


MANAGING COMPLICATED GRIEF: A QUALITATIVE STUDY OF THE  
AMERICAN FOUNDATION FOR SUICIDE PREVENTION NATIONAL CAPITAL  
AREA CHAPTER

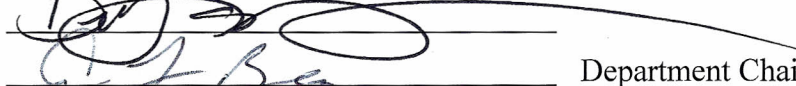
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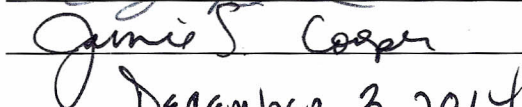
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Suicide Prevention National Capital Area Chapter

A Thesis submitted in partial fulfillment of the requirements for the degree of Master of  
Arts at George Mason University

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## **DEDICATION**

I dedicate this thesis to those who have ever lost someone to suicide and/or may be suffering through mental illness.

## **ACKNOWLEDGEMENTS**

I would like to thank my family and friends who have supported me through my education and encouraged this experience. More specifically I would like to thank the American Foundation for Suicide Prevention National Capital Area Chapter board members who agreed to meet with me and share their experiences making this project come full circle. I would also like to thank my committee for keeping me grounded and focused as I worked through my data. Finally, thanks go out to the Fenwick Library and the Data Services Lab for providing a clean, quiet, and well-equipped repository in which to work.

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## LIST OF ABBREVIATIONS

American Foundation for Suicide Prevention.....	AFSP
National Capital Area Chapter.....	NCAC
International Survivors of Suicide Day.....	ISOS Day
Mothers Against Drunk Driving.....	MADD
AIDS Advocacy Association.....	aaa+
Parents and Friends of Lesbians and Gays.....	PFLAG

## **ABSTRACT**

### **MANAGING COMPLICATED GRIEF: A QUALITATIVE STUDY OF THE AMERICAN FOUNDATION FOR SUICIDE PREVENTION NATIONAL CAPITAL AREA CHAPTER**

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George Mason University, 2014

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The following thesis is based on a qualitative study of the American Foundation for Suicide Prevention as a source of organized, formal support in grief management. This study aimed to contribute to our knowledge of grieving post-suicide in regard to the role of organized, collective support in response to the larger question of how survivors of suicide deal with the trauma of their loss. Drawing on interviews with the national capital area board as well as observations of AFSP activities I examine the role of involvement in an organization as part of grief management.



## CHAPTER ONE: INTRODUCTION

*Oh why, there's no comprehending  
And who am I to try to  
Judge or explain  
Oh, but I do have one  
Burning question  
Who told you life wasn't  
Worth the fight  
They were wrong, they lied  
Now you're gone and we cry  
'Cause it's not like you to  
Walk away  
In the middle of a song  
Your beautiful song  
Your absolutely beautiful song  
-- "Why", Rascal Flats, 2009*

As she sings, the audience cries. Some try to muffle their sobs and hide their tears, wiping their eyes on their sleeves. Others pull into their groups. Young adults surround one woman; they are hugging her and holding her as she cries. Two teens stand apart, one girl crying into her friend's shoulder. Mascara and eyeliner smear down the face of the woman a few feet away from me. The rest of the audience stands in silence, expressionless. Behind her on the stage are three canvases covered in mini-portraits of individuals smiling; most are still just sketched faces, though some have been painted in. The face of a young man stares out into the crowd smiling. His glasses are large and round, his eyes bright. Another painted face has large green star shaped sunglasses accompanying her big smile. Underneath each face, a name has been written. The song

ends and the sun sets. The ménage of tea lights lining the edge of the stage provide a luminescent glow to the solemn setting.

Families come onstage, still holding their tea lights. A woman steps up to the mike at her appointed time and starts to speak about her niece who kept a diary. After her passing, the family read some of what she had written. The young woman had been thinking about ending her life for some time, planning to wait until she was 18 before taking that step. Speaking to the crowd, the woman points again to the purpose of this walk: suicide awareness. She reminds us that there are probably other young girls who feel the same way, who are waiting to die. An appeal is made to the audience on the importance of awareness and support as prevention and grief management.

Another woman steps forward onstage. She makes a similar appeal to those in the audience that suffer from mental illnesses such as depression. She waves her hands as if to show off the 1,000 plus participants, asking everyone to look around and see all of the people who are there with us, who have lost someone close to us. Even if we may not see it now, we have someone who loves us, who will be broken if we are gone. We have made the choice to keep living, and we should continue to fight (Fieldnote 3).

The closing ceremony of the DC “Out of the Darkness” Community Walk 2013 for suicide prevention was one of the most emotionally charged and powerful events that I have attended. The number of people present was phenomenal, with at least 1,000 walkers alone. They have gathered to raise money and awareness for mental health and suicide prevention strategies in honor of those lost to suicide. Images of the loved ones lost are present throughout the setting, on T-shirts, signs, and even the murals that are

being painted throughout the event. This is a celebration of life, a time to remember, a space to grieve, and place to share. All of the participants have something in common—they are experiencing complicated grief as a result of the tragedy of suicide.

The taboo and stigmatizing death of suicide more often than not leaves those who were closest to the deceased confused, broken, and often alone. This is a familiar tale. We do not really know what to do with someone who loses a loved one to suicide unless an individual has gone through the same or a similar experience, for there is a level of social ineptitude. As it is, grief, loss, and death are rarely discussed, and Western society, particularly North Americans, do not really know how to deal with these emotions and realities collectively or individually. Survivors of suicide are often left to search for ways to continue living their life without social support, and, at the same time, respond to the expectation by others that they should be able to move on from their grief.

Grief management is rarely an easy subject to discuss; we tend to be uncomfortable with the concept of death and all that death entails. But, death is inevitable, and how we deal with our grief after loss provides insight into who we are as individuals, and our collectively held values and mores. Grief management involves processes of meaning making that are both collective and individual in form. Though each individual has their own grief process, counselors and researchers alike have noticed patterns in how we grieve. Cable (1996) notes that:

The griever needs an opportunity to work through all the emotions of the traumatic event, such as the sense of terror and helplessness. Often, the griever needs to find a way to turn the emotions into action. It is not unusual to find a griever who, in dealing with the death of a child caused by a drunk driver, turns his or her energy into fighting for new laws and

punishments for drinking and driving. This becomes a healthy outlet for one's emotion. This ultimately gives a sense of meaning to the death (123)

The sociological importance of suicide is in part tied to questions of support.

There is minimal social support made available to the bereaved except through specialized support groups usually organized by the bereaved themselves. Networks shared between those who have also lost are central to emotional recovery. These groups create safe havens, places of understanding and support to the bereaved. Some groups have even embraced an activist stance, taking their grief and turning it into advocacy to help those who have lost and to prevent further suicides. One such organization is the American Foundation for Suicide Prevention, comprised of local chapters across the nation. The chapters are made up of individuals and families, many of whom have either suffered from depression and considered or attempted suicide, or they lost a loved one to suicide (these people refer to themselves as survivors). The primary goal of AFSP is to educate the public about mental health and suicide prevention while providing a space of support for its members.

For this thesis, I conducted an ethnographic study of the AFSP national capital area chapter, where I participated in the group activities and interviewed members to learn about how survivors of suicide deal with trauma. Sociologically this research provides the opportunity to examine the concept of "courtesy stigma", a term first used by Erving Goffman, where stigmatization attaches to someone through relation to the original deviant.. The work of making meaning and transforming emotions into action and prevention is social at its core. It takes the support of others in similar situations and the ability to connect with them for the bereaved to move forward in their grief after

traumatic loss. The goal of this project was to gain deeper understanding of the social experiences of group members involved in what can arguably be regarded a social movement focused on suicide prevention, post-suicide loss of a loved one, and the role their participation plays in their grieving process.

This study aimed to contribute to our knowledge of grieving post-suicide in regard to the role of organized, collective support. How do survivors of suicide deal with the trauma of their loss when in an organized support system? More specifically, what are the experiences of American Foundation for Suicide Prevention national capital area chapter board? How does their work to bring awareness of suicide to the public impact their grieving process? This is relevant to understanding societal expectations and experiences of grief, especially regarding traumatic losses attached to stigmatized death. In the pages to follow, I examine more fully the effects of courtesy stigma on grief, shedding light on the complex emotional fields of loss and grief as part of mental health and mental illness.

The following chapter focuses on suicide research and grieving in general to build a better background for understanding and interpreting the experiences of those I studied. I then detail the research design. From there I discuss my findings on involvement in advocacy groups and how advocacy influences grief management.

## CHAPTER TWO: LITERATURE REVIEW

The research on suicide, stigma, and labeling is extensive. For the purposes of my research, I have limited the literature to focus on suicide as social phenomenon, suicide as stigma, with a specific focus on labeling theory, and grief as a sociological process.

### **Suicide as Social**

Durkheim was the first sociologist to study suicide as a social phenomenon. His theory regarding suicide, as explained in his seminal book *Suicide: A Study in Sociology* (1897;1979 reprint/translation), offers one of the best explanations for suicide and suicidal actions as shaped by large scale social processes. The overall concept derived from *Suicide* is that social integration has an important impact on the likelihood of suicide and attempted suicide. The act of suicide demonstrates, in Durkheim's view, the perfect example of the need and value of sociological explanations, based on the idea that large-scale social forces as well as the changing character of social bonds within a society can explain this private, personal act. Suicide stems from lack of social solidarity or, conversely, over-integration with society as well as ineffective social bonds. Suicide can be understood as shaped by levels of social integration and the rejection of social desire. Too much social integration can lead to over-identification with the group, which in turn can lead to altruistic suicide. Too little integration can also lead to suicide through loss of social norms. During periods of rapid change where social desire is less likely to be

regulated, society members can experience a sense of normlessness that contributes to anomie, and thus anomic suicide.

Durkheim describes four different kinds of suicide: egoistic, altruistic, anomic, and fatalistic. Egoistic suicide and altruistic suicide are dependent on social integration. He states, “One occurs because society allows the individual to escape it, being insufficiently aggregated in some parts or even in the whole; the other, because society holds him in too strict a tutelage,” (221). In the case of egoistic suicide, the individual experiences a lack of social integration, preventing them from being connected to the resources that would presumably prevent suicide. Altruistic suicide stems from what Durkheim describes as over-integration into society. Altruistic suicide can be in one of many different forms such as suicide of those who are close to dying or have reached a certain age; women who die when they lose their husband; and suicides of followers or servants upon the death of the leader (219).

However, anomic suicide and the less discussed fatalistic suicide emphasize the influence of social regulation on suicide. When individuals have a lack of commitment to group norms in such a way that they are unsatisfied with life, anomic suicide occurs. Society, in this case, is under regulated, and this affects the connection and commitment one has with society. Fatalistic suicide, on the other hand, is demonstrated by a commitment to group norms that is excessively strong, such as over-commitment. As Durkheim explains, “It is the suicide deriving from excessive regulation, that of persons with futures pitilessly blocked and passions violently choked by oppressive discipline,” (276).

Arguably youth suicide has received a majority of attention by social research, and Maimon and Kuhl (2008) find that Durkheim's theory of social integration/social regulation can be applied to understanding what causes youth suicide. They focused on individual- and structural-level integration for youths, looking towards the roles of religion, family and school (mirroring the societal structures implemented in Durkheim's analysis) and their possible effects on youth suicidal behavior. Durkheim's theory has also been applied to family, garnering an understanding of how anomie and egoism play into the regulation of social integration and thus its impact on suicide rates (Danigelis and Pope 1979). Both Maimon and Kuhl and Danigelis and Pope found support for Durkheim's assumptions regarding social integration on the likelihood of suicide. For Maimon and Kuhl, they found that suicide in youth is reduced in neighborhoods that are religiously conservative. Danigelis and Pope found the importance of marital and familial status as influential in suicide prevention and risk; sex is also important, though that was not fully studied in Durkheim's original work.

Suicide is a social act. Suicide has both social causes and social reactions. Irrespective of suicide type, suicide has social meaning. Due to the conceptions of suicide, especially as social phenomena, death by suicide is considered stigmatized. The following section looks at suicide as stigma, building on the work of Goffman in *Stigma: Notes on the Management of Spoiled Identity* (1986).

### **Suicide as Stigma**

Erving Goffman defines and evaluates stigma and identity in his work *Stigma: Notes on the Management of Spoiled Identity* (1986), where he analyzes social deviance



as a social production through interviews and statements of criminals and mental patients, among others. Goffman comes to define stigma as “a special kind of relationship between an attribute and stereotype,” (4). He discusses three kinds of stigma—bodily, moral, and tribal—and how these types as well as social reactions to them interfere with and pattern social interactions. Bodily stigma relates to physical deformity. Moral stigma stems from “blemishes of individual character”, such as mental disorder, imprisonment, addiction, alcoholism, etc. (Goffman 1986, 4). Tribal stigma deals with groupings based on race, nationality, and religious affiliation. Suicide falls under moral stigma.

Goffman points out that we “normals”, those he defines as the group without stigma, tend to treat the deviant as not quite human, no matter the reasoning behind the stigma. Society tends to discriminate, whether unintentionally or intentionally, through the inappropriate use of terms: “We use specific terms such as cripple, bastard, moron in our daily discourse as a source of metaphor and imagery, typically without giving thought to the original meaning,” (5). The widespread use of negative terminology contributes to a social reality where certain actions are considered deviant. Suicide, then, is regarded as a deviant type of death.

In most cases, the stigmatized individual is generally aware of the stigma placed upon them due to their particular “blemish,” sometimes holding the same beliefs about themselves and their marker as those defined as “normals” (7). But how do they respond to their situations? Depending on the particular failing, the individual may seek out treatment to correct the failing; this can lead to becoming someone who has corrected the failing (one cannot transform into a perfect semblance of normal) or a victim of

fraudulent cures that others might embrace. Either way, the stigmatized can go to extremes to change their status (9). Even if they do not seek to correct what is supposedly wrong within them, mixed interaction with normals can produce a great stress and burden to the stigmatized. They do not know what the others are really thinking of them; there is a lack of trust in the sincerity of the normals (14).

To resolve this problem, the stigmatized group together, forming their own social norms, and definitions to counter previous understanding. They engage in information control, deciding when to reveal aspects of the stigma and when not to. This set of sympathetic others are considered one's "own" in Goffman's terms; they share the same stigma as the others. In order to gain access to this information and knowledge about the stigmatized without actually having that specific stigma placed upon yourself, one must become what Goffman calls "the wise" (28). The wise are those who are normal but are not traditionally stigmatized; they have a relationship that allows them to be sympathetic to the stigmatized individual, accepting that person, and thus being informally considered a member of the group. One can become wise through personal experience, choice of career, and/or relationally, such as family. Having this role does place some discredit upon the wise, though not as much as on the stigmatized. This puts them in their own middle ground, where they are not truly a part of one group or the other, yet they have some kind of access to and information on both. AFSP can be examined as being comprised of both the own and the wise, as the members are a blend of survivors of suicide (those with stigma) and those that have an interest in suicide prevention.

Of sociological importance is the kind of group life in which the stigmatized individual partakes and the type of group they join. There are multiple types of groups that serve the stigmatized. For example, there are self-help, support groups such as Alcoholics Anonymous and Narcotics Anonymous. In these groups, a doctrine has been established to guide the participants through life. Goffman also talks of networks of former convicts and prison inmates. While Goffman doesn't specifically mention it, there are support groups and volunteer groups for advocacy. These groups offer support, even if there are not specific support agencies that represent them. Whether or not one is part of that particular group, information can be gathered about its members through pamphlets or websites, allowing for reinforcement that the stigmatized are not alone even if they do not participate. The material can also transform thinking and decrease stigma. Sometimes, stigmatized groups have officials, such as lobbyists, who are either native or part of the wise and attempt to educate and represent interests through the press or the government (24).

Though they are not necessarily affected directly, research has also shown that families of those who are mentally ill will experience, or believe they will experience, what is called a "courtesy stigma." A courtesy stigma is a stigma of association whereby the stigmatization experienced by the mentally ill is also transferred to those affiliated with that person (similar to the wise). Goffman states, "the problems faced by stigmatized persons spread out in waves, but of diminishing intensity," (30). Courtesy stigma can be easily tied to the modified labeling approach described by Link, Cullen, Struening, Shrout, and Dohrenwend (discussed in the following section) because the labeling of the

mentally ill blemishes the family caregivers through affiliation. Fear has been constructed in relation to how the public responds to children (as well as adults) that have been diagnosed and treated for some kind of mental disorder (Martin et al. 2007).

One could suggest the idea that courtesy stigma carries forward bereavement after the death of a mentally ill individual, particularly through suicide, as suicide is quite obviously a stigmatizing death. Goffman defines similar, patterned experiences by stigmatized individuals as they progressively reconceive themselves and their moral status as their “moral career”. (Goffman 1959). Each moral career can follow different patterns, such as possessing an inborn stigma or becoming stigmatized later in life. He points out

Regardless of which general pattern the moral career of the stigmatized individual illustrates, the phase of experience during which he learns that he possesses a stigma will be especially interesting, for at this time he is likely to be thrown into a new relationship to others who possess the stigma too (36)

Essentially, the stigmatized, or in the case of my research those possessing courtesy stigma eventually find others “like them”. The separation from normal society creates a network of social support for the stigmatized individuals, providing the reminder that they are not alone by enabling group affiliation, and helping them to construct a new narrative of self and situation.

Building off of Goffman’s work on the moral career, Johnson and Best (2012) address advocacy as a form of support in the moral careers of parents of gay children in their article on “radical normals”. Their emphasis is on parents of gay children in the organization Parents and Friends of Lesbians and Gays (PFLAG) who are in the process

of adjusting to their new reality of having a gay child. These parents struggle to “come out” to others about this new identity in a social setting; they often start by reaching out to the group and attending meetings, then having practice disclosures where they test out sharing in spaces that they consider safe, such as with coworkers who are gay or even with a hairdresser before addressing those with whom they have a stronger social bond whose reaction they fear the most. PFLAG offers resources for the production of new selves, especially in meetings. As Johnson and Best state, “In acquiring energy and advice from PFLAG meetings, parents feel a sense of moral solidarity to reframe the terms of the debate over homosexuality when they go out into the world beyond the safe space of these meetings,” (332). These parents can easily be considered reluctant advocates in that they likely would not have participated in this organization prior to their own child’s coming out. This will be an important part of my considerations regarding grief management for suicide survivors.

### **Labeling Theory and Suicide**

Labeling theory has had a considerable impact on the sociological study of mental illness and stigma as well. Labeling theory is often associated with stereotyping and self-fulfilling prophecies because, as the theory goes, we label someone as a deviant; this label makes him or her act and become deviant, thus reinforcing the original assumption that they are in fact deviant. Terms used to classify someone can in turn become his or her identity. This theory has received much criticism and varying interpretations and understandings since its conception, though it has remained rather prominent in the study of deviance. Criticisms aside, labeling theory offers an understanding of the effect of

labels and reactions to them, not of behavior and subsequent actions, and thus remains an important framework sociologists use to understand how reactions impact actions and our understanding of them.

Others have chosen to modify labeling theory in their approach to understanding the stigmatization of mental disorders as well as the effects stigma plays on families and former patients. Link, Cullen, Struening, Shrout, and Dohrenwend propose the modified labeling perspective because it “claims that even if labeling does not directly produce mental disorder, it can lead to negative outcomes,” (Link et al. 1989:400). They based their modification on Scheff’s original modified labeling approach which identified devaluation and discrimination through internalized societal stigma, the importance of the official label as applied through treatment, the patients’ responses to the stigma status through either secrecy, withdrawal, or education, the negative consequences on the patients’ lives, and their potential vulnerability to a future disorder (402-404). For their version of the modified theory, Link et al. choose to emphasize the variability of beliefs about mental patients. They also “highlight the individual’s response on the basis of his or her beliefs about how others will react unless he or she does something to avoid their reactions,” (404). Most importantly, Link et al refuse to give the label direct power over the creation of mental illness, instead looking at how labeling and stigma are possible causes of negative outcomes, which could put an individual at risk for recurrence or prolongation. Markowitz (1998) builds from this approach to look at the relationship between stigma, psychological well-being, and the life satisfaction of the mentally ill post-hospitalization, demonstrating consistency in the understanding that ex-patients feel

they will be devalued and discriminated against even if they do not experience a direct example of this behavior.

These analyses are interrelated and influence how we understand and make sense of deviance and stigma and are useful as we work to understand the experience for family and friends of the mentally ill who have completed or attempted suicide. How does this courtesy stigma influence and affect the lives of those who are trying to mourn and understand the tragic loss of someone close to them?

### **Social Regulation of Grief**

In general, American culture is not particularly comfortable with death, dying, and human experiences of grief, as we lack the appropriate mechanisms and means to handle grief (Cable 1998). Collectively held beliefs pattern how we grieve, what it should look like, how long it should take, often limiting the grieving process. As a culture, we have come to define a relatively short period of public mourning after a loss. We have specific spaces and times to express our grief publicly, namely funerals, wakes, and memorial services. After this time of public mourning, we are expected to continue our grief privately, and preferably quickly, and are expected to be ready to face the world and move forward. Many have noted our society created an “efficient” model of grief (63). Because of this need to conceal our grief and keep in private, we are not as aware of the grieving process as we could be (62). However, Worden developed a stage model for understanding the grief process that many continue to use as a general guide today (cited in Cable 1996: 120-122) These stages are to accept the reality of the loss, to process the pain of grief, adjust to life without the deceased, and to find an enduring connection with

the deceased while continuing to embark on their new life. Through these stages, the bereaved work towards healing.

Though the following sets of researchers do not specifically focus on suicide and suicide survivors, the message continues to be clear: how we conceptualize grief continues to hinder the ability for healthy grieving processes often presenting more “complicated grief” in situations of traumatic death such as suicide. Following the death of a loved one, bereavement is a natural part of the life course, though it is rarely acknowledged as such. Bereavement is not a simple stage to move through, and this can be even more difficult for those who are caregivers. McHorney and Mor (1988) look at clinical depression or primary affective disorder post-bereavement and how this may affect health care utilization or overutilization. Often, they found that bereaved spouses are seeking help from physicians more than may actually be necessary, whether or not they suffer from depression. They did not provide a clear reason as to why this may be the case, aside from the possibility of unidentified and untreated depression which tends to remain a likely factor in potential burdens on the health care system, as is somatization, defined by the continued feeling of physical pain without an identifiable cause. It seems as though there may be a level of misunderstanding of what a normal grieving process looks like and what depression looks like, and thus what the appropriate needs of the bereaved may be from the health care system. Focusing on the grieving experiences of caregivers of dementia patients, Aneshensel, Botticello, and Yamamoto-Mitani (2004) sought to understand “the course of emotional well being following bereavement and the cessation of caregiving.” Their research showed a more



heterogeneous response to the end of caregiving across their sample, leading to the idea that perhaps social conceptions regarding the appropriate actions of grieving may be mistaken.

Bouncing from this idea of mistaken social conceptions, Fowlkes aims to explore the ways that grief feelings/behavioral manifestations generally applicable to society are socially regulated to either allow or deny mourning from a socially legitimate grief role, thus invoking a sense of social understanding and validation for the experiences of the mourner, particularly for those that have stigmatized or undervalued losses (Fowlkes 1990:636–637). She finds that a loss that is not familial will not elicit the “ritualized expressions of sympathy” that usually are invoked by the death of family (Fowlkes 1990:638). Such relationships and situations that have been stigmatized are also delegitimized, or rather have always been considered illegitimate, which can invoke powerful grieving due not only to feelings of loss but possibly shame, disapproval, or even guilt. Cable (1996) points out that often, especially in cases such as suicide, we forget that the griever has lost someone because we are too enrapt by blaming the deceased or our own confusion for the situation, leaving little room for social recognition of loss (69). There is little support for survivors for we lack the understanding of how to help them.

Attitudes toward survivors of suicide loss tend to be negative, with a range of assumption applied to family. They are often perceived as less likeable, blameworthy even, and in some cases psychologically unhealthy prior to the death (Judith M. Stillion 1996: 43). Overall, a sense that they have significant guilt and shame contributes to

rejection. Even amongst themselves, survivors note similar emotional stressors. They have a lot more to sort through, and often can be considered victims of post-traumatic stress (48-50). Stillion suggests that sharing names of other suicide survivors is extremely beneficial to the bereaved, allowing them to foster a relationship with someone else at a different point in the process. Sharing names offers a connection for the newly bereaved to others who share their courtesy stigma.

Within the realm of grief studies, the form of grief experienced by suicide survivors is referred to as “complicated grief,” a long-term grieving process usually induced by tragedy (Groot, Keijser, Neelman, Kerkhof, Nolan, and Burger 2007; Hawton 2007). As Hawton describes:

Some bereaved people develop severe long term reactions to their loss. This kind of reaction may be associated with adverse health outcomes and has recently been termed "complicated grief." The syndrome is more common after unexpected and violent deaths such as suicide... Complicated grief may be associated with increased risk of cancer, hypertension, cardiac events, and suicidal ideation,' plus adverse health behaviours such as increased smoking and alcohol misuse. Although complicated grief is associated with an increased risk of depressive disorders, it is clearly distinguished from depression (962-963)

So how can we make sense of “complicated grieving” for those who have experienced a stigmatized death? Groot et al (2007) argue that we should be prepared to work on prevention and to assist those who are left because they may require more attention. Agerbo (2005) assesses suicide risk amongst the population of Denmark in a gender specified study of suicide rates, with attention to various situations such as the loss of a partner or child by suicide or how marital status may play into suicide rates. Based on his analysis, Agerbo finds that there are high risks of suicide in many situations,

such as a spouse being admitted to a psychiatric hospital or the loss of a child or, more specifically, loss of a spouse to suicide. The risk is highest in men who have lost a spouse (411). Hawton and Simpkin (2003) suggest that bereavement by suicide is different from bereavement through other sudden means, such as a heart attack or stroke. They argue that there is a great need to help the bereaved by suicide; helping to find what types of care may be most effective. For instance, they mention the potential benefits and forms of support available; individual counseling and support from others who have had similar experiences are some of the main considerations in support (178).

To evaluate certain kinds of therapeutic support, Groot et al conducted research on family-based therapy for those experiencing “complicated grief” and found that counseling had no effect on their experiences of grief, though it did allow for a reduction in perceptions of blame or guilt despite the level of depression or suicidal ideation that may have been aroused due to the situation. They argue that having a chance to reflect on what their loved one may have been experiencing prior to the suicide allowed them the opportunity to acknowledge that they did nothing wrong; it is most likely that the education process (learning about the psychiatric context of suicidal behavior) provided a challenge to their personal perceptions of guilt and blame (996).

While understanding the effects of therapeutic support are important to the context of understanding grief management, we also must acknowledge that there are some limits to what we know from research. The following section looks at the limits of the research and lays out my goals for moving forward.

## Limits of Research

We have been researching some of the benefits of social support for the bereaved, but little research has delved in the role of advocacy groups in grief management in particular. Can participating in some kind of activist movement offer its own level of support and be grief management for participants? I look at this as “active grieving”, which I define as when the bereaved uses their story of grief as motivation to help others through social groups that raise awareness or through fundraising; this is a positive activity post-bereavement. Some research has acknowledged that people do join groups like Mothers against Drunk Driving after the loss of a loved one, but we know very little about the role of the support system that the fellow active grievers offer for each other (Cable 1996).

As it is, survivors of suicide have a difficult road ahead of them as Dransart (2013) points out in her article on sense-making and meaning-making:

Survivors of suicide are faced with the difficult task of integrating a loss which seems incomprehensible into the pre-loss meaning structures that gave their life stories purpose and predictability... meaning-making may be among the specific characteristics of suicide bereavement (318)

Her article focused on the general pattern of bereavement for suicide survivors while looking at how they worked from sense making to meaning making. She identifies four types of survivors based on the patterns that developed in how survivors managed their grief (329). The findings she has come across are relevant to understanding grief management through advocacy, as will become evident later.

In the next chapter, my design and methodology in studying the relationship between the American Foundation for Suicide Prevention and grief management post-trauma for those who have lost someone by suicide is provided.

## **CHAPTER THREE: METHODOLOGY AND RESEARCH DESIGN**

This study aims to contribute to our knowledge of grieving post-suicide in regard to the role of organized, collective support. The previous literature focused on aspects relating to complicated grief, but there has been little research conducted that allows us to understand the experiences of grief for those bereaved by tragedy, such as suicide. My design is a qualitative analysis focusing on an organization created by and for families and friends of those who have died through suicide. My question is: How do survivors of suicide deal with the trauma of their loss? More specifically, what are the experiences of American Foundation for Suicide Prevention National Capital Area Chapter board members, and how does their activity and mutual support impact their grieving process? The goal has been to learn more about their experiences by listening to their voices; this enables us to improve grief scholarship, which could in turn improve how we as a society think about grief and how we interact with those who have lost someone by suicide.

### **Research Design**

My personal interest lies in methods of grieving practices for families and friends of those who have died in some form of tragedy, such as suicide. Previous research has focused on the courtesy stigma attached to the family because of the social ideas regarding those who commit suicide (Ginsburg 1971; Herman and Reynolds 1992; Martin et al. 2007). Other research has looked at the stigma related to mental illness

(Goffman 1986; Markowitz 1998). I am specifically interested in the dimensions of grief, and how formal and organized supports play a role in managing what could arguably be called “stigmatized grief”.

I attended an “Out of the Darkness” Community Walk hosted by the American Foundation for Suicide Prevention with a friend in September 2013. After the walk, I was inspired by the collective actions of the group and how they appeared to be managing their grief within this public space. I have been interested in grief and memorialization as a sociological concept, and this setting fit my research interests. The basis for this project stemmed from this initial event and opened a door for further research over the next sixth months.

The American Foundation for Suicide Prevention (AFSP) hosts community and overnight walks as well as various other fundraising and educational events throughout the year. AFSP is a mixed collection of individuals and families that have lost someone to suicide; are suffering from a mental disorder, or both. Specifically, AFSP is known for being

the leading national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide (Anon n.d.)

With such an emphasis on prevention through research, education, and advocacy, this organization includes membership of those who are actively involved in the cause of mental health awareness. For this study, I focused on the national capital area chapter (NCAC), as this is the local chapter and thus offered the most accessibility for me.

I engaged in participant observation at events as both a regular participant, such as “walker” at the fundraising walks, as well as volunteer at other events. The role of participant required that I register and walk with the other participants, which enabled me a chance to listen to the conversations that they were having as they walked and to engage in various activities for memorialization as well as learning what the chapter had provided as part of the events. I am also a volunteer and serve with the Publicity Committee for the NCAC. For this I have been participating in meetings to discuss improvements in publicity and awareness as well as attending events held in the area. All in all, I have established a place for myself within the organization that allowed me to gain access to the population and work closely within them through connections I have made.

All events were public, providing easy access. Events I attended were the Rockville Out of the Darkness Community Walk 2013, the Washington, D.C. Out of the Darkness Community Walk 2013, the 2013-2014 volunteer orientation, the International Survivors of Suicide (ISOS) Day 2013, and volunteering to help supervise a table at a health expo. The walks were fundraising events where I walked along with family and friends who consider themselves “survivors” of suicide. The volunteer orientation was a training session informing the potential volunteers of what AFSP does as well as what opportunities they have for participation. ISOS Day is a conference-like setting for survivors to come together and share a safe space to talk about suicide and grief. Each event brought insight into the world of survivors and their lives after their loss through story sharing, usually in speeches.



Because this group is open and public, there were no immediate ethical issues with my presence or obstacles to entry. I share characteristics with the other participants, such as an interest in mental health awareness, and I am from the area. I did not inform every individual participant that I was a participant observer as that would be practically impossible. However, I was always honest. If someone asked me about why I was present, I told them the truth that I was there for both personal reasons and research interests regarding grieving practices. I had previously talked with some of the board members about my project and had been allowed access with genuine encouragement.

I carried a small notebook for jottings with me, as well as a camera for photos. This allowed me to make notes to jog my memory prior to writing my fieldnotes. However, when I wanted to take a photo, I gained verbal consent by asking participants if I could take their pictures. None of these photos will be nor have been made public.

I primarily utilized interviews (both formal and informal) with members of the board as the main source of data for analysis. I intended to interview ten people, though I only interviewed seven board members and felt that I had reached saturation for the purposes of this particular research project.

To find people to interview, I used a simple sampling procedure; starting with contacts I have made with the board through volunteering and was thus able to contact other members of the board. I originally emailed the area director who encouraged me to contact the board individually. I started with asking the chair of the publicity committee for help and gathered participants based on their interest and response to my call for participants (a copy of this is in Appendix A). Those who contacted me were chosen.

Because of this, none of the participants were entirely random from within the organization.

I interviewed seven women of varying ages (mid-twenties to late-fifties), all of who had lost a male relative. Losses included a younger brother (2), a son (4), and a husband (1). Each person had some sort of role on the board, ranging from chapter chair to general board member. All considered themselves active in the organization.

Interviews were relatively short, lasting between 30-45 minutes apiece and were recorded with the consent of the participant. Half of the interviews took place in a public setting, specifically at coffee shops, while the other half took place at the home of the participant. Names of interviewees have been changed and any identifying characteristics have been altered somewhat; names of the deceased have been edited out, though the gist of the stories have been maintained.

Questions focused on membership as part of loss and grief management. For example:

- How long ago was your loss?
- What are some of the reactions you have received in reaction to knowledge of your loss?
- Tell me about your experience with your extended family, close friends, and neighbors after your loss.
- How has this impacted your grieving process?
- Can you remember a time where you hesitated telling someone about your loss? Can you explain?
- How do you feel when you talk to strangers about your loss?
- How do you feel when you talk to your family about your loss?
- How soon after your loss were you introduced to AFSP? Can you tell me more about this?

(See the interview protocol in Appendix B for the full list of questions asked.) I preferred to hear their stories and experiences regarding the after-effects of the suicide and how their participation is or is not helping in their active grieving process and was less interested in the suicide itself. Their narratives provide insight into what they think and how they feel regarding their situation in a much more detailed fashion than if they were to respond to a closed-ended survey. Taking the time to personally get to know them and talk with them also offered a chance for them to open up and share more with me than they might otherwise. After the interviews, I transcribed the interviews while listening to them multiple times to make sure that I was being as accurate as possible in grasping exactly what they said.

Utilizing these ethnographic techniques of participant observations and interviews, I gained a better understanding of the experience of loss and complicated grief, focusing on this method of making meaning out of grief through active participation in a cause. I spent about six months in the field before fully analyzing the data, but data analysis occurred along the way to keep me grounded and interested in what I was collecting. I collected all data and extensively open coded and focus coded all materials. As I started coding, I made copies of my fieldnotes and interviews, reading them and re-reading them, highlighting and noting quotes, patterns, and themes that were interesting. For the final rounds of coding, I imported the data into NVivo, the qualitative analysis software, and recoded everything again. This program also enabled me to visualize the quotes that shared different themes to strengthen my analysis. I was able to

identify emergent themes that elucidate the social processes of grief and the role membership in AFSP plays in grief management for this particular subset of members.

### **Concerns/Limits**

There are some inherent difficulties with the choice of method I have made relating to the reliability and validity of the measurement of my research data. As I was on my own in the field, collecting and analyzing the data by myself, results were reliant on my observations. Reliability was easier to determine. Because many events I attended were similar, such as the community walks I attended, I had the opportunity to see if patterns occur across the cases because I went to multiple events. I expected that behaviors would be similar at events of the same kind, but may change with different kinds of events. I also aimed for internal consistency through the interview process, using multiple questions to tackle one concept at a time.

Through participant observation and interviews, I was able to capture the voices of those involved to gain a better understanding of the organization, the people that make up this organization, and how this organization facilitates specific forms of grief management. However, I was limited in the fact that I only interviewed seven people who all happened to be women. They did have varying losses, which gave some difference to the data, and I believe that this did not provide too great of a hindrance to the argument of advocacy in research. This may speak to a gendered pattern in grief management post-suicide and the likelihood to engage in advocacy work as a part of active grieving. The hope for future research would be to include more variability in the sample size with male board members and those who are not members but still participate.

With the above design, I aimed to improve our understanding of grieving practices, primarily through the process of “active” grieving. My hope is that my data will foster a discussion about methods of grieving that work for some individuals. What can we do with the information gathered? What improvements can be made to grief counseling and support networks? Is this a healthy method of grief management? These questions and more can potentially be answered through this project and further research.

## CHAPTER FOUR: GETTING INVOLVED

After a traumatic loss such as suicide, family and friends of the deceased are left to put their lives back together. The bereaved need a support system to help them move through their grief journey. Without social support of some kind, the grieving individual runs the risk of becoming isolated in their grief, making it more difficult to cope with their situation.

There are some options for the bereaved to gain the support they may need as they piece their lives back together. This support can come in many shapes and sizes including informal support from family, friends, and coworkers, and more formal support may take the form of bereavement support groups or therapy. Another resource is advocacy groups that focus on a specific cause, often related to a terminal disease or cancer that takes multiple lives a year. There are numerous groups and organizations, but some of the better-known groups include Mothers Against Drunk Driving (MADD), the Susan G. Komen Foundation, and the AIDS Advocacy Association (aaa+). Groups, such as AFSP, that focus on advocacy are often forward thinking and action oriented with a goal towards some kind of change, such as suicide prevention. This gives the bereaved an action-filled space to work through their grief. Advocacy groups fundraise for research towards a cure and offer educational material about causes, symptoms, and treatment. Within these groups, the bereaved often find others like themselves in a safe setting that allows them to

share if they want, and offers examples of what others in similar situations and stages of grief are doing to take care of themselves. This is similar to what Goffman refers to as one's "own" stigmatized group, where one feels safest or at least comforted in the fact that others like them surround them. In the case of this thesis, I focused on a specific advocacy group—the American Foundation for Suicide Prevention. This organization researches mental health care and treatment as well as assessment of suicide risk and intervention practices, with the aim of prevention.

Based on the seven interviews I have conducted with members of the AFSP NCAC board, I established a pattern of what it is like for survivors to start their involvement in this organization. This chapter focuses on participation and involvement in the organization, looking at what drew the members to participate, how they originally got involved, what kind of involvement they have, and how this involvement affects their healing process.

### **What draws them to participate?**

Generally speaking, losing someone can have a great impact on how we feel about our usefulness in the situation at hand; the bereaved often feel at a loss of how to react, wondering what their new place in this world is now that things have changed. They suffer from a kind of role engulfment, consumed by their new reality. It is common to struggle internally with guilt, denial, and anger, among other emotions, as the bereaved start to readjust to a new life without someone. When a death is unexpected, the information comes as a setback, leaving them to feel helpless or useless—there is literally

nothing that they can do about their new situation in life and they are forced to make sense of this with little to no preparation.

Each of the board members I interviewed expressed similar feelings in that they needed to do something, whatever that something might be. It became a need to take some kind of action to move through their grief journey. They were all in slightly different stages in their grieving process when they were first introduced to AFSP. Part of that also has to deal with the presence that AFSP had at the time (AFSP was established in 1987 and the earliest loss experienced by the interviewees was 14 years ago; Anon n.d.). Most were introduced just months after their loss either by noticing a flyer on the way to work or through the help of a friend who came across information about a community walk for suicide prevention. In only one instance was a person introduced within a week or two after their loss through what is termed a “postvention” in which members of the Survivor Outreach Program visit newly bereaved families to discuss suicide, mental health, and what happens next for them. However, no matter what stage they were in or how long it had been since their loss, these individuals felt a pull to join and participate in one way or another as a way of dealing with something they could control.

Grace (Interview 6) is a young woman who lost her 14-year-old brother in 2001. He was living with their parents in Florida at the time and she was called home immediately after his passing. Listening to Grace, I got a sense of what it was like to feel the immediate impact of grief and that feeling of uselessness. Here she describes an emotional moment when she tried to get out of the house for a bit with her friend:



My best friend flew down as well, and got a hotel room and got us to get out of the house; it happened at the house. We went to the mall because there was nothing to do, right? Just sitting there. There's actually nothing to do, besides like arrange the funeral. But there's not really a whole lot of that to do. Um, and I remember going to a mall, and the person asked, like the door greeter at, I don't know, Macy's or something, say, "Good morning, how are you today?" And I just burst out into tears (laughing) like, "how dare you say something like that to me?" Um... I just sort of become very sensitive to what people say.

Grace felt lost and adrift, beset by inactivity. This was made worse because she needed some sort of active outlet that she had not found yet that would allow her to process everything that was going on inside her emotionally and mentally. Part of what made things even more difficult was that her parents and her were on different paths and were dealing with the loss very differently; they never really talked about the loss or how they were dealing with it.

Both Grace and Ashley (Interview 4) experienced strain in their familial relationships that led each of them to seek out other support resources of their own to move forward. Ashley, who also had lost a younger brother, explained some of this:

The most interesting thing, I think, has been that for my parents, my life has become about my brother. And, I don't mean that in like a... like I'm not like actively upset about it, but it's hard because I remember, when I got married, my dad was talking about how we needed to say something about \_\_\_\_\_ at my wedding and I just felt so strongly that that wasn't okay with me, and that I had to be able to have a normal wedding, and I didn't want to talk about my brother's death. But, it's like every event he's not there, you know? My dad'll come over for dinner and talk about how \_\_\_\_\_'s not here, and I can't... I can't avoid the topic, and somehow, somehow my life has become about him for them. Which is weird. I can't talk to either of them about anything serious without it coming up. We can't go through any family events or rights of passage for the other two of us who are left without it somehow weirdly being about him. So, in that sense, like, it's just weird, and I feel like, um, it's oddly immortalized him in a way that seems kind of unhealthy...

The situations with Grace and Ashley raise questions about how a family should interact with each other and acknowledge the needs of each individual as they grieve in their own ways. Their informal support network of family was so disconnected that they were not getting the actual support that they personally needed. Their needs required a more action-oriented stance allowing them to channel their grief outwardly as opposed to dwelling on the loss. Grace and Ashley sought to educate and to turn their grief into something positive. Again, Ashley provides insight into why she wants to participate in AFSP:

... feeling like the only positive thing that could come out of this, and the only positive legacy that I feel empowered to try to help my brother's life leave is to um try to help somebody else by using his story for the good, and trying to get the word out there that you can look fine, and it can look like you've turned a corner in your life and you've moved on past all the problems you had, and sometimes that's a really bad sign

In the case of Ashley, the focus is on the legacy of her brother and the memory of the loss, particularly as a learning mechanism for others. The hope is that they will hear her story and see that even if you feel like there are no other options, there are still people who care and want to help you.

Two of the first interviews I conducted were with Sarah (Interview 1) and Laura (Interview 2) who had both lost a son. Sarah's loss was 14 years ago when her family lived on the West Coast. Her son was in the Navy at the time of his death. Laura's son was a senior in high school and she was extremely close to him; she lost him just two years ago. Sarah and Laura both had familial experiences with suicide loss prior to their own losses (a cousin and an uncle respectively), and that encouraged their involvement even more so. In both cases, these women felt that the family was too quiet about the first

losses/attempts, and there was thus a need to talk more about the loss, about suicide, and about mental illness. According to Sarah:

...we've been very open about it because we had the suicide in the family before and we never talked about the suicide. We always talked about my cousin but not the suicide. And there had been numerous attempts in the family that no one ever talked about before, including me, so now I'm very open. The whole family is very open

These two women recognize that societally, even within families, people are uncomfortable talking about mental health and suicide. Instead these stories are kept as family secrets or things that are not actually discussed aside from possibly keeping the memory alive. With growing awareness of treatment, some families are becoming more open about their experiences as a way to keep their family whole, though not everyone is willing to talk about it yet. Families have focused on memorializing their loved one without discussing the actual loss, but this has been changing with time.

Families are faced with many conversations that can be considered uncomfortable. When a child "comes out" to their parents, even the parents have something to struggle with understanding. Johnson and Best found that in the case of parents of gay children, there were similar sets of difficulties in openly discussing their new reality; they self-censored, which illustrates courtesy stigma. The families are concerned with whom to share this new reality, how to tell them, and what to tell them. But as Johnson and Best point out, getting involved in a group such as Parents and Friends of Lesbians and Gays (PFLAG) opened doors for these parents to discuss effective ways to accept their shifting stance in life, to be able to share with others, and to be proud of their child.

The same could be said about joining in with an organization like AFSP that allows survivors to gather together and talk about suicide and loss, but also love and change. The families and friends who have lost someone to suicide are also aiming to shift their stance in life as they accept and learn from their loss. From this, we know what has drawn the members to involvement and seen some of the impact they feel they are having, but how did they actually get involved? What were their introductions to the group like?

### **Involvement**

For the most part, the seven board members I talked with were brought into the field through a community walk or an overnight walk. Introduction to involvement stems from talking with friends and colleagues who happen to be fellow survivors, reaching out on one's own to try and find out more information, and program outreach. This is all part of the stages of the moral career of stigmatized grievers; they connect with others like them as they adjust to shifts in their moral status and identity. For instance, Stephanie (Interview 3) lost her husband a few years back. As she was moving through her grief journey and starting to recover, a fellow survivor told her about AFSP and invited her to get involved. It was not long before she was enveloped in participation. Here, Stephanie discusses the speed with which she got involved:

\_\_\_\_\_ passed away in the end of May... and I did the DC Community walk that September. Um... A friend of mine, or actually a colleague, client had lost her cousin to suicide and suggested... introduced me to AFSP and suggested that I get in touch with them... Well I guess it was a month before that when I started to go to volunteer and that kind of thing, but then I went to the walk

She started volunteering before her first walk as a way to test the waters of the organization and it was not long before she delved in with full force. Stephanie moved around within different roles within months of her introduction to AFSP. This was a relatively quick turnover for board member participants, based on what the others have told me.

Sarah was one of the few who had heard about AFSP before she started to participate and was willing to make a connection due to her previous familial experience with suicide loss:

... before my son died, I heard about the Out of Darkness overnight on the radio... And I thought, maybe wait, I could do this for (her cousin) That's something I should do for (her cousin). And then when (her son) died, that's one of the first things that went through my head. Now would be the time to walk. And we signed up for it pretty close after (son) died. And the walk itself was in August of the following year, and (son) died in November, so that was what? Eight, nine months. Something like that. So it was at that period of time, it was fairly soon, 'cause not too many people, I don't know that anybody knew what AFSP was at that time

Despite the fact that AFSP as a whole organization was still new at the time of her loss, Sarah was ready to get involved from the start. She, like Angela (Interview 5), reached out on her own to the organization for more information and to participate. They acknowledged that it was time to do something to help them process their grief, thus taking it into their own hands.

Angela lost her son 2 years ago while he was in school at Yale University in his freshman year. The AFSP NCAC Survivor Outreach Program met with her and her family, which eventually led to their involvement with the organization:

So, AFSP came and they did a home visit. And it was Maggie and Christina. The "main" funeral home where we had the viewing, they

contacted us and asked if it would be okay to have some people from AFSP come visit us. I had actually called AFSP too because I went to the website, and they didn't call us. But the "main" called up and I think it was because a local chapter read about \_\_\_\_ and put it together and contacted us. It was really beneficial to us to meet them. ... So that was, I would say that was in the first week? The first week or two? ... It was relatively soon after we left \_\_\_\_\_. And they came over and they talked to (her remaining son and husband) me, my parents, my sister, and my nieces. So it was a big, we were all there in my front room, and um they just told us about their experiences and then answered a lot of our questions. It's been really helpful to me to talk to other mom's with similar losses...

As a public speaker and trainer professionally, Angela feels comfortable in front of a room of people. This spurred her involvement, as she was already going to speak with her son's high school after his passing:

I got asked to speak at my son's high school. At TJ. And then, in the course of getting ready to do that, they also asked if I would speak to the entire Fairfax County counselors and social workers and, you know, everybody. It was a big in service training. Massive. And this was all like fall, the time frame, and when I was there, it turned out that... We had kind of reached out also to AFSP for the, um, it was the International Survivor's of Suicide Day, which is what, the first... like the Sunday before Thanksgiving, or something like that? ... It's always the Saturday before Thanksgiving. So it was um... So we had reached out to Stephanie and were putting feelers out, and then at the same time I had been asked to speak at TJ and then at this other... And it turned out that AFSP was there and so I met Sam and Maggie and kind of got tucked in under the AFSP banner there. So that's how that happened. (Interview 5)

While Angela's case is interesting, from the group I interviewed, her story is unique. Everyone else began involvement through the community and overnight walks and then slowly began volunteering and taking on leadership roles. In comparison, Angela was given the opportunity to meet with the organization on a much more personal level, sharing her experience alongside members of the board before really starting to participate. They were there for her from the start as support during the initial grieving

process and gave her the crucial introduction she needed before truly stepping into any role.

It is obvious that introduction to AFSP is only part of the involvement process. So what happens next? Someone starts to participate in walks, but what else can they do if they feel passionate? If they are still passionate about the loss, they could become passionate about the cause and thus reach out to be involved. Generally, involvement is gradual and progresses in stages, following the pattern of loss, grief, and grief activism. This makes up their moral career. What began as a private matter transformed to something public. The following section looks at the kinds of involvement.

### **Kinds of Involvement**

All of the people I was able to interview were board members of the national capital area chapter for AFSP; membership roles require a high level of commitment to participation and thus involvement in the group. However, despite sharing a general role as board member, each person also had their own specific role with the board, leading to varying types of involvement. Some members have very involved roles within the organization and have a high level of investment in the overall cause. Others focus their energy on smaller aspects of the cause, such as being a part of a committee. Still others find ways to be active despite conflicting obligations through virtual participation. And others work in outreach to bring others into the circle of survivors.

Stephanie has the most senior role on the board; she is the chair of the chapter. Before taking on this role as chair, she had also been involved with the education committee as a volunteer and then chair. Though this is obviously a serious commitment

for her, something that is comparable to a full-time job, she continues to find ways to stay passionate about her involvement by acknowledging the need to negotiate commitments.

She explains her view on involvement:

I try to remind the board every board meeting that they are, have every right to step away if they need to step away, that there may be periods of time throughout the year for whatever reason that they can't engage themselves with us, for more than just other work related issues such as too much emotionally, that its too hard to be around all of us. And I do think that there are times when people decide that they've moved passed AFSP. Its not that they've forgotten about their loss or they've moved passed their loss, it's that they've just realized that this doesn't need to be the focal point of their life anymore. And I'm okay with that; I think that's actually fine. I believe that, you know, as much as I want to work with AFSP for the rest of my life through retirement, I'm also, I also acknowledge that that could possibly happen to me where I wake up one day and just realize that I have a different focus in my life and that this isn't it anymore. Um, I don't think that will happen but I'm open to that. Um... I guess my journey's been a little different because I have taken on a leadership role so fast, of which they were cautious about and they were concerned about. And now I understand, rightfully so, why they were because you start to look at this as a job and so I do have to check myself to remember that I have to get something from it too emotionally. That it, yes, it's a job, but I have to actually get something from it too

There is a clear concern for burnout from over-investment in the cause. Stephanie also acknowledges that burnout could happen to anyone, including herself, especially since she has one of the most demanding roles. This level of commitment (by having a role on the board) is time consuming and it does require balancing obligations. She clearly acknowledges the need for support that this organization can offer her and her fellow survivors through a more formal support network. What is more is that she encourages



the board to look at the organization in a similar way, trying to emphasize that while the work is important, it is voluntary and meant to be beneficial to them as well.

Other members I talked to aside from Stephanie also work closely with the education committee among other interests they have with the chapter's outreach. For example, after the loss of her teen son, Laura continues to demonstrate a strong desire to help educate and work with youth who may be going through depression, as suicide remains the third leading cause of death in youth between the ages of 10-24 (CDC 2010). In her case, educating the public has become her mission:

I think that I focus more on the youth. But when I do talk to people, I talk in general as far as helping them understand what people deal with depression because I think for me, I am more um, not tired, but I think I get a little... well not even upset. It's just I feel some people are not educated. Or they don't educate themselves about suicide. So when I hear those phrases, "Oh, they were looking for attention" or "they took the easy way out...", you know, all those little phrases are... I have to make it a point to stop that and help them understand what that individual may have been going through.

Laura's involvement enables her to have the ability to reach out to others in this way and to work on changing minds regarding depression and suicide; she personally focuses on protecting the youth and challenging conventional conceptions of why people choose to take their lives, which her role on the education committee opens for her. It is not uncommon for survivors to feel frustrated with the way that others understand suicide and how to cope with and react to those who are survivors. Survivors like her participate in education and outreach as their primary type of involvement. They are choosing to manage their loss through advocating change in the field of social understanding

regarding mental health and suicide, trying to break the stigma surrounding it and getting people to talk about it through awareness and education.

Sometimes participation is hard to accomplish with heavy workloads and varying schedules. Board members find ways to continue their participation and still have an active role despite their other obligations. Ashley in particular discusses how she has an active yet primarily virtual role in the chapter as a board member at large and the editor of the newsletter. In the case of the newsletter, she is able to maintain email communications with the other publicity committee members who help to write the contributing articles for the newsletter. She also strives to make an effort to make it to the meetings whenever she can, and definitely participates for phone meetings. Other than that, her schedule conflicts with the other needs of the organization, such as tabling events at health fairs and other events such as that which are primarily public roles. Virtual participation and involvement can still be active and opens doors for others to continue involvement as they balance their lives and commitments. This is a more behind the scenes kind of involvement as opposed to being the face of the movement, out in the public eye.

Sarah has a very different take on participation, especially as her loss is the farthest out from the others I interviewed (14 year ago). She is the Survivor Program Lead, which is responsible for the Survivor Outreach Program. Due to budget cuts for the county, she also runs a support group that is affiliated with AFSP, though it is not specifically a project of AFSP. She is additionally the person responsible for the memory quilt, which is composed of different blocks representing different lost loved ones, and

can be seen at various events throughout the year. Because of the amount of time she has had to cope with her loss and work through her grief, her role with survivor outreach is extremely fitting. Sarah is able to provide an almost mentoring role within the chapter, giving those who have more recently lost someone a positive example of a griever who has taken her grief into her own hands through active involvement in the cause.

The roles that the participants have taken on in the organization blend well with their personalities, talents, interests, and skills. For example, Grace has an interest in working with children as she used to be an elementary school teacher. She also has an interest in the LGBTQ community as she identifies as lesbian. Laura has focused on youth, primarily of high school age, as that was when her son took his life. Angela works as an orientation leader for the new volunteers with the organization and does a lot of speaking with AFSP, which parallels her actual job, which involves public speaking and training. Stephanie is a woman with a strong social network and a drive to do something important, making her role as chapter chair an appropriate fit. All of their background experiences shape their ability to fulfill their roles within the organization, which also allows for a stronger chapter and social network for other survivors to look towards. In the interest of the chapter, they take into account the interests and talents presented to them within the volunteers and board as they work to assign roles. Their background experiences also shape the meanings they take from the organization as well as their types of involvement.

The next section looks at how involvement has impacted their lives after their losses. This stems from the different experiences that they have had since getting

involved that encourage them to keep doing what they are doing. It also clearly suggests that the work they are doing is not only beneficial to others but also for themselves.

### **How has this helped?**

Participating with AFSP has allowed those who grieve to create new social relationships and bonds with those they may never have met before because of a shared situation in life, albeit a tragic one. These connections offer support that one may not necessarily get from a basic support group or therapy. The board and participants are doing something active together. This action-oriented work provides them with the sense of purpose and meaning that they are accomplishing something as they work through their grief. Like the parents in PFLAG that Johnson and Best studied, these members are reluctant activists in the realm of mental health awareness and suicide prevention; they too would more than likely not have been involved if it were not for their experiences with suicide (Johnson and Best, 2012). They also have the opportunity to feel moral solidarity with others who have had the same or similar experiences, emphasizing the fact that they are not alone.

Listening to the stories that the board members shared helps to understand how and why they feel successful in what they do. Each person shared at least one experience with me about events they participated in that left an impact on them. Here I have included two stories that I felt captured the sense of community and support available. They demonstrate how participation impacts the grieving process.

Their narratives offer insight on who they are and what they think about their new role in life. Chapter chair Stephanie talks of her first volunteering experience with AFSP:

One of the first events that I volunteered for, the NBC4 Health Fitness Expo, which we do every year, and it was the first what we call tabling event that I went to and I really had no idea what I was supposed to say and had idea of the statistics or anything and I felt completely out of my element but they had said to me “hey come because there’s lots of us that come and do this and so we’ll kind of show you the ropes.” And I kind of quickly felt comfortable having, you know, kind of understanding when to allow someone to come up to the table and speak or when they were uncomfortable with the whole thing, and would sort of just back away or would sort of linger near. And there was a gentleman who just lingered for a while picking up brochures and all that, and I said “if there’s anything I can answer or offer assistance with, please feel free to ask; I’m happy to answer.” And just opened up about a loss he had had for about 30 minutes where I had to finally take him around the table and we moved to the side and he really was engaged in sharing his story and that’s the first time that I really had someone really share their story in that kind of depth and not about the details of it, but again about the loss and how he felt and that was just incredibly, I think, even more than the walk that I first did, I think that was just... I felt like I really helped him. I felt like I did nothing but stand there and listen and yet I know that he walked away feeling better than he had beforehand and that was what really what made me decide that that is what my mission was, that if I could help one person in the slightest way by just being there and being of comfort, that was it. That’s all I needed to do.

Dransart (2013) mentions that narration is fundamental to the meaning making process; this allows them to find understanding of their situation, which is why Dransart, too, utilized interviewing techniques to gain in-depth information (319). She defines meaning making as both an interactive and a relational process that pulls from resources both social and personal (319). Allowing fellow survivors the opportunity to share their stories and talk through their memories provides that chance to start the process towards healing. Stephanie had created that space for the man at the health expo within her own set of first experiences.

Grace shares about how her friend’s family embraced the involvement with her and the willingness to include others:

So I wasn't going to do the overnight again this year; I feel like I don't want to be a drain on my friends by fundraising time after time, but my friend has three kids that are 11, 10 and 6 and, um, I used to be a teacher and when I left teaching, they, um, I gave them a bunch of my books. I taught fourth grade, bought a whole bunch of kids books, and then some were my brother's and so they said Jason in the front, so when the kids got a hold of it, they said, oh Miss Grace, who's \_\_\_\_\_? And their mom, who is very honest and truthful said well Miss Grace had a brother... I never met him... Oh well he died by suicide. And they start having a conversation about suicide and depression and getting help, I mean connecting with a trusted adult and all these things, sort of brings up this conversation, and they were like we want to walk with Miss Grace, so they come to the community walk and then again in Philadelphia they met us, like this big event for them this summer to go to sleep, get up at 11 pm and then meet us in the middle of the night somewhere. So they walked for like a mile with us and just... It's a reason to have those conversations and, you know, when we're there, we're just hugs and walking and talking and chatting to kids and whatever, and then my friend afterwards, like in the car there and on the way home the reason, just having them up gives us the reason to have this conversation without someone having to die for us to have that conversation. And for that, it gives me goose bumps right now, I feel like that's of such value in addition to what I get from healing and the people I've met and sort of, but really nice the people I've sort of met along the way. I met a woman last year walking at the walk, and then we walked again together this year, and just a couple of my friends, and this woman walking next to us and seemed alone and we grabbed her and brought her into our group and told her you're walking with us. She was like a young Navy girl and we're like, in you go, and there were the five of us, so I think there's this sort of amazing, comforting, accepting community, you know, and in some ways even if people are conservative social or religious beliefs, it's much easier to put them aside when you have this shared trauma, you know, kind of like whoever you are, whatever you are, I can empathize, well not empathize... That's probably not the right sociological word, but... I feel you.

In both stories, the board members talk of connecting with others, of including them, and even just being there for them to talk and share what is on their hearts and minds. The ability to be a part of something like that is very gratifying for them and it serves as a constant reminder that they are not alone in their grief and that they can do something to help others. This utilization of advocacy groups and networks is key to

understanding this active grieving that some survivors of suicide strive for as they learn to manage their grief.

This emphasis and utilization of advocacy networks is key to understanding grief management. With this in mind, the next chapter will be focusing on grief management through advocacy. The focus derives from the support that the board members give and receive within the organization and how this benefits them and others during the long and difficult road ahead. Advocacy groups are different than average support and offer alternative opportunities for the bereaved, which will be explored in the next chapter.

## **CHAPTER FIVE: GRIEF MANAGEMENT THROUGH ADVOCACY**

In regards to loss in general, informal support from family and friends is a key part of the grieving process and moving forward after the loss. However, the loss of a loved one through suicide brings a significant loss of support for the bereaved, or at least what feels like a significant loss. Some have lost spouses, siblings, and even children, people who are usually part of their main support system. Friends can start to turn away, to say things that are cliché and thus don't feel genuine, or they just don't know what to say or do to comfort the grieving. When it comes to bereavement, the lay public tends to lack the necessary knowledge for supporting the bereaved without having experienced a similar loss. Counseling can help, but support groups and similar resources seem to be the most beneficial way to find support outside of the family and friends.

As Johnson and Best (2012) and Dransart (2013) both point out, advocacy can play a major role in support and management of grief. Johnson and Best focus on a specific advocacy group (PFLAG) that is a support network for straight parents and friends whose children have come out. The network offers others who have had shared experiences and have come to terms with their situation and thus can serve as resources for the newer parents. Dransart looked at suicide survivors in general that she divided into four types of groups, with the "commitment type" being the most prevalent group of suicide survivors. Both articles tie well with what I have seen in my own research thus



far. This chapter focuses on the different aspects of grief management, emphasizing support, meaning and memory making, and advocacy as significant in this process.

### **Support Networks**

One thing that seemed to continue to pop up as I reviewed interviews and fieldnotes is the importance of developing survivor networking as a means to manage this kind of traumatic and stigmatizing loss. These networks are comprised principally of those new to grief and seasoned grievers. Ashley mentioned the idea of a mentoring relationship between survivors where there are those who are further along (in that their loss happened multiple years ago, “seasoned grievers”) offer support and guidance for those that are more recently bereaved. This is a fundamental part of the survivor outreach program, which has already briefly been discussed by some of the board members in the previous chapter. Angela offered a brief explanation of immediate survivor support after the loss of her son 2 years ago: two women who also lost sons at a similar age to her own came to her house to talk with her and her family about suicide, mental health, loss, and experiences for everyone involved. This triage was extremely helpful for her and she has formal, deep connections with those women following this, and has personally continued to contact others with similar losses for the purposes of gaining and giving support.

Support groups can be very useful resources. Because Grace’s loss occurred just a few weeks after 9/11, she was unable to join any support groups for bereavement that would be beneficial to her; all were focused on that specific tragedy. Her belief is that a support group focused on suicide loss would have been beneficial for her if there had been one available. She says, “I could see how powerful, I can imagine how powerful

that would have been.” Instead her grieving process was a bit delayed and did not really blossom until she started to work with AFSP. Sharing her loss in a support network of other participants was important to her recovery, as her family did not talk about the loss. Grace came to this conclusion through training how to facilitate child support groups for children who have lost someone to suicide, which she felt confident in as a former elementary school teacher. However, this does not mean that she lacked support during her grieving process, only that she was unable to partake of a group environment where collective grief was expressed.

### **Barriers to Support**

Perhaps one of the most difficult aspects of support in this situation is the fact that while there may be resources available, people are not necessarily aware of them. Christina (Interview 7) is a social worker and she mentioned that she knows of different resources now that she didn't know about prior to her loss, which she feels was her own fault; she should have known about them for her clients. Even at the first Out of the Darkness Community Walk (Rockville—Fieldnote 1) I attended as part of my research, a leading suicidologist talked about how at a conference he attended, the clinicians admitted to not being well trained in risk assessment and prevention in a way that would be successful, which could also imply that they aren't as prepared to deal with and support those that have lost someone to suicide due to similarities (acknowledging research that suicide loss can lead to suicide).

Many of the participants identified problems with the resources that are available in addition to the absence of resources that should be available to the newly bereaved. For

instance, Sarah discussed problems with the lack of support groups available still, and also cited that psychiatrists need to be better trained. She also focused on the need for sensitivity training amongst first responders for civilians and military. Sarah shares her thoughts:

I think we need more counselors that get it, that understand... And we need support groups. We need support groups for children, for teens, for specific support. From what I hear from siblings, its great what they go through now. But there is a difference between the loss of a child and the loss of your brother or sister. I've heard a lot of people say they would like to have a sibling support group. Um, in general we just need to get the word out that there are outreach programs out there, which we are trying to do. Um, the stigma with it has a lot to do with people reaching out for it I think

Sarah's concerns with the insufficiency of resources and support were shared among others. Laura mentioned how faculty and staff from various schools she has spoken with don't know about resources that are available to discuss mental health and suicide prevention with students. The school systems do not reach out, though educational prevention resources are free. In Fairfax County alone, between four to seven youth take their lives a year. Even while the numbers are relatively low, any number of losses is considered high, and this demonstrates a need for intervention. However, schools do not necessarily reach out to find the programs that would properly address mental health care and suicide prevention, both of which are needed in high schools (Anon 2013). Laura also expressed concern with lack of church involvement in grief management and support in cases of suicide by having stronger programs to engage the members and care for them beyond the funeral stage. Even Grace, who admits to not

having strong religious inclinations, acknowledged that churches/religious groups would and could be more useful support for the bereaved.

Despite all of this, there are resources available, at least for suicide prevention, which AFSP has had advertised at walks and events as well as on their website. They also provide links to places that offer survivor support, such as Haven of Northern Virginia and The Wendt Center, which offer support groups and group therapy designed specifically for suicide loss. AFSP is a link in itself to other resources, making it an important communication channel for survivors. Due to the fact that the county-run program was cut because of budget declines, Sarah had started her own survivor support group for the Fairfax and Northern Virginia area.

Some people have found support groups and group therapy helpful. Others have felt discouraged by the others that are at support groups. These people have been trying to deal with their loss for a long time, but in seemingly unhealthy ways. Dransart addresses these “unhealthy” grievers as her “vulnerability type,” which she describes as those who could find no meaning in the suicide loss of their loved one, focusing on the pain and emptiness of the loss (329). These people may have sought help and support in others and could still make no sense out of their situation, finding no peace. In this specific situation, the vulnerability type is being contrasted with the primarily “commitment type” found in AFSP board members—those who chose to honor the memory of their loved one through continuing to live their lives and to serve others, especially through causes such as suicide prevention (329). None of the board members I interviewed wanted to be that vulnerable and broken, instead wishing to continue living through their darkest time.

Many spoke of the need for specified support within suicide survivor support, naming the specific type of loss as the connecting factor (sibling, son, parent, extended family, etc.). This comes from the feeling that those who share the specific style of loss “get it” and understand what it feels like as you learn to cope with the loss and start to try and heal, for each type of loss brings the bereaved into a different kind of grief. One of the best examples of forged societal bonds based on shared experiences, aside from the connection that Angela and Christina shared from the initial survivor postvention (as Christina was one of the survivors who visited Angela and her family), is that of a discussion at the ISOS Day 2013 event between two mothers that lost their sons; they shared similar experiences when it came to the pain and the energy required to keep moving and to attend any kind of event. This excerpt explains the process by which the women connected:

Maria asks him (Mr. D, a man suffering from depression) how he is able to take that step past his anger. Her feelings are starting to show a little more; she sounds upset, angry, frustrated. Maria mentions that her son had passed in June, and that her husband and second son are coping differently than she is. It was hard enough for her to come today to the event, and it has been hard to go to almost anything and everything, whether or not you RSVP'd or you have an “actual” excuse other than “I just don't feel up to it” ... Rachel tells her that it is the same for her. The one-year anniversary for her son's death is approaching in December, and she has been finding it really hard to be here right now. Both mothers seem to understand each other (Fieldnote 5)

So, while each individual grieves differently, a shared loss is a shared experience, which allows for support and understanding from others in the group. The mothers mirror each other in experiences, showing them that their experiences with this loss are shared and understood by others.

Each of the interviews point to the need for better coordination of resources. Better trained facilitators as well as other professionals are needed for survivor response and support and to connect the dots between institutions that have the capacity to provide support. What would be even more beneficial, but harder to accomplish, would be a long scale shift in how we deal with grief at a societal level. Because people tend to avoid talking about grief and bereavement, they never have fewer resources at their disposal that teach them how to cope with or respond to their own grief and the grief of those around them. As Stephanie opines, we see death all over the news but no one ever talks about the rest of it. Groups like AFSP help to make grief support a priority seeing this as a main goal alongside prevention.

### **Meaning Making and Memory Making**

In her article on meaning making, Dransart (2013) suggests how engaging in memory making can be beneficial to the grieving process. Memory recall is a way to connect with the deceased after tragic loss. This allows suicide survivors to create a counter-narrative that pushes aside the general societal narrative of suicide for others to respond to socially as they are redefining their loss and learning to make sense out of what has happened (328). Usually, the narrative of suicide focuses on the deviance of the death itself, negative connotations around the deceased person, and an emphasis on the character of the family. The bereaved are working to adjust the narrative to reflect a more positive memory of their lost loved one. We can see the importance of memory making and meaning making when looking at some of the activities at different events as well as some of the work that different interviewees have undertaken on their own.

From the different events I attended, I observed a range of rituals and gestures surrounding memory making and commemorating the deceased while also focusing on prevention. When I participated in the Rockville Out of the Darkness Community Walk 2013 (Fieldnote 1), I noticed that there were shoes that lined the front of the stage. On closer inspection, I saw that people had placed pictures of loved ones with them or notes or both. It was as if they were bringing their loved one with them on this walk by having this simple possession present. At the DC Out of the Darkness Community Walk 2013 (Fieldnotes 2 & 3), there were a lot more memory activities. Local artists had been brought in to paint a “Loved Ones Lost” mural that depicted small portraits of different family and friends that had died by suicide. The children were encouraged to participate in activities such as making memory bracelets where they were to share beads with each other along with a story about why they were there. Half-way through the walk, we could collect electronic tea-lights to carry with us back to the main stage area, which provided a luminescent glow with the setting sun as more and more people contributed candles to honor of someone they had lost. These objects serve as surrogates for the lost loved one, and also serve as reminders about that person.

Sarah told me that she is responsible for the creation of the “memory quilt” that can be seen at various events. The memory quilt is a central commemorative object at the walks. This quilt has blocks depicting photos and information, such as dates of birth and death, as well as epitaphs. The other visuals that were present were those of the team shirts that different walk teams wore which bore similar information and imagery. These

simple shirts become walking memorials, publicly displaying and commemorating the loved one.

Perhaps the most poignant examples of memory making and holding on to a loved one comes from two different women who had their own way of connecting to their loved one and were willing to share this with me. Angela spoke to me of how she carries her son's senior photo with her whenever she goes somewhere. She used to talk to him at night, and she wrote letters to him expressing how she felt regarding losing him and what he was missing. In a much simpler fashion, Millie, who I met at the International Survivors of Suicide Day (ISOS) 2013, carries her partner's old sketchbook that has pictures she drew and painted as well as photographs she took (Fieldnote 6). Again, these objects serve as a sort of surrogate for the lost loved one. In either case, the point behind such gestures and actions is to keep the memory alive, both publicly and privately. While Angela and Millie both shared their possessions with me, the objects served primarily a private function of personal memory making. However, other memory making took on a decidedly public role that is central to building a movement and advocating for change.

All of these examples draw on the fact that bereaved people do not want to forget their loved one. The strongest way to keep them alive in one's thoughts is to have something visibly present that was theirs or to wear something in memory of them. This use of memory works to persuade and compel others to care. Memories become public objects.



## **Advocacy**

At my introduction to the field, prior to the research actually starting, there was a woman at a walk that had a table set up. She was passing out rubber bracelets that said “Decriminalize Suicide” and was asking people to contact the state’s representatives to let our opinion on the matter known. In front of the table she had a photo of her daughter with prison bars super-imposed over her face and then a red line through the whole picture. She was making it clear that in Virginia, someone who dies by suicide is considered a criminal, as suicide is a criminal offense.

People such as this woman are angered by the stigma that comes with suicide, so they construct a counter-narrative for others to respond accordingly. They do not want the memory of their loved one tarnished based on this one act, and the counter-narrative allows them to reconstruct that image of the deceased by upholding their reputation. As Dransart points out

Survivors engaged in memory-making, not only to fulfill their own need to honour the life of the loved one, but also as a way of defining a framework and providing hints and clues to others as to how to interpret the suicidal event. This allowed for reputations to be preserved and for the presentation of an acceptable social image and a public storyline about the person who died (326)

This emphasizes the public grief instead of private grief in how we as a society are expected to grieve, especially in a tragedy. In order to maintain a positive public image and reputation for their loved ones and themselves, the bereaved reposition their private grief in the public sphere. We, as non-grievers seek cues from the bereaved on how they want to be treated and how we should approach them and the loss. Perhaps the easiest

way to learn how to construct and utilize these social cues comes from participation in groups such as AFSP, which focus on advocacy.

Even though the emphasis of their advocacy can vary, different advocacy groups share similar characteristics. The “radical normals” that Johnson and Best (2012) discuss in their article of the same name are comparable to the “grief activists” I worked with as part of this study. Radical normals, or reluctant activists, are those that remain “deeply committed to a conventional life trajectory as middle-class parents,” (337). These straight parents are rooted in their traditional beliefs and expectations for their lives and the lives of their children; they want their family to be considered “normal” and to be accepted by society. Despite their strong commitment, these parents still make an effort to become active in the advocacy group as a form of support for their child and for themselves. The same could be said for the family members, mostly women, of those who have died by suicide who step into roles with AFSP and assume public identity. Public expectations with how they are supposed to be reacting and grieving can be intense and add strain to something very private. These people are trying to redefine their new situation in life.

Public acknowledgement is mostly developed through the advocacy efforts of the group participants of PFLAG and AFSP. Participants have chosen to make their personal and very private experiences public in an effort to reach others and change minds. They have brought what would be relegated to the realm of the private to the foreground and in this they engage civically. For PFLAG parents, much like the action that their child makes, the parent is forced to “come out”. We can draw parallels between “coming out” for parents to public displays of grief in which these participants of AFSP engage. For

AFSP, the same sort of event occurs where the individual shares that they lost someone to suicide in the public sphere of civic action. In both cases, the families have utilized advocacy groups as their own way of seeking an outlet for their grief and their love, and in the process catalyze social change.

Advocacy groups such as PFLAG and AFSP allow spaces for families and friends to progress through their moral careers. From the interviews I have conducted, the board members assume a public role as they manage their private grief. They are shifting within their moral career. As Goffman points out, there are different patterns to a moral career for the stigmatized, or in the case of this research, someone possessing a courtesy stigma. For those adjusting to the changing circumstances in their lives, groups like AFSP create a haven for the stigmatized and provide a network of social support of others like them. Christina refers to this in her interview when she mentions that every time she comes to an AFSP event of any kind, she feels like she is “with my people.” The support from others like them enables them to construct new narratives of self and situation.

Even with this newfound support from others like them, there are still challenges to the newly bereaved face. Their advocacy does not solve all of their problems. Interacting with those who are not part of their close circle of family and friends can be a bit uncertain. The bereaved are still learning to cope with these uncertainties as they start to engage in social activities again. There is uncertainty in how others will react to knowledge of the loss. A few of the women I interviewed mentioned hesitation when they had the opportunity to share about their loss, even if it was something as simple as saying that their loved one had passed. Ashley felt that she was placing a burden on the

other person because it is such a heavy, emotional weight to bear. Again, this is comparable to the situational and interactional uncertainties expressed by Johnson and Best when discussing the hesitations that parents had when sharing this newfound information about their child with others, whether they be other family members, coworkers, or people in a club with them. However, in the safe space of the meetings, the PFLAG parents could talk about their experiences and share insight into how best to approach situations. Much like in PFLAG, AFSP does not push the members to share if they do not want to, but they encourage them to talk about it as a learning process. The members offer each other support and advice.

The connections that people make with each other are what make the organizations stronger, enabling them to work towards their goals. Without some of these networks and the support that they offer, people would still be trying to muddle through their situations alone. Sarah mentioned that her husband often says that he doesn't know where they would be without AFSP. The organization gives them support and honors their loss, providing an outlet for action.

After a traumatic loss like suicide, the bereaved need support and outlets for their grief. Finding advocacy groups such as AFSP provides space for those who need to "do something" as they feel hopeless and lacking. They can participate as little or as much as they want, and still receive the formal support they need through their ties to others in their situation that are also choosing a more action-based approach to managing their grief. With this support and their advocacy work through advocating for better mental health care and suicide prevention, the bereaved are better able to manage their grief.

## CHAPTER SIX: CONCLUSIONS

*I don't want to stifle it. I would rather tell people the truth about what happened so that hopefully, um, there can be some learning from it, or maybe we can help someone else with a cautionary story about death – Ashley, Interview 4*

*I've always felt that there's, kind of like I said a few times, like there was nothing I could do, there was no good that can come out of it and like in some way there's, because I've had this terrible experience, maybe, just maybe one person doesn't then that's worth it. And that feeling, just to even make that possible, to set up the conditions for that to be possible, um, for there to be an environment where someone, you know, says my mom committed suicide and I've never really told anybody about it... -- Grace, Interview 6*

*And I think, for people, it's not for everyone, but I've encouraged a lot of people to get involved with AFSP when they've had a loss just because you are surrounded by like-minded people who care. And you find out that you can actually hang out with a bunch of people who deal with depression, who have maybe attempted suicide, people who are survivors of someone else who... You know, the community. And you can actually sit together and laugh. You know, have a glass of wine and laugh together. And I never thought that would be possible. Um... But, you know, that's... And that part of it is when you're around people like that, you see them being functional. – Angela, Interview 5*

The focus of this thesis has been on the effect of participating in advocacy groups on grief management for those who have lost someone to suicide. My main questions were: How do survivors of suicide deal with the trauma of their loss? The board members I interviewed experienced significant and encompassing participation. How does their activity to bring awareness of suicide to the public combined with the mutual support the organization provides impact their grieving process? This research aimed to understand

the social dimensions of suicide by examining the post-suicide phenomena of grieving for a group who sought to transform their private grief into a public good to be used for positive social change.

I interviewed seven members of the AFSP NCAC board about their experiences with AFSP and outside of the organization from the time of their loss. I also participated in various events held by AFSP throughout the fall of 2013 and spring 2014. I identified emergent themes in support received, both informal or formal, as well as the impact of action-oriented grieving practices. The combination of formal support and an action-based organization proved to be a successful set of grief management tools for those I interviewed as they were able to meet and connect with others like them who shared similar losses, and, at the same time they were working towards a common goal of preventing more suicides and breaking the silence and stigma surrounding mental illness.

As the literature shows, interacting with others in similar situations allows the bereaved to learn from them and to gain the confidence they need to rebuild and redefine their lives after the loss (Dransart 2013; Johnson and Best 2012; Cable 1996; Stillion 1996). Ashley referred to this relationship as comparable to a mentorship. Angela reached out to many people within and outside of AFSP who shared similar losses as part of her healing process to learn about how others coped with the situation. With that kind of support, seeing other functional survivors encouraged the bereaved to keep moving.

Deep involvement, at least in the case of the board members that I interviewed who became involved, provided a community of others coping with stigmatized grief

enabling the bereaved to feel safe. For most their involvement was gradual and progressed in stages. In this way, we can treat their progression from loss, through grief, to becoming grief activists as a moral career. What began as a private matter transformed to something public. However, involvement can stem from earlier introduction, such as through the suicide postvention process, which Angela experienced within a week of her loss. As part of the Survivor Outreach Program that AFSP offers, survivors who have experienced a similar loss and have gone through training are invited to the home of those who have recently lost someone to suicide to discuss suicide loss and grieving. Part of the reason that people feel the need to get involved comes from their feeling like there is nothing that they can do, nothing that they can control at the moment. Becoming part of an advocacy group or attending a walk for suicide prevention, the bereaved report feeling like they have finally found something that they can actually do.

Based on the interviews I conducted and the events I participated in, I feel that this thesis contributes important information for the study of grief management post-trauma. There is still more that could be done. My research was limited by the small sample size of willing participants. It is noteworthy that a majority of the board members that were willing to participate were women. A potential area of inquiry would be to examine the role gender plays in involvement. A larger selection of board members, which would include males as well as females who have lost someone, is needed, as well as a cross-section of those who only participate in events and do not hold some kind of role on the board. Due to time constraints, that was not possible for this particular study. Other research would benefit from comparing alternative forms of formal support, such

as group therapy or support groups, to the types of participants this study examines. The hope is to continue the conversation as a way to benefit survivors by offering knowledge of resources available for them.



## APPENDIX A

### RECRUITMENT EMAIL

SUBJECT > Managing Complicated Grief: An Ethnographic Study of the American Foundation for Suicide Prevention National Capital Area Chapter

Dear AFSP Participant,

I am a graduate student in the Sociology department at George Mason University and am working on my Masters thesis. I have been studying issues regarding grief and grief management. I am looking for adults (ages 18+) who would like to participate in a brief interview that should last no longer than one hour. Questions will relate to experiences with AFSP events and their personal grieving process so far, what has worked for them and what hasn't. Multiple members of a family may participate, but I ask that they participate separately, as each individual has their own experiences to share.

If you are willing to be interviewed for this, please email me at [amarcus@masonlive.gmu.edu](mailto:amarcus@masonlive.gmu.edu) so that we may schedule a time and place to meet at your convenience. Also, please email me if you have any questions regarding the project.

If you have any concerns about me, I have attached my resume to this email detailing my experiences.

I hope to hear from you soon.

Sincerely,

Amanda Marcus  
Sociology Masters Student  
Department of Sociology and Anthropology  
George Mason University  
[amarcus@masonlive.gmu.edu](mailto:amarcus@masonlive.gmu.edu)  
(757) 746-3656

## APPENDIX B

*Managing Complicated Grief: An Ethnographic Study of the American Foundation for Suicide Prevention National Capital Area Chapter*

Researcher: Amanda Marcus

### INTERVIEW PROTOCOL

#### Intro:

My name is Amanda Marcus and I am a graduate student in the Sociology department at George Mason University. I am interviewing you today about your experiences with the American Foundation for Suicide Prevention and your grieving process post-trauma. As a reminder, you have the right to stop this interview at any time if you are uncomfortable, and you do not have to answer any question you would prefer not to answer. This interview is being recorded and will be transcribed by me, though no identifying information will be attached to the interview. I am the only one who has access to this interview and it will be destroyed once I have completed my thesis.

Do you have any questions for me before we get started?

#### Questions:

How long ago was your loss?

What are some of the reactions you have received in reaction to knowledge of your loss?

Tell me about your experience with your extended family, close friends, and neighbors after your loss.

How has this impacted your grieving process?

Can you remember a time where you hesitated telling someone about your loss? Can you explain?

How do you feel when you talk to strangers about your loss?

How do you feel when you talk to your family about your loss?

How soon after your loss were you introduced to AFSP? Can you tell me more about this?

When did you first get involved with AFSP? Why?

How many events have you participated in?

What role have you had, if any? (Examples include but are not limited to: participant, volunteer, staff, walk lead, speaker, board member, etc.)

Would you consider yourself an active participant in AFSP? Why or why not?

Can you tell me more about your participation with AFSP? (E.g.: specific experiences or memories from events, any kind of emotional reaction you may have had during an event, etc.)

Have you found other means of support outside of AFSP? (E.g.: other organizations, support groups)

(If yes): Please tell me more about this.

How do your experiences differ, if they do?

How has the support you have received impacted your grieving process?

What are some of your thoughts regarding grieving practices available to those who have lost someone tragically?

Are they sufficient?

Do you think they should be different? How?

Do you have any last comments that you wish to share?

Conclusion/Debriefing:

Thank you, again, for participating in this interview. If you have any more questions or need to talk more, please feel free to email me ([amarcus@masonlive.gmu.edu](mailto:amarcus@masonlive.gmu.edu)) or call me at (757) 746-3656.

## REFERENCES

- Agerbo, Esben. 2005. "Midlife Suicide Risk, Partner's Psychiatric Illness, Spouse and Child Bereavement by Suicide or Other Modes of Death: A Gender Specific Study." *Journal of Epidemiology and Community Health (1979-)* 59(5):407–12.
- Aneshensel, Carol S., Amanda L. Botticello, and Noriko Yamamoto-Mitani. 2004. "When Caregiving Ends: The Course of Depressive Symptoms after Bereavement." *Journal of Health and Social Behavior* 45(4):422–40.
- Anon. 2010. "10 Leading Causes of Death by Age Group, United States- 2010." Retrieved November 3, 2014 ([http://www.cdc.gov/injury/wisqars/pdf/10lcid\\_all\\_deaths\\_by\\_age\\_group\\_2010-a.pdf](http://www.cdc.gov/injury/wisqars/pdf/10lcid_all_deaths_by_age_group_2010-a.pdf)).
- Anon. 2013. "Suicide in Fairfax County: A Report to the County Board of Supervisors." Retrieved November 4, 2014 (<http://www.fairfaxcounty.gov/living/healthhuman/reports/suicide-in-fairfax-county.pdf>).
- Anon. n.d. "Mission and History." *American Foundation for Suicide Prevention*. Retrieved December 2, 2013 (<http://2007www.afsp.org/about-afsp/mission-and-history>).
- Danigelis, Nick, and Whitney Pope. 1979. "Durkheim's Theory of Suicide as Applied to the Family: A Empirical Test." *Social Forces* 57(4):1081–1106.
- Doka, Kenneth J., ed. 1996. *Living with Grief After Sudden Loss: Suicide, Homicide, Accident, Heart Attack, Stroke*. Bristol, PA: Taylor & Francis.
- ... Cable, Dana G. 1996. "Grief Counseling for Survivors of Traumatic Loss." Pp. 117–26 in *Living with Grief After Sudden Loss: Suicide, Homicide, Accident, Heart Attack, Stroke*, edited by Kenneth J. Doka. Bristol, PA: Taylor & Francis.
- ...Stillion, Judith M. 1996. "Survivors of Suicide." Pp. 41–51 in *Living with Grief After Sudden Loss: Suicide, Homicide, Accident, Heart Attack, Stroke*, edited by Kenneth J. Doka. Bristol, PA: Taylor & Francis.

- Doka, Kenneth J., and Joyce D. Davidson, eds. 1998. *Living with Grief: Who We Are, How We Grieve*. Washington, DC: Hospice Foundation of America.
- ... Cable, Dana G. 1998. "Grief in the American Culture." Pp. 61–70 in *Living with Grief: Who We Are, How We Grieve*, edited by Kenneth J. Doka and Joyce D. Davidson. Washington, DC: Hospice Foundation of America.
- Dransart, Dolores Angela Castelli. 2013. "From Sense-Making to Meaning-Making: Understanding and Supporting Survivors of Suicide." *The British Journal of Social Work* 43(2):317–35.
- Durkheim, Emile. 1979. *Suicide: A Study in Sociology*. edited by George Smith. New York, NY: The Free Press.
- Fowlkes, Martha R. 1990. "The Social Regulation of Grief." *Sociological Forum* 5(4):635–52.
- Ginsburg, G. P. 1971. "Public Conceptions and Attitudes About Suicide." *Journal of Health and Social Behavior* 12(3):200–207.
- Goffman, Erving. 1959. "The Moral Career of the Mental Patient." *Psychiatry: Journal for the Study of Interpersonal Processes* 22:123–42.
- Goffman, Erving. 1986. *Stigma: Notes on the Management of Spoiled Identity*. First Touchstone Edition. New York, New York: Touchstone: Simon & Schuster, Inc.
- Groot, Marieke de et al. 2007. "Cognitive Behaviour Therapy to Prevent Complicated Grief Among Relatives and Spouses Bereaved by Suicide: Cluster Randomised Controlled Trial." *BMJ: British Medical Journal* 334(7601):994–96.
- Hawton, Keith. 2007. "Complicated Grief after Bereavement." *BMJ: British Medical Journal* 334(7601):962–63.
- Hawton, Keith, and Sue Simkin. 2003. "Helping People Bereaved By Suicide: Their Needs May Require Special Attention." *BMJ: British Medical Journal* 327(7408):177–78.
- Herman, Nancy J., and Larry T. Reynolds. 1992. "Family Caregivers of the Mentally Ill: Negative and Positive Adaptive Responses." *Michigan Sociological Review* (6):28–41.
- Hughes, Marylou. 1995. *Bereavement Support: Healing in a Group Environment*. Washington, DC: Taylor & Francis.

- Johnson, J. L., and Amy L. Best. 2012. "Radical Normals: The Moral Career of Straight Parents as Public Advocates for Their Gay Children." *Symbolic Interaction* 35(3):321–39.
- Kastenbaum, Robert. 1986. *Death, Society, and Human Experience*. 3rd ed. Columbus: C.E. Merrill Pub. Co.
- Lemert, Edwin M. 1972. *Human Deviance, Social Problems, and Social Control*. 2d ed. Englewood Cliffs, N.J: Prentice-Hall.
- Link, Bruce G., Francis T. Cullen, Elmer Struening, Patrick E. Shrout, and Bruce P. Dohrenwend. 1989. "A Modified Labeling Theory Approach to Mental Disorders: An Empirical Assessment." *American Sociological Review* 54(3):400–423.
- Maimon, David, and Danielle C. Kuhl. 2008. "Social Control and Youth Suicidality: Situating Durkheim's Ideas in a Multilevel Framework." *American Sociological Review* 73(6):921–43.
- Markowitz, Fred E. 1998. "The Effects of Stigma on the Psychological Well-Being and Life Satisfaction of Persons with Mental Illness." *Journal of Health and Social Behavior* 39(4):335–47.
- Martin, Jack K., Bernice A. Pescosolido, Sigrun Olafsdottir, and Jane D. McLeod. 2007. "The Construction of Fear: Americans' Preferences for Social Distance from Children and Adolescents with Mental Health Problems." *Journal of Health and Social Behavior* 48(1):50–67.
- McHorney, Colleen A., and Vincent Mor. 1988. "Predictors of Bereavement Depression and Its Health Services Consequences." *Medical Care* 26(9):882–93.
- Scheff, Thomas J. 1966. *Being Mentally Ill: a Sociological Theory*. Chicago: Aldine Pub. Co.
- Scheff, T. J. 1974. "The Labelling Theory of Mental Illness." *American Sociological Review* 39(3):444–52.
- Tausig, Mark, and Dr. Aliza Kolker Collection. 1999. *A Sociology of Mental Illness*. Upper Saddle River, N.J: Prentice Hall.

## **BIOGRAPHY**

Amanda Marcus graduated from Manhattan High School, Manhattan, Kansas, in 2008. She received her Bachelor of Arts in Sociology and Spanish from Hollins University in 2012. She received her Master of Arts in Sociology from George Mason University in 2014.