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The Differential Impact of Suicide Type on Provision of Social Support:  
A Qualitative Comparison

by

Daniel Paul Villa

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Philosophy

in

Social Welfare

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Andrew Scharlach, Chair

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## Abstract

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Doctor of Philosophy in Social Welfare

University of California, Berkeley

Professor Andrew Scharlach, Chair

The objective of this exploratory study was to examine how various modes of death impact the availability, perception, and allocation of social support to bereaved survivors. Specifically, case vignettes describing different types of suicide were utilized to address the following inquiry: *What factors typify how and why social support is offered to survivors of traumatic death, particularly suicide?* Twenty-five participants, consisting of graduate students and older adults, engaged in semi-structured interviews to explore responses to four fictitious instances of suicide and one instance of non-suicide as a control case. Data analysis via selective coding, immersion/crystallization, and content analysis generated ten themes (reflective of three overarching categories) as the most salient features typifying the provision of aid to mourners: Patterns and Variations in Type of Aid (“Core” versus “Vignette-Specific” Support), General Considerations in the Provision of Aid (*The Culture of Helping*, “Filling the Void,” “Let the Need Be My Guide,” *Identification, Survivor Relationship (“Closeness”), Degree of Immersion, “Casserole Lady” Dilemma*), and Vignette-Specific Considerations in the Provision of Aid (*Social Significance of the Death, Perceived Culpability*).

Based upon these findings, various conclusions can be drawn. First, there exists an inherent proclivity within observers to offer aid to survivors, as all respondents indicated the need to provide support regardless of the individual conditions surrounding the death. Second, the manner in which a death occurs appears to affect the degree to which support is rendered, especially if the death somehow deviates from social norms or raises inquiry regarding culpability on the part of the decedent and/or the survivor. Third, the survivor’s own adjudication of the situation, as evidenced in his or her personal experiences, perceived relationship to the survivor and/or decedent, and assessment of needed support, also influences what is offered. Interestingly, while some themes related more directly to suicide-specific vignettes, most reflected generic features indicative of how respondents would offer aid under any case of death, signaling the need for continued research within this domain. Considerations to address in future research include the further exploration of other typologies of suicide and the incorporation of other methodological techniques to compare different modes of death.

Implications for future practice are also considered, underscoring the significance of identifying social factors related to specific instances of suicide. Because the study could not possibly capture the full scope of this type of death, individual assessment of survivor needs by social workers and allied professionals becomes crucial in addressing and attenuating a range of potentially negative grief experiences, including stigma, shame, guilt, and depression. Overall, the study's findings are intended to advance the scope of qualitative attitudes research with respect to social support availability and modality of suicide, as the current body of literature contains no studies that investigate the nuances of this particular phenomenon.

Dedicated to Aunt Susie, who I hope found what she was looking for.

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*“Congratulate yourself if you have done something strange and extravagant and broken the monotony of a decorous age.” ~ Ralph Waldo Emerson*

In the greater scheme of the universe, I will hardly look back at this dissertation as a product of extravagance. Rather, I will see it more as a testament to the morbid curiosities, fitting synchronicities, and exasperated sighs from which it was conceived and executed. Despite an eighteen-month-long barrage of eyebrow raises, puzzled looks, and hesitant nods of acquiescence, I managed to turn a once quixotic ambition to rattle the cages of the American consciousness into a full-fledged reality. Suicide, unequivocally one of our county’s least comfortable issues to broach, became the focus of what I initially thought would be little more than an exercise in shock value. In the end, it emerged into a cautionary tale warning against holding tight to first impressions. Interestingly, people were much more receptive to discussing the topic of death with a mature and diplomatic disposition than I had anticipated. I was pleasantly surprised that the study’s content encouraged people to embrace an inordinately challenging topic to ponder, much less discuss. That being said, I recognize that my efforts to cultivate this dissertation could not have been possible without the support of a number of individuals.

First and foremost, I owe everything that I was, am, and will become to my parents, Lori and Frank. Their tireless efforts to sustain a loving, albeit occasionally aggravating, family life for me and my sister, Candice, reiterated time after time that the struggles we endured were well worth it in the end. Although they admit to rarely grasping the nuances of my writing or speech whenever I volunteered to enlighten them with my dissertation, they were always considerate enough not to interrupt me. To my sister, Candice, who I know will want her moment of recognition, I thank her for limiting her eye rolls only to those sporadic occasions when I would mention my frustrations with school in her presence. My grandparents, Mary and Paul, who were helpful with many aspects of the dissertation, were even more helpful as unwavering sources of love and support, always ending their birthday and Christmas cards with, “We are so proud of you” as a reminder of how far I have come. While my family continues to rebuild and heal after the untimely passing of a beloved daughter and sister, their willingness to embrace my research efforts extends well beyond anything that I could ever articulate here.

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me, the wisdom, skill, and encouragement that they took the time to impart will forever influence my continued evolution from a curious, passive knowledge seeker to a budding scholar whose research career has only just begun.

## CHAPTER 1: INTRODUCTION

### Statement of the Problem

The inevitability of death can serve as a jolting reminder of the transitory and oftentimes unpredictable nature of the life cycle. Following the death of a loved one, survivors often face a complex barrage of anger, panic, and disbelief that typify a course of emotional upheaval universally known as the grief process (Fitzgerald, 1994). Entrenched within an array of social, psychological, physical, emotional, and cultural domains, the reality of death oftentimes presents numerous challenges for those left to grieve and mourn a loss (Worden, 2002). In certain contexts, survivors fail to garner adequate support and validation for their grief reactions (Doka, 1989). These cases can reflect a phenomenon known as “disenfranchised grief,” that can create stigmatizing, socially invalidating, or clandestine mourning experiences that can complicate already existing reactions to loss. Disenfranchised grief, according to Doka (1989), refers to “the grief that persons experience when they incur a loss that cannot be openly acknowledged, publicly mourned, or socially supported” (p. 4). One example where this type of grief can emerge is from death due to suicide, as survivors of such experiences oftentimes feel stigmatized as a result of the circumstances surrounding the nature of the loss (Doka, 2002).

### Significance of the Topic

Regarded as a type of disenfranchised death, suicide and its bereavement-related processes can result in special challenges for survivors. Loved ones of individuals who complete a suicide have been identified in the literature to experience a barrage of unsupportive social responses (e.g., insensitive or rude comments, gossip, negative attention, etc.), as compared to those who experience other types of death, which can prompt internal decisions to avoid disclosing the nature of the death (Dunn & Morrish-Vidners, 1987; Solomon, 1982-1983). However, past research has largely failed to take into account the impact that different types of suicide can engender, specifically in terms of the provision of social support.

### Purpose of the Study

The objective of this exploratory study is to qualitatively examine how different types of suicide might be expected to impact the availability, perception, and allocation of social support for bereaved survivors of such experiences. Specifically, responses to case vignettes involving different instances of suicide are examined to determine how such variations are likely to affect behavior toward survivors. Thus, the study aims to explore the following research question: *What factors typify how and why social support is offered to survivors of traumatic death, particularly suicide?*

## CHAPTER 2: CONCEPTUAL OUTLINE AND THEORETICAL UNDERPINNINGS

### Introduction

This chapter provides an introduction to the primary conceptual domains that underlie the study. The conceptual “map,” or outline of features pertinent to the dissertation, reflects a myriad of elements germane to the social experience of survivors bereaved to various types of death. Considering type of death along a continuum, at one end, certain forms can be conceptualized as *sanctioned* within society as valid losses to mourn. As such, survivors of these deaths are generally afforded certain social rights granted from within their milieu that legitimately recognizes them as mourners, typically resulting in support from others. The antithesis of this social response results from losses that are conceptualized as *unsanctioned*, whereby an individual or individuals experience a death that receives less recognition from others (Doka & Weisman, 1995). In considering this continuum, the aim of this chapter is to examine how these dynamics are addressed within the context of three overarching frameworks: social support, stigma, and disenfranchised grief. These key elements are discussed in terms of their signifying features, applications, and influences. To commence this broad discussion, a more detailed description of these domains is provided below.

#### The Role of Social Support in the Bereavement Experience

Regardless of the nature of the death experienced by a survivor, research in the field of social support and grief has identified the bereavement experience, according to Stylianos & Vachon, (1993), as a “social network crisis” (p. 397) consisting of numerous structural and functional processes. To further address the specific role that social support plays in this experience, three questions are considered: What is “Social Support?”, What Is Known about Social Support and Bereavement?, and What Influences People to Give Support and Why? Each is considered below.

#### *What is “Social Support”?*

The term “social support” has been defined in numerous ways. The most succinct definition, according to Cohen & Syme (1985), is “the resources provided by other persons” (p. 4). More specifically, Albrecht & Adelman (1987) describe it as “verbal and nonverbal communication between recipients and providers that reduces uncertainty about the situation, the self, the other, or the relationship, and functions to enhance a perception of personal control in one’s life experience” (p. 19). Regarded as a “process,” Leatham & Duck (1990) assert that social support can be described by four elements: *structure of the network in which support occurs* (i.e., an individual’s psychological representations of closeness and distance to others); *nature of the relationships* (i.e., how one defines his or her closeness to others based on “preferences of access,” such as accessibility of others, role requirements, etc.); *contents of interaction* (i.e., the actual dialogue that transpires between individuals, determining how support is offered); finally, *impact of support* (i.e., how support rendered impacts the recipient, the giver, and the larger social context(s) in which it occurs).

While social support can emerge in many forms, past literature has identified several sources, including friends, relatives, formal and informal support groups, and professionals (e.g., Funck-Brentano et al., 2005; Guay, Ratelle, Senecal, Larose, & Deschênes, 2006; Newman, 2005; Nezlek & Allen, 2006; Vos, Garssen, Duivenvoorden, & de Haes, 2005; Woody, 2004). Associated with health and well-being, social support has been identified to be a significant factor in understanding, treating, and addressing psychosocial factors associated with illness and disease (Cohen & Syme, 1985). Furthermore, it has been consistently shown to serve as a protective factor against outcomes such as depression and anxiety, while enhancing well-being and coping in response to life changes (e.g., Brown, Parker-Dominguez, & Sorey, 2000; Hyman, Gold, & Cott, 2003; Johnson, Winett, Meyer, Greenhouse, & Miller, 1999; Neugebauer & Katz, 2004; Swift & Wright, 2000). For example, Bonanno, Galea, Bucciarelli, & Vlahov (2007) found social support to be a predictor of resilience after a traumatic event; similarly, Lache, Meyer, Hermann-Lingen (2007) identified the availability of social support as a significant predictor in cardiac patients' reduction of anxiety.

### *What is Known About Social Support and Bereavement?*

Currently, much of what is known about the relationship between social support and bereavement has been identified in research examining the experiences of bereaved spouses, specifically in terms of both perceptions of support from the mourner's view as well as actual encounters with members of one's social network (Stylianos & Vachon, 1993). Network density (i.e., how members of social groups know one another), specific functions of support (e.g., companionship, social exchanges, etc.), perceived and actual support in the adaptation to bereavement, and potentially negative implications of support networks have been examined (e.g., Antonucci & Israel, 1986; Hirsch, 1980; Rook, 1987; Walker, MacBride, & Vachon, 1977).

Within the context of bereavement, social support has been shown to promote a range of benefits, including, but not limited to, reducing grief-related stress (e.g., Gluhoski, Fishman, & Perry, 1997; Lennon, Martin, & Dean, 1990), increasing the survivor's appreciation for himself/herself and others (e.g., Sakaguchi, 2002), mitigating the prevalence of depression, Post Traumatic Stress Disorder, and other mental illnesses (e.g., Murphy, Johnson, Chung, & Beaton, 2003; Vanderwerker & Prigerson, 2004), enhancing purpose and meaning processes (e.g., Frantz, Farrell, & Trolley, 2001; Ulmer, Range, & Smith, 1991), and facilitating optimism (e.g., Rogers, Hansen, Levy, Tate, & Sikkema, 2005). Social support is also considered a factor in positive adaptation to loss. For example, Thuen (1997) found better long-term psychological adaptation to bereavement for subjects when informal social networks, particularly friends and family, are present. Such findings are also consistent among survivors of conjugal loss, indicating social support as a factor in one's ability to adapt to the loss of a spouse (e.g., Levy, Martinowski, & Derby, 1994).

### *What Influences People to Give Support and Why?*

While not a specific focus within much of the literature surrounding bereavement, many potential explanations for what prompts individuals to offer social support can and should be considered. Thus, what follows are a number of such possible explanations that provide a useful,

but not all-inclusive, platform from which to understand some potential underlying processes associated with offering aid.

*Empathy and sympathy.* The experience of losing a loved one oftentimes arouses feelings and actions of support among observers, who can either personally relate to, or place themselves into the emotional situation of the survivor. Expressions of sympathy in the form of greeting cards, for example, have been a prominent method of offering support to survivors (e.g., Caldwell, McGee, & Pryor, 1998; McGee, 1980-1981). The significance of empathy has also been highlighted within a theoretical context. For example, Loewenstein & Small (2007) suggest from earlier schematic models of human sympathy and caring that individuals are often prompted to offer aid when faced with stimuli that they feel warrant attention. According to this perspective, Loewenstein & Small (2007) claim that two distinct, interacting factors contribute to how human support manifests: sympathy and deliberation. *Sympathy* involves harboring “caring but immature and irrational” (p. 112) responses that cause observers to show outward emotion (e.g., crying); *deliberation* prompts observers to determine who and what is worthy of such sympathy. Thus, an observer who feels both a sense of sympathy toward an individual and believes that it is warranted might be more likely to offer support. In terms of sympathy related to bereavement, Jordan & Neimeyer (2003) note that, among theories of posttraumatic growth and searching for meaning from loss, empathy for bereaved survivors exists in part due to the observer’s own past distress. This notion also provides some theoretical insight into why another factor, previous experiences with loss, might also be an important consideration in what prompts an individual to offer aid.

*Cognitive and affective factors of empathy.* Arising out of early conceptions of cognitive functioning and gradually extending into more contemporary notions surrounding affective responses, the role of empathy in the human condition has engendered a range of theoretical support in the identification of factors that contribute to why people offer aid to others. Multidimensional perspectives on emphatic development noted by Goldstein & Michaels (1985) address such factors. For example, Hoffman (1982) describes empathy as a significant mediator of “pro-social behavior,” describing six modes that facilitate emotional response: “*reactive newborn cry*” (i.e., “stimulus” cry an infant engages in at the sound of another infant’s cry); *classical conditioning* (i.e., infant’s identification of another’s distress that cues his or her own distress responses); *memories of previous distressing events*; *motor mimicry* (i.e., imitation of another’s emotional expressions); *recognition of symbolic cues*; and *imagining himself or herself as the individual in distress through associating the victim’s experience with their own*. Feshbach (1975) describes a “three factor” model of empathy focusing on two cognitive components (*identification of cues* and *assuming the perspective of another*) and one affect component (*ability to experience the emotions of another*).

Role identification and perspective taking are also noted as prominent factors in empathy. Goldstein & Michaels (1985) indicate that literature on early development de-emphasizes the role that egocentrism plays as children mature cognitively; instead, theorists address the significance of recursive thinking and non-egocentric reasoning in understanding the evolution of empathy. Models such as those developed by Flavell, Botkin, Fly, Wright, & Jarvis (1968) and Selman (1980) depict various “acts” or “advances” that an individual engages in to understand how he or she relates to others, such as recognizing the need to understand the

perspective of another through reciprocal thought, considering individual as well as group perspectives, and applying appropriate responses.

*Biological factors.* Biological factors also contribute to one's ability to attain "emphatic skill." Regarding one's ability to express empathy as "a function of our inner senses" (p. 62), Katz (1963) postulates that humans possess the ability of autonomous capacity, or, inherent understanding, as "part of our biological heritage is the capacity to visualize and to apprehend the feelings of other members of society" (p. 62). Ruesch & Bateson's (1951) study of communication hypothesized that empathy is possible because humans share identical anatomical, physical, and sensory structures, theorizing that an individual's "built-in" capacity to understand one another, as opposed to simply sharing similar experiences, is what facilitates empathy. Katz (1963) also notes that research conducted on instinctive responses of animals, such as analyzing changes in pupils, hair, teeth, and forehead muscles, indicates their ability to recognize one another's expressions. This ability is oftentimes described as "archaic, primitive, or instinctive because it precedes the more cultivated use of secondary processes of thought" (p. 70), yet is also seen as "a 'natural' or automatic form of communication because it involves more of the instinctive apparatus which still forms part of the human equipment" (p. 70).

*Necessity of intervention.* While not specifically related to bereavement, research on bystander intervention may also provide insight into why people choose to offer aid to grievers. Darley & Latane (1968) found in their classic study of bystander intervention during an emergency that subjects were likely to assist when in the presence of others than when alone. These findings prompted Darley & Latane (1968) to identify three salient factors that determine an individual's decision to intervene: *recognition of an event*, *identification of the event as an emergency*, and *a feeling of responsibility to assist*. It is plausible to surmise that one's willingness or reluctance to offer grief support to bereaved individuals could correspond to various influences that Darley & Latane identify in their findings, such as *the number of bystanders* (e.g., others might be available to assist the bereaved, closeness to the individual, etc.), *social desirability* (e.g., expectations regarding the need to help people who are grieving), and *internalized shame and guilt* (e.g., for failing to support/assist, feelings of responsibility for the death, etc.).

*Social labeling.* Another consideration in understanding why others might offer aid involves the role of social labeling of behaviors. Embedded within this notion is the idea that individuals oftentimes assess situations based on prevailing norms or ideas regarding what is socially appropriate, an issue frequently cited in social psychology and mental health research (e.g., Allen, 1997; Guéguen, 2001; Niemeyer, 1991). Kraut (1973) notes that labeling theory largely reflects how others perceive behaviors as "deviant" or "normal" and the extent to which an individual's image of himself or herself is shaped as a result of it. In his study assessing the social repercussions of giving to charity, Kraut (1973) found that labels of "charitable" or "uncharitable" were assigned to subjects based on their willingness to donate, which further influenced how much they gave to a subsequent charity. While social labeling in this context has not been extensively researched within grief and bereavement, the theory's underlying principle can be useful in explaining social attitudes toward survivors.



## The Burden of Stigma on the Experience of the Survivor

A second prominent concept that underscores the study reflects that role that social stigma plays in the grief experience of survivors. The theoretical underpinnings and application of this notion indicate a range of salient features that are significant in understanding how society adjudicates the actions and behaviors of others in determining how (and if) aid is rendered. To facilitate this discussion, a general overview of stigma's definition, overarching features, and influences is provided below.

### *What is "Stigma" and Whom Does it Affect?*

Social stigma, or deviance, has long been a feature in the experience of marginalized groups. The concept of a *stigma*, Latin for "brand," is defined as "a mark of shame or discredit," and has been used in reference to the wounds of the crucified Christ (Merriam-Webster, 2005). More contemporary notions of this concept, most notably addressed in Erving Goffman's 1963 book, *Stigma: Notes on the Management of Spoiled Identity*, conceptualizes stigma as "an attribute that is deeply discrediting" (p. 3) that, in effect, taints a person's social identity. This, essentially, results in one of two labels according to Goffman (1963): *discreditable* (i.e., surreptitious conditions unknown to others, such as homosexuality, substance use, or criminal history) and *discredited* (i.e., known, observable manifestations of stigma, such as physical handicap or deformity). While there are cultural variations regarding what constitutes stigma based on an individual society's norms and values, its contextual origins reside in what Falk (2001) describes as two forms of deviance: *societal* (i.e., widely known conditions that are stigmatized) and *situational* (i.e., actions caused by an individual that are later stigmatized).

The term "stigma" has been identified in the literature surrounding topics relating to psychopathology and mental health, sexual orientation, disability, illness, physical, sexual, and substance abuse, poverty, and ethnic diversity (e.g., Feiring, Taska, & Lewis, 1996; Fields, 2001; Jacoby, 2002; Green, Davis, Karshmer, Marsh, & Straight, 2005; Jenerette, Funk, & Murdaugh, 2005; Latner, Stunkard, & Wilson, 2005; Norris & Alegria, 2005). Similar in scope to this definition, deaths that are considered to be stigmatized essentially "brand" certain individuals for their involvement with the decedent (e.g., homosexual courtship, extramarital affair, survivor of suicide, witness to murder, relative of loved one lost to HIV/AIDS, etc.). Falk (2001) asserts that, among Americans, death is currently regarded as "the most stigmatized event in the life cycle" (p. 21). Whereas most deaths occurred in the home a century ago, death gradually became more institutionalized, taking place in hospitals or other health care settings (Corr, Nabe, & Corr, 2003).

### *What are the Dimensions of Stigma?*

According to Katz (1981), there are four "dimensions of variation" that individuals consider when adjudicating someone or something as stigmatizing or stigmatized: visibility, threat, sympathy arousal, and perceived responsibility. These are described in greater detail below.

*Visibility.* This first feature reflects people's cognizance of a stigmatizing element. Goffman (1963) distinguishes this ability, which he termed "evidentness," from other similar

concepts, primarily “*known-aboutness*” (i.e., past knowledge about an individual through unsubstantiated claims), *obtrusiveness* (i.e., the degree of distraction the stigma causes for others), and *perceived focus of the stigma* (i.e., people’s perception of how the stigma “disqualifies” the stigmatized individual). Ultimately, these features dictate how outsiders judge the deviance of the individual, or “possessor” of the stigma.

*Threat.* A second dimension of stigma involves the degree to which others perceive the stigmatized individual as a threat to their safety or identity. Some individuals, such as homosexuals, criminals, radical idealists, the mentally ill, religious zealots, or cultists, are labeled as threatening by virtue of their perceived disruptive behaviors that engender inimical reactions among others. For example, the presence of an individual with a terminal illness may be perceived as threatening and stigmatizing given the discomfort it might evoke about one’s own mortality or the irreversibility of the condition, whereas an individual with a curable affliction may not arouse the same degree of threat among those who are well.

*Sympathy arousal.* Despite the notion of stigma as one of deprivation from society, such is not always the reality for groups who have been historically marginalized. Some subsets of individuals, such as the mentally handicapped, may evoke more sympathy from others if it is clearly evident that their deficits place them at a greater societal disadvantage. The degree to which an individual’s stigma is inherently disabling also impacts sympathy arousal. For example, limitations that are often life-long, such as a physical handicap, are likely to be seen as more “incapacitating” than criminal record. Thus, it is possible to surmise that some established stigmas might evoke sympathy for some, particularly if they are cognizant of the social admonishment that such individuals and/or groups are likely to encounter.

*Perceived responsibility.* A final dimension that distinguishes differing stigmas reflects the level of responsibility that the stigmatized individual holds for his or her own deviance. Conditions that are perceived to be within an individual’s control or believed to be a product of one’s own volition are likely to negatively affect how an individual is judged by others. For example, physical conditions, such as obesity, might arouse negative reactions from others due to the perception that the stigmatizing element (i.e., the obesity) resulted from the individual’s lack of self control.

### *Interpersonal and Intrapersonal Dynamics of Stigma on Social Support*

In considering dynamics of stigma noted above, there are a number of potentially negative outcomes associated with the experience of the stigmatized individual. Within the context of the grief and bereavement experience of survivors, instances of shame, guilt, and culpability (any of which can be self-induced or precipitated by social responses) are prominent features in the theoretical underpinnings of the dissertation. They are addressed in greater detail below.

*Survivor shame and guilt.* The extent to which individuals harbor feelings of shame or guilt after a death may place them at a disadvantage in receiving outside aid, as they may abstain from seeking outside supportive networks as a form of self-punishment (e.g., for failing to prevent the death, surviving when another has died, etc.). Themes of internalized guilt and shame

remain pervasive within what Kauffman (2002) calls “self-disenfranchisement,” a term describing the process by which a mourner “may imagine that societal sanctions exist where they do not exist in real social situations” (p. 62) which, consequently, precludes the individual from fully accepting his or her own grief. This might prompt survivors to erroneously assume a lack of potential support, thereby preventing them from seeking out such aid. Self-disenfranchisement can also be exacerbated by feelings of guilt, particularly when an individual already feels or expects some level of shame (Kauffman, 2002). Given this, it is logical to assume that both self as well as social disenfranchisement are likely to reduce a survivor’s opportunity for outside aid, even though its specific source may vary by situation. Disenfranchised grief will be formally explored later in this chapter.

*Blameworthiness.* Feelings of blame, both toward the decedent and toward the survivor, may also impact how social support is likely to be offered. Particularly in situations where the loss contains stigmatizing elements (e.g., HIV, death due to alcoholism, etc.), there exists a tendency to be less sympathetic toward the decedent. Such death may engender this reaction among others if the decedent’s lifestyle or poor decision-making (e.g., sexuality, substance use, etc.) was somehow a contributing factor (Kuhn, 2002). Self-blame is also a common feature of the grief experience and has been theorized within the literature. For example, according to Lerner’s (1980) “Just-World” theory, individuals believe the world to function in a fair manner, with rewards and punishments appropriately dispensed. However, in the face of a traumatic event, the individual may utilize coping strategies, such as self-blame, as a mechanism for reasserting control. Weinberg’s (1995) study addressing self-blame in recovery from bereavement showed that those survivors who sought to make amends for a death (e.g., apologizing or “making up” for something the survivor had done or said that may have contributed to the death) experienced better adjustment to the loss than those who had not.

Instances of blame toward others have also been noted in the literature. For example, Calhoun, Selby, & Faulstich (1980) found blame to be a prominent social experience among survivors of loss, particularly when the death was considered a choice (e.g., suicide); suicide survivors were regarded as being more at fault for the death of their loved when compared to situations in which the death was seen as beyond their control (e.g., illness). Additionally, Weinberg (1994) found in a study of 200 subjects that blame was attributed more toward survivors when deaths mourned were considered unnatural (e.g., suicide, homicide), with approximately 47% of subjects finding survivors at fault. When deaths were considered “natural,” approximately 39.5% of subjects indicated attitudes and reactions of “dual blame” (i.e., self-blame as well as blame toward others).

### Disenfranchised Grief and the Social Experience of the Survivor

As an extension of the previous framework, ‘disenfranchised grief’ is the third and final theoretical construct to guide the dissertation. Its major features and conditions are described below.

## *What is “Disenfranchised Grief?”*

Generally, reactions toward grief are recognized to be a socially appropriate response to death and are facilitated by various cultural norms. However, there are instances in which the circumstances surrounding the nature of the death (e.g., stigmatized loss via suicide, AIDS-related complications, homicide, etc.) can infringe upon the receipt of adequate support and validation for the survivor’s grief reactions, thereby negatively impacting the grief process (Doka, 1989). In these cases, there exists a heightened propensity for stigmatizing, socially castigating, and surreptitious mourning experiences for remaining survivors in ways that can exacerbate already existing reactions to loss, referred to in previous literature (e.g., Doka, 1986; Doka, 1987) as “disenfranchised grief.”

The general course of disenfranchised grief can be encapsulated into three primary features noted by Doka (1989): 1) experience of a non-sanctioned or stigmatized loss; 2) a lack of social support and validation for the survivor’s experience; and, 3) an increase in the survivor’s grief reactions. The current study aims to specifically address the extent to which such non-sanctioned deaths (i.e., suicide) impact the availability of social support. They are described in further detail below.

*Experience of a non-sanctioned loss.* The social construction of “legitimate loss” has been cited in the literature to encompass a variety of aspects with respect to one’s right to grieve publicly for deaths that are considered to be sanctioned (e.g., Fowlkes, 1990; Kamerman, 1993; Martin, 2005). Thus, the first component of disenfranchised grief involves a survivor’s experience with a death that is seen as stigmatized, non-normative, or otherwise antithetical to socially acceptable standards as an appropriate loss to mourn. Doka (1989) concedes that one’s disenfranchisement need not pertain specifically to death; declines in cognitive capacity due to age-related processes, the termination of a romantic relationship, emotional and/or physical separation, or general life transitions can also be considered as non-sanctioned (e.g., Baum, Rahav, & Sharon, 2005; Craik, 2006; Goffman, 1963; Griffin, 2001; Harvey, 1998; Kupferschmidt, Lewis, Molloy, Standish, & Babineau, 2006; Lowes, Gregory, & Lyne, 2005; Pottinger, 2005; Schneider & Phares, 2005). The nature of an individual’s death due to reasons deemed as self-induced, avoidable, or socially inappropriate (e.g., HIV/AIDS, suicide, elective abortion) can also be stigmatized and thus non-sanctioned by society, further affecting the survivor’s grief and mourning processes.

*Lack of social support and acknowledgement of the survivor’s experience.* A second prominent feature associated with disenfranchised grief involves a survivor’s lack of recognition with respect to his or her loss. Within the context of grief-related research, several studies have noted the importance of social support as a moderator of the bereavement experience of survivors, including increases in purpose and meaning in life as well as decreases in depression (e.g., Ingram, Jones, & Smith, 2001; Krause & Markides, 1990; Ringler & Hayden, 2000; Stroebe, Stroebe, Abakoumin, & Schut, 1996; Sutor & Pillemer, 2000; Ulmer, Range, & Smith, 1991). When a loss is disenfranchised, however, support systems may be inadequate or non-existent. As a result, the individual is likely to sustain a barrage of potentially negative complications, such as impacts on physical health, increased likelihood of interpersonal distress, poor mental health, and suicidal ideation and behavior (e.g., Briere & Jordan, 2004; Rigby, 2000;

Simons, Beaman, Conger, & Chao, 1993; Smyth, Dunn, Myer, & Maccio, 1999; van Servellen & Lombardi, 2005). For example, Melchiora, Berkman, Niedhammer, Chea, & Goldberg (2003) found that a lack of social support, as opposed to the weak presence of a social network, is a predictor of overall poorer health.

*Increase in adverse grief reaction.* Research has identified that increases in grief reaction beyond “normal” parameters (e.g., protracted or chronic grief) have been identified among those who have experienced a non-sanctioned loss. For example, in a qualitative review of literature on survivor reactions to suicide, Sveen & Walby (2008) found that survivors are no different from those bereaved to non-suicides in terms of the development of PTSD symptoms, depression, and anxiety; however, those bereaved to suicide are more likely to experience shame, guilt, and blaming than those non-bereaved to suicide. Ness & Pfeffer (1990) noted in reviews of studies featuring survivors of suicide that feelings of guilt and shame are socially reinforced when mourners experience blame or avoidance by others.

### *“Grieving Rules” and Lack of Recognition in Disenfranchised Grief*

Inherent in this broadly circumscribed concept of disenfranchised grief is an array of socially constructed “grieving rules” that stipulate the duration and extent of mourning one is permitted to endure when a loss is experienced. Such rules reflect a society’s attitudes toward a particular type of death. For example, grieving rules may apply only in situations in which survivors are seen as having a valid right to mourn their loss, which may be based on factors such as kinship (e.g., familial relation) and the extent to which the loss is socially recognized (e.g., death of a spouse versus death of a pet). Bereaved individuals are considered disenfranchised by virtue of experiencing societal repercussions antithetical to reactions associated with socially sanctioned losses. These repercussions may include a lack of recognition for one’s grief experience, the unavailability of support due to violating socially-defined “rules” of grieving, and the inability to publicly mourn a particular loss (Doka, 1989). Additionally, Doka addresses three forms of lacking recognition that can describe the source of one’s disenfranchisement. They are identified and described below.

*The relationship is not recognized.* Societal norms often dictate the direction in which the grief and mourning process materializes for those left to cope with the reality of their loss. Traditionally, grief responses from relationships based on kinship are perceived to be most socially acceptable, while other types of survivor-decedent relationships might go unrecognized (Doka, 2002). For example, associations based on friendship (e.g., Deck & Folta, 1989; Smith, 2002), homosexual courtships (e.g., Gluhoski, Fishman, & Perry, 1997), relations with former spouses (e.g., Parkes, 1996; Doka, 1986; Sprang & McNeil, 1995), and cohabitation (e.g., Littlewood, 1992) represent examples of situations in which the nature of the relationship may not be conducive to outward grief expressions.

*The loss is not recognized.* In other cases, the focus of the grief is directed toward a loss that is regarded as trivial or of minor consequence, such as the loss of a pet, cherished object, an appendage of the body, or an elective abortion (Corr, Nabe, & Corr, 2003). Because of its potential for social dismissal, such losses are often given a cavalier reception in comparison to other types believed to be of greater importance and, therefore, worthy of social recognition. For

example, while suicide has endured a history of secrecy in terms of publicly disclosing the nature of the death, Doka (2002) asserts that it is not as highly stigmatized today. However, survivors, especially families, oftentimes erroneously assume that their social circle is likely to offer support, thereby inducing a sense of self-stigmatization and withdrawal from social networks (Dunn & Morrish-Vidners, 1987).

*The griever is not recognized.* Lastly, an individual may not be regarded as a griever. This is most commonly identified in particularly vulnerable populations that are perceived to lack the capacity to comprehend and/or grieve a loss, such as children (e.g., Burman & Allen-Mears, 1994; Corr, 2000; Grollman, 1995; Lenhardt, 1997), the cognitively impaired elderly (e.g., Moss & Moss, 2002), those with mental and/or developmental disabilities (e.g., Lavin, 2002).

In considering these forms of lacking recognition, the rationale for incorporating the disenfranchised grief framework involves its distinct utility in 1) recognizing the impact that stigma carries with respect to non-sanctioned deaths such as suicide, and 2) addressing both the social and personal aspects pertaining to one's experience as a mourner. Past research has presented numerous examples that have addressed not only the intrapersonal dynamics associated with being a bereaved survivor of suicide (such as the experience of shame and guilt, as evidenced in studies such as those by Demi & Howell, 1991 and Dunn & Morrish-Vidners, 1987) but also the social responses that oftentimes preclude the receipt of adequate emotional and social support (such as negative reactions as indicated in work by Begley & Quayle, 2007 and Wagner & Calhoun, 1991-1992).

### *Distinguishing Disenfranchised Grief from Other Types of Grief*

To facilitate this discussion, the following three topics will be considered: Observable Manifestations of Disenfranchised Grief; Similarities in Grief Responses; and Cultural Aspects of Hidden Grief. Each will be described in greater detail below.

*Observable manifestations of disenfranchised grief.* The visible manifestations of disenfranchised grief can be regarded as both an internal process (in terms of the development of grief reactions reflective of both internalized norms as well as negative social reactions) as well as a social process (in terms of the lack of societal recognition), with the focus of this study placing greater emphasis on the social dynamics associated with it. One of the distinguishing features of disenfranchised grief and loss in comparison to those that are granted social recognition lies in the fundamental "rights" that a society grants certain individuals to publicly mourn. Corr (1998) suggests that unlike those who are *enfranchised*, or given permission to grieve their loss, those who are *disenfranchised* are generally denied their right to both social validation and recognition for their experience. Thus, a common denominator that identifies such individuals as being "disenfranchised" reflects the societal response to his or her experience of loss, which can come in such forms as lacking recognition for the survivor, as well in increases in shame, guilt, and feelings of powerlessness (Doka, 1989).

*Similarities in grief responses.* It is difficult to pinpoint the degree to which the social responses that make up disenfranchised grief are universal across all age groups and situations.

The current literature, however, has identified similarities among identified social reactions and particular experiences that are deemed non-sanctioned (e.g., deaths that deviate social norms, reflect flaws in individual character or behavior, etc.).<sup>1</sup> For example, stigma experienced by survivors of murder might carry similar social implications for survivors of suicide, despite enduring a different type of loss (e.g., Clements & Burgess, 2002; Cvinar, 2005; Stillion, 1996). Similarly, the social implications of AIDS-related loss (e.g., stigma associated with the disease, such as how it was acquired) are also prevalent among individuals who identify with both heterosexual as well as homosexual orientations (e.g., Bor, Miller, & Goldman, 1993; Wright & Coyle, 1996). Internal reactions to losses that are deemed disenfranchised oftentimes induce guilt and shame for survivors due to psychological processes affecting one's ability to recognize their grief, reflecting another commonality that differentiates such individuals from enfranchised grievers (Kauffman, 2002).

*Cultural aspects of hidden grief.* Cultural dynamics that reflect expectations regarding the bereaved also play a significant role in the extent to which one experiences disenfranchisement. In reflecting upon how various cultures cope with grief and loss issues, Doka & Martin (2002) posit that some cultures regard overt grief expressions as a normative process that is both encouraged and expected. In contrast, other cultural systems, such as those found in Bali, perceive outward reactions as impediments to ritual practices and/or beliefs concerning the decedent, which may imply an inherent disenfranchisement of any and all overt expressions of grief (Doka & Martin, 2002).

Grief in the American context has also influenced the nature of the grief process. For example, Cable (1998) concedes that the values of the United States culture have shifted dramatically over the course of time, with expectations for the success of technological and medical advancements that are used to increase the longevity of life. Thus, normative views regarding the inevitable death of certain individuals (e.g., the elderly) are seen as expected, which may not accurately reflect the values of every ethnic or cultural group. Other instances of loss, such as suicide and HIV/AIDS, are seen as self-induced and are oftentimes stigmatized (Doka, 2002). Expectations regarding what and who is considered "appropriate" to mourn is also an important cultural consideration. As previously indicated, Doka (1989) notes that social norms, in the form of "grieving rules," specify the "who," "when," "where," "how," "how long," and "for whom" with respect to an individual's mourning process. He further asserts that public grief is typically reserved for immediate family members of the decedent as opposed to those who may be only peripherally involved by society's standards (e.g., friend, co-worker, in-law, etc.), is expected to be present when a death has occurred as opposed to a generic loss (e.g., ending of a relationship, loss of possession(s), etc.), and should conform to the parameters of what is considered socially acceptable (e.g., taking a week off of work for the death of a child, three days for a sibling or parent, etc.).

Based on these dynamics, can it be surmised that disenfranchised grief is a universal construct? Research has shown support that disenfranchised grief exists outside of the United States. For example, an Ireland-based study of grieving fathers by McCreight (2001) found similar features of this phenomenon, as many male participants described the lack of recognition they had received over a perinatal death. In some cultures, however, there appears to be an

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<sup>1</sup> Not all stigmas result in the same reaction, however.

absence of disenfranchised grief. For example, in Brazil, the violent deaths of children reflect a normative way of life for mothers, who appear unaffected by these seemingly commonplace occurrences (Scheper-Hughes, 1995). Currently, the literature has not widely determined if such practices are considered a mainstream reaction to unsanctioned losses within different cultural environments.

### Summary

This chapter provided a review of the dissertation's major theoretical underpinnings. While primary emphasis was placed upon highlighting these concepts within the context of the study's research area of grief and bereavement, sufficient attention to the broader purview of social support, stigma, and disenfranchisement was integrated to provide an understanding of these areas and their overall significance to the study. The next chapter will continue to address these features, with a particular emphasis on further validating their utility through a review of key literature. A description of the study's featured hypotheses is also provided.



## CHAPTER 3: REVIEW OF SUPPORTING LITERATURE AND PROPOSED RESEARCH INQUIRY

### Introduction

With the previous chapter serving as an introduction to the study's primary conceptual underpinnings, this chapter aims to delve deeper into the empirical support for these dynamics. More specifically, emphasis is placed upon addressing how the dissertation's overarching concepts of social support, stigma, and disenfranchised grief are supported by previous research, thereby laying the foundation for the utility of the current study. A detailed description of the study's proposed research inquiry concludes this chapter.

### Factors Affecting the Availability of Social Support

There are a number of factor that contribute to the provision of aid to survivors, three of which are considered in this section: Social Norms, Values, and Perceptions Regarding Death; Circumstances Surrounding the Death; and Impact on Survivor's Amount and Type of Support. Each is described in greater detail below.

#### *Social Norms, Values, and Perceptions Regarding Death*

As indicated in the previous chapter, society often imposes expectations regarding what is perceived to be "normative" for that particular environment. Adherence to social norms and values, reflecting the degree to which the survivor falls within the parameters of what his or her society acknowledges to be worthy of recognition, is one such factor in the provision of support. Previous literature (e.g., Doka, 1989; 2002) has noted that survivors who mourn losses appropriate to their social status (e.g., a parent grieving the loss of a child) tend to receive the most social acceptance. For example, in a study in which Thornton, Robertson, & Mlecko (1991) assessed subjects' perceptions of support under different fictitious instances of loss (both instances of loss of another as well as role/status losses), the death of a child was recognized by participants as one to be offered more social recognition and support given its kinship nature (e.g., parent/child relationship) than the death of a same-sex partner, spouse, or experiencing a miscarriage or abortion, for example.<sup>2</sup>

Survivors mourning deaths considered legitimate enough to warrant the expression of grief have been identified in the literature to receive support. For example, research has identified formal venues that have been initiated to cater to survivors grieving particular types of loss, such as support groups for loved ones mourning deaths under hospice care (e.g., Davies et al., 2007; Field, Payne, Relf, & Reid, 2007; Sahler, 1999), natural disasters (e.g., Murphy & Stewart, 1985-1986), and victims of homicide (e.g., Miller, Moore, & Lexius, 1985; Rynearson & Sinnema, 1999). Schwab (1986) notes that support groups are typified by "shared emotional trauma, high levels of trust, and security" (p. 100) and have further utility in identifying vulnerable members who may need additional intervention. Natural support networks, such as friends and family members (e.g., Levy, Martinowski, & Derby, 1994; Ringler & Hayden, 2002; Thornton, Robertson, & Mlecko, 1991; Thuen, 1997) have been shown, according to survivors,

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<sup>2</sup> Further details of this study will be presented in the "Circumstances Surrounding the Death" section.

to offer higher amounts of both actual as well as perceived social support when losses were socially recognized as legitimate to mourn. The common denominator validating the legitimacy of such losses is human casualty: in comparison to other types of deaths or losses, such as that of a pet or a romantic relationship, the cessation of human life is overwhelmingly regarded as more legitimate to grieve than other events in which loss of life has not been incurred.<sup>3</sup>

In contrast to deaths regarded as sanctioned, unsanctioned deaths can also be typified by a number of features. One such primary feature involves the failure of the survivor to adhere to society's set of defined "grief rules." While these rules may vary by society and culture, examples of violations of these rules reflect a survivor's engagement in any number of perceived "deviant" behaviors, such as experiencing protracted and/or abnormal grief patterns, expressing grief at inappropriate times and places, and having a non-traditional relationship with the decedent, such as being a same-sex partner or extramarital paramour (Doka, 1989).

Grieving losses deemed insignificant or minimal, such as the death of a pet, an elective abortion, or other form of perinatal casualty are examples of deaths further questioned by society in terms of their legitimacy. The experience associated with losing a pet, for example, has been cited as a situation in which disenfranchised grief may occur, particularly among children. One of the first significant losses a child most commonly endures is that of a cherished family pet. Such circumstances may introduce the potential for disenfranchisement of grief when parents, out of a desire to protect themselves from the discussion of death, inadvertently avoid full disclosure of the nature of death and dying (Meyers, 2002). Additionally, people's dismissal of close attachments between individuals and animal companions can exacerbate pre-existing grief (Corr, Nabe, & Corr (2003).

Other conditions, such as experiencing a perinatal loss, may trigger similar social responses. Enduring a perinatal death can present a barrage of emotional and psychological trauma that oftentimes mirrors other instances of loss in terms of experiencing self-blame or lacking social acknowledgement (Littlewood, 1992). To date, a great deal of the research on the topic of perinatal loss has emphasized the nature of grief reactions, as well as psychological implications inherent to this experience (e.g., Franche & Mikail, 1999; Kavanaugh, Trier, & Korzec, 2004; Kroth et. al., 2004; Theut, Zaslów, Rabinovich, & Bartko, (1990). Social aspects of disenfranchisement have also been studied. For example, in Hazen's (2003) qualitative investigation of perinatal loss across different decades, 22-year-old Mary Ellen was interviewed, whose birth to a full-term baby girl named Kristen in 1971 resulted in death four days later due to congenital heart disease. Mary Ellen vividly recalls the devaluation of her experience by those in her immediate community:

Some people said to me, 'Oh, aren't you glad it was only four days?' People said, 'It's probably better, if it was going to happen, it happened quickly,' or 'It could have been millions of surgeries.' I just always said, 'I loved her for nine months before she was born. I didn't just love her for four days!' (pg. 152)

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<sup>3</sup> A notable exception to this is loss due to medical illness resulting in impairment of functional capacity, such as mental acuity and physical ability. Examples in research, particularly in areas of dementia (e.g., Mittelman, Roth, Clay, & Haley, 2007) and cancer (e.g., Horowitz, Passik, & Malkin, 1996) have been noted to address the importance of social support groups for caregivers and loved ones experiencing these and similar losses.

### *Circumstances Surrounding the Death*

A second overarching factor in the provision of social support involves how others perceive the circumstances surrounding the death. As previous evidence has suggested (e.g., Calhoun, Selby, & Faulstich, 1980; Weinberg, 1994), deaths that occur in situations where the decedent was believed to have had some measure of control are likely to result in negative outcomes for survivors (e.g., blameworthiness) as opposed to deaths that are unavoidable or natural. Other examples in the literature also support this finding. For example, factors that deem deaths as “stigmatized” (e.g., suicide, abortion, HIV, etc.) are generally regarded less favorably in terms of how survivors are likely to be perceived and supported, such as personal perceptions of the mourner (e.g., Weidner & Griffitt, 1984), feelings of discomfort regarding the nature of the death (e.g., Calhoun, Selby, & Steelman, 1988-1989), and the extent to which the death could have been avoided (e.g., Calhoun, Selby, & Faulstich, 1980).

Some studies have found overall support for the notion that the experiences of those who mourn non-sanctioned deaths are significantly different from those of other types of losses mourned. For example, in an attitudes-based study assessing college students’ perceptions of social support availability for survivors of fictitious case vignettes, Thornton, Robertson, & Mlecko (1991) found variations in how respondents assessed different instances of loss. For example, the average rating on a scale from 1-5 (where “1” indicates higher agreement with statement and “5” indicates lower agreement with statement) of how likely friends and family were to offer support to people mourning the death of a child was 1.8 (i.e., higher agreement to offer support), as opposed to 2.9 (i.e., lower agreement to offer support) for the death of a same sex partner.

Within the context of suicide, Calhoun, Selby, & Abernathy (1984) note that, compared to other types of deaths, 91% of their university-based student sample indicated that suicide was regarded as more uncomfortable to discuss with the surviving family compared to other losses (e.g., accidents or natural causes). Respondents also considered suicide to be the most difficult type of loss to offer sympathy for, as compared to natural death or accidents that were not seen as self-inflicted or preventable. The findings of Silverman, Range, & Overholser (1994-1995) are also consistent with other studies (e.g., Reed & Greenwald, 1991), that show elements of stigma, shame, and rejection to be higher among college students who had survived a suicide as opposed to those experiencing other kinds of deaths. Additionally, increased negative bereavement reactions were noted among survivors in the study, particularly in terms of higher tendencies toward self-destructive behavior. Lastly, in a study of attitudes towards adult parents of deceased children, Calhoun, Selby, & Faulstich (1980) found that, when the death was the result of illness, parents were liked more by a sample of urban respondents compared to when children had died by suicide. Similarly, parents whose children had died by suicide, as opposed to illness, were also blamed more for the death by respondents. Similarly, in comparing parents who had survived a child’s death due to an accident as opposed to a suicide, Séguin, Lesage, & Kiely (1995) found that survivors of accidental death received more helpful overall support from others, particularly from within the immediate and extended family unit.

The death of an individual due to his or her perceived “deviant” behavior is yet another situation where social support might be compromised. As indicated at length in the previous

chapter, suicide has been considered one such type of socially deviant death that has numerous implications for remaining survivors. One study encapsulates a number of these implications. Solomon (1982-1983) implemented a study involving ninety participants who had lost an individual to suicide. Respondents underwent structured interviews where they were asked describe various instances of stigma that they had experienced. The answers provided by respondents yielded a category of subjects who had been found to endure stigma (“S” respondents) and a category of those who had not endured stigma (“N” respondents). Findings revealed that three of the study’s fourteen generated indicators of stigma (i.e., gossip, negative impressions of the conduct of officials, and moving place of residence within one month after the suicide) had reached a statistical significance of .01 or less, with more “S” respondents having experienced all three indicators to a greater extent than the “N” respondents.

### *Impact on Survivor’s Amount and Type of Support*

In considering these key issues, it becomes evident that a variety of considerations are embedded within one’s decision to offer support to bereaved survivors. These factors are speculated to influence the amount and type of aid that is ultimately offered, specifically in terms of three outcomes: sympathy and empathy received for the survivor’s loss, recognition of grief by others, and implications for bereavement. Each is described below.

*Sympathy and empathy received for the survivor’s loss.* Receiving sympathy and empathy from others can be a positive social outcome for those mourning a sanctioned loss. In a case study of her own experience mourning the death of her son from cancer, Holmberg (2007) notes sympathy as one of the four sources of support identified over the course of two years of narrative recorded in a personal diary. Specifically, she states the following:

Thanks to support from some very good friends, in whom I had the utmost confidence, I had company whenever I asked for it. My ‘chocolate friend,’ [dark chocolate given by a friend] mentioned in the narrative, is only one example of the solid friendships that contributed helping me through a hard time...The mere knowledge that my friends stood by supported me. (pg. 22-23)

Certain losses have been shown in the literature to evoke more empathy and sympathy than others, and such is the case under conditions in which the death is particularly traumatic. Research on observers who are able to empathize with survivors of extreme trauma can provide some insight into why such instances of death might arouse more emotional reactivity. For example, Regehr, Goldberg, & Hughes (2002) conducted a mixed-methods study to determine how routine exposure to human tragedy by ambulance paramedics affects levels of distress. Eighty-six paramedics were assessed via survey and interview, with findings revealing that subjects expressed emotional empathy (e.g., sharing and experiencing feelings for another) rather than simply having a “cognitive understanding for the loss or suffering...” (p. 510). For example, subjects felt the most empathy in situations such as when a survivor’s loved one may have died without the presence of others, being part of a family unit affected by devastating losses, and surviving the suicide of a socially isolated individual. Sympathy and empathy can also be more accessible to individuals mourning a sanctioned death. Calhoun, Selby, and Abernathy (1984) found in their investigation of attitudes toward loss among college students that certain events

resulting in death, such as uncontrollable accidents and natural causes, were perceived to be “easier” to provide sympathy for as compared to deaths resulting from self-destructive behaviors that were within the decedent’s control.

Showing less sympathy and/or empathy for a survivor has been noted when losses are regarded as socially unsanctioned. For example, Calhoun, Selby, & Steelman (1988-1989) conducted structured interviews with twenty-five funeral directors to understand their experiences with deaths involving suicide. Participants noted that suicide often evokes social embarrassment and shame among family members of the decedent compared to other types of death. Additionally, they indicated that funeral participants are uncomfortable expressing sympathy toward the family, and feel less confident in the sympathy that they do express. This can result in less or no support for survivors, thereby precipitating increased grief reaction, psychological distress, and intensifying feelings of guilt and shame, all of which are highlighted in greater detail in the “Implications for Bereavement” section.

*Recognition of grief by others.* Within the social environment, the grief reactions of survivors of sanctioned losses are often well received by others, ultimately resulting in support. Thus, the importance of acknowledging grief endured by bereaved survivors has been regarded as a crucial issue to address during the bereavement process. For example, Wilson (2001) conducted semi-structured interviews with eight families bereaved to perinatal death. “Recognizing and Acknowledging the Child’s Grief” was the first of three primary themes noted, which involved using words such as *listening* and *answering questions honestly* in addressing the issue with their children. Understanding the context of their feelings through the allowance of individual expression was also noted, as one mother stated, “He [the child] will tell you in his own way” (p. 59) when referring to children openly expressing their grief. Recognition of grief from professional entities has also been shown to have utility. Farrugia (1996) notes that counselors working with bereaved families have the opportunity to recognize the individual nature of the grief experience, and acknowledge recent encounters with other professional entities (e.g., hospitals) where staff members may have lacked sensitivity toward them. Employing active listening techniques, providing a safe space to share memories of the decedent, and being comfortable with the survivor’s expression of feelings are also potential benefits that counselors can offer.

Acceptance of an individual’s grief and mourning is also validated through his or her allowance to participate in events that facilitate resolution, such as funerals, memorial services, and other related activities. Depending on the social situation of the survivor, such opportunities might only be extended to those whose relationship to the decedent falls within the parameters of what is considered “normative” for that particular social context, which may exclude non-family members and/or same-sex partners (Sprang & McNeil, 1995). Attig (2004) argues that the denial of one’s right to participate in grief and mourning practices reflects the denial of a human, as opposed to simply a conventional, right. Disenfranchisement of grief, therefore, is regarded as a “failure” on the part of society to empathize with the bereaved, is an abuse of authority by individuals who cannot understand the mourner’s grief, and presents ethical conundrums as a result of the lack of human dignity experienced by survivors. Thus, it stands to reason that supportive behaviors and attitudes reflect a sort of social permission for survivors to engage in grief. Research has indicated that support may be triggered differentially as a result of how losses

are recognized by society. Acknowledgement of grief has been shown to be contingent upon factors noted throughout Chapters 2 and 3, such as the nature of the death (e.g., Range & Thompson, 1987; Silverman, Range, & Overholser, 1994-1995), the relationship between the decedent and the survivor(s) (e.g., McCreight, 2004; Thornton, Robertson, & Mlecko, 1991), and the extent to which the death is considered socially valid (e.g., Hazen, 2003; Weidner & Griffitt, 1984).

As opposed to losses deemed socially sanctioned by social norms and values, unsanctioned losses have been identified in the literature to receive very different responses. Specifically, such deaths have been regarded as unworthy of recognition given the conditions of the death itself. The nature of the death need not be particularly stigmatizing; however, social responses have been noted in the literature to contain features similar to such types of deaths, particularly in terms of minimizing the survivor's grief experience. For example, in a qualitative study involving fathers grieving a perinatal loss, McCreight (2001) conducted a narrative analysis consisting of fourteen men living in Northern Ireland. In interviewing the bereaved fathers, an assortment of patterns emerged among men, ages 21 to 43, with respect to three main themes: self-recognition, supporting role, and acknowledgment of loss by the wider community. Each is evaluated in greater detail below.

*Social recognition.* According to Ireland law, a stillbirth (considered as such if death occurs after the twenty-third week of gestation) is required to be documented and certified. In the event that the father is not married to the mother at the time of death, he is not permitted to register the stillbirth, thus severely limiting his opportunity to engage in the normative social procedures that married parents are afforded. One subject had experienced this, while six subjects indicated that they were not socially recognized as mourners (e.g., their loss was not considered "viable"), and were not permitted the opportunity to bury the remains.

*Supporting role.* The notion of grief suppression among men identified by Murphy (1998) further supports the study findings, as the men oftentimes found themselves tending to their partner's emotional needs in an effort to provide solace. This was succinctly stated by one participant, Robert, when he said, "I had to be strong for her" (p. 337).

*Acknowledgment of loss by the wider community.* All of the men in the study expressed varying degrees of insufficient recognition for their loss within the social milieu. For example, one participant, Eric, noted responses by others, such as "It could be worse" and "He [the child] could have been six years old and run down by a car" (p. 342). Another participant, Patrick, reflected upon the challenges associated with living in a society that does not sanction the grief reactions of men, stating:

It was hard because all the time when you're growing up you're told, 'You're a big boy now,' when you fell in the playground you were told 'Big boys don't cry, boys are strong,' you are always fighting those emotions really, but when you lose your baby, it sort of confuses you, you want to tell someone how you feel, but you think, 'I'm a man, I shouldn't be feeling like this' (p. 342).

## *Implications for Bereavement*

Ultimately, survivors who mourn losses recognized as socially sanctioned can have lasting positive implications on their ability to navigate through the bereavement experience. For example, survivors who receive support from others tend to evaluate their bereavement experiences more positively. For example, Lang, Goulet, & Amsel (2004) conducted a longitudinal study involving how factors such as resiliency, support, and appraisal predicted health outcomes for a sample of 110 couples bereaved due to infant death. Findings indicated that all three factors were significant predictors, and that “social resources may enable individuals to muster effective strategies to manage and redefine an event in a more positive light” (p. 877). Furthermore, it was found that a combination of hardiness and social support may have been used to facilitate more meaning-making for bereaved couples in terms of the event itself, their relationship to one another, and their relationship to outside supports. Such findings have been consistent with other studies (e.g., Edwards, Nazroo, & Brown, 1998; Schaefer & Moos, 1998; Stroebe & Schut, 2001). Research has found that social support serves as a buffer against intense grief reactions that might ordinarily be present when support is lacking or unavailable. For example, in a study examining social support as a mitigating factor in grief reaction, Yan & Tang (2007) found among their sample of 255 Chinese women who had experienced reproductive loss that intense grief reactions were more common among women who felt they had less emotional support from their spouse, along with other factors such as strong attachment to the embryo/fetus and having fewer children. Similarly, Yazgan (2006) notes that social support is often identified in the literature to be a “protective factor” against excessive grief reactions among groups such as the elderly.

When supportive networks are unavailable, the potential for survivors of unsanctioned loss to experience intensifying grief reaction and psychological distress becomes more likely. In a study conducted by Lennon, Martin, & Dean (1990), 180 self-identified gay men were given structured, face-to-face interviews in an effort to examine the relationship between grief reactions and the type of support (either instrumental or emotional) received upon experiencing the loss. The primary hypothesis of the investigation—that higher forms of social support would indicate lower levels of grief-related reactions—was assessed using a combination of personally developed as well as existing instruments, including the *Texas Inventory of Grief* and the *Grief Reaction Scale*. Two types of support—*instrumental* (e.g., care-giving responsibilities) and *emotional-social* (e.g., the availability of others to talk to)—were assessed. The results showed that overall grief reactions were higher among those who had indicated no availability of emotional support ( $N = 10$ ) as opposed to those who had received either emotional or instrumental support ( $N = 168$ ).<sup>4</sup> The adequacy of emotional support yielded similar results, with overall grief scores being lower among those who regarded the type of support received to be adequate.<sup>5</sup> These findings further suggest that grief-related symptoms experienced by gay men are similar to symptoms found in bereaved parents and spouses. Because the results suggest a relationship between social support systems and grief reactions, the study appears to be consistent with two pertinent findings identified in previous research: (1) grief reactions experienced by those who endure an AIDS-related death are not unlike those encountered by other groups, and (2) the grief reactions of gay

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<sup>4</sup> In terms of availability of support, the findings indicate that, among those who received support ( $N = 168$ ), the mean grief reaction score was 16.9; for those who did not receive support ( $N = 10$ ), the mean grief reaction score was 20.7.

<sup>5</sup> Specifically, among those indicating adequate support ( $N = 52$ ), the mean grief reaction score was 17.4, whereas those believing their support to be inadequate ( $N = 23$ ), the mean grief score was 23.0.

men in the context of their loss have the potential to be heightened when social support either does not exist or it fails to engender adequate assistance to survivors (e.g., Glick, Weiss, & Parkes, 1974; Lindemann, 1944; Parkes, 1986).

In a study conducted by Gluhoski, Fishman, & Perry (1997), a sample consisting of 598 self-identified gay men engaged in a longitudinal study initiated in 1987 to identify various potential moderators of bereavement-related distress. Of the men selected to participate, 58% were negative for the HIV virus, while 42 % were positive. Social support was assessed with the *Interpersonal Support Evaluation List*, which contained forty items of true/false statements regarding the subject's involvement with others during the bereavement process. The findings revealed significant main effects (the grief reaction score as the dependent variable) for social support ( $F(2,338) = 15.42, p < 0.0001$ ) and hardiness ( $F(2,338) = 10.98, p < 0.0001$ ). Interaction effects between social support and number of losses ( $F(2,338) = 4.55, p < 0.01$ ) were also noted. Overall, the results concluded that higher levels of bereavement-related stress were reflective of increased psychological distress for survivors, with social support acting as a buffer against such stressors when present.

### Stigma and the Grief Experience

Lacking recognition for one's grief can also be the result of socially-induced stigma. Research has supported the existence of stigmatizing patterns as experienced by survivors. One such socially castigated loss, elective abortion, illustrates this dynamic. In a study of male attitudes toward abortion conducted by Weidner & Griffitt (1984), seventy-one female and seventy-three male subjects agreed to participate in a two-part process involving a battery of assessments, including the *Attitudes towards Women Scale*, the *Sexual Opinion Survey*, and the *Bentler Heterosexual Behavioral Inventory*. A second component involved each participant rating one of four fictional individuals (a woman having an abortion, a man asking a woman to have an abortion, and male and female "control" target). The study findings suggested that abortion "targets" (i.e., women who were described to have undergone an abortion and men who advised women to undergo an abortion) were seen as less desirable to date ( $M = 3.51$ ) and marry ( $M = 2.93$ ) as opposed to the control targets ( $M = 4.23$ ;  $M = 3.62$ ). Sex characteristics also played a role in the perceptions of women who underwent abortion. A three-way interaction among marriage desirability, sex of subject, and sex of target suggested that the female study participants had higher attitudes of social rejection toward the male target than did male study participants ( $M = 2.5$ ;  $M = 3.39$ ), and male subjects indicated more attitudes of social rejection toward the female target than did female participants ( $M = 2.88$ ;  $M = 3.75$ ). Additionally, stigma toward the female target was found to be most closely associated with three variables: negative attitudes toward women, restrictive attitudes toward abortion, and lack of identification with the target.

Stigma attached to a death can manifest in a number of ways. Blaming the survivor has been identified as a common manifestation of stigma within the literature, particularly when deaths involving suicide are involved (e.g., Calhoun, Selby, & Faulstich, 1980; Dunn & Morrish-Vidners, 1987). Another potential implication for those grieving an unsanctioned loss can be the presence of increasing isolation, guilt, and shame that might already compound the bereavement experience. Previously addressed research has supported the existence of these elements, to



varying degrees, within the bereavement experience for survivors of unsanctioned loss (e.g., Beder, 1998; Dunn & Moorish-Vidners, 1987; Silverman, Range, & Overholser, 1994-1995). While these outcomes can be the result of insufficient aid, research supports the notion that the individual may, given the stigmatizing nature of the death, fail to act in ways that would otherwise facilitate social responses from others to provide aid during the grief period. Aside from Kauffman's (2002) theoretical notion of "self-disenfranchisement" noted in Chapter 2, empirical evidence, such as that found by Séguin, Lesage, & Kiely (1995), also supports the existence of this phenomenon. Sixty subjects (thirty who had experienced death due to suicide and thirty who had not experienced suicide) were interviewed twice up to nine months after the death of a child due to either suicide or a car-related accident. Results indicated that survivors of suicide-related death had experienced heightened feelings of shame and indicated fewer numbers of supportive individuals. Furthermore, the authors found that a number of the suicide survivors were hindered in their social relations with others, due in part to the shame and stigma they had experienced. Specifically, they made the following suppositions:

Survivors feel awkward within their families and with friends. They no longer feel they are competent providers for the rest of the family. This feeling is extremely distressing and hurtful, and it creates dissonance in their concept of self by bringing to the forefront actions or attitudes that are inconsistent with their own idea of who they are or who they ought to be. This may explain why survivors of suicide complain of low social support, even if, quantitatively, social support is present and offered. Survivors tend to isolate themselves more than other bereaved, thus making it hard for family and friends to offer support. (p. 495)

Similar findings are also noted in research affecting sub-populations of survivors of HIV/AIDS-related death. Mizota, Ozawa, Yamazaki, & Inoue (2006) conducted interviews with 225 families grieving the deaths of HIV-infected hemophiliacs. Findings suggested that, even though the affliction of HIV was placed upon "innocent" victims, many families noted a sense of anxiety over potential discrimination they believed they would receive in the social environment. Some refused to talk about issues related to hemophilia, fearing others would attribute the disease to HIV or members of the family as potential carriers. Themes of isolation were also prevalent, largely due to the survivor's feelings of shame and guilt; it was not uncommon for families to move or refuse to disclose aspects pertinent to the death:

For these reasons, they said 'no one supports me, because I keep quiet.' They still had difficulty in securing practical or emotional support, had no opportunity to give expression to their sufferings and hardships, and had to turn to a very limited number of people for support as suggested by the statements, 'I had to share a burden with a very limited number of people' and 'I had it keep it to myself.' (p. 2402)

## Suicide as Disenfranchised Grief

Serving as a significant concept within the study's core framework, the notion of disenfranchised grief has been identified in the literature as a salient feature of the grief experiences of survivors who experience an illegitimate, stigmatized, or invalidated loss. Below is a description of the research that brought attention to this phenomenon, while addressing its utility within the context of suicide-related bereavement.

### *Early Research*

The development of the disenfranchised grief concept stems from two specific pieces of literature by Doka (1986; 1987). Prior to these initial investigations, very limited bereavement-related research had attempted to focus empirical attention on the occurrence of this phenomenon. In an effort to understand the impact of hidden loss within the context of divorce, Doka (1986) conducted a small-scale study using a limited number of participants who had endured the death of a former spouse. Of the eight study participants who had encountered a loss, two had indicated emotional stress resulting from feelings of guilt and regret, while another equated her loss to be “as normal and poignant as any widow” (pg. 444). Role ambiguity among the subjects was a frequently noted barrier to the expression of grief responses, as were themes of lacking social support and the discouragement of overt grief reactions. Doka (1987) also identified a myriad of outcomes consistent among disenfranchised grievers, such as shame, guilt, embarrassment, isolation, and persecution. These reactions were particularly present in socially isolated groups, such as homosexuals, former spouses, and extra-marital partners. Additional stressors often precluded the display of appropriate social responses to grief, including exclusion from the participation of care and support for the dying, lack of social support, denial of engagement in funerary practices and memorials, and pragmatic legal difficulties.

### *Suicide as a Case of Disenfranchised Grief*

Thus far, an array of empirical evidence highlighting social support, mode of death, and disenfranchisement has been presented in support of the proposed study. However, it still remains unclear how the nature of suicide qualifies as a type of death that differs from other types, particularly within the context of social support availability. Suicide can be considered a particular instance of stigmatized death in that it engenders a “double bind” phenomenon of sorts for survivors that has implications for social support: disclosing the nature of the death can result in loss of support due to potentially negative perceptions of suicide, while failing to disclose precludes survivors from availing themselves of potential sources of untapped support (Doka, 2002). Given this, the need to address the underpinnings of suicide as a type of stigmatized loss becomes crucial. Thus, an exploration of general features distinguishing suicide from non-suicide is provided below.

*Suicide versus non-suicide.* The act of completing a suicide has been the subject of much controversy and social castigation within both secular and theological domains. It has been noted in the literature that there exist certain experiences inherent among survivors of suicide that distinguish the grief experience from non-suicides. Such perspectives have been identified in various studies differentiating suicide-related grief from “normal” grief in terms of the stigma

and lack of recognition it can engender, such as unsympathetic social responses and reluctance to talk about the death with others. The element of stigma attached to this form of death, for example, usually originates from deviations from the norms and expectations of a particular society. Previous literature suggests that deaths are deemed more stigmatizing when they are a result of one's own behavior (e.g., substance abuse, promiscuity, ineffective coping, etc.). These negative reactions have the ability to affect, or "spill onto," the bereaved survivors of these deaths. Examples of such studies are noted below.

In a qualitative study involving survivors' psychological and social experience with suicide, Dunn & Morrish-Vidners (1987) found themes of lacking of social support and acknowledgement of loss among a sample of twenty-four subjects. While participants indicated varying degrees of support from others, the data implied instances of distancing by individuals secondary to their primary support system (e.g., colleagues, acquaintances). One subject, for example, commented that it was "five or six months" (p. 189) before fellow students ever broached the topic. Demi & Howell (1991) applied a grounded theory approach to addressing intrapersonal resolution after the suicide of a family member. Qualitative themes of stigma, self-blame, lowered self-esteem, and lack of disclosure about the death were found among a majority of subjects, suggesting potential long-term consequences impacting well-being into adulthood, particularly if the suicide was experienced at a young age. For example, a majority of respondents noted feelings of stigma (e.g., feeling "tainted" by the suicide), prompting many to express concern over future stigmatization. Additionally, secrecy was also a common coping mechanism employed by subjects, causing some to go to great lengths to avoid disclosing the nature of the death. For example, one individual whose biological mother completed a suicide approached his stepmother and asked to be considered a brother to future siblings rather than just a stepbrother.

Grieving difficulties are also cited as a response to the lack of outside support that suicide survivors might receive (Barnes, 2006). These individuals are prone to feeling a sense of shame and/or guilt over the nature of the death which might preclude them from accessing supportive networks, further complicating existing grief (Doka, 2002). Furthermore, in a review of the 2001 International Association for Suicide Prevention (IASP) conference in Chennai, India, Grad, Clark, Dyregrov, & Andriessen (2004) addressed the lack of bereavement-related support available for mourners of suicide, citing "social helplessness" (i.e., inability of social networks to respond in ways helpful to the bereaved) and lack of openness (e.g., speaking about the suicide) as barriers to obtaining sufficient support. Additionally, Farberow (1998) described the limited formal support available to bereaved suicide survivors within countries affiliated with the IASP, noting that only 27% offered grief support services, a majority of which were facilitated by paraprofessionals. In a study addressing the needs of survivors bereaved to suicide in Belgium, Andriessen, Cosyns, Verthriest, & Veys (1998) found that survivors wanted respect and social recognition from others and wanted sufficient opportunity to mourn their loss. They also indicated the need for caregivers to be proficient in issues related to suicide bereavement, many of whom, when asked, were not.

Recently, research has attempted to capture the essence of suicide and its societal implications through phenomenological investigation. In past studies, the use of qualitative data has illustrated the social experiences of survivors within the context of their environment,

specifically in terms of the negative social responses endured, such as abandonment by friends, people within the larger social milieu feeling “uneasy” around survivors, and survivors’ beliefs that only others who have endured a suicide could understand their grief experience. For example, Begley & Quayle’s (2007) phenomenological investigation examining the lived experiences of suicide survivors identified the theme of *social uneasiness*: a number of subjects felt the need to self-isolate due to persistent thoughts about the death, describing fears of rejection and feeling “let down” by initially supportive communities once memorial rituals ended. Additionally, Wagner & Calhoun (1991-1992) offered evidence to suggest that survivors experience social pressure from supportive networks to recover from their grief: while all twelve interviewed survivors had experienced helpful formal and informal support, eleven claimed to experience support that was inadequate or hurtful. Seven subjects indicated that supporters pressured them to “complete the bereavement process and move on” (p. 70), placing what they felt to be unrealistic time frames for recovery.

Findings addressing social responses to suicide have also been identified in quantitative research. For example, Calhoun, Selby, & Abernathy (1984) identified, through analysis of variance, challenges such as social difficulties (e.g., respondents rating greater difficulty in speaking to survivors of suicide compared to survivors of natural causes and accidental deaths) and inhibited expression of sympathy (e.g., respondents rating survivors of suicide as most difficult to express sympathy for). In terms of reactions to suicide, Farberow, Gallagher, Gilewski, & Thompson (1992) found that, in comparing older adults who had experienced the death of a spouse, those who were bereaved to suicide reported less emotional support and recognition for their loss as opposed to those who were bereaved from death due to natural causes. Three groups of subjects, consisting of 110 survivors of elderly suicides (“SS”), 199 natural death survivors (“NDS”), and 163 non-bereaved controls (“NBCs”), were assessed at four different times after the death to identify social supports, coping mechanisms, and physical health status. Between group analyses revealed that “NDS” subjects received more practical assistance than those of “SS” subjects who also experienced less overall contact with members of their supportive network than “NDS” subjects.<sup>6</sup> Within group findings revealed “NDS” subjects received significantly more emotional support across the four data collection periods compared than “NBCs,” with both groups receiving more than “SS” subjects. Overall, the findings suggested that the nature of social support seemed to change for subjects depending on whether or not the death was due to suicide; survivors of these deaths experienced lower emotional and practical support, especially at six months after the death.

### Overview of Proposed Research Inquiry

As indicated throughout various points of the dissertation, the underlying general supposition of this study is that social reactions and responses toward different instances of death are likely to vary depending upon the context of the situation. As such, support for survivors is apt to be higher for deaths that are perceived to be less stigmatizing than deaths that carry some element of discredit. From this, the current study aims to address the extent to which this holds true for specific instances of suicide. Currently, research has yet to provide evidence to support the notion that different types of suicide can result in variations in social support outcomes for survivors. Within much of the literature, suicide tends to be discussed in a broad context, seldom

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<sup>6</sup> This finding was consistently found to hold throughout the four time periods of data collection.

distinguishing features or motivations behind different types. Only a small handful of studies (e.g., Range & Thompson, 1987; Silverman, Range, & Overholser, 1994-1995; Thornton, Robertson, & Mlecko, 1991) have sought to explore social support variations in different modes of death. Similarly, limited research (e.g., Calhoun, Selby, & Abernathy, 1984; Calhoun, Selby, & Faulstich, 1980; Farberow, Gallagher, Gilewski, & Thompson, 1992; Range & Calhoun, 1990) has been devoted to examining the social experiences specific to survivors of suicide in comparison to other deaths. To date, no studies have been conducted to qualitatively compare the social responses of different types of suicide to one another. Claims and evidence addressed in reference to type of death throughout this chapter have been used to support the supposition that the circumstances involving the death do, in fact, matter in terms of support offered. Thus, the study seeks to address the following inquiry: *What factors typify how and why social support is offered to survivors of traumatic death, particularly suicide?*

As a method for examining the relationship between suicide type and social support for the proposed study, Emile Durkheim's (1897; 1951) sociological typology of suicide, consisting of four types (i.e., egoistic, altruistic, anomic, and fatalistic), provides a useful framework for distinguishing variations in such types of death. Past research has supported the utility of Durkheim's typology, particularly as it pertains to social integration (e.g., Leenaars & Lester, 1999; Lester, 1998; Lester & Yang, 1992; Wiedenmann & Weyerer, 1994), and has provided evidence supporting specific types of suicide indicated within the typology, including anomic and egoistic (e.g., Fernquist, 2007), fatalistic (e.g., Stack, 1979), and altruistic (e.g., Blake, 1978). Durkheim's typology, as it pertains to identifying variations among types of suicide, also has implications with respect to supporting the proposed research inquiry. More specifically, case vignettes can be constructed using the typology in an effort to present a hypothesized continuum of social support. What follows is a brief description of each type of suicide, its utility in past research, and its anticipated outcome in the study. Each is described below.<sup>7</sup>

#### *Egoistic Suicide (Lowest Support, Highest Stigma)*

*References in literature.* Regarded as a type of suicide that involves a low level of integration, egoistic suicide reflects the demise of the "unhappy" individual (Leenaars, 2004). Thus, those committing a form of egoistic suicide are likely to have isolated themselves from group membership, ultimately "los[ing] their reason for living" (Watson, Milliron, & Morris, 1995, p. 702.). Specific evidence regarding the provision of social support for survivors bereaved to egoistic suicide is very scant; however, in a study assessing attitudes toward survivors of suicide, Lester (1990-1991) found that college student subjects were likely to be less sympathetic toward bereaved survivors when the suicide was motivated out of self-involvement (e.g., self-blame) as opposed to more fatalistic purposes (e.g., end to pain/suffering). Furthermore, this study supports the notion that stigma attached to the bereaved survivor is influenced by the type of death mourned. This may have implications for how respondents are likely to respond to the survivors, given the social norms that are violated (e.g., lack of group membership, extreme violence, etc.) when a suicide is considered egoistic.

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<sup>7</sup> The manner in which elements of the study's conceptual underpinnings are hypothesized to occur (i.e., social support and stigma) will be addressed for each specific type of suicide.

*Rationale for placement.* Given the nature of this type of suicide as one that can potentially be motivated out of self involvement and interest, it is proposed that an egoistic form of death will generate the lowest offering of social support for survivors. This might be due primarily to the violations of social norms that are committed when such a suicide is completed, such as a disregard for the safety of others, failure to form successful social ties, extreme self-deprecation, or inability to overcome personal challenges. In practical instances, deaths of this nature might involve situations such the suicide of an individual who feels he or she has no reason to live, or a murder-suicide. These instances could be regarded as those in which the decedent might be perceived to have had a reasonable level of control over his or her situation, similar to findings noted more generally in Séguin, Lesage, & Kiely (1995) or more specifically in terms of different suicides noted in Lester (1990-1991).

Hypothetically, survivors of egoistic suicide might be socially admonished by observers for failing to recognize ideation, intent, or other features that might otherwise alert them to the possibility of suicide. The nature of the death, particularly in cases of suicide that may have taken place in the midst of violence or anger, might also cause survivors to be stigmatized in ways that can minimize the amount of support offered. This might be further precipitated by observers' negatively associating the manner of death with those closely tied to the decedent (e.g., the survivor shares similar traits as the decedent, the gruesome nature of the death reflecting negatively on survivors, etc.). Such factors could culminate into an overall lower availability of support in comparison to the other three types of suicide.

#### *Anomic Suicide (Lower Support, Higher Stigma)*

*References in literature.* Anomic suicides are the result of dramatic shifts within the social environment; individuals of this type are often detached from the society in which they live, similar to those who complete an egoistic suicide (Leenaars, 2004). However, anomic suicides are often prompted by significant changes to an individual's life that can result in his or her detachment from society, unlike an egoistic individual who may have been more likely to have endured extended periods of isolation prior to death. In a review of the social dynamics of suicide, Marra & Orrù (1991) note Durkheim's belief of this type to be fraught with lacking morality and discipline. Thus, anomic suicide according to Durkheim, is largely responsible for criminal acts, such as homicides and suicides, in areas of rapid social change. For example, Lester (1999-2000) noted instances of negative social responses (e.g., insults, property damage, etc.) perpetrated upon a mother grieving the death of her son, a convicted murderer, in the 1970s. Additionally, Clements & Burgess (2002) found themes of stigma among children bereaved to parental homicide, particularly when the death was sensationalized by media sources. While these examples do not necessarily involve direct acts of suicide, it is reasonable to suggest that such instances of anomie can, in fact, generate unfavorable responses with respect to how bereaved survivors of anomic suicide could be perceived and ultimately supported.

*Rationale for placement.* Proposed to be slightly higher than egoistic suicide along the continuum of support offered to survivors, forms of anomic suicide might potentially involve situations in which an individual may have had some control over his or her suicide, but felt overwhelmingly compelled to do so based on social or personal shifts that conflicted with their previous lifestyle, such as economic difficulties or experiencing a personal crisis. Unlike egoistic

forms of suicide that may generate significantly less support for a survivor, situations prompting an anomic suicide might be perceived as observers as more understandable. Essentially, this form of suicide is hypothesized to offer more in the realm of social support to a bereaved survivor compared to an egoistic form out of speculation that subjects might personally be able to sympathize with an individual's decision if social and/or personal changes seem insurmountable. Despite this increase in potential support compared to egoistic suicide, the stigma attached to this form of death is still likely to remain pervasive, given its violation of social norms, such as failing to find alternative solutions to one's problems, perceived inherent personal weakness, or inability to adapt to changing social dynamics. This might also play a role in how survivors are viewed, as they still may not be regarded as favorably overall.

### *Fatalistic Suicide (Higher Support, Lower Stigma)*

*References in literature.* Fatalistic suicide reflects one's over-regulation within society. The individual "is choked by oppressive discipline" (p. 2) or feels their future is somehow inhibited (Leenaars, 2004). While this form of suicide can exist in a variety of forms (e.g., being a prisoner of captivity, extreme social oppression, etc.), terminal illness has been identified as a prominent example of fatalism in the literature. From a theoretical perspective, Beder (1998) suggests that individuals bereaved from assisted suicide, for example, experience shame, guilt, and stigma surrounding the death, particularly in instances where family members experience ambivalence toward the dying person or feel they have unduly influenced one's decision to end their life. In such instances, survivors might be more likely to withhold the true cause of death to avoid negative social reactions (Range & Calhoun, 1990). While these reflect an array of aspects related to the bereavement experience, research has identified varying evidence in both support of, as well as opposition to, assisted suicide within different populations. For example, general public attitudes, such as those found in Williams, Dunford, Knowles, & Warner (2007), favored physician-assisted suicide (PAS) in extreme cases of dementia, with 60% in overall support of PAS. Similarly, Fenn & Ganzini (1999) found strong support for PAS among a majority of Oregon psychologists after the passage of the Death with Dignity Act of 1996. Conversely, Watts, Howell, & Priefer (1992) found a sample of geriatricians to hold generally negative views regarding willingness to assist demented patients suicide as well as loosening restrictions on assisted suicide in general. Cicirelli (1998) found acceptability toward assisted suicide among elderly subjects to be only 12%, as opposed to 52% favoring efforts toward sustaining life. Thus, it is clear that overall attitudes toward such instances of suicide vary considerably, reflecting possible variations in terms of how survivors are likely to be socially supported (e.g., Lester, 1990-1991).

*Rationale for placement.* As compared to the previous two instances, completing fatalistic forms of suicide might involve cases in which an individual could have exhausted other options to alleviate difficulties but to no avail, such as extreme instances of terminal illness or severe deprivation of freedom or faculties. As such, these cases may be deemed "easier" in terms of offering social support to survivors who might be involved with the decedent and can attest to his or her physical and/or psychological pain, such as being a long-time caregiver or loved one of a kidnap victim. While cases of fatalistic suicide have been shown to reflect variations in support based on the literature noted above, it is hypothesized to rank on the higher end of the continuum of social support. Despite continued debate regarding the ethical and moral implications of

assisted suicide, for example, stigma is hypothesized to be less prominent in this particular instance. This might be due to the fact that, compared to the previous instances of suicide, subjects might be more likely to have had direct or peripheral involvement with another who has faced fatalistic situations (e.g., terminal illness or prisoner of war) regardless of whether or not suicide was considered. Thus, empathy for bereaved survivors by observers (i.e., subjects) might be easier to obtain, particularly if severe suffering is apparent.

#### *Altruistic Suicide (Highest Support, Lowest Stigma)*

*References in literature.* The final form of suicide, altruistic, occurs when the individual is highly integrated within his or her society; as a result, the death is regarded as a duty or honor (Leenaars, 2004). Examples of altruistic suicide within the literature have generated inquiry regarding the support, or “praiseworthiness,” of such acts. For example, Leenaars (2004) noted that altruistic acts regarded as “optional” are recognized by society to be favorable. Thus, such instances of self-sacrifice (e.g., risking death to save the life of another) are oftentimes regarded as heroic. While not specifically referenced in the literature, one could make a reasonable argument that, given how such acts are perceived to be laudable within the larger social milieu, adequate social support for bereaved survivors would be a reasonable, if not expected, outcome. If an act of suicide is considered altruistic, support may be more readily accessible to survivors whose loss might be considered beneficial or useful to society.

*Rationale for placement.* Ultimately, it is hypothesized that grieving a loss that is altruistic will engender the highest level of support for survivors, given the potentially selfless nature of the circumstances. In comparison to the previous forms of suicide, selflessness serves as the primary motivation for this type of suicide. Acts of sacrificing one’s life for another, such as during wartime combat or physical altercation, could trigger sympathetic reactions by others considering the heroic or laudatory efforts attached to the death, as noted in Leenaars (2004). Additionally, subjects may be able to relate to this form of suicide in a similar fashion to that of fatalistic given the higher likelihood of personal involvement with members of the armed forces, such as police officers and service men/women.

#### Summary

This chapter addressed a range of literature pertinent to the utility of social support, stigma, and disenfranchised grief within the scope of the dissertation. Clearly, it has been demonstrated that a number of factors, such as social norms, nature of death, perceived and actual stigma, and lack of recognition are important considerations in the provision of aid to survivors. Additionally, this chapter brought attention to the study’s research focus: to examine how the type of death (specifically type of suicide) affects the amount and type of social support rendered, and that aid reflects a continuum in which highly stigmatized suicides (i.e., egoistic, anomic) engender less support than less stigmatized deaths (i.e., fatalistic, altruistic). The remaining chapters will focus exclusively upon the pragmatic elements pertinent to the dissertation, beginning with the study’s methodological considerations.



## CHAPTER 4: METHODOLOGY

### Introduction

This chapter describes the methodology utilized in the dissertation. Specifically, it summarizes conceptual underpinnings of the methods used, procedures employed in the recruitment, collection, and analysis of data, as well as justification for their use. What follows is a detailed review of the study's methodological paradigm and overall research design.

### Conceptual Paradigm

Given the lack of current knowledge with respect to the proposed domain of research, the dissertation utilized a qualitative methodological framework with an emphasis on exploratory research (Miller & Crabtree, 1999). Within this form of research are three specific methods that the study sought to incorporate: identification, description, and explanation-generalization/association. *Identification* of phenomena occurred through the direct naming of concepts most pertinent to the study; *description* of the nature of the phenomenon was facilitated by examining variations in respondent perceptions and attitudes with respect to the study's core concept; lastly, *explanation-generalization/association* addressed relationships and patterns that emerged from the data (Miller & Crabtree, 1999). Using these methods, the dissertation aimed to answer the following research question:

*What factors typify how and why social support is offered to survivors of traumatic death, particularly suicide?*

In accordance with the proposed research question, the dissertation incorporated a paradigm of *interpretive*, or constructivist, inquiry (Miller & Crabtree, 1999). Given the study's objectives to capture the range of respondents' experiences, perceptions, and ideations with respect to social support under various conditions of death, an interpretive approach was deemed as the most appropriate framework. This was selected for several reasons. As a paradigm of "constructivist inquiry," Guba & Lincoln (1989) assert the "iterative, interactive, hermeneutic, at times intuitive, and most certainly open" (p. 183) nature of this framework as one that takes a non-linear approach to understanding phenomena in comparison to conventional inquiry. Through the use of this technique, the researcher sought to identify variations in how respondents responded to each presented case vignette to underscore the relativity, as opposed to objectivity, of each individual's perspective (Miller & Crabtree, 1999). Additionally, while the paradigm reflects the nature of reality as one that is socially constructed, it also permitted the researcher to "cocreate with the texts" (p. 10), permitting the derivation of meaning from the data based on his own interpretations of it. Thus, the proposed methodology presented in this chapter as well as the findings examined in the next chapter relied heavily upon this paradigm.

### Research Design

#### *Sampling*

*Criteria.* Participants were limited to graduate students and older adults. This was considered appropriate for several reasons. First, this is the only investigation to qualitatively

describe social support availability under different conditions of suicide. Limiting the study to these groups was important in determining not only the initial utility of the proposed research, but in identifying potential variations in what social support is given, how it is given, and why it is given among and between groups that are likely to differ in terms of their experiences with death. Second, isolating groups to these characteristics was important in terms of managing the analysis of data, since identifying specific patterns from within select groups was considered more useful and time-efficient to examine as opposed to generalizing from multiple groups. Lastly, selecting participants based on these criteria was important to providing a sample with sufficient variation in terms of death-related experiences and individual characteristics.

Three criteria for participating in the study were employed. First, all respondents were required to be at least 18 years of age or older. Second, no potential respondent who had experienced the death of a close loved one less than one year prior to the commencement of the study was eligible to participate. Third, respondents were required to be able to speak and write in English. The first two criteria were set in place to specifically address the research content. The age of 18 was used as a minimum requirement with respect to answering questions of a highly sensitive and adult-oriented nature; excluding respondents with recent experiences of loss aimed to attenuate the influence of grief-induced responses and emotional upset. The third criterion reflected use of the monolingual presentation of all related materials (i.e., informed consent document, case vignettes, and verbal instructions) that were only provided in the researcher's proficient language (i.e., English).

Since the study sought to describe attitudes and perceptions of social support among graduate students and older adults, interviewees were recruited from universities, retirement communities, and senior-oriented agencies, such as community centers and learning institutes. These locations were selected based upon the age, academic attainment, and death experience characteristics that typified the overall sample the researcher sought to investigate. Respondents were self-selected, as interested participants who met eligibility criteria contacted the researcher at their convenience by phone, e-mail, or directly during the researcher's in-person recruitment. A more detailed description of this procedure is provided in the *Recruitment* section.

*Sample size and plan.* A target sample size of thirty (fifteen graduate students and fifteen older adults) was initially proposed as appropriate in order to assure saturation of responses. Ultimately, a total of twenty-five respondents (thirteen graduate students and twelve older adults) constituted the final sample. Initially, twenty-seven respondents committed to participating; however, two potential older adult respondents had indicated recent experiences with death prior to their interviews, rendering them ineligible. All remaining respondents met the minimum criteria and completed the entire interview process. A purposive sampling method was employed to limit the sample to participants with specific characteristics (Patton, 1990). The rationale behind this method was to assure that participants met criteria that the researcher deemed as appropriate to the goals and objectives of the dissertation, while seeking to obtain general attitudes reflective of the target groups of interest. Graduate students, as opposed to undergraduates, generally possess more educational experience and intellectual maturity; older adults possess more personal and life history. Snowball sampling was also incorporated, but with very limited use.

*Recruitment.* All recruitment efforts were conducted within Alameda, Los Angeles, and Orange Counties in California between October 2008 and March 2009. Graduate students were recruited in Alameda County from seventeen academic departments at the University of California, Berkeley: Anthropology, Art History, Buddhist Studies, City & Regional Planning, East Asian Languages, Education, English, French, German, History, Political Science, Psychology, Public Health, Scandinavian Languages, Social Welfare, Sociology, and Theater. A flyer containing a description of the study, criteria for eligibility, and researcher contact information was sent to graduate advisers within these academic departments, which were then forwarded electronically to students. Recruitment of graduate students consisted of two phases. In Phase I, ten departments were initially selected by the researcher during the Fall 2008 academic semester. Names of individual departments were written on small slips of paper, folded in half, and were drawn at random by the researcher. To increase recruitment, a second phase involved the selection of seven additional departments during the Spring 2009 semester utilizing the same process.

Older adult recruitment efforts were conducted within all three counties, including two locations in Orange County (Huntington Landmark Senior Community and Orange Senior Center), one location in Los Angeles County (Culver City Senior Center) and five locations in Alameda County (North and South Berkeley Senior Centers, North Oakland Center, Emeryville Senior Center, and Osher Lifelong Learning Institute). These sites were specifically selected based on their central location to the researcher during the period of data collection. Recruitment of older adults also consisted of two phases. In Phase I, requests to send electronic copies of the recruitment flyer were submitted to agency/center directors. All directors consented to posting the flyer on their information/community boards. Approximately one month later, the researcher, with the consent of the directors, conducted in-person recruitment efforts at the four senior centers within Alameda County, making lunchtime announcements to participants regarding the study. Those interested contacted the researcher through e-mail as well as in-person; it was at this time that the researcher discussed further details regarding the study, eligibility for participation, and, if applicable, scheduled a day and time for an interview.

### *Characteristics of Study Sample*

Graduate student respondents ( $N=13$ ) who comprised the final sample came from six of the seventeen academic departments selected from the University of California, Berkeley: Education ( $N=1$ ), German ( $N=1$ ), History ( $N=1$ ), Psychology ( $N=3$ ), Public Health ( $N=3$ ), and Social Welfare ( $N=4$ ). They ranged in age from 23 to 41. Ten were female and three were male. Eight identified as Caucasian, two as Latino/Latina, and three as Asian. All but two respondents indicated experience with the non-suicide related death of a close loved one (e.g., grandparent, grandparent, sibling, aunt). Six respondents experienced the suicide of another, though their involvement with the deceased was mostly peripheral (e.g., friend of friend, principal).

Older adult respondents ( $N = 12$ ) who comprised the final sample came from six locations, including Huntington Landmark Senior Community ( $N = 5$ ) in Orange County; the remaining seven came from various locations in Alameda County, such as North Berkeley Senior Center ( $N = 3$ ) South Berkeley Senior Center ( $N = 1$ ) North Oakland Senior Center ( $N = 1$ ), Osher Lifelong Learning Institute ( $N = 1$ ), and the University of California, Berkeley ( $N = 1$ ).

They ranged in age from 55 to 86. Eight were female and four were male. Eleven identified as Caucasian, and one identified as African-American. All had experienced the death of a close loved one (e.g., parent, grandparent, sibling, spouse). Eight had experienced the death of a close loved one by suicide (e.g., brother, aunt, uncle, sister).

### *Data Collection and Procedure*

The modality of data collection involved the use of a semi-structured interview format (Kuzel, 1999). This format was selected based on the study's exploratory nature and allowed for the consistent inclusion of relevant questions, while permitting the development of new areas of inquiry as necessary. The interview itself incorporated the use of five fictitious case vignettes that described different types of traumatic loss: four situations pertained to suicide-related death and one reflected a generic death as a "control" case. Suicide-specific vignettes were loosely based upon Emile Durkheim's (1897; 1951) sociological typology to provide variation in terms of the traumatic deaths presented to respondents. This format was also used to identify how, if at all, the circumstances surrounding each death affected what respondents indicated they would offer in terms of social support. Durkheim's typology was operationalized using the following case examples: an infantry soldier's self-sacrifice to save the lives of others (altruistic suicide), a murder-suicide involving a man with a history of violent behavior (egoistic suicide), a woman suffering from a painful illness (fatalistic suicide), and a man experiencing a number of significant life changes (anomic suicide). The fifth vignette, unrelated to Durkheim's typology, described a woman's death from a head-on collision with a drunk driver, and was used to identify contrasts, if any, in how support might be offered in comparison to the previous cases involving suicide. Each vignette included reference to a surviving spouse/partner.

Two primary domains were assessed during the interview. The first domain addressed how respondents believed others would react to each death. Initial questions posed aimed to identify how respondents interpret social responses toward death (specifically suicide), and how these responses would be likely to reflect in the support a survivor might receive. Specifically, after reading each vignette, respondents were asked to comment on public attitudes and responses regarding the nature of the death (i.e., "How do you think people may react to how this person died?"), subsequent support for the surviving spouse/partner from others (i.e., "How much support do you think this person's spouse/partner might receive?"; "What specific factors do you think might influence this?"), and, for vignettes two through five, variations among vignettes (i.e., "In what ways are these reactions similar/different from those in the previous vignette(s)?").<sup>8</sup>

The second category involved respondents indicating specific examples of social support that they would be most likely to offer the survivor in each vignette. Questions asked were used to identify the extent to which the respondents' answers were congruent with the views that they indicated others would hold, and to identify factors that facilitated and/or precluded their decisions to be supportive. Specifically, for each vignette, respondents were instructed to imagine themselves as a friend of the surviving spouse/partner, and were then asked to indicate concrete examples of three types of social support based on conceptualizations by House (1981): emotional (i.e., "What might you say to the person to make them feel better?"; "What type of

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<sup>8</sup> See Appendix 3 for a copy of the interview guide.

physical contact/affection might you help the survivor with?"); practical (i.e., "What sort of daily tasks might you help the survivor with?; "What tangible items/goods might you give them?"); and informational (i.e., "What types of resources might you want to offer the survivor?"; "What kind of information might you want to offer them?").<sup>9</sup>

As an extension of the second domain, probes and other questions regarding the respondents' motivations and influences for offering support were also included as part of the interview. Specifically, questions asked included reasons for offering support (i.e., "Why did you choose to offer this kind of support?"), feelings about the support offered (i.e., "How does it make you feel to offer all of this support?"), types of support that would be considered uncomfortable to offer (e.g., "What would you not feel comfortable doing to support the survivor in this case?"), how the circumstances surrounding each death affected support offered (i.e., "How, if at all, did the circumstances of the death affect how involved you wanted to be in supporting the survivor?"), and internal (i.e., "When you consider all aspects relevant to this case, what were your internal motivations for wanting to support the survivor?") and external (i.e., "When you consider all aspects relevant to this case, what external factors influenced your decision to offer support?") motivations for wanting to support the survivor in the ways they had indicated.

As data collection progressed, additional questions were asked that reflected issues raised by previous interviewees. These questions were important both in the probing for potential themes as well as the identification of variations and/or conflicts in previously confirmed data. Specifically, two questions were asked. The first reflected the respondent's closeness to the survivor as a factor in offering support (i.e., "How does your closeness matter in terms of the support you would offer?"). This was added early on the interview process after a number of respondents had indicated that the intensity of their involvement was largely contingent upon how intimately associated they believed they would be to the individual. The second question asked the respondent to identify potential risks associated with supporting the survivor (i.e., "What potential risks/consequences do you think you might experience as a result of supporting the survivor?"). This question was asked toward the latter half of data collection, as the researcher began to identify patterns of reticence in offering aid among some respondents. Two summative questions were asked afterward, at which time demographic information was also collected.

### *Interview Format*

Prior to the formal collection of data, a small pilot test sample was taken to assess initial reactions to the researcher's interview format, case vignettes, and interview guide. Changes were made based on the recommendations of pilot test respondents in collaboration with the dissertation committee. The final interview format contained the elements below.

1. *Introduction of study.* At the commencement of each interview, the researcher reiterated the study goals to the respondent, the nature of questions being asked, and the approximate commitment time (initially conceived to be 30-60 minutes, but ultimately ranged

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<sup>9</sup> For the purposes of this study, specific types of appraisal support as indicated by House (1981) were not asked of the participant, but were included as a form of emotional support.

between 60 and 90 minutes based on individual responsiveness). It was during this time that the researcher informed the respondent that the interview would be digitally recorded to assure the accuracy of responses as well as for transcription purposes. This then segued into a discussion of the informed consent document that was required to be signed by the respondent prior to the interview.<sup>10</sup> Each participant was asked to sign both an original as well as a duplicate form; one was given to the respondent and one was kept with the researcher. At that time, the researcher asked the respondent to select a pseudonym which would be used to reference him/her in the presentation of findings. Occasionally, the researcher provided a pseudonym on behalf of the respondent when he or she had no particular name in mind. Once a pseudonym had been selected, the respondent was given the opportunity to ask any remaining questions prior to formally starting the interview.

2. *Oral introduction of vignettes.* The researcher began by informing the respondent that he/she would be asked to read five different case vignettes describing various fictitious instances of traumatic death, and afterward would be asked a series of questions. The vignettes, one per page, were bound together with a cover sheet, labeled simply as “Case Vignettes,” as the top page. Respondents were handed the vignettes and were instructed to read one vignette at a time in the order in which they were presented.<sup>11</sup>

3. *First case vignette and questions.* The researcher then asked the respondent to turn the cover page and take a moment to read the first case vignette, “Mark,” which describes the death of a young infantry soldier who saves his platoon from an imminent grenade blast. When the respondent finished reading, the researcher began to ask the interview questions.

4. *Repeat of procedure for each additional vignette.* After the questions for the first case vignette had been answered, the researcher repeated the same procedure for the four remaining vignettes, read one at a time: “Adam” (a murder-suicide perpetrated by a man with a history of violent behavior), “Martha” (a woman who takes a lethal dose of medication to end chronic pain due to cancer), “Bill” (a lottery winner with mounting life difficulties), and “Jenny” (a woman killed by a drunk driver). The questions for each vignette were identical; however, vignettes two through five included a question asking respondents to compare and contrast social reactions of other vignettes (i.e., “In what ways are these reactions similar/different from those in the previous vignette(s)?”). This question was not asked for the first vignette, since there was no previous vignette to make a comparison with.

5. *Additional questions and demographic information.* At the conclusion of the standard set of questions, respondents were asked two summative questions regarding overall impressions and reactions to the vignettes (i.e., “How would you order [each suicide-specific vignette] in terms of the intensity or amount of support each person (i.e., survivor) might receive, ranging from lowest to highest?”; “Any other thoughts on how the different types of death may have affected your reactions to them or how you thought others might react to them?”). Demographic questions (i.e., age, gender, ethnicity, and employment/departmental affiliation) were asked afterward. Respondents were also asked about previous experiences with death (generally and suicide-specific), and the extent to which those events affected how they might support survivors

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<sup>10</sup> See Appendix 1 for a copy of the informed consent document.

<sup>11</sup> See Appendix 2 for a copy of the study case vignettes.

in actual situations. At the conclusion of the questions, the researcher officially ended the respondent's participation in the interview by asking if there were any remaining questions or if he/she had anything else to share with respect to any insights or responses to the vignettes or the interview in general. Contact information for the researcher was reiterated to the respondent.

The researcher coordinated and conducted all respondent interviews. Interview days and times were determined based upon the availability of the researcher and the respondent, and, if applicable, the availability of private space (e.g., at the senior centers where older adult respondents had participated). When a date for the interview had been determined, an agreed upon location for an interview was also discussed. Interview locations included the researcher's Graduate Student Instructor (GSI) office for interviewing graduate students and a limited number of older adults, and private residences and senior centers for interviewing older adults. Three graduate student respondent interviews were conducted via the internet, as they were unable to be physically present for in-person interviews. Procedures for these interviews varied slightly from in-person interviews. Respondents were e-mailed a copy of the case vignettes and informed consent document in advance when a day and time for the interview had been determined. In lieu of written consent, respondents were asked to provide oral consent to participating prior to the start of the interview. All respondents, both in-person as well as online, were only interviewed once.

### *Data Analysis*

*Data management and coding.* The process of selective coding was utilized as the primary technique for organizing data (Glaser & Strauss, 1967). This was selected given the researcher's identification of a core code of interest (social support) prior to the collection of data. In the incipient stages of this process, efforts were made by the researcher to develop a number of broad codes based upon themes conceptualized prior to data collection as well as those that emerged from the data itself (Glaser & Strauss, 1967). From this, five codes were identified: *Need for Support*, *Closeness*, *Spousal Involvement in the Death*, *High versus Low Support from Others*, and *Circumstances of Death*. Gradually, the utility of these codes was expanded as data collection progressed, providing a dual function both as interview probes in the collection of remaining data as well as beginning points of reference from which to develop more specific codes.

Future iterations of coding reflected efforts to broaden the scope of findings with the inclusion of additional codes, such as *Social Significance of the Death*, *Identification of Deficits*, *"Match What He/She Needed,"* *Identification*, *Intrinsic Validation and Acknowledgement*, *Innate Proclivities/Role Expectations/Social Norms*, and *"Self-Preservation."* For the coding schematic utilized in the final analysis, updated themes were integrated into other codes, re-coded with slightly different titles, or removed altogether upon the completion of data collection. Ultimately, a total of ten codes constitute the study's findings. All codes were developed by hand without the aid of computer software, and randomly selected transcripts were read by two other individuals aside from the researcher to assure reliability of codes. These codes are described at length in the next chapter.

*Immersion/crystallization.* The immersion/crystallization (I/C) process was utilized to interpret data through the researcher's direct immersion into the interview texts (Borkan, 1999). Using a reflexive approach, the researcher integrated I/C through a combination of *horizontal* as well as *vertical* techniques for reviewing data, given the researcher's interests in responses to particular lines of inquiry and how they related to the totality of the data provided by respondents. Beginning at the initial commencement of interviews and continuing throughout the course of the data collection process, the researcher read individual transcripts from start to finish in the sequence in which vignettes were presented to respondents (i.e., *horizontal* approach). All interviews were analyzed in this manner repeatedly, with the goal of extrapolating preliminary themes from each transcript that reflected consistency in topics and ideas indicated by the respondent. For example, when a respondent expressed the importance of offering aid to a survivor regardless of the nature of the death, *Need for Support* was marked as a potential theme; this, along with other themes for consideration, were labeled in pencil at the top of the respondent's transcript. The consistency of similar responses provided by other respondents using this technique yielded more cohesive themes, as their associated titles and contents became more specific as analysis progressed.

Further crystallization of themes was solidified by reviewing transcripts *vertically*, a process in which the researcher read interview data in "blocks," or sections. For the purposes of analysis, transcripts were partitioned into sections of five, one per vignette. Theme-specific topics indicated by respondents were labeled in pencil in the left-hand margin of the transcript. For example, *Perceived Culpability* emerged as a noteworthy sub-theme to a larger theme, *Social Significance of the Death*, specifically pertinent to vignettes two ("Adam") and four ("Bill"); similarly, the theme of *The "Casserole Lady" Dilemma* reflected respondent concerns in offering support to survivors of the opposite gender, particularly within vignette three ("Martha"). These techniques were also used to analyze variations and conflicts within identified patterns, many of which are described in the next chapter.

*Content analysis.* A final method for analyzing data involved the use of content analysis to identify patterns in words and terms used by respondents throughout data collection (Meadows & Dodendorf, 1999). The researcher sorted words and semantic units of meaning used by respondents into categories that were compiled as part of the basic coding of themes. Data provided by respondents, in the form of specific words and phrases used, were used in the researcher's identification of labels, or social meanings reflective of each death. For example, labels such as *Heroism* and *Innocence* were based upon references used consistently by respondents in their interpretations of vignettes one ("Mark") and five ("Jenny"). Similarly, specific words indicated by respondents, such as *bravery*, *sacrifice*, and *admiration* identified in vignette one ("Mark") reflected words specifically used by respondents to describe these interpretations of the vignettes.

### *Human Subjects*

*Confidentiality.* The assurance of privacy remained a central facet in the protection of respondents throughout the course of data collection. No names, birthdates, medical information, social security numbers, or personal history beyond experiences with death were collected. A pseudonym was provided in place of the respondent's real name and was used throughout data



collection and subsequent analysis. All study components (i.e., paper interview materials, digital recorder, laptop computer) were stored at the researcher's residence; only the researcher had access to these items during the course of the study.

*Risks and unforeseen events.* While conducting the study, the researcher acknowledged the potential for participants to experience emotional upset when reading the case vignettes or reflecting upon his or her own experience(s) with death. In the event that a respondent became upset during the interview, the researcher asked him or her if they wanted to take a momentary pause or stop altogether. Three respondents opted to pause at various times during individual interviews, but all consented to proceed. Referrals to community services were also available for respondents after participating; these resources were not requested by any participant at any time. It was also understood that respondents could potentially verbalize suicidal ideation and/or intentions to harm others during the course of the interview. The informed consent document given to respondents made specific reference to actions that would be taken in the event of this occurrence. Should a participant articulate threats of suicide or harm to others, the researcher would cease all data collection immediately and notify the Committee for the Protection of Human Subjects (CPHS) and any other pertinent entities. At no time did any respondent indicate intentions to harm himself or herself or others.

### Summary

This chapter addressed a range of methodological considerations in the development of the dissertation study, with particular emphasis on the conceptual paradigm of interpretive inquiry, and research design elements pertinent to the sampling of respondents, the collection and analysis of data, and human subject considerations. The next chapter will present a detailed overview of the study's findings, including the ten identified themes.

## CHAPTER 5: RESULTS

### Introduction

This chapter provides an overview of the study's findings. More specifically, these data provide insight into the dissertation's central research question, as indicated in previous chapters:

*What factors typify how and why social support is offered to survivors of traumatic death, particularly suicide?*

Ultimately, a number of factors contributed to how respondents assessed the provision of aid to survivors of traumatic death, particularly within the context of 1) sample-wide patterns and variations in aid, 2) general considerations in the provision of aid, and 3) vignette-specific considerations in the provision of aid. Within the scope of these overarching foci are ten specific themes that exemplify the most pertinent features, as indicated by the respondents. Each of these is addressed below.

### Key Themes and Features

#### *Patterns and Variations in Types of Aid*

In general, respondents' reactions toward vignettes (both in terms of how they believed others would react as well as their own personal reactions to the deaths) reflected a range of variation in terms of the hypothesized provision of aid to survivors. This was identified to be a function of both the respondent as well as the nuances of each vignette, thus implying a synergistic, as opposed to mutually exclusive, effect in the overall provision of support. More specifically, patterns of support fell into one of four possible categories: *universal/largely universal* (i.e., most respondents indicated similar support in most or all vignettes), *respondent-specific* (i.e., certain respondents indicated similar support patterns in response to most or all vignettes), *vignette-specific* (i.e., many respondents indicated similar support patterns in response to specific vignettes), and *distinctive* (i.e., varying numbers of respondents indicated fluctuations in support across the vignettes). Examples supporting these variations can be further elaborated upon in the theme identified and described below.

(1) "*Core*" versus "*vignette-specific*" support. Various examples of social support that respondents indicated as those they would most likely offer to survivors were identified throughout the course of the interviews. Examples of aid provided were categorized into one of two types: "core" items (i.e., baseline items of respondent-specific aid most frequently mentioned in some form across all vignettes), and "vignette-specific" items (i.e., items of respondent-specific aid offered based upon the circumstances of individual cases). The charts below provide a list of the most common examples of aid as indicated by respondents.

### “Core” Items

Emotional Support	Practical Support	Informational Support
*Condolences *Hugs *Hand holding *Listening *Being present	*Meal preparation *Cleaning *Child care *Offer food *Assist and/or attend related services	*Suggest counseling *Support groups *Provide relevant literature *Internet sources

### “Vignette-Specific” Items

Emotional Support	Practical Support	Informational Support
*Alleviate survivor guilt *Deflect/shift focus (e.g., if deceased’s actions were negative)	*Buffer/shield survivor (e.g., from media, negative responses, etc.) *Assist/handle bureaucratic affairs (e.g., Veteran’s affairs, coroner, etc.) *Financial assistance	*Legal resources *Financial planning *Social activism groups (e.g., MADD, etc.).

Responses provided by virtually all respondents revealed a consistent “baseline” set of various emotional, practical, and information-based modalities of support (in the form of “core” support items), regardless of whether or not the death was considered a suicide. While variations in the amount, duration, and intensity of these supports existed among respondents, the general consensus was that each type of support, in some capacity, was deemed as important to offer all of the survivors in the presented vignettes. While noted less consistently than “core” support items, “vignette-specific” items were also important forms of aid described. Unlike “core” supports, these items reflected respondents’ efforts to accommodate survivor need based upon the dynamics of individual cases. Aid was rendered based on the perceived social context of the death (e.g., protecting survivor from inimical social responses if the death was somehow perceived negatively, providing legal resources in particular instances of suicide, etc.)

“Core” *emotional supports* described by respondents involved a range of efforts aimed at providing basic comforts to survivors, primarily in the form of verbal as well as non-verbal gestures of compassion. *Condolences* were considered as a standard practice among most respondents, typified by phrases they believed they would use to acknowledge the survivor’s loss (e.g., “I’m sorry for your loss”) or the decedent directly (e.g., “He/she was brave,” “He/she was suffering,” etc.). *Hugs* and *hand-holding* constituted much of the respondents’ physical affection toward survivors, with the degree of intensity dependent upon how well the respondent felt he or she knew the survivor (which will be explored in the “Survivor Relationship” theme). Finally, *listening* and *being present* were frequently cited as forms of emotional support, particularly among respondents who felt that words were ineffectual in comforting survivors. “Vignette-Specific” emotional supports largely involved efforts to attenuate the survivor’s negative feelings related the death, such as *alleviating survivor guilt* (e.g., over the decedent’s behavior and/or resulting suicide, failing to prevent the death, etc.) and *deflecting*, or *shifting focus* from the decedent’s actions if they were negative (e.g., emphasizing the decedent’s positive traits, etc.). A majority of these responses were identified in vignettes two (“Adam”) and four (“Bill”), as these situations were oftentimes perceived by respondents to warrant such aid.

Modalities of “core” *practical support* centered upon task-oriented endeavors, such as *meal preparation* and *cleaning* for the survivor in his or her home, *child care*, if applicable, *offering food* as a customary token of sympathy, and *assisting and/or attending related services*, such as memorials and funerals. “Vignette-specific” practical support involved an array of efforts to address specific pragmatic concerns. For survivors who had experienced particularly violent deaths, the respondents’ need to *buffer* or *shield* the survivor from the social repercussions of their loss was common, such as protecting the survivor from unwanted media attention or inimical outside networks. *Assisting with or handling bureaucratic affairs* on behalf of the survivor was also noted, such as going with him or her to related offices and related entities (e.g., coroner, veteran’s affairs) as well as assisting with paperwork (e.g., insurance, benefits, etc.). Additionally, *financial assistance* was also considered a form of aid that respondents felt they would offer, assuming that the need was present and that it was within their ability to offer it. Examples of vignettes in which these forms of aid were frequently mentioned included “Mark” (vignette #1), “Adam” (vignette #2), and “Bill” (vignette #4).

Lastly, “core” *informational support* focused on relevant resources that respondents indicated that they would share with survivors, primarily in the form of *counseling* (e.g., grief/bereavement therapy), *support groups* (e.g., survivors of suicide, spousal loss, etc.), *literature* (e.g., stages of grief, suicide, etc.), and *internet sources*. “Vignette-specific” resources included *legal referrals* (e.g., insurance eligibility, lawsuits, etc.), *financial planning* (e.g., moving/relocation, budgeting, etc.), and *social activism groups* (e.g., Mothers Against Drunk Driving, Blue Star Moms, etc.). Vignettes one (“Mark”), two (“Adam”), and five (“Jenny”) were often cited by respondents as instances where these supports would be useful.

Overall, the presentation of the study’s first case vignette (“Mark”) provided the most description in terms of the aid indicated by respondents. Given that this was the opening case presented to respondents, “core” items of support (e.g., offering comforting words, helping with child care, recommending support groups, etc.) were oftentimes described at greater length than in the other vignettes; respondents frequently answered subsequent questions regarding the provision of such aid in later vignettes as being “the same” as in the previous case(s). “Core” items surfaced in various incarnations from case to case in ways that reflected what the respondent regarded as most germane or appropriate to the situation.

Sally, a 26-year old Caucasian graduate student, describes her consistency in offering specific, “core” types of support items across all five vignettes. Here, she indicates examples of the emotional support she felt she would offer:

*(In reference to ‘Mark’):* I think I would just be, you know, like a shoulder to cry on...and yeah, just be there for her [the survivor]. *(In reference to ‘Adam’):* Um..I have a feeling it would be similar, you know...offer a shoulder. Just try to help her [the survivor] see that it’s not her fault and she’s not the bad guy...*(In reference to ‘Martha’):*...just be a shoulder to cry on, bounce stuff off on, someone to talk to. *(In reference to ‘Bill’):* Just the same way: a shoulder to cry on, talk to. *(In reference to ‘Jenny’):* Just the same way in terms of listening and offering a shoulder. (#1, pp. 1-10)<sup>12</sup>

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<sup>12</sup> Quotes from respondents are cited using the interview number and specific transcript page(s) referenced.

In terms of offering practical assistance, most respondents focused on offering to help execute tasks of daily living with the survivor or completing tasks on his or her behalf. For 76-year-old Caucasian senior center participant, Karen, practical support reflects a myriad of these elements:

*(In reference to 'Mark')*: All right: do you [the survivor] need rides to go places? 'Cause I'm assuming this is a younger person, a lot of times they're too upset to drive or they don't have a car...*(In reference to 'Adam')*: All right: see if she [the survivor] has enough food, kind of food *she* will eat...um...be there to go places with her. I haven't got a car but I could go [with her]...*(In reference to 'Martha')*: Feeding, 'cause most men-and this is just a generalization-most men, unless this has been a long illness for, they don't fend too well by themselves. *(In reference to 'Bill')*: Well, I'd say, 'Do you need any help, like come for dinner? Would you like me to bring over some food? Do you like apple pie?' *(In reference to 'Jenny')*: All the help that he [the survivor] seems to think that he would need, you kind of look around to see...(#20, pp. 2-26)

Recommending forms of formal and informal therapeutic resources was identified as the prevailing method of informational support that most respondents indicated they would be likely to offer survivors. Most often, this involved suggesting professional counseling and/or support groups.

Here, Dr. D., a 33-year-old Latino graduate student, considers these types of support throughout the various case vignettes:

*(In reference to 'Mark')*: ...I would try to encourage them [the survivor] to see...other spouses and partner to share that when they're ready... I know that for sure there are survivor groups...*(In reference to 'Adam')*: They [the survivor] need[s] some serious help here (*laughs*). Definitely some therapy; professional help. *(In reference to 'Martha')*: The person who's living, the spouse/partner, you know, definitely...probably get them the resources they need as far as...spiritual help and emotional help and all that kind of thing. *(In reference to 'Bill')*: There's groups out there, there's support...like, psychological, professional support that can help people cope with feeling, like being left behind, like if the survivor has guilt. *(In reference to 'Jenny')*: Similar to what I said before: counseling, therapy...(#11, pp. 1-14)

Among some graduate student respondents, the disruption that the death engendered for the survivor prompted them to consider offering support. In explaining the reasoning behind his consistency of emotion-focused forms of support between case vignettes "Mark" and "Adam," 23-year-old Caucasian graduate student, Squirrels, addresses the underlying theme of loss:

I think in both cases, somebody's world has changed fairly drastically...and I guess even in both cases it was two people [survivor and decedent]...even though the spouse in both cases who died, even though the circumstances were different, I tend to strive to understand the best you can, and also to appreciate the fact that you

can't always understand the circumstances of the death. And so, it's a loss in both cases for the spouse who is still alive. And being there for them appears to be equally important in both cases. (#5, pp. 4-5)

Another explanation for the consistency in "core" support reflects what some respondents believed they would personally want if they had been the surviving partner in each case. This was particularly true among a small number of older adult respondents who had indicated at some point during their interviews having experienced deaths mirroring particular vignettes.

Jack, a 69-year-old Caucasian senior center patron, considers the significance of empathy in justifying the consistency of his responses:

'Cause that's what you would want; that's what I want. If I feel that I want somebody to make me feel good, and hug is a good thing. Understanding is a good thing. Empathy is a good thing. I don't like sympathy so much. Sympathy, to me, is more, uh, actually it's more of an insult. Empathy, I understand, and it's really understanding the person's pain. A person actually feels what you feel if you understand. Um...try not to tell them they know how they feel, 'cause you may not, and to them, uh, so you may not want to say, 'I understand how you feel.' (#19, pg. 20)<sup>13</sup>

### *General Considerations in the Provision of Aid*

A second broad category exemplifying respondent aid addresses overall considerations that respondents took into account when contemplating whether and how they would assist survivors. Generally, respondents described a number of salient factors reflective of themes identified across the vignettes, such as social norms and expectations regarding helping, situational needs and interests of the survivor, and the characteristics of the survivor/helper dyad. Many respondents made emphatic distinctions between their personal reactions toward certain suicides and those of outsiders, particularly if they believed their support was antithetical to that of mainstream society. This was found to be an important feature of these interviews, as they contributed to the overarching theme of *The Culture of Helping* identified in other incarnations by respondents. Examples of these and other overall considerations in offering aid are reflected in the seven themes below.

(2) *The culture of helping.* For many respondents, the rationale behind the provision of their aid reflected their personal expectations to assist others in times of distress. For these individuals, ideations regarding helpfulness reflected what they themselves envisioned as normative responses for both reacting to as well as attenuating another's grief. Thus, general explanations regarding one's desire to be of assistance were based largely upon his or her own personal expectations, influenced by societal norms and personal experience, to show visible support to survivors of death, regardless of whether or not the mode of death was by suicide.

For some respondents, offering support was precipitated simply by what they believed one is "supposed" to do when faced with a situation in which it appears warranted. In this

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<sup>13</sup> Respondent empathy will be discussed in further detail in the "Identification" theme.

instance, aid was conceptualized as a function of typical actions that a person associated with the survivor (in this case, a friend) might be expected to execute in a similar situation. This, in turn, prompted respondents to consider examples of support that they believed they *would* offer in reality. Despite the fictitious nature of each vignette, respondents were generally able to apply their own guiding principles and logic into how they expected to assist a fictional survivor in an actual situation.

Beki, a 26-year-old Caucasian graduate student, follows a creed consistent among many respondents who felt compelled to justify support based on cultural norms. Here, he expresses this as a factor that motivates his support for the survivor in the fourth vignette (“Bill”), despite the ambiguity of the situation:

...it’s about the partner: it [the situation] might change the way I feel about the decedent, but to me, the partner’s the partner and they’re the one who needs support...[it’s] just probably my concept that...what I take as a cultural concept, that you’re supposed to support people who are going through this sort of mourning. (#10, pg. 14)

For other respondents, cultural expectations to be supportive revolved around the idea of helpfulness as a function of the human condition. In this context, social support is conceptualized, as one respondent remarked, as “a human thing,” characterized by a fundamental connection between two individuals. For these respondents, there was recognition of another’s suffering and a desire to intervene as a result.

Jack expresses the significance of the survivor as a human in justifying why it is incumbent upon him to offer aid in the second vignette (“Adam”):

...they [the survivor] are human beings and they need some help, you know...um...there’s no definition...it’s the, uh, definition of civilization. Basically, anybody can be nice to big, strong, powerful people, but if you could be helpful and nice to people that cannot possibly cause you any harm, can’t possibly in any way, uh, demand things of you, and then you’re civilized, you know? And, uh, it is, I think, the job, the duty, of any person capable to help the less capable...(#19, pg. 8).

For a few respondents, an innate tendency or “impulse” to assist a bereaved survivor was what motivated them to give support. Notable factors that contributed to this proclivity included the respondents’ level of comfort in offering certain types of assistance (e.g., showing physical contact, assisting with financial matters, etc.), past social responses to similar situations in which they were the recipient or provider of aid (e.g., experience as a grieving widow, loved one of accident victim, etc.), or self-identified personality trait characteristics (e.g., being demonstrative, skilled in specific practical tasks, etc.). Generally, respondents were not motivated by extrinsic rewards when considering their role as in offering support (e.g., capitalizing on a financial situation, taking advantage of a grieving survivor, etc.); for some, however, giving support to a survivor produced an added psychological benefit of helping themselves in the process (e.g., validation of self-worth and utility in helping another). A number

of respondents indicated that their participation made them feel “good” or “useful,” regardless of the nature of the death.

Burt, a 55-year-old Caucasian senior center patron, describes the care-giving nature of his personality in justifying how he gives aid to survivors across all vignettes:

Probably ‘cause that’s just the way I am. I guess I was a born caregiver to my grandparents, my parents, in my 30 years of being in nursing, you know, my volunteering here at the senior center and other senior involvements that I’m in. It [supporting others] helps to support yourself, and the losses and changes in your life...but it also helps others. (#24, pg. 16)

(3) “*Filling the void.*” Most respondents indicated that their decision to offer support was based, in part, on their own assessment of the help the survivor would need after considering what others would do. In attempting to fulfill a need, a number of respondents indicated that they would identify potential deficits through directly surveying the situation, such as checking to make sure food for the survivor was readily available and looking for visible indicators of depression. In cases of suicide where survivors were expected to receive significantly less support, most notably in the vignettes of “Adam” and “Bill,” the desire to provide various forms of aid was something that was considered necessary in an effort to, as one respondent cogently remarked, “fill the void” left by others whose support may be inadequate or even non-existent. While some indicated that close family and/or friends might be available to give immediate aid, the general perception held by respondents was that outside social networks would respond with apathy, revulsion, or anger toward the decedent, which, in turn, would “spill over” onto the survivor.

Christine, a 26-year-old Asian graduate student, addresses the differences in social responses from the first vignette (“Mark”) to justify offering practical assistance to the survivor in the second vignette (“Adam”):

In this case [‘Adam’], I feel there are less people who will help them [the survivor], so they might need more practical support. Also, the neighbors and others who, in the first scenario, might not be willing to help, and there’s more anger and tension, and so sometimes in those cases you can only ask casual friends, people who you can trust more to take on those responsibilities. (#3, pg. 4)

Sometimes, respondents noted that actions initiated by outsiders disguised as support could potentially be seen as disingenuous, unwarranted, or otherwise antithetical to the survivor’s needs. The supportive efforts of even the most well-intentioned of individuals, through the expression of overt physical affection, for example, could be unwanted by a survivor; conversely, others who aim to express meaningful words to a survivor may do so ineffectively (e.g., customarily saying, “I know how you feel” when an observer does not). Some even felt the need to serve as a protective buffer against, what one respondent noted, as “unscrupulous people who are more than happy to take advantage.”



Here, Jack cites this as a reason to safeguard the interests of the survivor in the fourth vignette (“Bill”):

Well, now you know you’re gonna find relatives you’ve never heard of (*laughs*), so what you do is screen their calls to make sure they aren’t calls that would upset them, you know, like, ‘He never would have killed himself...!’ you know...they don’t need that. God knows that they don’t need that. So, what you do is screen the calls and make sure that only nice things come through. And, uh, you make sure that any, you know....the guy’s dead, right? So, ‘Should I deliver the trailer now?’ or...you know...always a con man someplace, and really unscrupulous. You have to be able to be there to make sure you’re between them and the bereaved. Somebody’s gotta do that. (#19, pg. 16)

Many respondents who indicated a willingness to offer support to the survivor in the second vignette (“Adam”) did not find the circumstances of the suicide to greatly affect their overall involvement in either direction. For a few respondents, however, the circumstances propelled them to increase their participation. This was noted primarily due to factors that they believed would result in a significant decrease in support for the survivor, such as the violence component as well as the survivor’s association with the decedent.

For 57-year-old Caucasian researcher, Alice, the belief that the survivor would be castigated by society greatly affects her overall involvement in providing support, despite her personal objections toward the decedent’s actions:

Oh, if anything, it [the circumstances] would make me more involved...more inclined...because she [the survivor] has no one. The world is against her. The world hates her for being with him [‘Adam’], and she must be stunned, too, if she’s with him. And, um...I just...if she’s my friend, I can gag at the thought of what he did, but I also have to think that she must be just as horrified...and much more alone and much more frightened. (#9, pg. 10)

(4) “*Let the need be my guide.*” Many respondents discussed offering support at the cueing of the survivor. More specifically, this involved giving aid when it was asked for or somehow implied by the surviving spouse/partner. Unlike relying upon the respondent’s own perception(s) of unmet survivor need, many stated that their aid would be “guided” by the survivor, through either his or her direct request for specific support items, or through non-verbal modes of communication, such as affect and mood. Aid that respondents believed they would render reflected both the needs of the survivor as well as the needs of the situation. Among vignettes where respondents indicated that offering support would be either emotionally or logistically “easier” as opposed to others, more notably in vignettes one (“Mark”), three (“Martha”), and five (“Jenny”), “whatever was needed” within reasonable parameters was a typical response to offering aid requested by the survivor. Vignettes considered more challenging by virtue of the circumstances surrounding the death, such as vignettes two (“Adam”) and four (“Bill”), were generally met with less flexibility in offering aid that respondents would otherwise provide if asked by the survivor under different conditions, such as providing monetary assistance, engaging in discussions about the decedent and/or the death itself, participating in

public engagements (e.g., media conferences, making public statements, etc.) or handling personal affairs (e.g., finances, property, etc.). Some respondents indicated that they would be hesitant to offer such supports if asked, while others simply declined to indicate these as examples of aid they would offer.

For Sidney, a self-employed, 72-year old Caucasian, aiding the survivor in the first vignette (“Mark”) largely centers upon this idea. Here, she discusses this within the context of offering practical support:

It wouldn’t occur to me of my own volition to offer help with daily tasks, but if she [the survivor] asked for help with daily tasks, then I would offer to help with any daily tasks that she asked for...if she said something to suggest that she very badly needed some kind of help, I might offer it then. (#23, pg. 1)

Some respondents indicated that they would employ a “matching” technique in which they would essentially aim to “match” support within their means based upon some indicator of need, such as a lacking resource mentioned by the survivor (e.g., offering money if needed) or the survivor’s communication style (e.g., showing emotion when survivor shows emotion, etc.).

For 57-year-old, Caucasian school psychologist Katie B., there is an emphasis on tending to the needs of the survivor in this manner when asked why she suggests referring the survivor in the first vignette (“Mark”) for counseling:

Try to have the help match what she [the survivor] needed...I’m a school psychologist and I know the resources, so I have that information. (#16, pg. 4)

Vera, a 26-year-old graduate student, makes more emotion-focused efforts to “match” the survivor’s needs, identified as a common feature in her descriptions of aid in vignettes one (“Mark”), three (“Martha”), and five (“Jenny”):

*(In reference to “Mark”):* I’d offer kind looks and smiles and I’d try to match their [the survivor’s] emotion but take it one step up a little, so if they’re sort of happy, I’d try to be a little happier than them. If they were really sad in the moment, I’d probably match them, but not be as low as them. *(In reference to “Martha”):* Again, like with my mood and affect, I would try to match theirs. *(In reference to “Jenny”):* Same thing: just try to match their mood and just being there to check up on them. (#4, pgs. 2, 10)

(5) *Identification.* The extent of a respondent’s identification with survivors in the presented vignettes was yet another theme in the overall consideration of aid. During the course of the interviews, it became apparent that the range of personal experience with death varied greatly between the graduate student older adult respondents, which ultimately reflected in their responses to offer aid. Overall, the manner in which respondents identified with survivors within the vignettes incorporated a combination of features, such as sympathy, empathy, and personal experience. Interestingly, a review of personal losses of graduate students indicates that the deaths they had personally experienced were largely peripheral (e.g., grandparents, friends of

friends, etc.), while older adults experienced more direct losses (e.g., parents, siblings, spouses, etc.). These variations were reflected in how respondents approached the matter of offering support to survivors.

Generally, graduate students were less able to relate to the survivors and/or the situations presented within the vignettes, as a vast majority made no reference to instances in which they had directly experienced a similar situation when answering questions about the cases. Unlike older adults, whose identification with particular survivors promoted a sense of empathy that facilitated in their support, graduate students relied less upon experience in how they rendered aid. While many expressed their sympathy for survivors, the inability to personally identify with their situation often precluded the expression of empathy. Despite this, these respondents did not cite a lack of sympathy as a deterrent in offering various forms of support.

While she admits that she is unable to personally relate to the survivor's grief in the first vignette ("Mark"), it does not prevent Katie A., a 34-year old Asian graduate student, from offering an arsenal of practical assistance in the form of child care and doing household chores. Here, she explains that sympathy, as opposed to empathy, is what motivates her to offer this aid:

...this [situation] is something that I cannot, actually, relate to. I have a spouse-I've only had one spouse-you know...I haven't lost him. He's still with us, so I can't even begin to imagine what the emotions are that go along with losing a spouse. On *top* of it, losing a spouse in a war. On *top* of it, and I'm biased here, in a war that's very unpopular. And I'm not in support of the war, either. Um..but...and because I can't really relate that way, I, you know...there are other things that I can do, you know? While I really can't necessarily give this person empathy, I can give this person sympathy in the form of getting things done that the person needs just to survive everyday. (#12, pg. 2)

A few graduate students who were unable to identify with certain survivors questioned the sincerity of the support they believed they would offer. In situations of suicide where the spouse/partner would be perceived as less likely to get outside support, these respondents found it challenging to rely upon sympathy and/or empathy in the facilitation of their aid, thus causing them to question the sincerity of their support if faced with the situation in reality.

Even though he expresses difficulty in identifying with the survivor in the second vignette ("Adam"), Dr. D. believes that "they [the survivor] need someone in their corner" to provide emotional support. However, he calls his level of sympathy into question when he considers the extent of his involvement in offering pragmatic assistance:

...it's really hard to put myself in this position...I would try to do the same sort of things [as in the "Mark" vignette], the day to day kind of things...but, like...yeah, I'd be lying to you if I told you it would be easy to do this...it would be hard to have sympathy...as I'm speaking to you, stuff's been going through my mind, like, 'What would I *really* do?' I can talk about all these, like, 'God I'd love to be needed and there for them [the survivor]' and all that, but how would I really act? Would I really be as supportive as I would for the other person? (#11, pg. 5)

Unlike the graduate student respondents, the older adult respondents were more likely to relate to the vignettes on a personal level, as evidenced in the frequent use of experience and insight to address how they would offer support. Of the twelve older adults interviewed, approximately half made specific reference to experiencing similar situations as those of the survivors within various cases. Four of the five presented vignettes—"Mark," "Adam," "Martha," and "Jenny"—were identified by respondents as the most personally relatable to their own experiences.

For these respondents, the circumstances of a particular case engendered the recall of similar life events. Alice reflects on the parallels of the third vignette ("Martha") to her own mother's chronic pain:

I should tell you my mother is 81 and suffers from this condition, polymyalgia, and it cycles up and down every few days, and on down days, she uses her Oxycontin all day long because it hurts so bad, and I fear for her. If she weren't such a fighter, this [vignette] is what I fear...(#9, pg. 11).

Later, she explains how the circumstances of the death in the vignette affect how she would support the survivor:

I think about my mama...I think, I have such admiration for her courage in living with this horrible thing that she has. Her motto is, 'Tomorrow's another day.' And you make it through today. One more day. So, I can...I have sympathy, understanding for his [the survivor's] position...I think it's sad, I understand but I don't castigate her or think of her as a sinner...I guess I would want to help him see that this was her choice and that she felt it was the best choice for her and for him...

Interestingly, some respondents were able to relate to particular vignettes without having direct, personal experience as a survivor. Bob, an 81-year-old Caucasian retiree, finds that his personal struggles with alcoholism and his relationships with others in recovery "hits close to home" when reflecting upon the death of "Jenny," thereby greatly influencing how much support he feels the survivor should receive:

In my heart, in my mind, it's the fact that I am one of those people that drove drunk. I have known people, because of people being drunk behind the wheel, that they have killed people. And I have seen what the survivor, the drunk, goes through, living their lives after they've committed this kind of a thing. At least the ones that manage to get through it and become sober after they got outta prison or whatever. The spouse deserves all the help that they can possibly get...[because] it hits more closely to home...I'm putting myself in the spouse/partner's situation, I'd need a lot of help. (#15, pg. 17)

For other respondents, personal experience as a survivor influences the sympathy that they would be likely to feel for another. Jane, an 86-year-old Caucasian publisher's consultant, recalls how the death of her first spouse gives her perspective when she considers her degree of

sympathy for a survivor in the first vignette (“Mark”) when compared to what she might feel for someone else under different circumstances:

I lost my first husband in World War II, so I know something about war-related injuries and so forth. Um...this, as far as I’m concerned, this type of death is one of the worst that can happen to a person [because] they have no control over, and they can’t help it...this type of injury, so uh...as far as I’m concerned, this is completely different...I know people would have diseases-cancer-and go through lots of medical problems and so forth. Death sometimes can be healing to them [the survivor], but as far as I’m concerned, this is the worst that it can be. I’m much more moved by the death of a serviceman in Iraq than I am at the death of some drunk on the freeway. I don’t care who they are. (#13, pg. 3)

Similarly, Louise, a 55-year-old African-American medical clerk, discusses the influence that her own experience as a victim of workplace violence has on her willingness to offer emotional support to the survivor in the second vignette (“Adam”), despite the difficulty she may encounter in partitioning her own feelings from the situation:

...it’s [the circumstances] close to my heart; because something similar to this has happened to me, not necessarily shooting but the violence, the violence.

*Sounds like there’s a relatability factor.*

Yeah...and to me, it would be emotions because there’s triggers here.

*Knowing there are triggers for you, would that infringe upon your ability to offer...?*

I’d try to get past it as best I could.

*So you wouldn’t let it deter you?*

Mm-mm. Mm-mm. (#25, pg. 7)

Later, she goes on to explain that such “triggers” arouse anger over the situation, yet she continues to maintain her support for the survivor:

To me, anger struck up, within this...definitely within me. Um...basically, um, I’m angry at the fact that this did happen, and I’m angry that the fact that it...it could have been paid attention to. And, to me, there’s always sometimes when there’s signs and symptoms, there’s always something could have been prevented, or there’s always some kind of help this person [the deceased] could have had...I would still be supportive...verbally I would be supportive...the individual [the survivor] has got to want it...

(6) *Survivor relationship (“closeness”).* Among a majority of respondents, the extent to which they were intimately linked to the survivor fueled much of their intention to be supportive, regardless of the vignette. Described primarily during the presentation of the first vignette (“Mark”), most respondents indicated that specific types of emotional, practical, and informational support would, in some ways, be contingent upon how close they believed they would feel to the surviving partner. Generally, respondents felt more comfortable offering aid to those with whom they felt more associated. “Closeness” was expressed by respondents through the level of familiarity they believed they would have with the surviving partner and/or decedent. Respondents provided support based upon their own conceptualizations of friendship (e.g., “casual friend,” “close friend,” “best friend,” etc.), as support would be more or less forthcoming as a result of how one perceived their association to the individual.

Generally, while certain types of aid (e.g., helping with household chores, hugging, etc.) were mentioned by respondents as examples of what they would consider important to provide, it was often their perceived level of intimacy with the surviving partner that influenced the parameters of their support (e.g., providing more intimate aid for a closer friend versus providing less intimate aid for an acquaintance). Some were adamant that less closely associated individuals would receive less involved support from them out of the belief that others more closely related would already be providing aid.

As Lisa, a 26-year-old Caucasian graduate student, considers her association with the surviving partner in vignette three (“Martha”), she notes the role that her relationship plays in determining how much personal responsibility she is willing to assume in offering ongoing support:

...if I was in a network of other people who knew these people-who knows Martha and knows the remaining partner-I would certainly be willing to take turns, but I wouldn’t be willing to be fully responsible by myself unless it was, like, you know, a best friend or something. (#6, pg. 9)

For Christine, a lack of close connection with the survivor’s surrounding network influences the limited nature of her role as a casual friend in the first vignette (“Mark”):

I think the only thing [factor influencing support] is if I wasn’t close to the family, I’d feel awkward and be the busybody offering lots of help. If I was only a casual friend, I’d send flowers and attend whatever event they held and offer my condolences...but I wouldn’t push it on them. (#3, pg. 2)

For some respondents, a sense of closeness to any survivor was important to having a better understanding of who the person was, the status or context of the situation prior to the death, and how to offer the most meaningful assistance. As a result, friendships based on deeper levels of intimacy were believed to provide respondents with more awareness of what their potential role would be in optimizing the support they offered.

Such is the case for Dick, an 80-year-old Caucasian English teacher, who believes that being closely associated with the survivor facilitates greater empathy and attachment on his part:

I think you know the person more; you know....I think you can feel more of the grief, her grief, whatever it is...somebody you don't know at all, you don't attach it. (#17, pg. 2)

Ethel, a 79-year-old retiree, conceptualizes closeness based on a simple and succinct understanding of friendship, as opposed to the level of intimacy she shares with a survivor:

...they're human; there's no answer. A friend is someone who likes you. (#22, pg. 2)

While most respondents felt that their relationship to the survivor was a significant factor in their willingness to offer support, a few did not corroborate this sentiment. Among a few female respondents, the matter of closeness in the traditional sense was not relevant in their overall willingness to offer support to a survivor; these women relied more upon their instinctual reactions in terms of how they believed they would respond to another's grief experience. As opposed to needing a sense of closeness to the survivor prior to the death that most other respondents noted, these women *brought* closeness into the context of the situation, making efforts to create connections with the survivor. Those who "looked" like they needed help or a respondent who believed they would experience emotional reactivity toward a particular situation (e.g., feelings of sadness, shock, etc.) would always receive support. Thus, relationships based on typical "levels" of connectivity indicated by most respondents were not a consideration here.

For 23-year-old Caucasian graduate student, Susie, her inherent ability to "arrive," or make herself available to survivors within a given situation and adapt to a survivor's needs, is evident as she explains how she brings closeness to any situation:

...I think in general, I've been finding out, I just kind of, um...I arrive similarly to the situation. Even when I don't know people, I have this interesting thing to know them more, just extending, or...because some people, for example, they may not have anyone in their life to provide them with this. So, I think, 'Well, great, I can arrive, and...wonderful, you know? Bring closeness, and maybe make a new friend.' Yeah. (*laughs.*) (#21, pg. 15)

Similarly, Louise's feeling of connectedness to the survivor's ordeal reflects another instinctual reaction that takes over where closeness in the traditional manner is of no relevance:

It [closeness] doesn't matter because...it's just that emotional feeling you have when there's a loss. There's been a loss of family members where I work at, and with, like...automatically, we offer money, just to help out. And I'm not close to my co-workers so, it's kind of like a thing that you just automatically do...(#25, pg. 3)

(7) *Degree of immersion.* Despite efforts made by respondents to offer aid to survivors in every vignette, a majority indicated a number of limitations regarding what they could potentially offer in various cases, regardless of whether or not it was asked for by the survivor.

This can be explained by a range of factors identified in various vignettes. Generally, respondents felt that particular instances of suicide (e.g., “Adam” and “Bill”) would cause delays or reticence in “rushing” to the survivor’s aid. One respondent indicated that the stigma surrounding the suicide in vignette two (“Adam”) would “...take [her] longer to reach out,” citing the situation as “sticky” and fraught with “legal issues.” Ultimately, most explanations for this degree of hesitation largely reflect respondents’ concerns about becoming too involved with the situation. Many did not want to be perceived as “intrusive” or a “busybody,” and as a result, instituted personal limitations regarding how immersed they were willing to become into the situation as a supporter.

For some, there was an aversion toward getting too involved in cases of suicide where participation carried a perceived degree of risk. Among these individuals, becoming too close to the situation through prolonged or intimate exposure would place a strain on their level of comfort (e.g., feeling “drained of one’s resources”) or ability to offer genuine (e.g., “meaningful”) aid. Thus, the needs and interests of the survivor were not as highly valued in juxtaposition to the respondent’s own sense of “self-preservation.”

For Lisa, the perceived “high risk” behaviors of the decedent as well as the survivor described in vignette two (“Adam”) cause her to question her actual involvement with the survivor in reality. Unequivocally, this reduces her willingness to become more than marginally involved in the situation:

I don’t know if I’d be friends with someone where this [situation] would happen...there is risk involved, like a personal risk [to her ‘self preservation’], and I feel like these are high risk people then and I wouldn’t want to get involved with them beyond my comfort zone. And it would be beyond my comfort zone to offer more physical support because once you do it once, you’re gonna find yourself doing it again and again...it sort of drains of my own resources...(#6, pg. 5-6)

Even among vignettes in which the death was not considered particularly negative, reticence to becoming overly immersed in the situation was also noted. In such instances, this was mostly expressed through some respondents’ concerns about infringing upon the survivor’s grief experience, while being mindful of the overall circumstances contained within the vignette.

In describing what she would feel uncomfortable doing to support the survivor in the first vignette (“Mark”), Wren, an 81-year-old Caucasian retiree, emphasizes the importance of not impinging upon the spouse’s time and space. Here, she discusses her recognition and support for the survivor’s desire to cope in a variety of ways, but also acknowledges how this is ultimately reflected in her involvement:

Well not being too close, not being intrusive. She [the survivor] may be a person who wants time by herself. She may be a person who meditates, goes to church, prays, and I wouldn’t want to be intrusive on that. So knowing when to help would be a problem. (#14, pg. 2)



(8) “*Casserole Lady*” dilemma. For some respondents, opposite-gender survivors presented obstacles in offering emotional, practical, and informational support. Interestingly, this was a more pervasive pattern among older adult female respondents, some of whom expressed concerns about taking on supportive roles for male grievers that could potentially be misconstrued by survivors or others. As one respondent remarked, “he’d [the survivor] probably have lots of those casserole ladies calling on him quite a bit,” insinuating societal notions of what another respondent referred to as “grabbing the widower,” attempting to take advantage of an older male’s single status, or offering aid in an overbearing or pushy demeanor. This was a particular feature within the third vignette (“Martha”), as these respondents typically envisioned this to be the first presented case involving a widower and a potentially older couple. The women in this small cohort relied more upon social stereotyping regarding male/female relationships, variations in gender reactions toward death, and assumed care-giving for widowers.

For these women, the articulation of clear boundaries regarding the parameters of touching and other such intimate affection was a dominant theme in the provision of emotional support. A common reaction toward offering a male close affection involved hesitation on the part of the respondent, as concerns were raised regarding the social implications of such actions.

As Karen describes the type of affection she would engage in with the survivor in the third vignette (“Martha”), she reflects on a number of issues that she feels she must consider:

Well, because this is a woman that’s dying, and the spouse is a man, if I knew the person and knew about him, again, tender, quiet hug, you know? Holding. And tell, ‘You have to let go sometimes.’ But sometimes you can’t even do that because of culturally, or the other’s person’s temperament: some guys...NO, you don’t go that close, and I’m..I’m funny that way too, especially since it’s somebody else’s husband, you know what I’m talking about? We have a lot of things going on now...Here, in my age and culture, you don’t go after a widower. (#20, pg. 13)

Similarly, Sidney expresses her reservations regarding opposite gender interactions as she alludes to the potential for sexual advances that might be made on the male’s part:

I’m thinking of my next door neighbor whose wife died. He was old, and didn’t have very good sense. And the kind of support he sometimes wants was not...(laughs)...the kind of support I felt like offering. That’s unusual. In other words, sometimes if you’re a woman and if the bereaved person is a man, he might want a little more closeness...(#23, pg. 9)

The provision of other modalities of support also varied, as the ways in which female respondents perceived typical male grieving patterns also factored into how practical and informational support was rendered. In general, older adult women felt that men were less likely to be as forthcoming in the expression of their grief, prompting them to offer aid based on what they felt a widower might be more or less receptive to. Reliance on stereotypes of grief reactions exhibited by men fueled much of this belief, typically characterized by stoicism, dependency, and difficulty in emotional expression.

In contrast to Karen’s reticence in offering too much close contact, Alice places more emphasis on emotional contact while limiting her involvement in assisting with tasks she feels are better suited for the widower:

I might help with groceries or with some other things. We have that expectation that men can handle paperwork and those things so it may be that I’m stereotyping here...there’s also the stereotype of the woman who swoops in...I just...don’t want to play into that stereotype too. I think I would offer less practical and informational support and more of the emotional support. The more, ‘Let’s go for a walk. You don’t have to look at me but we can still talk.’ I think people find it easier in this situation. A man-men-find it very difficult to talk about feelings for the most part...He probably won’t need help with insurance and all the other stuff, and he won’t probably need help with the informational stuff. He can figure that out. (#9, pg. 14)

*Vignette-Specific Considerations in the Provision of Aid*

A third set of themes regarding the provision of support to survivors involves a range of considerations that respondents took into account when offering aid in particular instances of death. Respondents described certain situations, events, and/or character traits of individuals within specific vignettes that they believed would potentially alter their reactivity in some manner. The most common considerations involved how respondents responded to individual vignettes using specific words and/or phrases, identifying personal challenges associated with giving support under situations of extreme violence or culpability, and assessing the nature of the survivor’s relationship to the decedent. Examples of these responses are provided in the final two themes below.

(9) *Social significance of the death.* All of the respondents assessed the vignettes using an assortment of descriptive words and phrases. These words provided insight into their assumptions regarding how others would be likely to respond to individual survivors in comparison to their own responses. The chart below describes how respondents generally assessed each vignette.

Case Vignette	1. Common Words Characterizing Death (Respondent Generated)	2. Social Support from Others (Respondent Generated)	3. Resulting Social Label (Respondent and Researcher Generated)
“Mark” (Altruistic)	Bravery, sacrifice, admiration	Highest degree of support from others	Heroism
“Adam” (Egoistic)	Shock and anger <sup>14</sup>	Lowest degree of support from others	Crime/Violence
“Martha” (Fatalistic)	Right versus wrong, morality, religion	Variable support depending on views	Decision Making
“Bill” (Anomic)	Confusion, blame	Second lowest degree of support	Money/Wealth
“Jenny”	Lack of warning and/or preparation, anger, shock, unacceptability of drunk driving	Support equivalent to that provided in case vignette “Mark”	Innocence

<sup>14</sup> While respondents used words such as *shock* and *anger* to depict reactions to vignettes two (“Adam”) and four (“Jenny”), different labels are used to reflect the prevailing themes that reflect each vignette.

Using a semi-structured interview format, the researcher asked respondents to assess the social reactions of the five deaths based upon the provided descriptions of each. In doing so, they were asked to explain how they believed others would be likely to support individual survivors. Ultimately, the researcher identified social labels that most appropriately reflected the prevailing themes/ideas indicated by respondents based on their assessments. For example, nearly all respondents described the social attitudes embedded within the first vignette (“Mark”) using laudatory references of heroism and bravery, for which the primary label of “*Heroism*” was used to reflect this overall theme.

Initially, a range of *common words characterizing each death* were noted by respondents to illustrate general impressions. Respondents applied specific descriptors based on their own social judgments regarding the nature of the death itself. With the exception of the third vignette (“Martha”), most words depicting the cases of suicide were decidedly positive or negative as a reflection of how respondents believed others would adjudicate each. For example, the laudatory death of the decedent in the first vignette (“Mark”) was overwhelmingly described by a majority of respondents as “brave” and “heroic”; conversely, the stigmatizing and senseless nature of vignette two (“Adam”) oftentimes propelled respondents to describe the death using words such “shock” and “anger” given the extreme violence component (e.g., murder).

In considering their previous statements regarding the overall social impressions of each death, respondents were then asked to consider each survivor’s *resulting social support from others*. Oftentimes, respondents cited personal experience, factual or assumed characteristics of the decedent, or previous social treatment of suicide survivors in reality as justification for the aid they believed the survivor would receive. Respondents also indicated variations in the amount of support the survivors in each vignette might receive. For example, “a lot” of support was almost always associated with vignettes that respondents believed were less socially stigmatizing based upon its commendable (e.g., “Mark”) or overwhelmingly tragic (e.g., “Jenny”) circumstances, while “little” support was frequently noted in vignettes they believed were more negative by virtue of its social stigma, such as senseless violence (e.g., “Adam”) or personal deficits in character (e.g., “Bill”).

Lastly, based on the data provided by respondents, the researcher devised a general *social label* that corresponded to each death. At the most rudimentary level, labels typified prevailing themes and ideas routinely expressed by respondents; in some instances, actual phrases used by respondents to typify larger themes within particular vignettes were used. For example, the description of the first vignette (“Mark”) overwhelmingly reflected respondents’ social ideations of self-sacrifice for the safety of others, almost always characterizing the decedent as heroic; thus, the resulting social label selected to describe the vignette was *Heroism*. In contrast, the *Decision Making* label attached to the decedent in vignette three (“Martha”) reflected issues pertaining to individual self-determination, the right to die, and, and the ethics of assisted suicide.

Operationalized as Durkheim’s form of “altruistic” suicide, the first presented vignette involving infantry soldier “Mark” was perceived by nearly all respondents to receive the most amount of outside support among the four cases of self-inflicted death. Overwhelmingly recognized for its laudatory appeal and contemporary relevance, the circumstances leading to the

death engendered responses indicative of what some termed “the ultimate sacrifice,” largely typified by words such as “bravery” and “admiration.” When asked how much support others might offer the surviving partner in this case, nearly all respondents agreed that the selfless nature of the death would result in a “great deal” or “a lot” of support.

In reflecting upon general responses to this loss, 27-year-old Caucasian graduate student, Mary, provides a typical reaction expressed by a majority of respondents:

I think they [others] would feel like it was, like, a heroic sort of death. That he sacrificed himself for other people. I guess proud of him...I would guess that they [the survivor] would get a lot of support just because of the self-sacrificing nature of what her husband did...and a lot of admiration for his services...(#7, pg. 1)

In contrast to the heroic nature of the first vignette, the survivor in the second vignette (“Adam”) was expected by most respondents to receive the least amount of support from others. This was primarily due to the negativity attached to the murder-suicide nature of the circumstances. Largely characterized by respondents for its features of workplace violence and stated lack of acceptance (both socially and, for some, personally) toward violent crime, this “egoistic” form of suicide left most to surmise that sympathy for the survivor would be severely compromised, if not withheld altogether. This was the primary result of the anger respondents believed outsiders might harbor toward the decedent and/or surviving partner due to the highly violent aspects of the vignette. It was not uncommon for respondents to label others’ reactions as overtly negative, using phrases such as, “Good riddance to bad rubbish” and “He [‘Adam’] got what was coming to him.” In some instances, these reactions were mirrored by the respondents.

Here, Anna, a 41-year-old Latina graduate student, addresses similar reactions when asked about the survivor’s prospects for obtaining outside support from others in this case:

People would be very angry and would feel it was somewhat appropriately deserved that he died by his own hand...if you [the decedent] found it necessary and to take the lives of other people, than the sentiment is usually that he [the decedent] should die himself; the adage of, ‘Taking a taste of your own medicine’...I just I just think there is so little support in society, and even less in this scenario...(#8, pg. 6)

The case of “fatalistic” suicide, as depicted by the vignette involving cancer-stricken “Martha,” yielded a decidedly “mixed” or “split” reaction among most respondents. Whereas some indicated that support might be readily available to the survivor if people were sympathetic to the spouse’s diagnosis and pain or if the surviving spouse was unaware of her plans, most believed that support would be largely contingent upon one’s moral, ethical, and religious viewpoints regarding the decedent’s decision to terminate her life. Among respondents who believed others would be unsupportive of the decedent’s choice to end her suffering, these viewpoints largely typified theological (e.g., labeling it as “sinful”) and moral/personal (e.g., labeling it as “wrong”) opposition to suicide.

Katie A. addresses the fundamental issue of personal choice as she describes the vacillation in outside support the surviving spouse might receive:

There are gonna be some people who are going to feel that her [Martha's] choice was both a practical choice and a brave one...other people-many for religious reasons-are gonna feel that what she did was, you know, some kind of a copout and wrong...for those that think she committed a sin...what I would worry about is that in trying to support the spouse that those people would end up basically still blaming her...for others, I think it would be easy to give support...this is not a happy decision or an easy decision...(#12, pg. 14)

Largely viewed by respondents as the most ambiguous of the vignettes for its perceived lack of information, the “anomic” suicide of newly-minted millionaire “Bill” often raised the most inquiry. The nature of the decedent/survivor relationship, the serendipitous stroke of immediate wealth, and the general confusion regarding Bill’s decision to die by suicide prompted most to regard support for the surviving partner to be on the lower end when compared to the suicides described in vignettes one (“Mark”) and three (“Martha”). Unlike vignettes in which there were clearly identifiable reasons for suicide, the death of “Bill” was believed by most respondents to be unclear, needless, and, according to a few respondents, “stupid.” In lieu of concrete information to justify their claims, it was not uncommon for respondents to rely on assumptions about the decedent/partner relationship and the repercussions of instant wealth in helping them to determine the support they would offer. By some accounts, respondents felt the vignette depicted the adage of “Money doesn’t buy happiness,” characterized by a “whirlwind” series of events exacerbated by poor decision making. By other accounts, the vignette told a story of a man fraught with mental instability pitted against a spouse with potentially questionable motives.<sup>15</sup> In either context, each respondent was essentially left to “fill in the gaps” of the story, oftentimes leading them to surmise a range of potential explanations regarding the antecedents of Bill’s suicide.

Here, Jane provides a number of reactions typical among many respondents:

Here’s a person [‘Bill’] who is guilty of real bad judgment (*laughs*)...I’m afraid they’re [the survivor] not gonna get much...the money puts a cloud on everything...You may have a completely different personality: you may have a spouse here who thinks, ‘Oh, man, I’m just *waiting* for this to happen!’ We may have woman over here who’s just waiting for her husband to win the lottery and kill himself, and she may not care, instead of our just taking the normal, classic way of reacting to a situation like this...(#13, pg. 18)

The final presented case vignette (“Jenny”) did not depict a suicide; rather, it was used as a generic case of death as a means of identifying possible variations in support when compared to cases involving suicide. Most respondents regarded the survivor in this vignette as warranting as much support as the survivor in the first vignette (“Mark”) due to the perceived innocence of the decedent. Unlike cases two through four, which many respondents believed depicted

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<sup>15</sup> A number of respondents addressed issues of potential culpability on part of the decedent and/or survivor, which will be described in greater detail in the next theme.

complicated, or “sticky” circumstances of self-inflicted death, the situation involving driver “Jenny” was generally viewed as more straight-forward than others, largely typified by unforeseen circumstances beyond the decedent’s control. While the case lacked the selfless nature identified in the first scenario (“Mark”), both vignettes were viewed as comparable by many respondents, regarding each as similarly “tragic.” Many respondents also addressed the issue of drunk driving and its lack of social acceptability in further justifying the decedent’s innocence.

Susie explains the all-too-normative and tragic reality of this case in comparison to the suicide-related vignettes:

Jenny’s partner would receive, I’d say, a great amount of support...I’d say it’s different than the ones with the suicides: I’d say the suicides, you know, society may treat that quite differently. I’d say that it would be similar to vignette number one, without that heroic component, but more of that, like, general tragedy: being at *that* place at *that* time led to this...I think that’s a really common case, people hear that often: driving under the influence. And they think, ‘Oh, that poor Jenny’s partner.’ (#21, pg. 12)

(10) *Perceived culpability*. As a notable sub-theme to *Social Significance of the Death*, culpability was a prominent consideration in offering support among respondents, as the circumstances surrounding particular vignettes engendered decidedly negative reactions among them. While no respondent felt that any survivor should go without aid of some kind, over half expressed reluctance toward supporting partners in cases that were regarded as socially stigmatizing or unacceptable.<sup>16</sup> Such vignettes reflected “sticky” situations that contained some element of culpability, based upon the extreme violence, confusion, or questionable motives contained within a particular vignette (notably “Adam” and “Bill”). As a result, this played a significant role in the decrease in the amount and intensity of support they would consider offering particular survivors. Many of these respondents stated that they felt some degree of personal hesitation that precluded optimal support on their part, oftentimes surmising personality characteristics of both the decedent as well as the bereaved survivor. A number of respondents felt compelled to adjudicate the actions of each individual and identify the extent to which one or both partners contributed to the resulting suicide, causing concern regarding where to assign blame in the process. Vignettes two (“Adam”) and four (“Bill”) engendered these specific reactions of culpability among respondents, ultimately stifling their support.

Generally, respondents who were hesitant to offer aid to the survivor in the second vignette (“Adam”) expressed one of two conflicts, both of which universally labeled the decedent as the primary source of blame: either they had aversive reactions (e.g., anger) toward the decedent’s behavior that precluded support comparable to other cases, or they blamed the spouse for their willing involvement with the partner and/or resulting circumstances.

While Sidney believes that the surviving partner may have been a victim of the decedent’s past behavior, she notes that her response to offering direct, physical contact would

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<sup>16</sup> While these elements are reflected in the “Social Significance” theme, this theme provides a more in-depth discussion of specific factors that precluded support from respondents.

be affected. Here, she describes the challenges she encounters when determining her support for the survivor:

...probably I would do about the same thing as I did with the other one [the survivor in the 'Mark' vignette]; that is, to say, I would more or less go by impulse, but the impulse would probably not be as strong. It would probably not be as strong an impulse for physical contact, because there's some sort of confusion in my head; that is, to say, I've got my feelings about her and I've got my feelings about this man. And I have this conflict between them, which would lead to a little less impulse towards physical contact. (#23, pg. 8)

Christine notes a similar challenge in tending to the emotional needs of the survivor when there is clear revulsion for the decedent's criminal activity. Here, she discusses how the decedent's personal characteristics influence her support:

I would probably still give a hug and hold their [the survivor's] hand...that person is still grieving. It's challenging because you have to sort of suspend your anger or disgust at the person who's committed the act to feel empathy for the person that is left behind. (#3, pp. 3-4).

Some respondents focused more on the tendencies of the survivor in determining how support would be perceived. Despite his efforts to refrain from judging the survivor, Dr. D. admits that his continued involvement with the decedent would impact the degree of blame he would feel toward them:

Yeah, it [the circumstances of the death] would definitely affect me. You know, it would be hard for me not to attach some blame to them, even if...I could, as much as possible separate, you know, really, put that part of me and say, 'This person is a person who's been victimized, and they need help,' it would be hard for me to not think that this person couldn't have...I wouldn't say prevent what happened, of course, but I could say...didn't have to be in this situation. (#11, pg. 4)

Within the vignette involving "Bill," the main conflict plaguing respondents involved the lack of information pertaining to the nature of survivor's personal difficulties; many perceived the situation to contain insufficient information regarding the specific events leading up to the suicide. This left some to question their own judgment regarding how they felt about each partner. Nevertheless, respondents readily made assumptions that dictated the investment they would likely make in supporting the survivor. In many cases, the culpability of the survivor was questioned when respondents considered issues such as the pecuniary implications of the partner's suicide and the contentious nature of the relationship.

For Alice, the financial gain she believes the partner stands to inherit makes her question the emotional support she would offer. Admitting that physical contact would be "harder" for her, she attempts to make sense of a vignette fraught with "too many unknowns":

I don't know what was going on with Bill. I don't know what role this person [the survivor] played in those changes. How much of it was active and how much of it was just, say, neurotic thoughts from...having gotten this money and suddenly imagining things on his partner's part. I'm having a real hard time understanding this, feeling...the others it was really easy putting myself in that position...This is real hard; I'm having a real hard time. I think I'm subconsciously blaming this person, that's the difficulty. (#9, pg. 17)

She also explains how her feelings of culpability toward the survivor affect her ability to provide informational support:

I think that the money clouds my ability to reach out and give information. Again, there's a feeling that this person is to blame for this. It's terrible. (pg. 18)

Later, she proceeds to consider a range of possible situations in which she might reluctantly find fault in the survivor's actions, especially given the financial component of the vignette:

If they were happy before, then it [the money] probably wouldn't be as much of an issue. But if they were not happy before the money....yeah, then I'd just be very uncomfortable. I...I...this makes you feel very unsettled, my reactions feel very unsettled. That I would judge this person [the survivor] this way, I think it's because I can't put myself in that situation to have enough information to know. That's all I can say. (pg. 18)

Other respondents were less tenuous in their reluctance to offer support. Bob expresses how his uneasiness regarding the circumstances of the death greatly factors into his refusal to offer any type of direct, physical contact. Like Alice, he also expresses his own personal reactions to his unwillingness to offer aid due to the culpability he feels toward the survivor. However, he is more direct in describing the limits to his support.

...it would have to be verbal [support]; no touching or hugging...it seems that she [the survivor] played a part that led him to jump off building; I guess I blame the person for the suicide partially...I believe this person would have some part...[I'd feel] kind of cheesy, but not feel too good about myself, but still stick to it and not be willing to help too much. (#15, pg. 14)

### Summary

This chapter identified several features typifying the provision of social support to survivors of suicide-related death. Specifically, ten identified themes—"Core" versus "Vignette-Specific" Support, The Culture of Helping, "Filling the Void," "Let the Need Be My Guide," Identification, Survivor Relationship ("Closeness"), Degree of Immersion, "Casserole Lady" Dilemma, Social Significance of the Death, and Perceived Culpability-exemplify how respondents assessed each vignette and ultimately adjudicated how support for each survivor would be rendered. The variation in modality, length, and justification of the aid contained



within these themes has a number of implications for future research and practice, which will be discussed in the next concluding chapter.

## CHAPTER 6: DISCUSSION

### Introduction

The findings identified in the previous chapter have highlighted a range of salient factors and considerations in the provision of social support to survivors of suicide. Based on these findings, it is evident that the presented themes have offered incipient support toward understanding how perceptions of the type of suicide affect the receipt of various forms of aid. Taking into account the totality of these data, this final chapter provides a summative description of the study's major points of discussion, overall limitations, and prospective utility in future research and practice endeavors.

### Key Points, Issues, and Considerations of the Study

#### *When the Type of Suicide Does (and Does Not) Matter*

Unequivocally, the study's findings, as supported by past research (e.g., Calhoun, Selby, & Abernathy, 1984; Calhoun, Selby, & Faulstich, 1980; Reed & Greenwald, 1991; Séguin, Lesage, & Kiely, 1995; Silverman, Range, & Overholser, 1994-1995), buttress the general supposition that the nature of an individual's death can influence the aid that survivors receive. When suicide was the mode of death, most respondents were in agreement with the proposed continuum noted in the final section of Chapter 3, with a majority believing that the vignettes containing *egoistic and altruistic* suicide reflected the most extreme ends of the spectrum. The vignettes containing *anomic* and *fatalistic* suicides were less consistent in their placement, as some respondents interchanged these vignettes based on their perceptions of how they believed others would respond. However, the findings also suggest that suicide, as a mode of death, seems to matter less in terms of respondents' overall provision of aid in comparison to the perceived and/or actual antecedents of the death itself (e.g., decedent's behaviors that violate social norms, the spouse or partner's personality, etc.). Ultimately, this is reflected in the themes generated from the data.

Despite respondents' overall belief that support was necessary for the survivors in all vignettes, the nuances of each individual case ultimately affected the social attitudes and reactions that they expressed. While some resulting themes (i.e., *Social Significance of the Death, Perceived Culpability*) were influenced by certain suicide-specific vignettes (i.e., "Adam" and "Bill"), most reflected generic features, such as a desire to be helpful and allowing the survivor to indicate his or her own needs, that appeared to transcend all of the presented cases. In general, it can be discerned that deaths believed by respondents to contain elements of stigma, such as murder, culpability, and behavioral problems, tend to be regarded less favorably in terms of how respondents perceived others would respond to and support these survivors. As indicated in the previous chapter, about half of the respondents expressed similar attitudes and support availability as those of outsiders when asked about their own willingness to offer aid. Additionally, a respondent's personal reactions to a particular suicide (based on actual experience, political/social views, etc.) also influenced the manner in which they felt they would support survivors. Under these conditions, the context in which a suicide occurs does, in fact, appear to influence attitudes about offering a respondent aid.

The other eight themes, however, were routinely expressed in some manner by respondents, regardless of whether or not a suicide had been completed in a given vignette. When suicide was specifically addressed by respondents during the interviews, it was found that the social responses of others did not greatly impact what they indicated they would offer in any of the four cases; many expressed that potentially negative repercussions associated with aiding certain survivors did not factor into their decision to help. One potential explanation for this phenomenon might be that respondents were asked to imagine themselves as a friend of each survivor, which might have influenced their willingness to intervene more, as opposed to being only peripherally associated with him or her. Previous research, such as the findings described in Darley and Latane's (1968) study on bystander intervention, supports this notion. While the respondents were not considered bystanders for the purposes of the study, they were asked to consider offering aid individually rather than as part of a group, which might have increased their motivation to offer support. Many respondents also made reference to feeling a responsibility to assist, which was identified in the study as a salient factor in intervening.

Another possible explanation could be that respondents might have been influenced to offer more aid if they believed a particular survivor would be less likely to receive outside support. A few respondents indicated that they would be willing to provide more if he or she was the only source (or one of a small network), particularly in situations which they believed would engender aversive responses from others (e.g., "Adam" and "Bill"). Nevertheless, more research is needed to address other potential considerations that specifically pertain to suicide in the provision of support.

#### *Stigma, Social Labeling, and Cognitive Dissonance as Factors Contributing to Support*

Overall, the study found that elements contained within certain vignettes (e.g., personality traits of the decedent/partner, situational variables, etc.) adversely influenced how respondents believed they would offer support. But what potential explanations underlie this finding? Essentially, three constructs can assist in better addressing this dynamic: *stigma*, *social labeling*, and *cognitive dissonance*. To a certain extent, respondents who expressed reticence toward offering aid indicated some mixture of aversion (toward suicides in which stigma was a prominent feature) and internal distress (based upon their differing beliefs in comparison to others). Within the context of the study, respondents identified instances in which character flaws or "blemishes" similar to those described by Goffman were present in certain vignettes, such as weak will (e.g., failure to find alternatives to suicide), mental illness (e.g., questionable emotional stability), and unemployment (e.g., termination of employment prompting murder-suicide). Such instances might be regarded as stigmatizing due to the level of discomfort that they evoke in others.

Clearly, it can be surmised that some, but not all, respondents strongly identified with prevailing conceptions of stigma, ultimately reflecting in their reticence to offer support. It may be that this subset of respondents is more likely to endorse prevailing trends and expectations consistent with their social sphere's definition of "normality," consequently imposing such ideations on the circumstances within the fictitious vignettes. For example, some respondents expressed uneasiness with respect to certain suicides based on social attitudes regarding their

unacceptability, while others expressed views that generally depicted decedents by suicide as victims.

Another prominent feature of the findings presented in this study reflects the emergence and significance of social labeling. Ultimately, content analyses revealed a range of semantic representations of each suicide described by respondents in reference to how they believed survivors might be socially perceived. As Kraut (1973) suggests in his explanation of social labeling theory, an individual's image can be influenced by words they are described by. Within the context of this study, respondents who described suicides using positive words in reference to the nature of the death or the decedent (e.g., "hero," "brave," "tragic," etc.), stated positive levels of support they believed the survivor would receive (e.g., "a lot," "a great deal," etc.). Conversely, when respondents described suicides using negative language (e.g., "horror," "anger," "blame," etc.), less overall support for the survivor by others was indicated (e.g., "less," "very little," etc.). Interestingly, many respondents felt positively about their own participation as a supporter, regardless of the social acceptability (or unacceptability) of a given death. This may have been due to their own personal attitudes toward helping and how they envision themselves being of assistance to a survivor. Ultimately, more research is needed to address how social labeling theory and other constructs indicative of social attitudes translate to issues related to grief and bereavement, particularly social perceptions regarding suicide.

Cognitive dissonance is yet another potential factor influencing respondent support. Described by Festinger (1962) in his book, *A Theory of Cognitive Dissonance*, this supposition involves "...the notion that the human organism tries to establish internal harmony, consistency, and congruity among his opinions, attitudes, knowledge, and values...[and] there is a drive toward consonance among cognitions" (p. 260). The study's findings revealed that some respondents experienced a degree of discomfort in terms of how they felt about offering aid in particular vignettes. It can be postulated that some of the source of this discomfort could have been the result of a desire to attenuate distress they may have felt when their beliefs or actions differed from others. Not every respondent claimed to agree with or endorse mainstream attitudes regarding certain vignettes; for example, some respondents noted that while the survivor in vignette two ("Adam") might receive little or no support from most outsiders, they would still offer some assistance despite the discomfort they might personally feel. A potential explanation could be that some respondents experienced distress in situations which they may have felt anxiety over their differing views from the majority, but also felt a need to reaffirm their own personal beliefs that they are a supportive individual, as evidenced in the aid they believed they would offer. As a result, it could be hypothesized that some respondents may have attempted to distort their beliefs (e.g., verbal endorsement of attitudes and/or aid antithetical to their actual values), or avoid the situation (e.g., stating they would offer "the same" support as compared to a different vignette, stating that they were not sure, etc.) to attenuate this distress.

### *Mobilization of Internal Responses and External Resources*

A major consideration in the provision of social support to survivors of any type of suicide involved respondents utilizing their own internal resources to identify needs most germane to the situation. Two of these internal resources, responses of empathy and sympathy, were prominent in the feedback of many interviewees, thus corroborating past bereavement

research in which similar reactions had been identified (e.g., Caldwell, McGee, & Pryor, 1998; McGee, 1980-1981). During the course of interviewing, a number of respondents applied principles consistent with theoretical notions identified by Loewenstein & Small (2007) and Jordan & Neimeyer (2003), such as adjudicating the worthiness of a survivor by offering aid and referring to their own past bereavement experiences in feeling empathy for a mourner. While prompted to consider examples of these methods of aid during the interviews, respondents addressed how their help reflected, among other things, the support they themselves had experienced as a mourner or ways in which they had supported a mourner in a previous instance. Overall, various modes of social support indicated by the respondents in the study reflect similar elements identified in previous investigations, such as eliciting sympathy through verbal and written condolences (e.g., Caldwell, McGee, & Pryor, 1998), and emotional recognition of distress based on individual's "instinctual," or autonomic, reactions (e.g., Werner et al., 2007).

### Limitations of the Study

Ultimately, the implemented study encountered a number of limitations. First, the final sample consisted of respondents from relatively convenient locations (e.g., campus community, local senior centers, etc.), many sites of which were selected on the basis of ease of entry and/or recruitment. As a result, potential biases might have existed on the part of respondents, all of whom were self-selected and were thus more willing to discuss and/or endorse particular views regarding bereavement, suicide, and social support. Gender representation was also skewed, as a majority of the respondents were female; only seven of the twenty-five respondents (28%) from the final sample were male. This resulted in insufficient data regarding the identification of patterns and/or themes endemic to male participants. Third, not all data collection took place in-person; a small number of respondents were questioned online to accommodate those who could not be physically present for the interview. Some of these respondents were interviewed at work and/or home settings, thus increasing the potential for distractions that would have otherwise been significantly minimized in an isolated environment. Additionally, the length and repetition of questions asked may have resulted in respondent fatigue, which might have contributed to the lack of variation in some responses across vignettes. The fixed order of the vignettes also created difficulties in gauging first-impression non-suicide reactions from those of suicide. Given that the vignette describing the death of "Jenny" was the only situation not to depict a suicide, its placement as the final vignette to be read by respondents may have precluded them from describing in detail how their non-suicide attitudes regarding the death and resulting aid might have varied from the remaining suicide cases. Thus, it would have been more logistically practical to begin with the non-suicide case before introducing the remaining vignettes. Lastly, the content and nature of certain vignettes (e.g., "Bill," "Adam," etc.) was regarded by some respondents as confusing, lacking in information, or unrealistic, resulting in responses that might not have adequately reflected what they would do in reality.

### Implications for Future Research and Practice

#### *Finding Utility in Typologies of Suicide*

While the study presents only a limited number of examples reflective of self-inflicted death, it is clear that typologies of suicide, particularly Durkheim's (1897; 1951) four identified

examples, have potential use in describing how circumstantial differences can impact the social support rendered to survivors. Unequivocally, the integration of Durkheim's typology within the scope of this study allowed for the identification of various modes of suicide and their individual rationales within a sociological context. However, it failed to capture the full purview of the various incarnations in which these examples might occur in reality. It might be possible that Durkheim's conceptualizations need to be refined to reflect other "types" or "forms" that might be considered useful in identifying variations in self-inflicted death. Certain instances of suicide, for example, may not qualify for placement within any of Durkheim's categories, which might suggest the need to revise or extend the typology. Alternatively, a different typology, possibly rooted in a more social-psychological context, might be more useful in addressing a survivor's social experience. While Durkheim's typology describes different suicides based on their sociological underpinnings, the findings of the study do not endorse direct claims regarding a decedent's alleged "integration" within society, but alludes to factors (e.g., illness, isolation, etc.) that may characterize one's involvement within his or her milieu.

Based on the study's findings, it is clear that the nature of particular suicides makes some difference in the social reactions that they engender. Thus, more research is needed to explore the idiosyncratic dynamics of suicide through expanded methodological procedures. For example, quantitative comparisons of suicide to other types of death, such as those addressed by Thornton, Robertson, and Mlecko (1991) can be used to establish associations between mode of suicide (e.g., altruistic, egoistic, anomic, fatalistic) and the social support rendered. Ultimately, the basis of this study focused on establishing and describing the nuances of these dynamics in an effort to support the need for more research. The overall findings support the necessity of further investigation regarding various forms of suicide, each of which can individually determine the intensity and amount of aid offered to survivors.

### *Supporting Disenfranchised Survivors of Suicide*

Despite more accepting views regarding certain forms of suicide, the study, to some extent, supports the assertion made by Doka (2002) in which survivors of self-inflicted death continue to experience disenfranchisement of their grief experience. A majority of respondents believed that outsiders would generally admonish survivors of specific forms of suicide, as evidenced in what they believed prevailing attitudes would be and the support that would (or, would not) be rendered. Overall, respondents indicated clear instances in which social norms had been violated (e.g., extreme violence, mental illness, behavioral problems, etc.) or culpability had been raised, adversely affecting social support. Doka's conceptualization of "disenfranchised grief," when considering these specific elements, does, in fact, seem to be supported by the study's findings.

Where "disenfranchised grief" appears to fail in its attempt to describe a suicide survivor's experience may be in its outlined conditions indicated in Chapter 2. In general, no references were made by respondents to suggest that the survivor's relationship to the decedent (e.g., as a "spouse" or "partner"), the loss itself (e.g., as a human being versus loss of an object or a social status), or the survivor himself or herself (e.g., as part of an historically marginalized group, such as children or the mentally ill) would be socially unrecognized.<sup>17</sup> While certain

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<sup>17</sup> Comparing death to other forms of "loss" (e.g., object or item) was not a feature of the study, and as such, is not applicable.

suicides (e.g., “Adam,” “Bill,”) seem to violate social norms more than others (e.g., “Mark,” “Martha), it cannot be implied by the study’s findings that suicide, on its own, is sufficient to label a survivor as “disenfranchised.” For this to occur, one or more of the noted conditions would need to be fulfilled, which could then potentially label specific instances of grief-related suicide (e.g., same-sex partner of a mass murder-suicide) as disenfranchised. In any event, such would only describe a relatively narrow purview of situations in which suicide may or may not be a contributing factor to what makes a death disenfranchised in a given social environment.

While elements of disenfranchised grief are present in the study, it is clear that not every instance of suicide (i.e., “Mark”) involved elements of disenfranchisement, as nearly all respondents regarded the laudatory and sacrificial nature of the death, both from their own perspective as well as the perspective of outsiders, to supersede the suicide element contained within the vignette. Some respondents believed that the vignette did not depict an actual suicide, further suggesting that the social distinction between “good” and “bad” deaths remains pervasive and socially-constructed, ultimately reflective of the societal attitudes influencing the support that survivors receive. Despite this limited instance, the necessity of addressing support for survivors of suicide and other forms of ambiguous loss still remains an important focal point for further discussion and inquiry.

Overall, the study buttresses findings from past investigations that identify consequences of stigma, such as shame and guilt, along with decreases in social support, that the bereaved tend to encounter (e.g., Begley & Quayle, 2007; Demi & Howell, 1991; Dunn & Morrish-Vidners, 1987; Wagner & Calhoun, 1991-1992). The experience associated with being a survivor of suicide, coupled with the onset of potential disenfranchised grief, presents an array of opportunities for social workers and allied professionals to tailor therapeutically-oriented interventions to the needs of these clients. Because such individuals are likely to encounter various social and psychological repercussions associated with their loss, this study offered insight into what a client’s social experience might potentially contain, particularly in terms of the professional and/or informal support they might require. For example, survivors of suicides considered more laudatory or tragic may receive adequate emotional aid from outside networks, whereas survivors of suicide deemed more negative may have access to fewer supportive resources. Thus, practitioners with knowledge of the social repercussions of the survivor’s loss can identify potential “gaps” in their support structure to provide the most appropriate interventions (e.g., grief therapy) specific to their client’s needs and interests.

#### *Using Actual Accounts to Capture Actual Experience*

Ultimately, the exploratory nature of this study presented a range of salient themes that describe factors in the provision of aid to suicide survivors. While it lacked the real-life instance of actual suicides, the simulated vignettes underscore the utility of addressing this mode of death at it exists in various forms and circumstances. However, the study revealed that some respondents expressed difficulty in assessing particular cases in which they had no prior experience. Thus, future research should explicitly aim to explore actual accounts of different suicides to develop a composite assessment of reactions and support that is rooted in actual experience. Currently, there exists no social science research that has attempted to capture the nuances of this dynamic.

## Conclusion

This exploratory qualitative dissertation sought to address the following research inquiry: *What factors typify how and why social support is offered to survivors of traumatic death, particularly suicide?* In answering this question, the study provided the basis for understanding sample-wide patterns and variations in aid (i.e., consistent and sporadic examples of support), general considerations in the provision of aid (i.e., helpfulness, identifying deficits, survivor cueing, respondent identification, degree of closeness, immersion, opposite-gender support), and vignette-specific considerations in offering aid (i.e., social attitudes toward death, situational deterrents). While there continues to be relatively scant evidence within the scope of current research, the findings from this study serve as a useful and germane introduction to examining variations in modes of suicide as a factor in determining what, how, and why subsequent aid is offered to survivors.

Overall, the findings identified from this study address the varied elements reflective of the provision of social support to survivors of suicide. Through the investigation of these themes, it is evident that suicide, as a mode of death, is not sufficient to warrant a survivor's experience as disenfranchised; however, individual circumstances of the death may precipitate a range of social repercussions that might heighten the potential for this occurrence. The findings from this dissertation highlight a range of potentially salient features that may describe the social experience of survivors within a specified purview, but, as the discussion section indicates, further investigation to explore wider patterns and variations in aid is warranted.

Ultimately, this study has significant implications for the pursuit of both research as well as clinical endeavors. As a largely untapped domain of inquiry in the field of grief and bereavement, this study provides an incipient foundation from which to broaden the scope of research, through mixed or quantitative methods, to compare modes of suicide to other types of traumatic death in the provision of support. At the clinical level, knowledge of variations in aid can be used by social workers and other allied professionals to tailor interventions in response to potential deficits in support, help to identify social factors that influence the respondent/survivor relationship, and address grief-related complications specific to survivors of suicide.



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## Appendix 1: Informed Consent Document

<b>UNIVERSITY OF CALIFORNIA, BERKELEY</b>		<b>CPHS# 2008-756</b> <b>APPROVED 10/13/08</b> <b>EXPIRES 10/12/09</b>
<small>BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO</small>		<small>SAN FRANCISCO • SANTA BARBARA • SANTA CRUZ</small>

**INFORMED CONSENT DOCUMENT**

Title of Study: *The Differential Impact of Suicide Type on Provision of Social Support: A Qualitative Comparison*

Investigator: Daniel Paul Villa, M.S.W., M.A., Doctoral Candidate, Social Welfare

This is a research study. Please take your time in deciding if you would like to participate. Please feel free to ask questions at any time.

**INTRODUCTION**

The purpose of this study is to better understand how different types of death impact how people offer social support to survivors. You are being invited to participate in this study because you meet the minimum criteria for the purposes of this study (e.g., you are at least 18 years of age, have not experienced the death of a close loved one within in the past year, and can read and write in English).

**DESCRIPTION OF PROCEDURES**

If you agree to participate in this study, your participation will last for approximately 30- 60 minutes. During the study, you will be asked to read five case vignettes describing different situations involving death and answer questions related to offering social support. To assure the researcher's accuracy of your responses, a digital recorder will be used. You may skip any question that you do not wish to answer or that makes you feel uncomfortable. You may also request not to be recorded during the interview.

**RISKS**

While participating in this study, you may experience emotional upset when reading the case vignettes or thinking about your own experience(s) with death. Referrals to local community services will available upon request should you need them after participating. If at any time during the study you make any statements about harming yourself or others, please be advised that the study will end and the Committee for the Protection of Human Subjects (CPHS) as well as any other necessary parties will be notified. This is to ensure your safety.

**BENEFITS**


There are no directs benefit to you through your participation in this study. However, your involvement will be helpful in better understanding how different types of death impact how social support is offered to survivors.



# Appendix 1: Informed Consent Document

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### COSTS AND COMPENSATION

You will not pay any costs for participating in this study other than your time. You will not be compensated for participating in this study.

### PARTICIPANT RIGHTS

Your participation in this study is completely voluntary and you may refuse to participate or leave the study at any time. If you decide to not participate in the study or leave the study early, it will not result in any penalty of any kind.

### CONFIDENTIALITY

To ensure your confidentiality, you will be asked to provide a pseudonym (a fake name in place of your real name) that will be used during your participation of the study. Only the principal investigator and the investigator's study adviser will have access to your data. All records will be kept safely away from others at the lead investigator's residence. The records will be retained until the study is finished, and may be kept for future research use. If the results are published, no identifying information (e.g., real name) will be used.

### QUESTIONS OR PROBLEMS

You are encouraged to ask questions at any time during this study.

- For further information about the study, contact Daniel Paul Villa, M.S.W., M.A., [dps2101@berkeley.edu](mailto:dps2101@berkeley.edu)
- If you have any questions about the rights of research subjects or research-related injury, please contact the Office for the Protection of Human Subjects at UC Berkeley, (510) 642-7461, [ophs@berkeley.edu](mailto:ophs@berkeley.edu), or Director Rebecca D. Armstrong, D.V.M., Ph.D, (510) 642-7461, Office of the Protection of Human Subjects, 2150 Shattuck Avenue, Suite 313, University of California, Berkeley Berkeley, CA 94704-5940

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### PARTICIPANT AUTHORIZATION TO BE RECORDED AND SIGNATURE

Your signature indicates that you voluntarily agree to participate in this study, that the study has been explained to you, that you have been given the time to read the document and that your questions have been satisfactorily answered. You will receive a copy of the written informed consent prior to your participation in the study.

## Appendix 1: Informed Consent Document

**UNIVERSITY OF CALIFORNIA, BERKELEY**

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO



SAN FRANCISCO • SANTA BARBARA • SANTA CRUZ

I give my permission to be digitally recorded.

I do not give my permission to be digitally recorded.

Participant's Name (printed) \_\_\_\_\_

\_\_\_\_\_  
(Participant's Signature)

\_\_\_\_\_  
(Date)

**INVESTIGATOR STATEMENT**

I certify that the participant has been given adequate time to read and learn about the study and all of their questions have been answered. It is my opinion that the participant understands the purpose, risks, benefits and the procedures that will be followed in this study and has voluntarily agreed to participate.

\_\_\_\_\_  
(Signature of Person Obtaining Informed Consent)

\_\_\_\_\_  
(Date)

## **Appendix 2: Case Vignettes**

### Case Vignette #1: Mark

*The first case vignette describes the situation of a soldier who sacrifices his life for the safety of others.*

Mark is an infantry soldier stationed in Iraq. One night, a live grenade is thrown onto the ground on the platoon's quarters, and Mark appears to be the only one to recognize that it is about to go off. To save the others, Mark lunges to the floor, hovering over the grenade, just as it explodes. Mark dies from his injuries. He leaves behind a spouse/partner.

### Case Vignette #2: Adam

*This next vignette involves a man with a history of legal and personal difficulties who takes matters into his own hands when he is fired from his job.*

Adam has had a long history of unstable and violent behavior and has been jailed various times on assault and theft charges. Recently, Adam was fired from his position as a cashier at a local fast food restaurant. Angry from being fired, he storms into the restaurant with a shotgun, kills 3 employees and then shoots himself. He leaves behind a spouse/partner.

### Case Vignette #3: Martha

*This third vignette is about a woman who feels she cannot continue living any longer with a terminal illness.*

Martha recently learned that she was diagnosed with a rare form of cancer and is only expected to live for about 6 months. Being in extreme pain and feeling that her life was no longer worth living, she takes a lethal dose of pain medication to end her suffering. She leaves behind a spouse/partner.

### Case Vignette #4: Bill

*Vignette four involves the death of a man who experiences a number of life transitions.*

Bill recently won a large sum in a state lottery. However, his stroke of luck quickly turned into a curse when he started to experience a number of negative changes, including problems with his spouse/partner. Unable to cope with these difficulties, Bill climbs to the top of his newly purchased home and plunges to his death. He leaves behind a spouse/partner.

### Case Vignette #5: Jenny

*This final vignette describes a woman's sudden and traumatic death after a car accident.*

## **Appendix 2: Case Vignettes**

Jenny is on a windy two-lane highway en route to pick up her spouse/partner from work. On the opposite lane is a woman who is under the influence of alcohol. The woman swerves into Jenny's lane and causes a head-on collision, leading to her death. She leaves behind her spouse/partner.

### Appendix 3: Semi-Structured Interview Guide

Respondent Instructions: You will be introduced to five vignettes involving different instances of death. After reading each vignette, you will be presented with a set of questions. Please answer the questions with respect to each individual vignette. For each vignette, assume that both the deceased person as well as the bereaved survivor are of your ethnicity.

#1-Mark

#2-Adam

#3-Martha

#4-Bill

#5-Jenny

How do you think people may react to how this person died?

How much support do you think this person's spouse/partner might receive?

What specific factors you think might influence this?

- *Probes:* circumstances of death, social views about the death, etc.

(*For vignettes 2-5*) In what ways are these reactions similar to or different from those in the previous vignette(s)?

(*Mention during vignette #1*): There are many different ways in which a person might support someone who has just experienced a death. (*Repeat for all vignettes*): Imagine that you are a friend of the spouse/partner in the scenario you just read. Considering your own attitudes and beliefs with respect to the circumstances surrounding this death, I'd like for you to think about different kinds of support that you would be most likely to offer the spouse/partner in this specific case. There are some specific types I'd like for you think about.

How would you offer the following:

#### Emotional Support

- What might you say to the person to make them feel better?
- What type of physical contact/affection might you engage in with the survivor?
- *Probes: other emotional supports, decision(s) to offer given support, feelings regarding support*

#### Practical Support

- What sort of daily tasks might you help the survivor with?
- What tangible items/goods might you give them?
- *Probes: other practical supports, decision(s) to offer given support, feelings regarding support*

## Appendix 3: Semi-Structured Interview Guide

### Informational Support

- What types of resources might you want to offer the survivor?
- What kind information might you want to offer them?
- *Probes: other informational supports, decisions) to offer given support, feelings regarding support*

\*\*If closeness to the person is mentioned...

How does your closeness to the survivor matter in terms of the support you'd offer?

What potential risks/consequences do you think you might experience as a result of supporting the survivor?

What would you not feel comfortable doing to support the spouse/partner in this case?

- *Probe: rationale, factors, etc.*

How, if at all, did the circumstances of this death affect how involved you wanted to be in supporting the survivor?

- *Probe: rationale, factors, etc.*

When you consider all aspects relevant to this case, what were your internal motivations for wanting to support the survivor?

- *Probes: personal experiences, beliefs, etc.*

When you consider all aspects relevant to this case, what external factors influenced your decision to offer support?

- *Probes: social, cultural issues, etc.*

(after 5 vignettes) Wrap-Up Questions: I'm going to ask you 2 wrap-up questions and then I'll ask you for some demographic information to conclude the interview.

The manner in which a person dies can certainly have an impact on how people might offer support to survivors: some deaths may result in lower support, while others may result in higher support. If you were to consider the spouse/partner in each of the first 4 vignettes that you read, how would you order them in terms of the intensity or amount of support each person might receive, ranging from lowest to highest? You can refer to the vignettes again if you need to.

Any other thoughts on how the different types of death may have affected your reactions to the vignettes or how you thought others might potentially react to them?

## Appendix 3: Semi-Structured Interview Guide

### Demographic Information

Age:

Gender:

Education/Occupation:

Ethnicity:

Have you ever experienced the death of someone close to you that was not a suicide? If yes...

- Relationship to deceased?
- When did it occur?
- Nature/Circumstances of Death?

*(If answered “yes,” how, if at all, might this experience influence the support you would be likely to offer to people grieving a death in general?)*

Have you ever experienced a death due to suicide, specifically? If yes...

- Relationship to deceased?
- When did it occur?
- Nature/Circumstances of Death?

*(If answered “yes,” how, if at all, might this experience influence the support you would be likely to offer to people grieving a suicide?)*