were going together.

Addy: I did.

Sheri: Yes. I went first to a grief counselor here in town because the losses that I had previous in my life were nothing. The feelings I had after were nothing compared to what I was feeling after the suicide of my spouse.

Ellie: Not really. I had seen a counselor like probably 6 months before Craig died. I had gone because I knew something was wrong with him. I knew he was struggling with either depression or Bipolar Disorder and I just went to a counselor by myself just to kind of get a grip of what was going on with him and then we went to marriage counseling together a few times and then I saw that same counselor a few times after he died.

C. How long were you in treatment for?

Emma: For about a year. Well for the first twelve weeks I went every week and I would say after that I went I went every week for a while and then I would miss here and there, but I pretty much stayed during the year, and then I stopped for a period of time and then Matthew called about the LOSS team.

Kevin: Once a week… Every Tuesday that I could. Yea… And I'd come twice if I could. It's amazing.

Brandon: I'm still going… Yeah, I dropped out of it, maybe, for about a year, about a year ago, and of course for years I've been a co-facilitator, because I feel the need to go to get over my loss, but even though that's not the reason I'm going, frequently I pick up a little bit of something that somebody will say and I'll say, "yeah, that's right."

Ellie: I went to the group pretty regular probably for a year and then after a year I think I would go kind of sporadically maybe for another year and then I haven't been much lately.

Sheri: I went to group for four years before, weekly. Before I said I think that I'm strong enough that I may not need to come here every week…They asked me to be a co-facilitator. So, it's been, June will be 10 years I've been coming every Tuesday.

Addy: Well, at first I was pretty much going every Tuesday night… I very seldom ever missed at first. It was a very important part of my week. I would schedule my week around it more or less.

D. Are you currently in any sort of treatment?

Emma: No. When you say, "are you in therapy"? Really, this (the LOSS team) is my therapy…

Ellie: Nope… No.

E. How often do you go?

Brandon: Every week…Every Tuesday night yeah…

2. Have you ever been given a clinical diagnosis of depression?

Emma: No.

Brandon: No. I wasn't diagnosed, but my doctor gave me some antidepressants, which I took for several years.

Ellie: No.

Addy: No.

3. How would you define depression?

Brandon: I was not able to concentrate… wasn't able to think straight, lack of energy, loss all interest in things that were important to me.

Sheri: That's difficult. I've heard it described as a black hole. From my experience after Andy dying, the depression that I experienced, it had a slippery slope. The depression started out with the grief, but it's slippery and I don't think maybe you realize how far down you go until perhaps you're getting better.

4. **Do you consider yourself spiritual?**

Emma: I believe in God and my faith has helped me. My faith has helped me a lot in dealing with Regina's death, but more so the coping has come from the group.

Mel: Not really.

Kevin: Yea. Oh yea.

Brandon: Pretty much. Yea.

Ellie: Yes.

Sheri: Yes.

Addy: I do.

5. Do you consider yourself a religious person?

Emma: Yes. Catholic

Mel: No… I'm really not practicing. It's once in a while.

Kevin: Yep.

Brandon: If you mean spiritual, I do believe in a God and Jesus Christ and he's my savior. I believe in that.

Ellie: Yes.

Sheri: I don't know that I see a whole lot of difference in that. I have a personal relationship with Jesus. I'm involved in my church. That's a part of my relationship.

Addy: Not so much.

6. How might spirituality/religion come into play at the scene of a suicide?

Emma: I've been asked if I'm Catholic before. I have been asked on the scene, "are they going to go to hell?" and when that's mentioned, I bring up my experience with that same question that I had… that I worried about her soul going to hell because back then when I was growing up that's what we were told would happen if you committed suicide. Since then, the Catholic faith has changed with the with the whole study on mental illness and they've changed their views on that and so I was able to express that when that subject came up which is not that often, but when it came up I just related my situation, my discussion with my priest, and what he told me. So… If it's brought up, I will mention if I feel like it's acceptable or if I know if they're Catholic I will mention God if it's in the right way and said the right way. You hate to hear when something like this happens, "God has a plan," well that's about the last thing they want to hear, but if it's in the right context I'll bring it up.

Mel: No, it hasn't… No… The thought used to be a long time ago I know in the Catholic church that if you took your own life you're going to hell... I've never experienced that.

Kevin: No… Never has… Never has. Well, I take that back. There will be, sometimes people will say, "Why has God done this to me?" or words of the affect… I just tell them "No. I don't think that's right. He or she had a fatal disease and they died of the fatal disease like heart disease or cancer or a stroke or whatever," and 99.9% of them never hear that. They do not hear it.

Brandon: It came into play right after Eugene 's death and I would not go back to church. A lady at our church who is now a Methodist minister herself asked me if I was mad at God. Who could be mad at God? Let a bolt of lightning come down and strike you and the reason I wouldn't go was because a few weeks before he died he was at church with us and I looked over and he had tears running down his cheeks. The reason I gave for not coming back to church was it would bring back that memory and I didn't want that memory, but it finally dawned on me. I was very angry at God to the point of why didn't you take some wino living under an interstate bridge instead of taking my son, but I got over it. I realized God didn't want him dead. Some poor lady at church came up to me and said Brandon, it's God's will and boy did I light into her that it was not God's will for my wonderful son to pick up a gun and stick it to his head and pull the trigger. That was not God's will and I realize that and Eugene had other options. This was the one he chose.

Ellie: No. I don't. I don't ever really. I try not to go there unless somebody expresses something along those lines. I don't ever really tell them what my beliefs are, but I usually ask them if there is a spiritual person or religious leader that they would like to be called. If they comment or express anything along a spiritual line, then I definitely would kind of encourage

that. It seems like at one of the scenes someone said we believe that God is merciful and that our loved ones are taken care of by him or the one that they've lost. I would agree with something like that, but I don't really try to impose my beliefs or preach to anybody at that point.

Sheri: If they ask I will. I will say something. I do not bring that up because I just don't think that's appropriate unless they say something. I've had a few people ask me to pray with them and so I have prayed right there. I've had a few people ask me if their loved one is in hell and I've addressed that and that I did not believe that God judges us on the very last thing that we do in our life and it's not on one act in our entire life. I have not found that in the bible.

Addy: I don't know. I'm not so much an organized religion person anymore. I still have a great faith and I have a problem when people say if someone commits suicide they go to hell. I have a huge problem with that. First of all, I don't think it's our decision to judge that. So, if it's ever brought up, I'll tell them nowhere in the bible does it say that. You might want to talk with your pastor or priest. As a matter of fact, there are several suicides in the bible and it never says those people went to hell and I don't I try not to get into my personal beliefs with things like that. Some people will say, "Do you think they're in hell?" and I'll say, "Well, it doesn't say that in the bible, but talk about it with someone that knows more than I do."

7. **How did you first hear about the LOSS team?**

Emma: So I'm not sure exactly when the LOSS team was formed, but I came on about a year after it was formed… Well I knew that he had developed the team and I remember the team members because they were from group and they were trying to start and I felt I was a little too green for that and was worried about how I would handle a scene. So, after about a year when they were trying to grow, he called and I was a little more open to it and I felt that I could better

handle the situation after I had been through group and I would periodically go to group when I felt like I needed to go to group.

Mel: They were with the LOSS Team…They talked to me. He asked me if I had any questions. Of course, the number one question is "why?" and nobody can answer that and he told me take care of myself and drink plenty of water because you're gonna be dehydrated and you can't eat at that time and you're in shock and everything, all the emotions. The lady that was with him told me that her husband had killed himself. I thought "wow," I got the call at four o'clock in the morning and I don't know what time it was when they got there and it was probably five or six and I just couldn't believe these people would get out of their bed and come to the scene….I was very impressed so with the information that Dr. Jones had given me, I called him, and I had an intake, and then I started going to group meetings. Probably about six years…It's helps people who have lost someone to suicide and it's group discussion and it's very informative and it makes you feel a whole lot better because you might think maybe my family's not good enough.

Kevin: Through the group. The support group… Yeah and I thought well, I really need to do that and one day. A member of the team said why don't you come by and see about joining so I did and I don't remember what year probably 2000-2001 something like that. I don't remember, but I remember the first call I went on with two other people and it was an elderly man who shot himself in the back yard and when we sat down at the table with his wife and I told her that I lost my wife to suicide it was like instant connection. She didn't take her eyes off me and it's happened that way a lot on LOSS calls.

Brandon: I was a member of the SOS group and Dr. Jones told us, I don't know whether he chose a bunch of us, 12 if I remember correctly and explained his idea of the LOSS team and asked if we were interested in becoming a member. I, after thinking about it I said yea I would.

If I could help others, if it will help others and he told us I don't know if it will or not, but we're gonna find out if it'll help.

Ellie: When they came out. Yeah I didn't know anything about it… Of course it was real foggy but, it was very reassuring and I think about this a lot because I don't know if you remember me telling you this or our story, but Emma, it was Emma and Addy and Emma and I had went gone to college together and we were in the same sorority and so I often think about what if it would have been two strangers. Would that have made it different? And now that I'm on the loss team. I kinda think about was it the fact that it was Emma. That was probably a different comfort level to it, but I still think, I think I would have been receptive to it even if it had been two strangers, and the thing that I remember just so clearly was both of them saying they had lost someone to suicide and that there was help.

Sheri: The LOSS team came to my house the day my husband died.

Addy: Not too long after I started going to the support group, Matthew Jones, well he was in charge of it then and they started talking about starting this LOSS team and asking people if they thought it would have been helpful. Well, it would have been helpful because like I said, the night this happened, I did not know one person this happened to and I'm like how do I get up in the morning. How do I deal with it? I just thought, it would have been helpful. So, it started, I'm not sure in like 98 or 99 and I lost my son in 97. So I was still very active in the weekly support group and I knew all the people that were on the LOSS team. Aaron and Missy and Brandon and Maggie and Ava and I think Jordan. I can't remember, but anyway, I knew all of them and heard about their different trainings they went through and the bus trip they took to go to a training and just thought that it was a wonderful community program, that it would definitely help most people and I don't even know when I started as a member. I'm thinking 99

or 2000. They asked me to join them as a team member and so I've been a part of it since then. I didn't want to.

A. Why did you choose to become a member of the LOSS team?

Mel: They approached me… Dr. Jones and there was another girl who used to belong. Carey is her name and Brandon was a member so I couldn't believe they asked me. I thought oh I don't know if I could do this, but I felt the need to give back.

Kevin: I feel like I'm paying back for all the help I've gotten and it helps me to tell people "you're not in this alone. There is help out there. You can get through this." If I did it, anybody can do it. It's real easy. Just walk inside that door. That's all you gotta do. It just makes me feel better to know that maybe I'm helping somebody.

Sheri: That was almost never a question of why I would, but when I would.

Addy: Mainly because, not because I didn't want to. I just felt like I didn't have enough experience or I didn't have the answers. I felt like people were going to be looking for answers and I didn't have them and I would think oh my gosh. If there's a suicide and they get me rather than one of these other people that know stuff, that would be a shame for these people, but I felt like I needed to somehow give back to the crisis center because it had helped me so much and I felt like I might help one person and I kind of did it in the name of my son.

B. Are you involved in any other type of volunteer work?

Emma: I do. I volunteer for a Catholic nun and she has a prayer center and I volunteer active there two days a week and then I was in Junior League and my other volunteer stuff is here. I enjoy volunteering. You gotta give back. I think it's a faith development. I want to go to heaven and any little step ahead there, but I like to give back. I like to help other people. I got into the field of vocational rehab, a helping field and I've always kind of been driven to that.

Mel: No…Just here.

Brandon: I've been on the LOSS team and of course co-facilitate the group and I've worked at Baton Rouge General for a while volunteering there. I more or less just took over when people would be admitted to the hospital. I would take them with their paperwork and take them wherever they needed to go in the hospital and I had some things come up and I had to stop that. My intention is to go back and do it again.

Ellie: No not right now

Sheri: At my church I do.

Addy: Not really. Not really… I mean I do some. I've done some volunteer tutoring, but nothing on a consistent basis or anything.

C. Did you know anybody already on the LOSS team?

Emma: Yes I did because they were members of the group that I participated in.

Mel: No. Never heard of it…Never even know there was a center. Never heard of it. If I did, it didn't register. Baton Rouge Crisis Intervention Center, I had no idea what that was.

Kevin: Yea, we were in group… Brandon was the only one I knew and Matthew Jones.

Sheri: Yes, by coming to group because three people that came to my house that day and two of them, one of them was a co-facilitator and the other one was coming to group when I got here.

8. Since you've been a member of the LOSS team, do you look at suicide in a different way?

Emma: Oh yea. Yea, I do… the stigma of suicide and what happens to a soul after suicide. It's all it's all about learning and when you're exposed to something you don't know a whole lot about and then you're exposed to it and you start to learn about it and you find out that suicide is it's a mental illness. My friend was obviously depressed. I had no idea. No idea that she was

depressed and having the difficulties that she was having because she wore the typical mask and so I learned about that. The faces of suicide. I learned so much from sitting in group and just listening to people and how they handle their situations so all of that listening kind of helped me start coping, making me feel like I'm not crazy and when somebody, I don't know about anybody else, but, when Regina killed herself, I thought she was an okay person. So, when that happened, I start to question myself wondering am I gonna snap one day and pull out a gun and kill myself because that's what happened in my eyes to her.

Mel: Yes… I can't judge people, all the clichés, all the old stuff you hear. You still hear it and I still hear it, the person is selfish and crazy and all these different stereotypes and it's not at all like that. They're all different and I truly do not believe people want to die. I think they want to get out of the pain.

Kevin: Oh yea. I've learned a lot since I've been on the LOSS team about how people handle it and what it looks like because going through what I went through, I have no idea what it's really like. I know what it's like to me but I don't really remember much of it. I don't want to remember much of it. I don't want to go back there. It hurts too bad… I've come to realize that suicide is a disease. It is a fatal disease. Depression is a fatal disease that will kill you if you don't stop it and there have been times where I have been terrified. I've become more vigilant because I feel like somebody I know is going to kill themselves because I know somebody who did and I know what to look for…

Brandon: Well, the old wives tale that I believed, you kill yourself you're going straight to hell. There's no forgiveness. It's an unforgivable sin. My uncle was too good a man and my son was too good a man. The God that I know would not condemn him to hell. I have a son, Eugene and my uncle too, were sick, had clinical depression. They wouldn't take their medication properly

and it killed them. My son was an insulin dependent diabetic, well my oldest and my youngest, both insulin dependent diabetics. If they don't take their insulin medication, it's going to kill them and that's the way I look at it.

Ellie: Definitely, I think just having experienced it first-hand, I look at it in a different way. The LOSS team has opened my eyes to just all the different types of family situation all the different reasons why someone feels like they can't go on. I've just been exposed to a lot of things that I wouldn't have been exposed to normally.

Sheri: I still don't understand it any more than I did the day my husband died. I have a lot of empathy and compassion for the families. I think by being a survivor, I look at it differently. Being a survivor, I know how difficult it is to go through the complicated grief and I guess for other people that are having to go through it, I would like them to know that they don't have to do it by themselves. They don't have to walk that path alone. There are people who understand and not that they can tell you how and what to do, but they can share their experience and they can take what you like from it and try and just forget about the rest. Or maybe the rest of it will add or maybe the rest of it will be pertinent later on in your grief.

Addy: Not really… No. I still think it's a waste of a life and a future. When this happened to my son, I didn't know anyone this had happened to. At that time, I thought who does this happen to? What kinds of families have this? I must be a horrible mother. I must. I didn't know anybody and coming to group and meeting the wonderful people that have also lost children to suicide… Well, they're not horrible parents, maybe I'm not either. Being on the LOSS team and going on the different scenes, I've been in mansions and shacks and in between and highly educated and not educated and it's kind of made me realize that suicide is not a respecter of persons. It happens in all families and socioeconomic groups and so it has kind of put more of a

light on suicide that way in that you can't say because someone lives in a certain place or has a certain job or lived in a certain family that this couldn't happen to them. It's made me more aware of it that way. I still think suicide is such a destructive force in a family and it takes a very strong family to hold together afterwards and not to blame and not to grieve in their own ways and not together. I think there's so much involved in that and I'm still learning.

A. Do you read more literature about suicide?

Emma: Oh yea, I do and I recommend books to people that I think might help them if they helped me.

Kevin: No. I'm more aware of it…But I don't look at it. I, when I hear about suicide or a suicide, my ears perk up. But, I don't go looking for it. I don't go looking for answers anymore.

Addy: Yea.. I do. Not as much as I used to. When he first died, I read everything I could get my hands on.

Brandon: Well, I still don't read a whole lot. I do read a lot of books and pamphlets, anything I can find on suicide and particular on survivors… and I of course I went to a lot of conferences.

Sheri: I read a lot of books at the beginning. Probably in the first two years on suicide and families who had gone thorough losing a loved one to suicide. The books and the things I had read on people who had attempted, I was trying to change the outcome. I was trying to find a loophole that I could bring my husband back or I could get him help and he'd come back. That's irrational and perhaps I was trying to find some answer so I could make sure that it didn't happened again.

Ellie: Definitely. Yea, when it first happened.

9. Do you feel a sense of obligation for being a member of the LOSS team?

Emma: Obligation in what way? I don't think I feel obligated to give back. I want to give back. It's a form of therapy for me in a weird way…and I really feel very strongly that it's needed…I do. And I think when I get out to a scene and see where they're not quite getting the message of what's to come, you really want to help them even more and I think that's where we had come up with the idea of calling them afterward and reminding them about group because I feel that it's needed and I feel they're gonna need it.

Mel: No, the only concern I had was am I going to sound stupid? Can I do this? Just nervous.

Kevin: No… No obligation at all. It's strictly volunteer.

Brandon: No.

Ellie: No… No. No. It was something that I wanted to do. That I felt like I knew how much it helped me and I was I was scared that I wasn't ready maybe or that I didn't know if I'd be able to handle the situation in the middle of it, but it was definitely something that I did on my own. I didn't feel pressured to do it.

Sheri: No. I felt, I don't know the word to use.

Addy: No, it wasn't obligated. I guess I wanted to still make some sense out of my son's death or maybe have something good come from it. Not that going on a LOSS call is good, but like I said, to be able to help someone else and I guess I started the LOSS team about the time my friend's husband died… I guess in honor of my son or in memory of him or something. It wasn't that I was obligated. I don't really do things for that reason. I'll give it a try and if it seems to help or it doesn't seem to hurt somebody or hurt me. So, I've been doing this since then.

10. What do you tell yourself about why you are a member of the LOSS team?

Kevin: Maybe I'm helping somebody, showing them that you're not in this alone. It hasn't happened just to you and when a loved one kills themselves, you know you're the only one that's ever happened to. Why doesn't the earth stop? Why don't people stop doing what they're doing because she's dead. She killed herself. You oughta not be driving your car. You oughta not be going to work. You oughta not be going to a movie. You shouldn't be laughing. You shouldn't be cutting up. No, that's wrong. My wife killed herself. Stop what you're doing and grieve with me. Doesn't work that way. And everybody, I found out something else important. Everybody grieves differently.

Brandon: Because I knew how bad I needed help and I know how bad David Graham had helped me, had been an instillation of hope. If I could be an instillation of hope for other people, that's what I wanted to do.

11. Do you think you're changing anything by being a member of the LOSS team?

Emma: Changing anything? You're hoping to change them the way you've been changed. You're hoping that your experience and explaining to them what's happened to you is going to stick with them and change them and in turn the whole idea is to grow the LOSS team and get those people on the team and build this up.

Mel: Well, I'd like to change the number of suicides, but it just goes on and on. I don't know how I could really change anything.

Kevin: I hope so. I hope that I'm making a little change in somebody's life in helping them cope and get through what is probably the most horrible thing that will every happen to them. So, yea, yea. I hope I'm making a change. I hope I'm making a change for the better. That's my goal anyway.

Brandon: I would like to think so and I had people tell me that I was really a big help to them.

Ellie: I do. I mean, sometimes more than others and we kind of talked about sometimes it's so chaotic, those first few hours that it just seems sometimes like they just aren't receptive or hearing you or even aware that you're there and like a few days distance might make a difference. Yea, but I mean there's been several times where I've been on a scene and especially it seems like when it's been another wife that's lost a husband and when I say that I've lost my husband, you do see a connection. You just, you see them. They just look at you in a different way.

Sheri: Probably. Probably not for people who may be suicidal. For families, I don't know if change is the right word. It's throwing a rope. If you grab it, it's a lifeline. I try to show hope to people because I realize that within the first couple of weeks, chances are that they don't want to live. And I'm not necessarily saying that they want to take their life, but they would just assume God just take me because I don't want to go through this and it's throwing a life ring to someone and saying here, here is a group of people who have made it further than whatever you are in your grief and it's possible to laugh again. It's possible to smile. Some people grab it and some don't as far as coming to group. Maybe the information that we leave is all that they may need.

Addy: I don't know… I don't know. I do know that three members of the LOSS team are people that I went to homes on LOSS calls. So, maybe they felt like it helped them and maybe it's kind of passing it on. So, if nothing else, I think that's a good thing.

12. How much of your time do you spend dedicated to the LOSS team?

Emma: The monthly meetings when I can make them and just the call outs. I don't know how many hours I'm on call. I have certain days I know can go… If it's a volunteer day. Mondays and Wednesdays are always good for me. I really don't know my hours or anything.

Mel: How much time? Well, we have to sign up in shifts and I sign up on weekdays. So, whatever that comes out to be. It's 12 hours shifts. You just live your normal life because you can't sit home and wait for a call. And then of course, if you have something that comes up and you get a call, you can always pass it on to the next person.

Kevin: Not enough… Well, I can say during certain times of the year, I can't come to meetings and there are a lot of times during sports seasons that I can't go out on calls and I feel guilty about that. I don't really know.

Brandon: Well, on-call, I don't know if you want to call on-call time, but probably average 1200-1500 hours per year.

Ellie: Probably not as much as I would like to. I try to sign up as much as I can. I don't know… I would say I normally sign up for maybe I don't know 8 to 10 shifts a month.

Sheri: I had been taking call for the last two years for two days and two nights a week. Then if there's a call and someone wants me to go at a time that I'm not on call, chances are that I could be available, that I would go.

Addy: It varies from month to month. Some months I'm gone a lot to my daughter's, so it just varies. I would say most months when I'm on call I might spend 6 or 7 hours during the month. Some months I may have spent up to 8 or 9 or 10. A lot of months none except for the meetings. It just depends.

A. How does that affect your family life?

Emma: They understand. My husband's gotten used to the idea that it's something I need to do for myself that helps me which in turn helps everybody in the family. I think my son and daughter have just grown to know that's what I do. I think at first they were like "where'd you go in the middle of the night?" and my husband didn't like the fact that I was leaving in the

middle of the night, but I had one or two people that he knew I would be with. So…He was worried about my safety.

Mel: Well, I live alone and so the only one I have to worry about is my dog. She understands I'll be back. I give her a piece of cheese and tell her I'll be back.

Kevin: It doesn't… I get a call. My wife, bless her heart knows Baton Rouge like the back of her hand. I don't. So, she's very helpful. So, my family life is not affected at all.

Brandon: It didn't really interfere with it.

Ellie: Not really. My kids are grown… So, it really doesn't affect anybody

Sheri: It hasn't.

Addy: No. My family doesn't live here, so it really doesn't.

B. How does that affect your job?

Emma: No, I have a very understanding boss and if I do get a call out during the day, I leave and go. We have some members in our workforce that have been affected by suicide so they understand.

Mel: No. I don't work.

Kevin: No because when I'm at work I can't leave.

Brandon: Yea. I had a very understanding boss. I didn't have to go out during work hours. Most of my time on-call was at nights or on weekends, but if there was a need during the week, during working hours and I got the call, he was very understanding.

Ellie: Well I just can't sign up on a day that I have a cooking show or a meeting or something. I just avoid signing up on those days.

Sheri: Well my job is at home. So, I have a little bit of leeway there. Yes, emotionally it does, going out on a call does affect me on a certain extent. I'm at home. I live by myself…I need to

do something different that doesn't have anything to do with a LOSS call or what's going in my home prior to me going out on the call. I need to put some space there.

Addy: No, I'm retired. So, right now I'm back working for six weeks. I can't sign up when I'm working because I can't go during the days. At night, I can't. I don't really want to be out at 2 and 3 in the morning and have to teach the next day. I wouldn't say it affects my job. When I am taking a job, it affects my ability to volunteer. So, I am more able to volunteer when I'm not working.

C. How does that affect your social life?

Emma: It doesn't affect my social life.

Mel: Well that's my weekends. I have a pretty busy active social life.

Kevin: No… Whether I'm at my real job or LSU, I'm at work and couldn't leave and I'm sorry, but that's just the way it is sometimes. So, social life, no and family life, no.

Brandon: No.

Ellie: No, I mean, I tend to not sign up much on weekends. Just because I know we have a lot going on the weekends, but no. Everybody's very supportive and wants me to do as much as I want to do.

Sheri: I don't think so. No.

Addy: No. A couple of times I've been headed somewhere socially and would get a call. Everybody that I know knows that I do this and so they understand if I have to leave or if I have to cancel at the last minute. They're okay with that.

D. How does that affect any other volunteer work that you do?

Emma: No.

Sheri: No.

E. Do you, your family, friends, or job ever get sick of it?

Emma: No… Not at all.

Kevin: No… No.

Brandon: No. No I don't think. I really don't… If anything they encourage me.

Ellie: No. Definitely not.

Sheri: Not my girls. Not my son-in-laws. Not the very close people who walked with me, my very close friends who walked through the grief process with me. I think some other people may think if you want to volunteer there are many other things that you can do. The suicide is over. It's done with. Put it behind you and go on.

Addy: No, it doesn't happen that often…and I think most of them do and if they don't, that's their problem, but I think all my friends understand and they think admire me for doing this even though they shouldn't. I think they respect what I do… It's not something to admire. It's just something I do, but they think they could never do that, but you never know what you could do.

13. What are the benefits of you being a member of the LOSS team?

Emma: I think I think definitely the benefits are when you're trying to help someone, it's a good thing. You feel good about trying to help and anytime someone's trying to help somebody you're gonna feel good about it especially to the degree that you know that they're gonna need the help because you know where you were and you know that you survived it and I remember those days, the bleak days. I don't think you'll ever forget those days and so, you know that you want them badly to go through what you've been through so they can get the help. It's a disappointment to me when people don't come to group. I think if there's any drawback it would be that not enough people come to group…You can lead a horse to water, you can't make them drink and you can tell who's going to come and who's not. It's socioeconomic backgrounds and

education and you just know, but I think sometimes it's just a disappointment… It's not about me. It's about them. You know that they are gonna need that help and they're not reaching out to get it and it's free and it's available and it's just a matter of getting there. People don't feel like they need to be counseled. I never thought I would be counseled on anything. It was a little more than I could bear, but now I see it's not a bad thing and people need help in life. It's not a bad thing. I'm never afraid, I'm never ashamed or afraid to say I had to get help and sometimes you need help. So, I think there's a little bit of a stigma with people going to counseling…It feels good to help people especially when you know what they're going through benefits them. It's gonna benefit them in the long run and in turn all of the ramifications that go with suicide. If you can stop that one person and then that family member stops another family, it's just that whole ripple effect… It just doesn't benefit me, it would benefit everybody down the line. I think it just goes back to helping. People helping people… I think when you're doing something for good, you're feeling good about it… It's healthy, it's just healthy. When you're not doing something good, it's not healthy and you tend to drag down. You don't get depressed, but your overall mood and if you're not doing something helpful it goes the reverse way…Yea. Physically and emotionally beneficial. Yea.

Mel: Three benefits… Well, it makes me feel good about myself that I'm able to help somebody and it makes me feel good that that person trusts me and I can bring them into the meetings, the group, the intake and I don't know…That's all I can think of…Well, it helps the community… Being able to help somebody because I can remember the night I was in that person's shoes and somebody got out of their bed to be with me….Besides myself, the person, the community…It benefits me because I love giving back and helping people.

Kevin: Helping other people who have gone through this, who have been forced to go through this. Helping me and maybe helping the population in general because the more people we can touch, the more it's going to help somebody on down the road perhaps… I got interviewed on television one time about my loss. The LOSS team, the survivor's group, and some girl saw it and actually came in to the center because of it and I'm sure that's happened before in other newspaper stories, TV stories, whatever. So, you go to the scene of a suicide, and tell somebody at the center, and they're gonna tell somebody and that person's probably gonna tell somebody and it's gonna spread and the more you can tell people what's available the more likely you are to be able to help somebody. If I had seen something about the center on TV that would have perked me up right away and I probably would have gotten here sooner, but, it's just a domino effect… The more I talk about what happened to me, the easier it becomes for me to deal with it. It's been thirty odd years and I'm still dealing it. It just helps me. It probably helps me more so than somebody I'm talking to…To get it out of my system… Yea, emotionally, cause it's something I'm always gonna live with and the more I can get it out then that's just that much more I don't have to deal with and every time I talk about it, that's a little bit more gone.

Brandon: I don't know. I've always liked helping other people and definitely was helping other people. Going to a scene I pick up things that would make me more understanding and I know one thing that really helped me a tremendous amount. It was the second call that the LOSS team ever went on. It was on the LSU campus and a student driving across campus had picked his gun up in his car and shot himself in the head and Dr. Jones and I went out to that one and when I watched the police, the EMS, the Coroner's people, the funeral home people… The dignity that they showed this man's body, it really helped me. I was not present at my son's suicide. I didn't know until hours later, but it made me feel like he was probably treated the same way and that

was a big help to me because I was a law enforcement officer for a little over ten years and I know there can be some very cruel things said around the scene of a suicide… Oh, it absolutely helped me… There's a lot of them, but I don't really know how to put them in words … I think it made me understand, talking to some people, even though when I talk to most of them they were in a state of shock, but it made me understand maybe a little bit of what my son had went through, what his life had been like because he stopped talking about their wellbeing. I think it helped there. I don't know I don't know. I just don't know what to say, it's been a lot.

Ellie: Three benefits, I would say, for myself, just feeling like I'm hopefully making a difference to somebody else who is going through this horrible tragedy just like it made a difference for me. I mean that's the biggest benefit, that you're hopefully impacting them in a positive way. I think it helps me, just to continue. It's therapy for me to continue, it kind of puts what's happened to me in perspective. This is going to sound strange, but it keeps me in touch with it too because I find that the longer that time has passed, it's hard to explain, but it's almost like you just become sort of desensitized. It's almost like that event or that part of my life is like behind this foggy window and it's sometimes hard to get back in touch with those feelings and those memories and so, it just keeps me in the forefront without it being a painful thing, a really painful thing. It just keeps me in touch with that part of my life, cause I think the tendency sometimes is just to kind of push it aside and pretend like it didn't happen and then just friendships that I've made with the people on the team and just the personal growth.

Sheri: Well there's one more person on the LOSS team by me being there and I think the LOSS team is an asset to the community. I think it has the potential to change lives, not that the people on the team change lives, but I think sometimes the presence of someone or maybe information gives the individuals that are being visited by the LOSS team to perhaps have their lives

changed… You can't make them willing, but you can show them a little ray of light… I think that this kind of volunteering is much different than any other kind of volunteer work that I've don't in the past… Well because other volunteer work was real feel good stuff.

Addy: First I think is getting to know the other members of the team. When you go on calls with people, it's like you have shared this experience and there aren't many people that share that experience with you… Yes. It's a unique relationship. It's more than a friendship. It's not, but there's a camaraderie of understanding. I've never done it, but I really feel like I could call on any one of these people to help me with anything I need and I feel like they would be there for me… It has helped me to grow and realize how far I've come in this journey. That I'm able to talk about it with people and not fall apart. I never thought I'd be able to do that. So, I think it has made me grow as a person and hopefully it has helped, hopefully it has helped other people.

14. What are the detriments of you being a member of the LOSS team?

Emma: I don't know that there's any detriments. I think sometimes it takes you back a little close to that time, particularly if it's a woman… I think that I had never seen a dead body before and that's something you don't forget, but I don't think that's a detriment. It's just something I was afraid of. I'm okay with that now, but I had never been exposed to that… the two that I saw were hanging young boys. Young boys. I'm an older person, but 16 or 17 had hung themselves and it's just not something I'd intentionally gone to see… I was brought up there by law enforcement to help the mom which I was trying to do and it just so happened that the body was, there, so not that that's a detriment. It's just something that you just don't forget and it's sad. It's sad to see that… I mean there's no, there's no physical. I don't think I notice anything physically.

Mel: No. I don't think.

Kevin: No. No. Unless it's a very hot night and the mosquitoes are very active…. That's about the only down side… Well, the real downside is when you go to the scene of a suicide and nobody wants to talk. Nobody wants to listen. We find that to be the case a lot in black families and I don't know whether they feel like it's a bunch of rich white kids trying to come in and tell them what to do or what, but we have very few black families or blacks that will come to the survivors group or they'll come for a while and stop and apparently it's because they like to deal with things like this in their own society which I don't think is right, but that's neither here nor there… When you go to a scene and nobody wants to listen, nobody wants to talk about it, that's different. That I don't like at all because I feel like I'm not wasting my time, but their life is being wasted. They want the hurt to go away, but they don't want to hear the way to do it. I've got the answers. Well, let me tell you how it is cause I guarantee you 101% of the people who go through this think it's never going to get any better. It's always going to be like this and I'm the only one this has ever happened to. They're wrong… Getting called out at 2:00 in the morning, there was one incidence one weekend where I was called out twice the same night. It kind of ruins your sleep a little bit, especially if you have to go to work the next day.

Brandon: There were times I would being on the LOSS team have to co-facilitate the group, doing some talks and presentations and different things. I would really feel burnout and when I would feel burnout, I would kinda back away. Just for a short time. Just for a few weeks or a few months… Yea, especially after I quit taking my antidepressants. I could feel it then and like I said, I would just step back. I wouldn't start my medication again, I would just step back and kind of catch my breath and take a break.

Ellie: I never really thought of anything as a detriment, but just going back to the keeping yourself in touch. That could be a good thing or a bad thing. So just being able to kind of deal

with whatever the situation that you find yourself in because you never know what it's going to be. You never know how you're going to be received by the people there. So, that's a little scary. The main thing that I always try to find out before I get there is as much as I can so that I'm not blindsided by something because it doesn't affect me differently if I hear it's a spouse or a child or whatever the relationship is. That's not so threatening to me, but how it happened, if it's a gun, Craig shot himself in the head and so if it's a similar thing to that, I don't want to see that. I don't want to be put in a position where I'm exposed to that. So, that's I guess uncomfortable.

Sheri: No. I think it would be wrong for me not to do it. I just felt that desire like I said before. What if someone would not have been there for me and you can say that about anything. A teacher becomes a teacher because someone taught them and inspired them or someone touched their lives in a certain way and they go into a certain career… If there wasn't a LOSS team what would happen to these people? Would there be more suicides? Could be because I have gone on them and I mean it has happened one time that I know of and then later on someone else took their life and that information was passed to them and yet they didn't grab the rope, but other people grab it and they go through their grief and they're okay at the other end… Like I said, this isn't a feel good thing so you can't expect to feel good. Am I anxious before I go out on a call? Yea because I don't know what I'm going to be walking into. Am I sometimes antsy and think about afterwards, the family? I think you asked me something about my faith. That's where my faith comes in. That I can remember these people in my prayers and ask that God would be with them and to guide them and to comfort them. At this point, I don't know. I said I have been doing it now almost eight years… It has not affected my life to where I have to say I don't want

to do this. If I go to too may calls in too short a period of time that the calls are too close together then I know that you can't go on anymore for a while because it's too, it gets too much.

Addy: Well, I guess the only detriment that I can think of is that it makes me know suicide is still happening. I just want it to be over and even if I go and it's a 19-year-old male, it doesn't really bring back my loss, which surprises me. I would have thought that it would, but every loss is different and I've had a couple of those where I've thought I'm heading to the scene and this is a 19 year old white male, dear god help me get through this one, but, by the grace of God I guess I do and it doesn't make me overly anxious the rest of the day or anything like that and I thought it might. So, that, I guess is a good thing.

15. Do you ever feel emotionally overwhelmed with this volunteer work?

Emma: Emotionally overwhelmed… Yea you do because it's emotional. Period. When you're out there and everyone is emotional and you're trying to hold it together for them and sometimes you can't. Sometimes you're right there crying with them because it's emotional and you're feeling sorry for them because you know what they're going through. I don't know that I'm overwhelmed with it, it's just that sense that you know what's happening to them and you're so sorry for what they're going through. So, I don't know that it's overwhelming …Yea, just intense emotion and then there's that little bit of that adrenalin rush on your way out there and you don't know what to expect until you get there and sometimes it's a big scene which I think is more emotional because there's more people that are just distraught then the smaller scenes, but then again I've been out on one scene where the dad fully expected what had happened. He was trying to get the dogs together. He was so in control. I was worried about him cause you don't know how they're taking what's happening, but that was just a different scene. The scenes are

all different so you don't know to what emotional extent that you're going to be dealing with until you get out there…They can range all over the place.

Mel: No… No. I don't.

Kevin: Just that one time with the 18-year-old girl.

Brandon: Yea… Just occasionally like I said.. Though in fact, I guess enjoyed would be the wrong word to use, but I was more than glad to be on the team and respond to suicide scenes and help the people there.

Ellie: No… No cause I don't feel like I do it enough to. If I did it, if I went out everyday or something maybe it would be too much, but I haven't felt that.

Sheri: Well because I keep thinking about their thoughts, their thinking things that they said and it brings up stuff for me that just starts ruminating, ruminating and that's not good for me. I don't need to be there, but most of the time because of where I am in the healing that I can cut that off or realize look you're going down a slippery path here.

Addy: It hasn't been yet. I'm not saying it won't be, but it hasn't been yet.

16. Do you take part in any type of debriefing after a LOSS call?

Emma: When we have a particular scene that we feel like we need to talk about whoever I'm with, we'll talk about that… If we have questions for each other we might be with one party and they might be with another party and then we get together and try and put two and two together. What was said by these people and what was said by these people to try and put our notes together. So, there's a little bit of debriefing. Sometimes it's not needed. If it's just one or two people on the scene, we're both hearing the same thing. We pretty much both agree that when we're taking our notes, we don't need to debrief.

Mel: Sometimes…It just depends because, okay for example the girl I go out with a lot, we've debriefed in her kitchen. We've gone to a coffee shop and she's involved in a business so if she has something to take care of, we talk about it in the car. Because most of the time I'll go pick her up if I'm on call with her. So, we've been on so many…Well, it depends on what we have going on at home.

Kevin: Oh yea. Usually, that's the protocol when you're with somebody else… We go somewhere and get a cup of coffee and just talk about it. Here's what I got. Here's what I learned. Here's who I talked to. Here's what they told me. Here's who wouldn't talk to me or here's what I got from the family or the neighbor or whatever.

Brandon: Yes… It was good. When the LOSS team first started there was usually three people on-call all the time and three people would go out and we would go to a McDonalds, some place that was open, a Waffle House, some place like that and we would just talk about what had gone on and what we thought, and it helped… Oh yea. Absolutely… Should be mandatory.

Ellie: Just being, it's helpful to with whoever you're with on the call just kinda talk it through and debrief and it seems like a lot of times it's been Mel that I've been with lately and so we have just a really good relationship as far as going out and doing that. I think we work well together and so I kind of just, when I get out the car, when we separate, it's kind of like okay, back to back to normal life… We don't necessarily always get out and sit somewhere afterwards. It just depends. If we had a long car ride, we kind of do it in the car or if we feel like we need to sit down, we'll either stop somewhere or she'll come in at my house or whatever. So, some sort of debriefing goes on.

Sheri: Yes, with whomever I'm on the call with. We usually fill out our reports and talk about what we heard, what we saw and it could be different for both of us, or how ever many went.

We put that all in the report and then we talk about if it reminded us of anything with our particular loss and we'll discuss that for a little bit…. I don't think that I could do it without having someone to talk to. I don't think it would be healthy because even with that individual, you know that you could, if something comes up or some feelings, you can call that individual that you went on the call with and just chat about it.

Addy: Usually just with the person that's on the call with me. We'll talk about it a little, but I've never felt the need to call The PHONE or call anyone to debrief me yet. I'll say that because you never know what the next one's gonna bring, but usually whoever's on the call with me, we usually meet and ride together and I've actually been on a few by myself because I couldn't find someone else and that's okay too because I knew if I needed to I could call to debrief. It's almost like when I'm doing this I'm almost, it's almost like an out of body experience. It's like it's almost not me or something I don't know. It's really strange how I've learned over the years to put it in a separate place from my own self or something. I don't know...Yea, I know, I'm different, but anyway, that's how I look at it. I don't actually put myself in that situation again.

A. What is the goal of debriefing?

Emma: Not just making the notes match, but we're okay with what's going on. I always thought debriefing was you kinda had to take care of yourself. Debrief, get everything out make sure we're okay with what was going on, but sometimes the note taking can get a little tricky. Especially if it's big scene. I've been out on a scene where I got a bunch of different notes from friends about what their take was on this person and then you talk to someone whose been with the parents and they weren't depressed and then you start to realize what happened here. The friends all say oh yea, he went through depression and he took medicine for it and the parents are saying no.

Mel: So you don't carry all that into your life…the last call that we had gone on, the girl had shot herself in her apartment and the apartment manager found her. So, of course, we left information for someone to clean it up and the woman, it just dawned on us, wow, you've been an apartment manager for thirty years. She has come across some things in her day and we asked her how you deal with it. She said, just like the police, she's used to it. If you can ever get used to something like that. So, we have her some information too.

Kevin: I guess to get it out of your system. To tell somebody else what happened and from my standpoint it's to hopefully the other person will remember what I forgot, but it helps to talk about it. It gets it out of your system.

Brandon: Get some of it out. Regurgitate some of that trash. Regurgitate some of that stuff that's down in ya. I'm not sure what the official goal is.

Addy: I'm not sure what the official goal is. My goal is, we just kind of talk about mainly how we feel the families will do. Do they have support? What else might we need to do for them. Sometimes we get in the car and we forget we got to do this or we forgot to tell them this so we talk about what we said was helpful or what we maybe thought wasn't or to try and put in my mind, next time be sure to say this or bring this up or something like that.

B. Are some scenes more difficult for you than others?

Emma: Oh yea, yea. I would say that they are.

Mel: Yea. It just depends on the people. Sometimes they're just not receptive. Most of the time they are. Every once in a while you have a difficult one. You don't feel like you've done enough, you didn't get through, but maybe at that particular time they're just so distraught they don't want to listen, but we always leave material.

Brandon: I have been on calls where the survivors were absolutely devastated. I've been on calls where they seem like, ugh so what which was an act. I know that. It just hasn't hit them, yet and everything in between that. I have been on calls where most of them, the survivors there, family and friends are really pulling together, but you go to those where, an hour afterwards they're pointing fingers at one another and arguing. You must not love him because you're not even crying, that kind of stuff. I learned that people grieve differently and on different timetables, but most important they grieve differently… Everybody grieves different and don't think you understand what's going on in their head or in their heart.

Ellie: No… Not anymore difficult than any of them… Yea and I'm trying to think the scenes I've been on… I'm trying to think what may be the most difficult one. I mean anytime there's children involved. I've never been on a scene where's it's been a child that has been the suicide person, but I've been where there have been children that lost a parent and that's hard.

Addy: Yea the hardest ones to me are when they have no support and I've been to where they don't have neighbors that they know. They don't have family. I just feel so badly for them because you need somebody there. The young people are hard, many times they seem like they already know or they, it wasn't a surprise. That doesn't make it okay or easier, but it does help you understand, it's like we kind of expect this, but that's to me, the hardest are when you know these people are going to be by themselves to go through this so I encourage them to come to group and others too, but they especially need somebody they can talk to.

17. Do you ever think being a member of the LOSS team prevents you from moving forward in your life?

Emma: Oh no…No. Never…If anything, it helps you move forward with your life…It does help you through the grieving process…It will always help you through the grieving process.

There's always something different on every scene that you learn that may not be part of what you experienced, but you see something part of what they're experiencing and I think by that, you're educating yourself on maybe another scene that may be where that information might be useful to you and you can bring that information with you on another scene.

Mel: Oh, I have moved forward. Yea…Well, that means I've accepted my son's suicide. Although I don't approve, I don't agree because if I don't accept it, I can't live and the woman that was involved, the girlfriend that was 19 years older than him. I've never blamed her. As a matter of fact, last year I ran into her. We had a conversation and no butterflies, no bad feelings. I don't want to have that, the bad feelings. So, I guess somehow my coping skills must kick in and I think really it's all about your coping skills and I don't know where you get them, where they come from. Maybe people need to work on them, but everything I've learned in group, on my own, my own thoughts, I'll always have that empty feeling in my heart, but I've moved on.

Kevin: No. No. If anything, it helps because like I said it's my way of paying or paying forward. However you want to refer to it because I've gotten so much help and I've learning so much. I've learned how to cope. I've learned how to deal with it. I've learned how to talk to people. I've learned how to listen. I think that's most important, listening when they want to talk.

Brandon: No… To the contrary, I think it helped… Contrary that you wanted to know if it hindered me. No, I think it helped me to move on. To help me get through it.

Ellie: No. No. It's funny that you say that though because when I was going to group actually, a good friend of mine, it's more of a working relationship friend, but anyway she kind of suggested that maybe group was bogging me down and I just think that's a perception of people

who don't understand because they haven't been in that situation. So, I don't agree with her. I didn't agree with her, but I think there's a perception of that out there.

Sheri: I've thought about that, but I don't know necessarily. I don't necessarily believe that. I think that it's brought something good out of a very bad situation... I don't think that we go through experiences just for our own sake. What if people in any given situation learn something and don't turn around and reach a hand out to someone else. I think we're all interconnected and if we see someone that's in need, whatever it is, that we should help. I'll get the help I need and the next person will get the help they need. You support people… I don't think me being on the LOSS team is not that I feel obligated. I feel gratitude that the LOSS team was there where I have been. In what direction would my children have gone?

Addy: No… No. I think it has helped me move forward in my life.

A. Do you think it ever prevents you from getting involved in other activities?

Mel: Oh no.

Kevin: No… No. The LOSS team, I know it's help me deal with it. What I was going through. What I am going through. What I went through.

Brandon: No… No. Not that I can think of.

Ellie: No.

Sheri: I don't think so.

18. Do you think people view it as being over your loss if you are asked to be on the LOSS team?

Brandon: If there is, I don't know them… No. I don't think. I don't know of a survivor that I have ever been around or talked with or anything that would say they've gotten over their loss…

I know I haven't. Never will. For me to get over it, I'd have to forget about my son, that he ever existed and that's not gonna happen.

Ellie: Probably. I think a lot of people see you moving forward in any way think you're over it… I don't cry a lot in front of a lot of people. I find that I've almost gotten to be kind of unemotional about it just because I've had to be to a certain extent, publically. Probably there's a few people that think I'm over it because I'm not real emotional when I talk about it.

Sheri: I don't know what they think.

Addy: Actually, I think the opposite. I think, like different friends and different people have said, when are you going to stop that and get over it? I'm like probably never. I don't know if I might stop the LOSS team, but I'm never gonna get over it… Now, I don't know what it looks like to other people, but to people who know me think it's just kind of my way of hanging on to my grief which I don't see it that way… I'd say that's the way some people do look at it. You need to distance yourself from this. Maybe they're right. I don't know, but that's not how I see it.

19. How long do you see yourself staying on the LOSS team?

Emma: Until they kick me off…Yes, as long as I can stay on it.

Mel: Well, until they revoke my license and I can't drive my car…I'd come in a golf cart though… I don't have any intention of leaving.

Kevin: I don't see every quitting. I see no reason to. As long as I'm physically able because I am getting up in the years… It's a very good thing. It's something I wish everybody had access to. It'd make life a lot simple and a lot better for a lot of people. When you hear about a suicide in New Roads or Hammond or Shreveport, I want to reach out to those people.

Sheri: I think it will be just the same as when I decided this is what I'm gonna do. It's just I knew this is what I was gonna do and until a time comes where I say that within my being this is enough. I'll continue to do it whether that's six months from now whether that's thirty years from now. Who knows, but I do know that whether it's with the LOSS team or not because I'll talk outside of the LOSS team, but I will never hide the fact that we survived suicide. I won't do that in my private life.

Addy: I don't know. I don't know… No. If they got enough new members and fresh faces and things like that, I might say it's time for me to go and let these new people do it but. Now I think they still need me to do it so I will.

20. Would you recommend that everyone who has lost a loved one to suicide become a member of the LOSS team? Why? Why not?

Emma: No, I think that's a personal decision…I think it's good, but it's really up to the person and how they can handle it… No, that's a personal thing. I would recommend it, but it's personally up to them to say I need to do this.

Mel: No…Because a lot of people are still dealing with their own grief and their own problems and I don't think it would be good for others. Because I hear that from a friend. She says I don't know how you can do that. I don't know how you can do that. Although the LOSS team was there for her and that's been probably nine years ago and she still says I don't know how you can do that.

Kevin: No. No no no no…You've got to be able to come to grips with your own loss first and when you go to a scene you gotta be able to listen if somebody wants to say something rather than trying to convince them that your loss was worse. It's not. It's the same, but it's different.

Brandon: No…I just think some people are football players and some people aren't because they're just not talented. That's not in their makeup and some people are not compassionate. We've had them in group who show no compassion whatsoever and in fact, one recently not only did not show compassion, made a statement that I don't know why ya'll come to this group. All ya'll do is sit around and talk to one another about how you're feeling. Now, he's a survivor. He definitely would not be a good LOSS team member.

Sheri: No…because I think mental health has something to do with it and I think that you've got to have a passion for it… You've got to have that desire on the inside to want to go. Because it's not a feel good thing. It's not where it's going to help somebody paint a fence and then you stand back and you look and you say "aww, didn't we do good?" No. It's not that kind of volunteering. It affects you and it can affect you mentally and I just don't think that anyone can do it. Not that I'm above someone else. That's not what I'm saying.

Addy: Probably not… Probably not. Well, I mean it should be open to anyone that wants to, but I think of myself of being emotional, but I can kind of handle my emotions most of the time. I'm not sure on a LOSS team call you need to break beyond yourself, so I think it would have to be somebody that could handle it and I'm not the judge of that. I think most people know if they could and it would be up to the individual.

21. Do you think there should be term limits on the LOSS team?

Brandon: No. I think the more experience they get, the better they are at it and the more comfortable they are at it… Yea, I don't know why you would put a limit on it. If you see a member of the team beginning to show some signs of depression disconnect maybe then you might talk with them about taking a break at least.

Ellie: No. I don't think so. I don't know how you would do that… For one thing, there's not a lot. We don't have a lot of people, so that wouldn't be very good for the longevity of the team or the sustainability of the team. I just I don't think that it's necessary. I think if somebody seems like they're doing well and able to really help people and go out on calls and work well with other people then I don't think there needs to be a limit.

Sheri: Why? I've never heard that, but why would you? I don't see any reason. If you're going out there trying to save someone, you can't do that. So, I guess what your motive is. You can't save another human being. You can throw rope to them. You can't make up for something that's happened in the past. No, I don't I don't think so.

Addy: It might be a good idea or it might be like take a year off here and come back or something like that. Kind of like a sabbatical from it. I hadn't thought about that, but that might be good… Well the thing is I've kind of imposed that for myself. Every so often, I'll go a month without being on-call or something like that. Not necessarily that anything happened… Of course I've still gotten call outs during that month from people that need somebody which is okay too. I don't feel like if I'm on-call for the day, I feel like I should limit what I have planned for that day and sometimes that gets hard. I mean that would have to be up to the group as a whole. I did kind of the same thing being a facilitator in the support group when they get new people coming in ready to do it, it's time for me to move on.

22. Have you ever had any training in suicide prevention or intervention?

Emma: I did ASIST. Let's see we had to go through ASIST (Applied Suicide Intervention Skills Training) and there was some kind of classroom… Matthew had this kind of program that we went through... and then we were kind of interactive with the ASIST participating in certain situations… I think when I was in school in Vocational Rehabilitation I had taken some

counseling classes and I think it came up, but I don't really remember any details. That was way back when.

Mel: No. I knew people who had committed suicide, but I really never gave it a second thought. Even now I get questions like "how many children do you have?" Sometimes I tell them one and let it go and sometimes I don't know, it just depends on how I feel about it. I tell them what happened and so many times when I've said my son shot himself, that person comes back and well, my cousin or my uncle, unbelievable…Oh yea. I was upfront and honest right off the bat. I'm from Pennsylvania, so and I have a lot of friends from that area. I could have lied and said he was in a car accident, but I would never do that because if you tell the truth it always stays the same. Your story's not going to change.

Kevin: No... No. The only suicide I was aware of was celebrities: Janis Joplin, Jimmy Hendrix, something like that, but no I didn't know the warning signs to look for. I had no idea what suicide was. Didn't really care. Didn't know anybody who committed suicide cause it was a stupid thing, which it is. It's not an answer. Well, it is for the person who dies, but for the rest of us, it's a pain in the butt. Plain, pure, and simple. It ain't fun. I don't want to do it again. Ever. But, if it did, I could cope with it a lot better now because of the thing I've seen on the LOSS team and been exposed to

Brandon: Not at all… Nothing.

Ellie: Before? No

Sheri: No. No. This may go back when you talk about the training. I heard that they had an ASIST training and I took that. It was before I joined the LOSS team. Yea, it was.

Addy: No. At school sometimes we would have little things, but nothing. Nobody that was teaching us knew what they were… I mean it was like mandatory and they would basically put

up PowerPoint things on signs to look for and whatever kind of stuff. I don't want to say I didn't get anything from it, but basically. You knew that the person doing it was just doing it because they had to and it didn't mean anything to them and it was mandatory and that was it. Since then, I have actually gone to schools and done some stuff on suicide and they have been very responsive and so hopefully that meant a little more for them... Them knowing I was a teacher and I know that they have better things they could be doing right now than listening to me, but just sharing some stories and some things to look for and mainly ways that my son's worst problem was the assistant principal who bullied him everyday and I still see teachers who bully kids every day because they have that power over them. I talk about bullying and be careful how you treat kids and the ones who need you the most sometimes are the ones you don't like worst, mainly that's what I talk about is how they could make a difference in that child's life. Not necessarily about suicide, but make a difference and love them and know you may be the best thing, the best person they're around all day because we don't always think about that, so.

A. What kind of training did you get prior to becoming a member of the LOSS team?

Emma: A lot of observations…Well mostly the observation and listening to how the other responders handled certain situations and that all had to do with the observation and listening and then kind of coming into my own when I was approached by a mom or someone that maybe would connect with me more so than a male…Then I would kind of start opening up and then slowly getting in to the LOSS team and being able to respond and hold my own so to speak…We talked about it, he used to have this kind of spiel and I think what we did. I think we all went through it that were on the LOSS team. It was, he'd have a dry erase board and we'd talk about the canyon and how to handle certain situations and I don't remember how often that little bit of

training was but we would talk about proper things to say things not to say on a scene. How to handle a scene. We went through ASIST and then once I got out on to the scene those hours of observation.

Mel: That was years ago. I can't remember what it was called but I did have training…Yea…It was a whole Saturday… A lot of scenarios.

Kevin: I think there were a couple training sessions just for new members of the LOSS team. I don't remember exactly about what to expect. Learning the material, the printed material… Like the death of a child or things you do like drink water, get rest. The stuff we hand out at scene. I think the biggest training was in the survivor's group. It's amazing what you can learn and every Tuesday night I learn something new. Every time. Every time, so it's always the same, but it's always different.

Brandon: We went to Atlanta. Dr. Jones chartered a bus and we piled on the bus and we take off to Atlanta… Iris Bolton, we went to her organization, which was The Link I think they call it. It was a crisis intervention center and they trained us in active listening and that type, the biggest thing was listening.

Ellie: It was on a Saturday. It was so many people that I had seen before, but Ben from Clean Scene came and spoke… That's a medical waste cleaning service. They go out to the scenes of accidents and homicides and suicides and clean the surroundings or the home or whatever. So, he came and did a presentation and somebody from the police department I believe came and did a presentation and then we did some role-plays and things about different situations.

Sheri: I don't know if it was really, I think it was more, the one-on-one whoever I was going out with… It was 8 years ago and I was still in a fog… I did learn about crime scene etiquette. I learned what to do if someone says that they don't want to see us because we're supposed to go

to every scene and my first call that I went out on the people didn't want to see us. So we didn't get to talk to them, but we were out there and they knew who we were. Even that is a contact because they knew where we were from and you could still leave information. I've gone on other calls where people say they don't really need to talk to you and then the person stands there and talks for an hour. So, on the scene and then crime scene etiquette and what you can and what you can't do and not going by yourself and, the policies, the protocol. I have all that and we keep that in our notebooks, our LOSS team notebooks with our literature and how to phone in.

Addy: I don't really remember, I know we had several different training sessions and it was more about, similar I guess to the PHONE training which I did go through that to, but it was similar to that in how to listen which was good, a good training and then we would have people who had been on the team a while act out different scenarios of being on a call and what people might say to them and how they would answer and things like that and that was helpful.

B. In retrospect, would you change anything about the training process?

Emma: No, it was good training. Yea, it was good training.

Brandon: No. It was good because I had never even heard of active listening… It was really good and we did a lot of role-play and it was very beneficial to us all.

Ellie: I mean, I think ongoing training would be good and I don't think we needed to hear a lot about Clean Scene, stuff was real technical and very biological and I don't think that was something we needed to hear because we don't come in contact. We just need to know that those services are available to be able to pass the information on, but it was way more technical than we needed to get into, but I do think that it would be good for us to have more training and I mean I know we're not supposed to be counselors on the scene or anything, but just grief training

or just because we're all from all different walks of life. A lot of us don't have any of that background.

Addy: Not that I can think of.

23. Why were you picked to be on the LOSS team over another person in the support group?

Brandon: Why was I asked? I don't know. The only thing I can say is I was regular. I didn't miss group and I did participate and I think I tried to help others coming into group with a fresh loss. I tried to help them through.

Ellie: I don't know. Maybe they saw that I was attending regularly and that when somebody attends group regularly you do see the progression of them getting better and getting stronger and kind of coming to grips with it. Whereas, somebody who pops in or pops out or just never talks maybe. It's kind of hard to read how they're doing… Brandon was the main one that would have suggested that I join and Emma and I talk all the time. So, I think they just saw that I was doing really well.

Addy: I have no idea… I don't know… I don't know because I don't know what they use to determine who they ask or not. I really don't know.

24. What would you look for when picking a new person to join the LOSS team?

Brandon: First of all, I would look to see where they were in their grief. Make sure that they, I don't know if this is a social work term, but do no harm. Make sure the person was at a place in their recovery where being on the LOSS team would do no harm. Now, how long is that? I wouldn't put a time, I mean maybe a year. Maybe two years. Maybe three years. Maybe five years, but do no harm and someone who does seem to have compassion for others. You can

watch in group and you can tell people who really care about a survivor who may be having a particularly bad time in group that night and that's what I would look for.

Ellie: I think somebody who seems like they are on stable ground for themselves and not still struggling with the why and not overly emotional because I don't think that would be a good thing to go out on a scene. Just somebody who can kind of look at it and say, well this happened to me. It wasn't anything that I caused or somebody that didn't have a lot of guilt around the situation.

Sheri: What would I look for? Someone who has done some grief work. I don't necessarily think they have to be totally through with their grief work because sometimes it lasts a long time, but it also comes back and you have to revisit some of it… That's how I look at it. I think that perhaps going on a LOSS call, the new people, the brand new people who join, I think that they should go on calls for more than one with someone else and almost be in some ways observers. Let me put it this way. All I can go by is my experience and that was my experience. That's what was done with me. You can't go on any calls by yourself. You have to go with other people.

Addy: I think I would look for someone who can calmly tell their story and not get hysterical because some people do and I understand that, but I don't think we need that at a scene. I think I would want somebody that has empathy with other people. Not to judge them because we're all like this a little, only want to talk about their loss. They kind of want to monopolize the time in group and not hear about other people and their problems or something like that. So, I think I would want somebody that wants to listen as much as talk and I don't always get that impression. But anyway, that's what I would look for.

25. If someone says to you that they've been asked to be on the LOSS team and they ask you if they should join, what would you tell them?

Brandon: Well, I would have to know what their reasoning is for wanting to join and I really believe to really be effective, they have to be a survivor. Now, we had a couple of members on the team that were not survivors and they would go out, but there was always a survivor and that's what I would say. I would make sure that there is a survivor out there.

Ellie: I think I would tell that's something that they would really have to decide for themselves if they felt like they could handle the situations and so it wouldn't adversely affect them or set them back in their own situation.

Sheri: I would never discourage anybody from joining it. I would tell them to get in touch with whoever was the head of the LOSS team and to talk to them. Even if they were kind of iffy, I'm just not sure that I could do that. Well, why don't you come and see. Why don't you talk to whoever's in charge and you can come on a call and observe and see.

Addy: I would tell them that they should join if they felt like it, felt like they could. That it has been rewarding in its own way and hard in its own way. I hate every time I get a call. It's like oh gosh, but like I said I think it does help and I think it's gotten people into group sooner. I would recommend that they go on some calls first and see what it's like and that it's an individual decision. They can't do it because I think it's a good thing or helpful. It has to be their decision, but I think it would be rewarding in some way for them… Like I said, to feel like you've made some kind of a difference… Well, you're with people at the worst time of their life. That's hard and you just do the best you can. Whatever we can tell them that might help a little bit is a good thing. It's kind of like the doctors, first do no harm

Themes

After all of the meaning units were clustered by the researcher and the triangulating analyst reviewed them for accuracy prior to beginning the process of developing themes. The researcher then preformed the steps of imaginative variation to pull the emerging themes from the meaning units. The meaning units were compared to the original transcripts of each participant for validation. Eleven non-overlapping themes were developed and labeled by the researcher. The themes were then reviewed, modified, and agreed upon by the researcher and triangulating analyst. The list of 11 themes are listed in the table below

Table 2: Themes and descriptions of the lived experience of members of the Local Outreach to Suicide Survivors team

Theme	Description
Type of loss	Child Spouse Extended Family Friend Student
Length of time since loss	Short term Long term
Stigma	Religious Familial Societal
SOS group	Therapy Highly recommended Instillation of hope Worked after nothing else did
Spirituality/Religion	Source of support Solicitation of opinion

(Table 2 continued)

Theme	Description
Benefits	Personal Personal growth Empathy Compassion Nonjudgmental attitude Camaraderie Physical Emotional Form of therapy Volunteer No sense of obligation Familial, friendly, and professional encouragement No negative effect on family, social life, work, or other volunteer efforts No interference with day-to-day activities Community Suicide prevention Suicide awareness Suicide postvention View of Suicide Increased awareness Increased knowledge Affects all walks of life
Detriments	Disappointment in unreceptiveness Secondary trauma Exposure to trauma Anxiety provoking Emotionally overwhelming
Retirement	No intent to leave Reservations
Training and Development	Formal Informal SOS group
Self care	Debriefing Sabbatical Relaxation
Membership Qualities	Personal decision Mental stability Emotional control Come to terms with loss

Individual Textural-Structural Descriptions

Moustakas (1994) explained that the researcher is to construct an individual textural description of each participant's experience "using the relevant, validated invariant constituents and themes" (p. 121). Verbatim excerpts from the interviews were extracted for these descriptions (Moustakas, 1994). Individual structural descriptions were also developed for each participant by providing "vivid accounts of the underlying dynamics of the experience" through imaginative variation (Moustakas, 1994, p. 135). Reviewing the verbatim transcripts and taking the meaning units and themes into consideration, the researcher developed each of the participant's composites. The following text presents the thematic textural-structural descriptions of each participant.

Emma. Emma was the first survivor of suicide to be interviewed. The interview was conducted on Monday, March 26, 2012 at 3:00pm in the conference room at the Traumatic Loss Center in Baton Rouge, Louisiana. Emma is a 40-50 year old woman with a Master of Science degree. Emma has never had a clinical diagnosis of depression.

Emma lost her best friend over 15 years ago. Emma's best friend was the only person she knew who died by suicide. The LOSS team was not activated for Emma's loss because it was outside of the geographical area served by the LOSS team. Approximately one month after the loss of her best friend, Emma received a referral from a family member to the Baton Rouge Crisis Intervention Center and began attending the Survivors of Suicide (SOS) support group. Emma attended the SOS support group every week for the first twelve weeks and slowly weaned herself away from the group. When asked about therapy Emma said, "Really, this, the LOSS team, is my therapy." The SOS group was the only type of formal counseling Emma received after her loss.

Emma reported that after the death of her friend, she looked at suicide in a different way. Losing such a close friend who Emma considered to be "okay" made her question her own sanity to some extent. Emma recommended books that helped her through her loss to others. She tried to avoid movies that had anything to do with suicide because "it brings back just a little bit too much."

Emma explained in the interview that she is Catholic and believes in God. Her faith helped her get through her best friend's death. When asked about religion and spirituality coming into play at the scene of a suicide, Emma said that she does not bring it up, but will talk about it if it is brought up by the newly bereaved. In reference to her own friend's death, she said, "I worried about her soul going to hell."

Emma joined the LOSS team about a year after it was formed. Emma had initial hesitations about joining the LOSS team and said that she thought she was "too green" and not yet ready to help others. Emma knew several members on the LOSS team from being in the SOS group. She did not feel obligated to join the LOSS team and said, "I want to give back. It's a form of therapy for me in a weird way." Emma has Mondays and Wednesdays typically free to volunteer with the LOSS team. She attends the monthly LOSS team meetings and the majority of her volunteer hours come from the activation of the team. Emma's family and job are understanding of her having to go on a call-out at a moment's notice. She reported that being on the LOSS team does not affect her social life or other volunteer efforts.

Several times Emma said that she felt the LOSS team is a "needed" service. Emma also explained that she is hoping to change others by being on the LOSS team. She says, "you're hoping that your experience and explaining to them what's happened to you is going to stick

with them and change them and in turn, the whole idea is to grow the LOSS team and get those people on the team and build this up."

Emma reported four benefits of being a member of the LOSS team including 1) knowing it's a good thing to help others 2) feeling good for helping others 3) the ripple effect for suicide prevention within families and 4) it's healthy; physically and emotionally. Emma also explained three detriments to being a member of the LOSS team: 1) disappointment when people don't come in to group; Emma said, "You can lead a horse to water, you can't make them drink and you can tell who's going to come and who's not." 2) sometimes it takes you back a little too close to your loved one's death and 3) exposure to dead bodies. Emma also reports that doing this work can be emotionally overwhelming and intense emotions come out when she's at the scene of a suicide.

According to Emma, debriefing is a way to make sure you "take care of yourself." After leaving the scene of a suicide, Emma debriefs difficult calls with the person she went on the call with. Emma explained that debriefing is not only a way to take cure of yourself, but a time ask questions and put notes together. Emma thinks that some scenes are more difficult than others and sometimes she does not debrief. Typically this is if there are only a few people on scene.

When asked if being on the LOSS team prevents Emma from moving forward in her life she said, "Oh no…No. Never…If anything, it helps you move forward with your life…It does help you through the grieving process." She went on to explain how every scene is different and educational. She learns something new on every scene and can use what she has learned at one scene with newly bereaved survivors at another scene. Emma plans on staying a member of the

LOSS team as long as she can stay on it. Emma also thinks it's a personal decision when and if someone decides to join the LOSS team.

Prior to joining the LOSS team, Emma remembers discussing suicide in her counseling classes in her Vocational Rehabilitation Masters program. After losing her best friend by suicide, Emma attended Applied Suicide Intervention Skills Training (ASIST). Prior to becoming a member of the LOSS team, Emma observed other LOSS team members on scene. She said that this on-scene training was the best type of training she received. Emma also reported having gone through a formal training including what to say and what not to say to newly bereaved survivors of suicide. Emma said that this training was good and she would not have changed anything about it.

Mel. Mel was the second survivor of suicide to be interviewed. The interview was conducted on Thursday, March 29, 2012 at 1:00pm in the conference room at the Traumatic Loss Center in Baton Rouge, Louisiana. Mel is a 60-70 year old woman with a high school diploma. Mel has never had a clinical diagnosis of depression.

Mel's child died by suicide over 10 years ago. The LOSS team was activated for Mel's loss and two members from the LOSS team spoke with her following her child's death. A few weeks after the loss of her child, Mel went to the Baton Rouge Crisis Intervention Center and began attending the Survivors of Suicide (SOS) support group. Mel attended SOS support group "every Tuesday" and "never missed" for six years. Mel said that the SOS group was very important and she highly recommends it because she got so much out of it. The SOS group was the only type of formal counseling Mel received after her loss.

Mel explained that she is not really spiritual or religious. She said she practices "once in a while." Mel said that spirituality and religion are not really talked about when she is at the scene of a suicide.

Mel first heard about the LOSS team when they came out to the scene of her child's suicide. Prior to this she had never heard of the Baton Rouge Crisis Intervention Center or any of its services. Years later, someone from the LOSS team approached Mel and asked her to be a part of the LOSS team. Mel said, "I thought oh I don't know if I could do this, but I felt the need to give back." Mel did not feel obligated to join the LOSS team, but felt nervous and wondered if this was something she could do. Mel explained that by being a member of the LOSS team she would like to change the number of suicides, but she doesn't know how she could really change anything.

Mel signs up to be on-call for the LOSS team on week days. Mel explained that she lives her normal life and if she gets a call, she takes it. If she is unable to go, she passes it on to the next person. Mel said that being a member of the LOSS team does not affect her family. Mel is retired and is not involved in any other volunteer work. Mel said that she has a busy social life, but if she gets a call while she is busy, she passes it to another LOSS team member.

Mel reported that after the death of her child, she looked at suicide in a different way. Mel explained that she no longer judges people and believes that no one truly wants to die.

Mel reported three benefits of being a member of the LOSS team including 1) feeling good about myself 2) feeling good for helping others and 3) helps the community. Mel reported no detriments to being a member of the LOSS team. Mel also mentioned that she does not feel emotionally overwhelmed with the work she does with the LOSS team.

Mel said that they debrief "so you don't carry all that into your life." She does not always debrief after a call. She said that it depends on the type of call and what she and her partner have going on at home. Mel explained that some scenes are more difficult than others and that it depends on the people at the scene, particularly when they are not receptive.

Mel said that she has moved forward in her life and the LOSS team has not prevented her ever moving forward or getting involved in other activities. To Mel, moving forward meant accepting her child's suicide. Mel said that she does not have any intention of leaving the LOSS team.

Mel would not recommend that every survivor of suicide become a member of the LOSS team. She said that if people are still dealing with their own grief it may not be good for others.

Prior to the death of her child, Mel did not have any suicide training. Mel was unable to recall the specifics of her LOSS team training, but did remember that it was a full day training with "a lot of scenarios."

Kevin. Kevin was the third survivor of suicide to be interviewed. The interview was conducted on Thursday, March 29, 2012 at 3:00pm in the conference room at the Traumatic Loss Center in Baton Rouge, Louisiana. Kevin is a 60-70 year old male with a Bachelor of Science degree.

Kevin's wife died by suicide over 30 years ago. The LOSS team was not activated for Kevin's loss because it was outside of the geographical area served by the LOSS team. Immediately after the loss of his wife, Kevin saw a psychiatrist once. Over ten years later, he went to the Baton Rouge Crisis Intervention Center and began attending the Survivors of Suicide (SOS) support group. Kevin attended the SOS support group every Tuesday night and said, "I'd

come twice if I could." There were some Tuesdays that he missed due to his job. Aside from seeing a psychiatrist one time, the SOS group was the only type of formal counseling Kevin received after his loss.

Kevin said that since his wife died by suicide, he now understands that suicide and depression are diseases. Kevin said that it's a fatal disease and he is now more aware and vigilant. He said that he is "terrified" that someone else he knows may have one of these diseases. Kevin said that he is more aware of suicide, but does not go looking for information in books, articles, or websites.

Kevin said that he does consider himself a spiritual and religious person. When asked about religion and spirituality coming into play at the scene of a suicide, Kevin initially said, "no, never has" and then said, that sometimes people will ask if God has done this to them. He responds to them and says, "No I don't think that's right. He or she had a fatal disease and they died of the fatal disease like heart disease or cancer or a stroke or whatever." Kevin said that 99.9% of the people never hear what he's saying.

Kevin first heard about the LOSS team while he was attending the SOS support group and knew a couple members of the team. Kevin was approached by a member of the LOSS team and spoken to about joining the team. Kevin said that he did not feel obligated to join the team and that it is "strictly volunteer." When asked why he chose to join the LOSS team, Kevin said, "I feel like I'm paying back for all the help I've gotten and it helps me to tell people you're not in this alone. There is help out there. You can get through this. If I did it, anybody can do it." Kevin said that he is a member of the LOSS team because there's a chance he's helping someone and showing them that they are not in this alone. He hopes that he's changing things by helping

the newly bereaved survivors of suicide "cope and get through what is probably the most horrible thing that will ever happen to them."

Kevin said that he does not spend enough time dedicated to the LOSS team. He said that he feels guilty that he can't participate during certain parts of the year because of his job. Kevin's family is helpful when he has to go on a LOSS call and it does not affect his family, job, other volunteer work, or social life. Kevin also reported that he does not think his friends or family ever get sick of him being on the LOSS team.

Kevin reported four benefits of being a member of the LOSS team including 1) helping other people 2) helping himself through the grieving process 3) helping the population (Kevin calls this the "domino effect") and 4) it's emotionally beneficial to himself. Kevin also explained two detriments to being a member of the LOSS team: 1) disappointment when people at the scene do not want to talk to you and 2) a disruption in sleep when he is called out in the middle of the night. When further explaining the disappointment Kevin has when people are unreceptive, he discussed how it is uncommon for African American families to take advantage of the services offered by BRCIC. He went on to say that they either do not come to the center or come for a while and stop. Kevin said, "apparently it's because they like to deal with things like this in their own society." Kevin also said that he was only emotionally overwhelmed at one particular scene.

According to Kevin, the goal of debriefing is to get it out of your system. Kevin said that when he debriefs after a call it normally involves getting a cup of coffee and just talking about what happened at the scene.

When asked if being on the LOSS team prevents Kevin from moving forward in his life he said, "No. No. If anything, it helps, because like I said. It's my way of paying or paying forward.." Kevin continued on to say that being a member of the LOSS team has allowed him to learn how to cope, deal with the loss of his wife, talk to other people, and how to listen. Kevin does not think that being a member of the LOSS team prevents him from being involved in any type of activities. Kevin plans on staying a member of the LOSS team until he is physically unable to do so. He said that he does not see a reason to quit.

Kevin would not recommend that every survivor of suicide become a member of the LOSS team. He said, "No no no no…You've got to be able to come to grips with your own loss first and when you go to a scene you gotta be able to listen if somebody wants to say something rather than trying to convince them that your loss was worse."

Prior to his wife dying by suicide, Kevin had only heard about the suicide of certain celebrities. He said he had no idea what suicide was and didn't really care. Kevin said that his greatest training for the LOSS team was attending the SOS group. He also attended a couple training sessions where he learned the material and discussed what to expect.

Addy. Addy was the fourth survivor of suicide to be interviewed. The interview was conducted on Wednesday, April 4, 2012 at 2:00pm in the conference room at the Traumatic Loss Center in Baton Rouge, Louisiana. Addy is a 60-70 year old woman with a Bachelor of Science degree. Addy has never had a clinical diagnosis of depression.

Addy has known several people who died by suicide. Her most significant loss was her child nearly 15 years ago. Aside from her child, Addy has also lost three friends and two former students. Addy received a referral from the funeral home to the Baton Rouge Crisis Intervention

Center. Two weeks after her child's death, she called the center and began attending the Survivors of Suicide (SOS) support group. Addy attended the support group every Tuesday night for ten years, started coming less often, and then stopped attending the group. Along with attending the SOS group, Addy also saw her child's psychologist for a period of time after her child's death.

Addy said that she considers herself to be a spiritual person, but "not so much" religious. Addy said that when on the scene of a suicide, if someone mentions the person who died by suicide going to hell she says "nowhere in the bible does it say that. You might want to talk with your pastor or priest. As a matter of fact, there are several suicides in the bible and it never says those people went to hell."

Addy reported that after the death of her child, she does not look at suicide in a different way. Addy said, "I still think suicide is such a destructive force in a family and it takes a very strong family I think to hold together afterwards and not to blame and not to grieve in their own ways and not together." Addy reads more literature about suicide since the death of her child. She said that when her child first died, she read everything she could get her hands on.

Addy first heard about the LOSS team from the SOS support group. One of the group members was discussing starting the LOSS team and asked if it would be a helpful service. Addy told the group member that she thought it would have been helpful to her. Shortly after the LOSS team was started, Addy joined the team. By this point she knew all of the LOSS team members from the SOS group that she had been regularly attending. Addy said that when she was asked to join the LOSS team that she "didn't want to," but didn't feel obligated to join the team. Addy said, "I just felt like I didn't have enough experience or I didn't have the answers. I

felt like people were going to be looking for answers and I didn't have them." Addy said that she joined the team to try to make sense of her child's death. Addy said she doesn't know if she's changing anything by being on the LOSS team, but several of the members on team came from LOSS calls that she went on.

Addy's time that she spends dedicated to the LOSS team varies from month to month. Some months Addy only goes to the monthly meeting while other months she spends up to ten hours at the scenes of suicides. Since Addy's family does not live in the same city as Addy, being a member of the LOSS team does not affect her family life. Addy is also retired and has previously done some other volunteering, but "nothing on a consistent basis or anything," so being on the LOSS team does not affect her job or other volunteer efforts. As for Addy's social life, it has been interrupted on a few occasions, but she said that her friends understand. Addy also said that her family and friends do not get sick of her going out on calls.

Addy reported four benefits of being a member of the LOSS team including 1) having a relationship with other team members 2) personal growth 3) helping herself through the grieving process and 4) to help others. Addy also explained one detriment to being a member of the LOSS team: 1) still knowing that people are dying by suicide. Addy also reported that doing this work has not been emotionally overwhelming yet, but she can't say that it won't be in the future.

According to Addy, debriefing is a time to discuss how the newly bereaved family might do, what type of support they have, and what the LOSS team members can do for the family. After leaving the scene of a suicide, Addy debriefs calls with the person she went on the call with. Addy also said that she knows that if she needs to she can call someone to debrief or call

the 24-hour crisis line. Addy also explained that some calls are more difficult than others. For Addy, the most difficult calls are the ones where the family has little or no support

When asked if being on the LOSS team prevents Addy from moving forward in her life she said, "No… No. I think it has helped me move forward in my life." Addy thinks that sometimes her friends ask her when she's going to get over her loss. Addy thinks they are suggesting that being on the LOSS team is preventing her from getting over her child's death. Addy said that she will never get over it. Addy plans on staying a member of the LOSS team until new members join the team and they don't need her anymore. Addy also thinks it's a personal decision when and if someone decides to join the LOSS team and that it's probably not a good idea for every survivor of suicide to be a member of the team. Addy also thinks that creating term limits for the LOSS team may be a good idea. She suggested the idea of LOSS team members taking a sabbatical.

Prior to joining the LOSS team, Addy remembers discussing suicide in job as a teacher in formal trainings, but she said she didn't get anything from it. Prior to becoming a member of the LOSS team, Addy went through a training program that included learning listening skills and observing LOSS team members acting out different scenarios that might occur at the scene of a suicide. Addy said that she would not have changed anything about the training. Addy was not sure why she was asked to be a member of the LOSS team over other survivors in the SOS group, but if she were looking for a new member she would look for someone who could calmly tell their story, has empathy, is nonjudgmental, and wants to listen.

Brandon. Brandon was the fifth survivor of suicide to be interviewed. The interview was conducted on Monday, April 9, 2012 at 11:00am in the conference room at the Traumatic Loss Center in Baton Rouge, Louisiana. Brandon is a 70-80 year old man who completed some college. Although Brandon has never had a clinical diagnosis of depression, his doctor prescribed him antidepressants after his child's death. According to Brandon, depression occurs when you cannot concentrate, think straight, have a lack of energy, and lose interest in important things.

Brandon's child and uncle died by suicide. Brandon's uncle was the first person he knew who died by suicide over 20 years ago and he looked to his uncle as a father figure. Brandon's child also died by suicide over 15 years ago. Brandon speculates that there may have been a third suicide in his family when he was very young, but it has not been acknowledged by family members. Brandon did not get help after his uncle's death, but went to a local counseling agency after his child's death. After going there for five months and not making any progress, the therapist referred Brandon and his wife to the Baton Rouge Crisis Intervention Center. Brandon's wife went to the Baton Rouge Crisis Intervention Center immediately and Brandon went a little over a year later. At that point, Brandon attended the SOS support group. Brandon said that attending the group gave him an "instillation of hope" and he still attends group every Tuesday night. Brandon explained that he frequently picks up something new when he attends group.

Brandon reported that after the death of his uncle and child, he looks at suicide in a different way. Brandon said that he no longer believes the old wives tales about suicide including 1) if you kill yourself, you're going to hell, 2) there's no forgiveness and 3) suicide is

an unforgivable sin. After his uncle and son's death, Brandon said that he reads anything he can get his hands on that has to do with suicide or particularly survivors of suicide.

Brandon explained in the interview that he pretty much considers himself to be spiritual. Brandon further went on to say that he believes in God and Jesus Christ as his savior. When asked about religion and spirituality coming into play at the scene of a suicide, Brandon only commented on the judgmental comments that he received at his church following his child's death by suicide.

Brandon said that he was one of the original 12 members of the LOSS team. Brandon explained that the person who created the LOSS team approached him and asked if he wanted to be a member. Brandon knew the other members of the LOSS team from the SOS group and said that he did not feel obligated to join the team. Brandon joined the LOSS team hoping that he would be able to help others. He said that he joined the team because he knew how bad he needed help and wanted to be an instillation of help for others. Brandon said that he would like to think that he is changing things by being on the LOSS team and some people have told him that he was a big help to them. Brandon said that he typically volunteers 12-1500 hours per year. Brandon said that the LOSS team never interfered with his family life and his boss was very understanding. Brandon also said that being on the LOSS team did not interfere with his social life or the other agencies he volunteers with. Brandon also said that his friends and family do not get sick of him contributing his time to the LOSS team, but encourage it.

Brandon reported two benefits of being a member of the LOSS team including 1) helping other people and 2) helping himself through the grieving process. Brandon also said that the one detriment to being a member of the LOSS team was emotional burnout. Brandon also reported

that he was occasionally overwhelmed, but was happy to be able to serve the community in this way.

According to Brandon, debriefing is a way to get it out and talk about how they think the families will do, if they have support, and what else the LOSS team can do for them. After leaving the scene of a suicide, Brandon debriefs difficult calls with the people he went on the call with. Brandon explained that often times they would stop at a restaurant and debrief. He said that debriefing should be mandatory and it's very beneficial. Brandon said that he has been on many different scenes and the greatest thing he has learned is that "everybody grieves different and don't think you understand what's going on in their head or in their heart."

When asked if being on the LOSS team prevents Brandon from moving forward in his life he said, "No… To the contrary, I think it helped." He went on to explain how being a member of the LOSS team helped him get through his grieving and sadness. Brandon said that being a member of the LOSS team never prevented him from taking part in any activities. Brandon does not think that other people assume he is over his losses by being a member of the LOSS team. He said that he will never be over his loss because to be over it he would have to forget about his loved ones.

Prior to joining the LOSS team, Brandon never had any training in suicide prevention or intervention. Prior to becoming a member of the LOSS team, Brandon and the other potential LOSS team members went on a bus trip to Atlanta, Georgia for training. They visited a crisis center there and were trained in active listening and other skills. Brandon said that he would not change anything about the training because it was very beneficial.

Brandon was not sure as to why he was asked to become a member of the LOSS team. His assumption was because he was a regularly attending member of the SOS group. Brandon does not think that every survivor of suicide should be a member of the LOSS team. He said that some people are just not compassionate and would not be good LOSS team members. When looking for new members of the LOSS team, Brandon said that he would look for someone who was at a place in their grieving process where being on the LOSS team would not cause them harm. He also believes that LOSS team members should all be survivors of suicide. Brandon also does not think that there should be term limits for the LOSS team, but thinks that if someone shows signs of depression they may need to take a break.

Sheri. Sheri was the sixth survivor of suicide to be interviewed. The interview was conducted on Monday, April 9, 2012 at 1:00pm in the conference room at the Traumatic Loss Center in Baton Rouge, Louisiana. Sheri is a 50-60 year old woman whose highest level of education is a high school diploma.

Sheri has known three people who have died by suicide. The first person that Sheri knew who took their own life was her spouse nearly 10 years ago. Sheri also lost her great uncle and a friend a few years later. She said immediately following her spouse's death, she knew that she would need help for herself and her children and that at different times she got different kinds of counseling (individual and group). A few months after her spouse died, Sheri saw an individual grief counselor. After a few months, she decided that she was not getting what she needed and she went to the Baton Rouge Crisis Intervention Center. Sheri said that her first night in the SOS group she knew that was where she belonged and she has been going every Tuesday for the last ten years.

Sheri reported that after the death of her spouse, she does not understand suicide any better. She says that she has empathy and compassion for families who lose a loved one to suicide and understands that depression is a "black hole" and a "slippery slope."

Sheri explained in the interview that she considers herself to be spiritual. Sheri further went on to say that she was not sure that she saw a difference between spirituality and religion, but she does have a relationship with Jesus. When asked about religion and spirituality coming into play at the scene of a suicide, Sheri said that she never brings up the topic. She also said that on occasion she has had survivors of suicide ask her to pray with them and so she has. She has also been asked if their loved one is going to hell and Sheri tells them that is not true.

Sheri first learned about the LOSS team when they came to the scene of her spouse's suicide. Sheri said that it was "almost never a question of why I would, but when I would" join the LOSS team. Sheri already knew several people on the LOSS team from attending the SOS group when she joined the team. She also said that she never felt obligated to join the LOSS team. When asked if she thought she was changing anything by being a member of the LOSS team, Sheri said she looked at it as throwing them a rope. She said, "If you grab it, it's a lifeline." Sheri said that for the last two years she has been on call two days and two nights per week. She also goes out on calls at other times if she is needed. Sheri said that being a member of the LOSS team has not affected her family life, social life, job, or other volunteer efforts. However, Sheri did explain that it's hard to come home to an empty house so she tries to do something for at least thirty minutes prior to coming home to her house. She said that she does not think that anyone that is close to her is sick of her being on the team.

Sheri reported three benefits of being a member of the LOSS team including 1) an asset to the community 2) it has the potential to change lives and 3) it's different from other volunteer work because it doesn't just make you feel good. When asked about detriments of being a member of the LOSS team, Sheri mentioned 1) being anxious before going on calls a2) being antsy after calls and 3) sometimes there are too many calls in a short period of time and it gets to be too much. Sheri also reported that sometimes things can get overwhelming when she ruminates and thinks about the families and what they are thinking and going through.

After leaving the scene of a suicide, Sheri debriefs calls with the people she went on the call with. Sheri explained that debriefing includes a discussion about if the call reminded them of anything with their particular loss. Sheri said that she did not think it would be healthy to not have someone to debrief with after a call.

When asked if being on the LOSS team prevents Sheri from moving forward in her life she said, "I don't necessarily believe that. I think that it's brought something good out of a very bad situation." Sheri continued on to say that being on the LOSS team has not prevented her from getting involved in any type of activities. Sheri is unsure as to what other people think about her being a member of the LOSS team, but said that she will be on the LOSS team until she decides she is not going to do it anymore. She's not sure if that will be six months or thirty years from now. Sheri does not think that every survivor of suicide should be on the LOSS team. She thinks that people need to be mentally healthy and have a passion for doing this type of work. Sheri also thinks that there is no reason for there to be term limits for the LOSS team.

Prior to joining the LOSS team, but after her spouse's death, Sheri attended the Applied Skills Intervention Skills Training (ASIST) program. Sheri had a difficult time remembering

what type of training she went through when she joined the LOSS team, but remembered one-on-one observations with current LOSS team members. She also remembered learning about crime scene etiquette, policies and protocols, and what to do when newly bereaved survivors of suicide do not want to talk to LOSS team members. Sheri said that when looking for someone new to join the LOSS team, she would look for someone who has gone through the grieving process. Sheri said that she would never discourage someone from joining the LOSS team and would in fact encourage them to come and see what the LOSS team does when they go on calls.

Ellie. Ellie was the seventh survivor of suicide to be interviewed. The interview was conducted on Tuesday, April 12, 2012 at 10:00am in the conference room at the Traumatic Loss Center in Baton Rouge, Louisiana. Ellie is a 50-60 year old woman with a Bachelor of Arts degree. Ellie has never had a clinical diagnosis of depression.

Ellie lost her spouse over 5 years ago. When Ellie's spouse died by suicide, the LOSS team came to her home. Ellie had started to see a counselor approximately six months prior to her spouse's death to discuss his mental health. They went to a few marriage counseling sessions together and then Ellie went back to the counselor after she lost her spouse. Ellie's best friend was the only person she knew who died by suicide. Between four and six weeks after her spouse's death, Ellie went to the Baton Rouge Crisis Intervention Center and started attending SOS group. Ellie attended the SOS group regularly for the first year, sporadically the second year, and does not go much anymore. Ellie does not currently attend individual or group counseling.

Ellie reported that after the death of her spouse, she looked at suicide in a different way. She said, "The LOSS team has opened my eyes to just all the different types of family situations

and all the different reasons why someone feels like they can't go on." Ellie said that after the death of her spouse she now reads more books and pamphlets about suicide. She said that she remembered reading because she needed an explanation to try and make sense of the things.

Ellie explained in the interview that she considers herself to be a spiritual and religious person. While talking to the newly bereaved survivors of suicide, Ellie does not tell them her religious or spiritual beliefs. She explained that she will ask the person if there is a spiritual or religious leader that they would like to be contacted.

Ellie first heard about the LOSS team when they came to her house the night of her spouse's death. Although Ellie said that night was "foggy," she remembered that a friend from college was there with the LOSS team. She often wonders if it would have made a difference if two strangers would have been there. Ellie said that she never felt a sense of obligation to join the LOSS team and that it was something she wanted to do. Ellie thinks that she is changing something by being a member of the LOSS team. She said sometimes she makes a certain connection with someone and she can tell that they are receptive to what she is saying. Ellie said that although she does not spend as much time dedicated to the LOSS team as she wants to, she volunteers about 8 to 10 shifts per month. Ellie said that since her children are grown, being a member of the LOSS team does not affect her family life. Ellie also said that being on the LOSS team does not affect her job, social life, or other volunteer work that she does. She continued on to say that everyone is supportive and wants her to do as much as she wants to do.

Ellie reported four benefits of being a member of the LOSS team including 1) helping other people like she was helped by the LOSS team 2) continuing her healing and keeping in touch with her loss 3) friendships she has made on the team and 4) personal growth. Ellie

explained three detriments of being a member of the LOSS team 1) sometimes keeping yourself in touch with your loss can be a bad thing 2) it's sometimes scary not knowing how you will be received and 3) it's uncomfortable to be exposed to a dead body. Ellie also reported that doing this work is not emotionally overwhelming to her because she does not do the work enough.

According to Ellie, debriefing is a helpful way to talk through the things that they saw at the scene. After leaving the scene of a suicide, Ellie debriefs difficult calls with the person she went on the call with. Ellie explained that sometimes instead of going somewhere to debrief, they may debrief on the car ride home. Ellie initially said that no scene is more difficult than others. After thinking about it a little more, she said that any scene with children involved is more difficult.

When asked if being on the LOSS team prevents Ellie from moving forward in her life she said, "No. No." She continued on to explain that she previously had a friend suggest that attending the SOS group was "bogging" her down. Ellie thinks that this may be a common perception of people, but she does not agree with it. Ellie said that being a member of the LOSS team has not prevented her from getting involved in any activities. Ellie thinks that people probably think she is over her LOSS by being a member of the LOSS team.

Ellie does not think it is necessary to have term limits on the LOSS team. She thinks that if people are well and able to go out on calls, then they are okay to be on the team. Ellie also thinks that it would not be good for the sustainability and longevity of the team to have term limits due to the small number of current LOSS team members. Ellie said that if she was looking to recruit new members for the LOSS team, she would look for somebody who is on stable ground and knows that the death of their loved one was not something that they caused. If

someone asked Ellie if they should join the LOSS team, she would tell them that it's a personal decision and they have to be ready to handle the situations.

Prior to joining the LOSS team, Ellie did not have any suicide prevention or intervention training. Ellie attended the Applied Suicide Intervention Skills Training as part of her training to become a member of the LOSS team. Ellie also remembers a training from Clean Scene, the police department, and a training that involved role-plays and different scenarios that may occur. Ellie said that she thinks ongoing training is helpful because many of the team members do not have a mental health background.

Composite Textural-Structural Descriptions

The participants in this research study varied based on their type of loss and amount of time since their loss, yet they are all members of the LOSS team. The participants all lost someone to suicide including the following relationships: child, spouse, extended family members, friend, and student. Some of the LOSS team members have a more recent loss within the past five years while others have a loss that was nearly thirty years ago.

Some of the participants first heard about the LOSS team when team members responded to the scene of their loved one's suicide. Other team members did not hear about the LOSS team until they started attending the SOS group at BRCIC. Some of the participants in this research study came to the SOS group because other types of therapy were not working for them. All of the participants had positive things to say about the importance of the SOS group. Some of these positive comments included a recommendation to this group for survivors of suicide, the instillation of hope that the group brings to newly bereaved survivors of suicide, and how one participant would spend extra time in the group if he could.

Although none of the participants felt obligated to join the LOSS team, many of them felt that they were not ready to join the team. All of the participants said that being a member of the LOSS team does not interrupt or affect their family life, social life, work, or other volunteer opportunities. In fact, most of the participants said that their family members, friends, and colleagues encourage their participation in this volunteer effort. The participants in this research study had many motivations for being a member of the LOSS team. Generally speaking, the participants felt that being on the LOSS team was beneficial to themselves, the newly bereaved survivors of suicide, and the community. They joined the LOSS team with hopes to change people's experiences with the aftermath of suicide and decrease the number of suicides. All participants interviewed in this research study had no intention of retiring from the LOSS team. The participants said that unless they were physically unable or enough new members joined the LOSS team, they would stay indefinitely.

All of the participants in this research study identified with some sort of religious affiliation on the demographics sheet that was given to them prior to beginning the interview. Some of the participants even mentioned that their religion and/or spirituality helped them through the grieving process. Most of the participants made it quite clear that they do not bring up and religious or spiritual conversations while on a LOSS call. However, they all explained that if a newly bereaved survivor of suicide asks a religious or spiritual question, they will respond to the question.

Prior to the loss of their loved ones, the participants in this research study had a lack of knowledge about suicide. Some of the participants heard about suicide through their job, schooling, or the media, but their exposure and knowledge was limited. After the death of a loved one to suicide, each of the participants sought information on suicide. They are all much

more aware of suicide and have increased their knowledge on suicide including formal training in suicide prevention, intervention, and postvention. In fact, they each went through a formal training to be a member of the LOSS team and felt that the training gave them the skills that they needed to be a contributing member of the LOSS team. One participant mentioned that the greatest training that he received for being a member of the LOSS team was his experience in the SOS group. The participants also have different views about suicide than they had prior to their loss. Some of the participants reported that they now understand that suicide affects all walks of life, they understand that suicide is a disease, and they now have empathy and compassion for survivors of suicide

Aside from all of the positive things the participants had to say about being a member of the LOSS team, the participants mentioned several detriments to being a member of the team. Several of the participants in the research study think that being a member of the LOSS team is emotionally overwhelming and anxiety provoking at times. Several participants also explained that they feel a sense of disappointment when newly bereaved survivors of suicide are unreceptive to the LOSS team or never make it to BRCIC. Some participants also explained that sometimes being on a LOSS call it takes you back a little too close to your own loss. Seeing a dead body was also mentioned as being detrimental to individuals on the LOSS team. To take care of themselves, all of the participants engage in debriefing after difficult call. Some of the participants also mentioned having a cup of coffee with other LOSS team members and trying to do something for herself after a call to take care of herself.

The participants in this research study all had similar beliefs about who should be a member of the LOSS team. They all agreed that it is a personal decision to join the LOSS team, but that being a member of the LOSS team is not for everyone. One person said that LOSS team

members should only be survivors of suicide. All participants agreed that to be a member of the LOSS team, a survivor of suicide must be at a certain point in the grieving process and must be emotionally and mentally stable. One person mentioned that a LOSS team member must have empathy, a nonjudgmental attitude, and listening skills. While not everyone agrees that there should be term limits to the LOSS team, one participant thinks that it might be a good idea. Other participants mentioned that it may be beneficial for LOSS team members to take a leave of absence form the LOSS team if they are emotionally overwhelmed.

CHAPTER FIVE
SUMMARY, OUTCOMES, AND IMPLICATIONS

This chapter summarized the research that was conducted in this phenomenological study, the outcomes of the study, and implications that emerged from this research study. The summary of the research is organized following the arrangement of chapters within the dissertation. The outcomes are presented as the themes that emerged from the data.
The chapter is concluded by identifying implications of the outcomes of the study including implications for practice and recommendations for future research.

Summary

Chapter one presented an introduction into this phenomenological research study that was modeled from Moustakas (1994). This chapter began by explaining the need for this research study. As the 11th leading cause of death in the United States (CDC, 2010), not only do a great number of people die by suicide, but also suicide leaves behind a great number of survivors of suicide. The primary purpose of this study was to examine the experiences of members of an active postvention team for survivors of suicide. This team is referred to as the LOSS team and is located in Baton Rouge, Louisiana. The secondary purpose of this study was to assess the potential benefits and detriments of being an active member of this team. The research conducted in this study is of great importance to the population of survivors of suicide because the benefits and detriments of being on a team such as the LOSS team have yet to be researched. The chapter concluded with definitions of terms used in this research study.

Chapter two presented the review of the related literature including the theoretical framework. This chapter was organized in a way that began by giving a brief overview of the history of suicidology and statistics and risk factors associated with suicide. The chapter then detailed the population of survivors of suicide and postvention services offered to newly

bereaved survivors of suicide after a loss. The chapter concluded by introducing the concept of an active postvention model in the form of the LOSS team and the availability of similar services worldwide. After data collection was finished and themes for this research study were defined, additional literature was reviewed and the chapter was amended.

Chapter three outlined the methods used in this phenomenological research study. The chapter explained qualitative research, the phenomenological method, and the phenomenological process. The preparation process for data collection was explained including the development of a conceptual model, guiding questions, the researcher's role, credibility, the sampling strategy, informed consent and confidentiality, and the use of a pilot study. The data collection process was also outlined including the interview process, ethical dilemmas, and the van Kaam method for organization, analysis, and synthesis of data (Moustakas, 1994).

Chapter four explained how the data were organized, analyzed, and synthesized for this phenomenological research study using the van Kaam method. All of the data were viewed as having equal value and clustered into meaning units. From the meaning units and the verbatim transcriptions, themes were developed. The chapter also provided individual textural-structural descriptions of each participant as well as a composite textural-structural description of the data.

Outcomes

The outcomes of the study are presented as the themes that emerged in this phenomenological research study regarding benefits and detriments of being a member of an active postvention team for survivors of suicide.

Loss. This phenomenological research study confirmed that suicide affects all different types of people and does not discriminate against gender, age, education, or religious affiliation. The participants in this research study were both male and female and their ages ranged from 50

to 74. Their level of education varied from a high school diploma to a master's degree. Although all participants identified with a religious affiliation, several no longer practice their religion. These individuals have experienced the loss of a child, spouse, extended family members, friend, or student. The diversity of the participants shows that suicide affects all walks of life. In fact, the participants all identified a stigma that is associated with suicide. Familial, religious, and societal stigmas all came up in the interviews and the stigma associated with suicide is seen throughout the literature (AAS, 2012f; Jackson, 2003; Mitchell et al., 2005; Simon, 2012; Sveen & Walby, 2008). Although there was diversity amongst the participants, it must be noted that all participants in this research study identified with Caucasian as their race and no minorities were included in this research study.

Survivors of Suicide Support Group. Each of the participants in this research study attended the SOS group at BRCIC. Although they each attended for different lengths of time, they had similar things to say about this support group. The literature supports the fact that SOS groups similar to the one at BRCIC are a source of support for newly bereaved survivors of suicide after a loss and are considered to be very helpful in the grieving process (AAS, 2012f; AFSP, n.d; BRCIC, 2012c; Jackson, 2003; McMenamy et al., 2008). The participants in this research study discussed the importance of the SOS group in their grieving process and highly recommended it to other survivors of suicide. Several of the participants had explored other forms of therapy prior to beginning the SOS group and said that this group worked when nothing else did. The participants explained that the other individuals in the group provided an instillation of hope for them. In fact, a few explained that the goal of the LOSS team was to get newly bereaved survivors of suicide to the SOS group at BRCIC.

Benefits. The researcher was unable to find anything in the literature that examined the experiences of members of an active postvention team such as the LOSS team. After concluding this research study, the following benefits were drawn from the data: personal benefits, volunteer efforts, community benefits, and changed views of suicide.

Many personal benefits were discussed during the interview process with the participants in this research study. The participants discussed a sense of personal growth that developed from being a member of the LOSS team. They discussed having developed more of a sense of empathy and compassion for survivors of suicide. This is something that many of them did not understand prior to their loss or prior to joining the LOSS team. The participants also discussed the nonjudgmental attitude toward people that they now have since being a member of the LOSS team. A sense of camaraderie was also mentioned as a personal benefit to being a member of the LOSS team. Many of the participants explained how they have developed friendships from being on the LOSS team and have even reconnected with old friends from being a member of this group. Physical benefits were explained as a way of staying active and engaged. Members of the LOSS team said that being part of the team was physically beneficial to them. More importantly, the participants explained the emotional benefits of being a member of the LOSS team. Participants said that being a member of the LOSS team was a form of therapy for them and helped them continue working through the grieving process. Some participants also mentioned that being a member of the LOSS team helps to keep them in touch with their loss.

Participants in this research study also identified their volunteer efforts as a benefit to being a member of the LOSS team. All of the participants stated that they in no way felt obligated to become a member of the LOSS team. The participants in this research study also explained that being a part of a volunteer effort where they can help people is important to them

and beneficial. The participants in this research study explained that being a member of the LOSS team does not interfere with their day-to-day lives and the researcher found their membership on the LOSS team has no negative effects on their family, social life, profession, or any other volunteer efforts in which they are engaged. In fact, they stated that their family, friends, and colleagues encourage their participation in the LOSS team.

All participants had little or no awareness of suicide prior to their loss of a loved one by suicide. Although they may have heard of suicide, this was the first time that it hit close enough to home to have a lasting impact on them. Two of the participants received a limited amount of training in their profession prior to their loved one's death. Aside from this exposure, the participants only heard of suicide from what was portrayed in the media. However, after being a member of the LOSS team, the participants' noted that their views of suicide changed. The participants now have an increased awareness of suicide due to their personal loss and their experiences of being a member of the LOSS team. The participants also have an increased knowledge about suicide that they gained through their experience and research. One piece of knowledge that the participants explained as being critical to know is that suicide affects all walks of life and you never know what is going through someone else's head. Having been through the loss of a loved one by suicide and being active members of the LOSS team, the participants certainly are more empathetic to traumatic life events and crises of others.

A final benefit that the participants identified was the benefit to the community in which the LOSS team serves. The participants recognized the importance of having postvention services provided to their community, especially the active postvention services that the LOSS team provides in order to connect the newly bereaved survivors of suicide with the resources offered at BRCIC. The participants also spoke to the fact that the active postvention services of

the LOSS team function as a form of prevention for families of the newly bereaved and future generations in the community.

Ultimately, being a member of the LOSS team has allowed the volunteer survivors of suicide to keep in touch with their grief without being stuck in their grief. In some sense, the LOSS team has become a type of "security blanket" for the survivors of suicide. The LOSS team members know that other LOSS team members have also experienced a loss by suicide and they will always have someone with whom to relate. As a valuable and contributing member to the LOSS team and the community, the survivors of suicide are able to move forward and be an instillation of help to newly bereaved survivors of suicide.

Detriments. Many of the participants stated that there were not any detriments to being a member of the LOSS team. Several of the participants mentioned a disappointment that they feel when newly bereaved survivors of suicide are unreceptive to the LOSS team at the scene of a suicide. They also mentioned a sense of disappointment when they talk to the newly bereaved at the scene and they seem receptive, but never make it to BRCIC for the SOS group. Another detriment to being a member of the LOSS team is the secondary trauma that they may experience at the scene of a suicide. As some of the participants mentioned, being at the scene of a suicide sometimes brings them back a little too close to their own loss. Further, the participants stated that being exposed to dead bodies at the scene of suicides is a traumatic experience for them. Feelings of anxiety were reported when a participant is on their way to a scene of a suicide. Additionally, many of the participants noted that they are emotionally overwhelmed after spending time with the newly bereaved survivors of suicide.

Although there are some things that are detrimental to the members of the LOSS team, there are also safeguards in place to diminish the effects of these detriments. All of the

participants in this research study explained that they debrief after the majority of the calls. The participants explained that debriefing is a way to discuss what happened on the call, how it may have related to their loss, and a way to get rid of some of the emotions associated with the call so they don't carry those feelings around with them. Some of the participants also engage in some sort of relaxation after going on a LOSS call. Various participants have also chosen to take a break from the LOSS team at certain times throughout their volunteer experience. Some have taken off for a couple weeks and others several months. Regardless of the amount of time, this allows them to take a break from the LOSS team in an effort to not get emotionally overwhelmed or experience burn out.

Training and Development. Another safeguard to ensuring mental stability for the members of the LOSS team is training and development. It is evident that training is an ongoing process with these participants and that they have received both informal and formal training. Each of the participants were members of the SOS group before joining the LOSS team and mentioned that the group not only helped them work through their grief, but was also a form of training and preparation for the LOSS team. The SOS group functions as somewhat of a stepping stone to the LOSS team. After being asked to join the LOSS team, each of the participants went through a formal training. Although each of them may have received different training, they were all satisfied with the training and said that they would not have changed anything about the training. Most importantly, the participants explained that each time they talk with a newly bereaved survivor of suicide, they learn something new and this training is continuous.

Membership. Becoming a member of the LOSS team seems to be a selective process. The participants in this research study made it quite clear that being a member of the LOSS team

is not for everyone. They described the types of qualities that members of the LOSS team should have, including genuineness, compassion, and a nonjudgmental attitude. It was also mentioned that members of the LOSS team need to be mentally stable and at a certain point in their grieving process prior to joining the LOSS team. Participants also mentioned that new members of the LOSS team would need to be able to control their emotions when talking to newly bereaved survivors of suicide. Ultimately, it is a personal decision if someone joins the LOSS team, but the participants thought that not all survivors of suicide should be on the LOSS team and they need to have come to terms with their loss prior to joining the team.

Implications

The implications are organized based on their relevance to suicide prevention, intervention, and postvention practice nursing and the implications for future research in suicide prevention, intervention, and postvention.

Implications for Practice. One of the implications for practice is the importance of this type of service to the population of survivors of suicide. Being a member of an active postvention team for survivors of suicide is beneficial to the volunteer survivors of suicide. As previously noted, being a member of this type of team is personally, emotionally, and physically beneficial to the volunteers. Additionally, being a member of this team helps the individual to continue to work through the grieving process and be part of a close-knit group that considers each other to be friends and a source of support. Furthermore, this type of service is beneficial to the community as these active postvention services are prevention efforts for future generations. Although several detriments were identified, it is important to recognize that safeguards are in place to prevent the volunteers from being negatively affected from their experiences on the LOSS team. Being a member of the LOSS team has allowed these survivors of suicide to come

full circle and develop a new normal. They were once unable to make sense of their loved one's death and for some were in a dark place themselves. Now they are able to be contributing members to a service that is preventing future suicides and be part of their community.

There is a great need for expansion of these types of services worldwide. Over the past few years, there has been an increase in these teams nationally and a committee of LOSS team directors and leaders from across the country have established a national LOSS conference that is now planning its third annual conference. From discussions with LOSS team directors and leaders across the country, it is evident that there needs to be community engagement and support to develop a LOSS team in a community.

It was previously noted that all participants in this research study identified as Caucasian. Several participants made observations that it is rare for minorities who are served by the LOSS team to come to BRCIC for the SOS group. The fact that minorities rarely make it in to receive services needs to be further examined. It is important to remember that African Americans and Hispanics, along with other ethnic groups, die by suicide at a lower rate than Caucasians. However, it has been recommended by many practitioners that involving religious leaders of African American communities in the active postvention process may be a way to connect African American survivors to postvention services. Ensuring that LOSS teams are culturally adaptable is essential in making sure that services are accessible to all individuals regardless of race or ethnicity.

Implications for Future Research. Considering the lack of research regarding survivors of suicide and active postvention volunteer efforts, there is a great need for a continuation of research in this area. A continuation of qualitative research and an expansion into quantitative research studies for this topic is needed. Due to the recent increase of active postvention efforts

worldwide, the effect that this type of volunteer effort has on survivors of suicide needs to be explored. The researcher will conduct a follow-up to this phenomenological research study. This research study will quantitatively measure the benefits and detriments of being a member of an active postvention team for survivors of suicide nationally.

REFERENCES

Aguirre, R., & Slater, H. (2010): Suicide postvention as suicide prevention: Improvement and expansion in the United States. *Death Studies, 34*(6), 529-540. doi: 10.1080/07481181003761336

American Association of Suicidology. (2012a) Elderly suicide fact sheet. Retrieved from http://www.suicidology.org/c/document_library/get_file?folderId=262&name=DLFE-531.pdf

American Association of Suicidology. (2012b). Hispanic suicide fact sheet. Current (2007) statistics. Retrieved from http://www.suicidology.org/c/document_library/get_file?folderId=248&nam e=DLFE-415.pdf

American Association of Suicidology. (2012c). Risk factors for suicide and suicidal behaviors I. Retrieved from http://www.suicidology.org/c/document_library/get_file?folderId=262&name=DLFE-535.pdf

American Association of Suicidology. (2012d). Suicide attempt survivors. Retrieved from http://www.suicidology.org/suicide-attempt-survivors

American Association of Suicidology. (2012e). Suicide in the U.S.A based on current (2009) statistics. Retrieved from http://www.suicidology.org/c/document_library/get_file?folderId=262&nam e=DLFE-532.pdf

American Association of Suicidology. (2012f). Surviving after suicide fact sheet. Retrieved from http://www.suicidology.org/c/document_library/get_file?folderId=262&name=DLFE-533.pdf

American Association of Suicidology. (2012g). History of the American association of suicidology. Retrieved from http://www.suicidology.org/about-aas/history

American Foundation for Suicide Prevention. (n.d.). Surviving a suicide loss: A resource and healing guide. Retrieved from http://www.afsp.org/files/Surviving//resource_healing_guide.pdf

American Psychiatric Association. (2012). Persistent complex bereavement-related disorder (proposed for section III of the DSM-5). Retrieved from http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=577#

Andriessen, K. (2009). Can postvention be prevention? *Crisis*, *30*, 43–47. doi:10.1027/0227-5910.30.1.43

Andriessen, K. & Krysinska, K. (2012). Essential questions on suicide bereavement and postvention. *International Journal of Environmental Research and Public Health*, *9*, 24-32. doi: 10.3390/ijerph9010024

Anglicare. (2012). Arbor-support for people bereaved by suicide. Retrieved from http://www.anglicarewa.org.au/relationship-services-kinway/arbor-support-for-people-bereaved-by-suicide/default.aspx

Bäärnhielm, S., & Ekblad, S. (2002). Qualitative research, culture and ethics: a case discussion. *Transcultural Psychiatry*, *39*(4), 469–483. doi: 10.1177/136346150203900405

Baton Rouge Crisis Intervention Center. (2012a). *About us*. Retrieved from http://brcic.org/aboutus.aspx

Baton Rouge Crisis Intervention Center. (2012b). 2011 Annual report.

Baton Rouge Crisis Intervention Center. (2012c). Survivor services. Retrieved from http://brcic.org/survivorservices.aspx

Berman, A. (2011). Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide and Life Threatening Behavior*, *41*, 110-116.

Bertolote, J., & Fleischmann, A. (2002). Suicide and psychiatric diagnosis: A worldwide perspective. *World Psychiatry*, *1*(3), 181-185.

Campbell, F., Cataldie, L., McIntosh, J., Millet, K. (2004). An active postvention program. *Crisis*, 25, 30-32. doi: 10.1027/0227-5910.25.1.30

Campbell, F. (1997). Changing the legacy of suicide. *Suicide and Life-Threatening Behavior. 27*(4), 329-338.

Campbell, F. (2001) Dissertation: "The Influence of an Active Postvention on the Length of Time Elapsed Before Survivors of Suicide Seek Treatment" (Doctoral Dissertation, Louisiana State University, 2001).

Carmean, S. (2007). *Suicide postvention: How can we improve existing models?*. (Master's thesis, Smith College School of Social Work) Retrieved from http://ohiospf.org/files/seana_carmen_thesis_ postvention_11_2009.pdf

Center for Disease Control and Prevention. (2010). Suicide: Facts at a glance. Retrieved from http://www.cdc.gov/ViolencePrevention/pdf/Suicide_DataSheet-a.pdf

Center for Disease Control and Prevention. (2011). Suicidal Thoughts and Behaviors Among Adults Aged ≥18 Years — United States, 2008–2009. MMWR;60(13).

Cerel, J., & Campbell, F. (2008). Suicide: Survivors seeking mental health services. *Suicide and Life-Threatening Behavior*, *38*(1), 30-34.

Claassen, C., Yip, P., Corcoran, P., Bossarte, R., Lawrence, B., & Currier, G. (2010). National suicide rates a century after Durkheim: Do we know enough to estimate error? *Suicide and Life Threatening Behavior*, *40*(3), 193-223.

Culver, L. (2012). *Suicide prevention coalition of Tarrant county loss team*. Retrieved from http://www.lossteam.com/newsTARRANTCOUNTY.shtml

Davis, C. & Hinger, B. (2005). Assessing the needs of the survivors of suicide: A needs assessment in the Calgary Health Region (Region #3), Alberta. Retrieved from http://www.albertahealthservices.ca/InjuryPrevention/hi-ip- pipt-chc-pro-assessing-needs-of-survivors-report-lit.pdf

Durkheim, E. (1897). *Suicide: A study in sociology*. The French Press.

Jackson, J. (2003). *A handbook for survivors of suicide*. Washington DC: American Association of Suicidology.

Jordan, J., & McIntosh, J. (2011). *Grief after suicide: Understanding the consequences and caring for the survivors.* New York, NY: Routledge

Kim, C., Seguin, M., Therrien, N., Riopel, G., Chawky, N., Lesage, A., et al. (2005). Familial aggregation of suicidal behavior: A family study of male suicide completers from the general population. *American Journal of Psychiatry, 162,* 1017–1019.

Krug, E., Dahlberg, L., Mercy, J., Zwi, A., & Lozano, R. (2002). *World report on violence and health (Chapter 7)*. Retrieved from website: http://whqlibdoc.who.int/publications/2002/9241545615_chap7_eng.pdf

Krysinska, K., & Andriessen, K. (2010). On-line support and resources for people bereaved through suicide: What is available? *Suicide and Life-Threatening Behavior, 4*(6), 640-650.

Leenaars, A. (2010). Edwin S. Shneidman on suicide. *Suicidology Online*, *1*, 5-18.

Linn-Gust, M. (2004, Fall). Six suicide survivors per suicide…Who decided? *Surviving Suicide*, 16, 1, 7.

McIntosh, J. (2012a). USA State Suicide Rates Among the Elderly and Young, 2009. Washington, DC: American Association of Suicidology.

McIntosh, J. (2012b). USA State Suicide Rates And Rankings By Gender, 2009. Washington, DC: American Association of Suicidology.

McIntosh, J. (2012c). *U.S.A. Suicide: 2009 Official Final Data*. Washington, DC: American Association of Suicidology.

McMenamy, J., Jordan, J., & Mitchell, A. (2008). What do suicide survivors tell us they need? Results of a pilot study. *Suicide and Life-Threatening Behavior*, *38*(4) 375-389.

Miles, M., & Huberman, A. (1994). *Qualitative data analysis*. (2nd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Mitchell, A., Gale, D., Garand, L., & Wesner, S. (2003). The use of narrative data to inform the psychotherapeutic group process with suicide survivors. *Issues In Mental Health Nursing*, *24*(1), 91-106.

Mitchell, A., Kim, Y., Prigerson, H., & Mortimer, K. (2005). Complicated grief and suicidal ideation in adult survivors of suicide. *Suicide and Life-Threatening Behavior*, *35*(5), 498-506. doi: 10.1027/0227-5910.25.1.12

Moustakas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks, CA: SAGE Publications, Inc.

National Alliance on Mental Illness. (2012). *Someone you love has ended their own life- and yours is changed forever*. Retrieved from http://www.namiut.org/inform-yourself/suicide survivors

National Association of Social Workers (NASW) (2012). Code of Ethics. Retrieved from http://www.naswdc.org/pubs/code/default.asp

National Center for the Prevention of Youth Suicide. (2012). *Youth suicidal behavior fact sheet*. Retrieved from http://www.suicidology.org/c/document_library/get_file?folderId=248&name=DLFE-500.pdf

Nebraska LOSS Team Local Outreach to Suicide Survivors. (2012). *Nebraska loss*. Retrieved from http://nelossteam.nebraska.edu/

Ross, E. (1997). *Life after suicide: a ray of hope for those left behind*. New York, NY: Plenum Press.

Rossman, G., & Rallis, S. (2012). *Learning in the field.* Thousand Oaks, CA: SAGE Publications, Inc.

Runeson, B., & Åsberg, M. (2003). Family history of suicide among suicide victims. *American Journal of Psychiatry*, *160*, 1525–1526.

Shear, K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N.,...Keshaviah, A. (2011). Complicated grief and related bereavement issues for DSM-5. *Depression and Anxiety*, *28*, 103-117. doi: 10.1002/da.20780

Shneidman, E. (1969). *On the nature of suicide*. San Francisco: Jossey-Bass.

Shneidman, E. (1972). Foreward. In A. Cain (Ed.), *Survivors of suicide*. Springfield, IL: Charles C. Thomas.

Shneidman, E. (1973). Suicide. *In The New Encyclopedia Britannica* (Vol. 21, pp. 383-385). Chicago, IL: Encyclopedia Britannica

Shneidman, E. (1975). Postvention: The care of the bereaved. In R. Pasnau (Ed.), Consultation in liaison psychiatry. (pp. 245-256). New York: Grune and Stratton.

Shneidman, E. (1994). Comment: The psychological autopsy. *American Psychologist*, 39, 75-76.

Simon, N. (2012). Is complicated grief a post-loss stress disorder? *Depression and Anxiety, 29,* 541-544. doi: 10.1002/da.21979

Suicide. 2011. In *Merriam-Webster.com*. Retrieved November 28, 2011, http://www.merriamwebster.com/medical/suicide

Suicide Prevention Coalition of Tarrant County LOSS Team. (2012). *icap final report: Loss team pilot project executive summary*. Fort Worth, TX

Suicide Prevention Task Force of Union County, Ohio. (2011). *Suicide prevention task force*. Retrieved from http://www.here4hope.org/SPC/index.shtml

Suicidology. 2011. In *Merriam-Webster.com*. Retrieved November 28, 2011, http://www.merriam-webster.com/medical/suicidology

Sveen, C., & Walby, F. (2008). Suicide survivors' mental health and grief reactions: A systematic review of controlled studies. *Suicide and Life-Threatening Behavior*, *38*(1), 13-29.

Vessier-Batchen, M., & Douglas, D. (2006). Coping and complicated grief in survivors of homicide and suicide decedents. *Journal of Forensic Nursing*, *2*(1), 25-32.

APPENDIX
LOUISIANA STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB) FOR PROTECTION OF HUMAN SUBJECTS

Application for Approval of Projects Which Use Human Subjects

This application is used for projects/studies that cannot be reviewed through the exemption process.

Institutional Review Board
Dr. Robert Mathews, Chair
131 David Boyd Hall
Baton Rouge, LA 70803
P: 225.578.8692
F: 225.578.6792
irb@lsu.edu
lsu.edu/irb

– Applicant, Please fill out the application in its entirety and include two copies of the competed application as well as parts A-E, listed below. Once the application is completed, please submit to the IRB Office for review and please allow ample time for the application to be reviewed Expedited reviews usually takes 2 weeks. Carefully completed applications should be submitted 3 weeks before a meeting to ensure a prompt decision.

– A Complete Application Includes All of the Following:
(A) Two copies of this completed form and two copies of part B thru E.
(B) A brief project description (adequate to evaluate risks to subjects and to explain your responses to Parts 1&2)
(C) Copies of all instruments to be used.
*If this proposal is part of a grant proposal, include a copy of the proposal and all recruitment material.
(D) The consent form that you will use in the study (see part 3 for more information.)
(E) Certificate of Completion of Human Subjects Protection Training for all personnel involved in the project, including students who are involved with testing or handling data, unless already on file with the IRB. Training link: (http://phrp.nihtraining.com/users/login.php.)
(F) IRB Security of Data Agreement: (http://www.lsu.edu/irb/IRB%20Security%20of%20Data.pdf)

1) Principal Investigator*: Krisanna Machtmes, PhD, Associate Professor **Rank** Associate Prof.
*PI **must be** an LSU Faculty Member

Dept: HRE **Ph:** 578-7844 **E-mail:** machtme@lsu.edu

2) Co Investigator(s): please include department, rank, phone and e-mail for each
Brittany Buquoi, MSW, LMSW
Doctoral Student
School of Human Resource Education
504-813-4244
bbuquo3@lsu.edu

3) Project Title: Benefits of Local Outreach to Suicide Survivors (LOSS) team

4) Proposal Start Date: 3/5/12 **5) Proposed Duration Months:** 3

6) Number of Subjects Requested: 10 **7) LSU Proposal #:**

8) Funding Sought From:

IRB# 3258 LSU Proposal #
- ○ Full
- ✓ Expedited
- ✓ Human Subjects Training
- ✓ Complete Application

Jy Approved By:
Robert C. Mathews, Chairman
Institutional Review Board
Louisiana State University
203 B-1 David Boyd Hall
225-578-8692 | www.lsu.edu/irb
Approval Expires: 3/29/2013

ASSURANCE OF PRINCIPAL INVESTIGATOR named above
I accept personal responsibility for the conduct of this study (including ensuring compliance of co-investigators/co-workers) in accordance with the documents submitted herewith and the following guidelines for human subject protection: The Belmont Report, LSU's Assurance (FWA00003892) with OHRP and 45 CFR 46 (available from http://www.lsu.edu/irb). I also understand that copies of all consent forms **must be maintained at LSU for three years after the completion of the project.** If I leave LSU before that time, the consent forms should be preserved in the Departmental Office.

Signature of PI Krisanna G. Machtmes Date 2/27/12

ASSURANCE OF STUDENT/PROJECT COORDINATOR named above. If multiple Co-Investigators, please create a "signature page" for all Co-Investigators to sign. Attach the "signature page" to the application.

I agree to adhere to the terms of this document and am familiar with the documents referenced above.

Signature of Co-PI (s) Brittany Buquoi Date 2/27/12

VITA

Brittany Buquoi was born in New Orleans, Louisiana to Craig Ostarly and Sheri Samec. She attended elementary and high school in New Orleans, LA and graduated with honors in 2004 from De La Salle High School. Brittany obtained a Bachelor of Science degree in Psychology from Louisiana State University Agricultural and Mechanical College in May 2008 and a Master of Social Work degree in May 2010. Brittany will receive her Doctor of Philosophy degree from Louisiana State University Agricultural and Mechanical College in May 2013.

Brittany is a Licensed Clinical Social Worker with a clinical and research interest in the field of Suicidology. Brittany is also an Instructor in the Department of Social Work at Louisiana State University Agricultural and Mechanical College. After graduation, Brittany plans to move to Minneapolis, Minnesota with the hopes of becoming a tenure-track faculty member at a local university.