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# Changing the Legacy of Suicide

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In the United States, despite the increase in knowledge about suicide, the rate of suicide has remained virtually unchanged for the past 30 years. The members of the American Association of Suicidology (AAS) are uniquely qualified to determine what, if anything, can be done to reduce the rate of suicide. The restructuring of the association has produced the potential for cross-divisional collaboration, and yet conventional membership boundaries have resulted in unrealized opportunities to impact the rate of suicide. Dr. Edwin Shneidman, stated in Albert Cain's 1972 landmark book *Survivors of Suicide* that "postvention is prevention for the next generation" (p. x). The ability to design, implement, and study an effective model of postvention is within the considerable talents of our membership; however, doing so will require the commitment and flexibility of the entire association. By making postvention collaboration a goal of the association we can bring a national focus on suicide that could change the legacy of suicide.

*We shall not cease from exploration  
And the end of all our exploring  
Will be to arrive where we started  
And know the place for the first time.*

T.S. Eliot, *Four Quartets*

The 30th Annual Conference of the American Association of Suicidology (AAS) had as its theme the legacy of suicide. The legacy I discuss in this article involves our society's and the AAS's response to survivors through postvention and survivor support services. I present a model that is consistent with AAS's goals of cross-divisional collaboration, one that can be implemented in any community with the cooperation and leadership of the members of the AAS. If an association-endorsed model of community postvention response can be formulated, implemented, and found to be effective through rigorous research, then the AAS can provide a blueprint to change the legacy of suicide for survivors of all ages.

Our founding President, Dr. Edwin Shneidman, in the foreword to Albert C. Cain's (1972) *Survivors of Suicide*, stated that "postvention is prevention for the

next generation" (p. x). Shneidman added "postvention" to the existing concepts of prevention and intervention, yet, like many of the terms he coined, postvention is not a household word or even a well-known term among mental health providers. Its definition requires explanation and action. The action involves being with those who have been impacted by the most stigmatizing cause of death known to our society. This group has been named survivors, a term that often confuses the general public and the survivors themselves, as noted in this passage from *Suicide and Its Aftermath* (Dunne, Dunne-Maxim, & McIntosh, 1987):

In other circumstances, "surviving" implies that the individual has undergone some life-threatening ordeal and emerged from it more or less physically intact. Following such an ordeal the "survivor" experiences a burst of life-affirming energy, a sense that the odds are in his or her favor. But we suicide "survivors" did not feel that sense of relief and energy, nor did we feel that our own lives were no longer in jeopardy. Indeed, some of us felt that we had been touched by death in a unique way, in a way that threatened our lives by making suicide a readily available option to us when presented with difficult situations" (pp. xxii-xiii).

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Since 1986, I have had the privilege of working with survivors and watching them climb out of canyons of pain in order to stand on mountaintops, forever changed by this indescribable and complicated bereavement. Survivors have found their voices through art, film, literature, and occasionally, research. However, society's inability to deal with survivors in an honest and caring way remains a negative legacy of suicide. Even within survivors' families there exists an inflexibility that is reinforced by society's standards, which often create role reversals and confusion. Well-meaning and misinformed people may be actively working in ways that inadvertently reinforce attitudes and approaches that are maladaptive for survivors during their grief recovery. Although these "well-meaning" people are spreading their suggestions to survivors of all ages, the examples are most clearly illustrated in advice given to children. Young sons are told that they have to be the "man of the house" now or daughters have to be daddy's "big girl." Children of suicide often rise to such challenges and enjoy the new role of adult. They surrender their childhoods and never view their sacrifices as such, instead believing what they surrendered was trivial.

A mother in the adult survivors group at the Baton Rouge Crisis Intervention Center, 1 month following her husband's suicide, asked me to see her 7-year-old daughter due to some regressive behaviors the child was exhibiting. The mother stipulated that I could not tell the child how her father died. The mother had told her daughter that Daddy died in a car accident (advice given by a well-meaning family member) and, at that point, that was all the mother could share. I agreed to the mother's request because I knew she was in the adult group and, if treatment was required, our agency would be able to support the family through the process. The daughter was honest in her grief and could connect her feelings with her memories of her dad. She talked openly about how sad she was that her dad was dead and how happy she was when remembering the piggyback rides he

would give her just before bed. Then she looked at me and said, "You know my daddy killed himself?" "How did you come to know that?" I asked her. "When we came back from the building with all the flowers [the funeral home], I heard Aunt Sally and Uncle Joe talking about it." She continued her story, giving me more accurate details than her mother had given about the suicide. When she finished, she put her finger to her mouth and whispered, "Don't tell my mommy, though, because she thinks he died in a car accident!" The process of children taking care of parents, when the children are not emotionally nor developmentally ready, can lay a foundation for hypermaturity and developmental problems. Parents are doing the best they know how to do, and in a proactive postvention model, resources will be made available to educate and assist parents with the grief process. This parent's and child's legacies of suicide were so positively impacted by supportive postvention services that we must make sure that those types of services are available to all survivors through a proactive model of postvention. Regrettably, in our society the means for identifying resources for all survivors is less than proactive, most survivors must personally seek the resources themselves. To change the legacy of suicide, the model for implementing the use of resources should be definitively proactive, with resources seeking the survivors.

I have seen too many people who as children were not given an opportunity to know the facts about a parent's or a sibling's death and years later were in an inpatient setting because of their own suicidal behavior. Hereafter I will refer to adult children of suicide as those adult survivors who experienced the loss of a parent or sibling when they were children. These adult children of suicide (ACOS) often report in their psychosocial histories problems with alcohol, drugs, interpersonal relationships, and work. Working with many adult children of suicide who have foreshortened futures, chronic trust problems, hypervigilance, and accelerated startle responses has convinced me

that this legacy is connected to their survivor status. These adult children of suicide all agree that to have talked about the suicide they experienced as a child when they were children would have helped. In 1989, the Baton Rouge Crisis Intervention Center began a bereavement program for children between the ages of 6 and 12. Our goal was to intervene on the legacy of suicide that ACOS survivors helped us to understand. To see the relief these children experienced after being able to talk about their loss was overwhelming.

Typical personnel policies for business list relatives for whom funeral leave benefits apply. That policy is consistent with our industrialized society; it is efficient and defined. You get 3 days of leave if the funeral is in town and 4 if it is out of town. Our society has problems dealing with death, and these problems are reinforced by what I have referred to as our "national grief policy." Even within the AAS, the figure that is often used to calculate the number of survivors is based on a similar perception of designated grievers. The ratio of six survivors to each suicide has never been confirmed. McIntosh (1996) wrote in a recent *Newslink* article, "What seems most needed is a solid, well designed and conducted epidemiological study to define survivorship in an operational fashion" (p. 3). If personnel policies and the survivor ratio are accurate, then why have 28 different relationships (see Figure 1) been identified that sought services through one agency as a result of suicides? These survivors representing 28 different relationships to the deceased, were all dealing with the same issues historically associated with the smaller (6 : 1) group that society and AAS have accepted as "survivors."

From January 1989 through June 1994, Doris Bland (1994) studied 214 cases of individuals and families requesting services from the Baton Rouge Crisis Intervention Center's survivors of suicide program. Bland's review clarified several relevant points about survivors. Seventy-seven percent of those seeking services did so within 1 year of the suicide (Figure 2), and

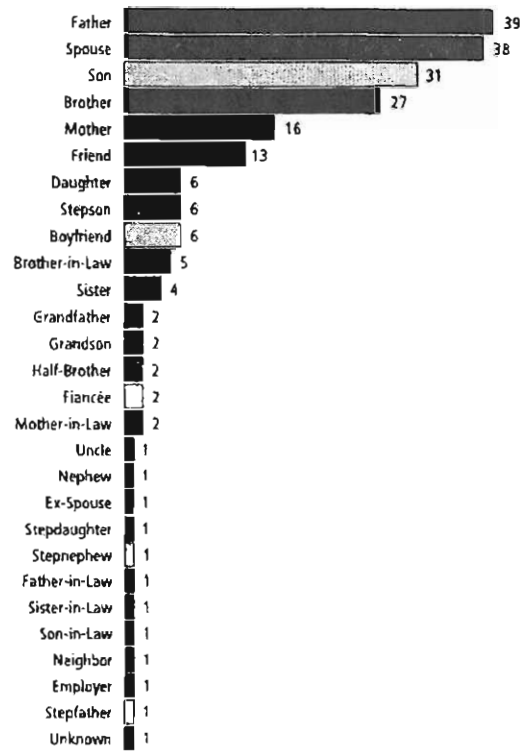


Figure 1. Relationship of deceased to survivor. From Bland, D. (1994). *The Experiences of Suicide Survivors: 1989-June 1994*. Reprinted by permission.

many reported symptoms of acute anxiety disorder. A large number of the survivors reported changes in their activities of daily living (Figure 3). Bland also determined that the majority who presented for services were Caucasians (84%, compared to African Americans, 7%; Asians, 3%; Unknown, 6%) and that 65% of females and 43% of males had received counseling prior to coming to the Crisis Intervention Center. The majority of survivors were in the 30-50 year age range (Figure 6). Women were overrepresented in the survivor data at a ratio of 3 : 1 (Figure 7). This ratio could be the result of males completing suicide 3 times more often than women. However, it is perhaps more indicative that women seek help for emotional issues more often than men do (Figures 4 and 5).

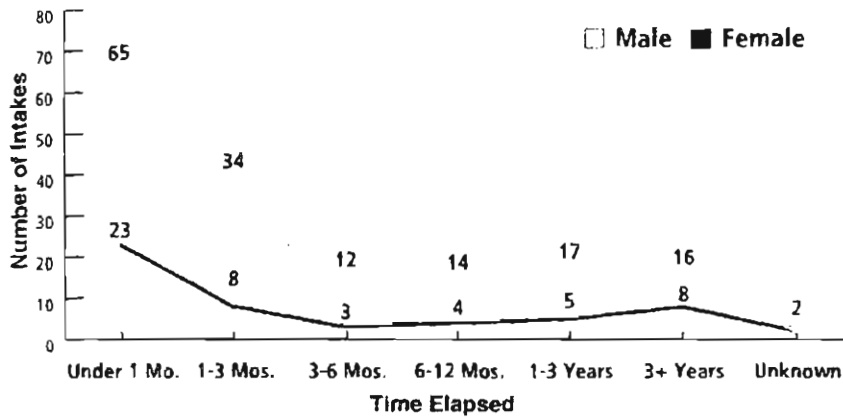


Figure 2. Time elapsed between death and intake. From Bland, D. (1994). *The Experiences of Suicide Survivors: 1989-June 1994*. Reprinted by permission.

Because finding the deceased can generate trauma and lead to reduced coping and impairment to activities of daily living, it is important to question the survivors regarding how they found out about the suicide (Table 1). The trauma of finding the deceased or handling the body is often compounded by the method of suicide chosen by the deceased. In East Baton Rouge Parish, Louisiana, firearms account for approximately 75% of all suicides (followed by overdose, 9%, and hanging, 7%; a variety of other methods account for 8%

of the total; Bland, 1994<sup>1</sup>). In contrasting the overall survivor community with those who seek services, it is apparent that those seeking services comprise a nonrepresentative sample. Contrasting the percentage of non-Caucasian suicides (23%) to the African American survivors in Bland's study (7%) it reveals a lack of participation by minority populations in survivor services

<sup>1</sup>Rounding rule produces a total representation less than 100%.

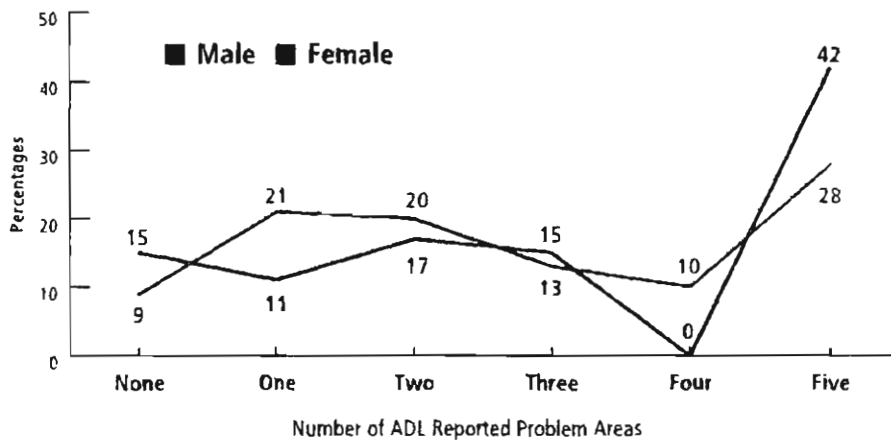


Figure 3. Percentages of reported activities of daily living (ADL) problem areas, by gender. From Bland, D. (1994). *The Experiences of Suicide Survivors: 1989-June 1994*. Reprinted by permission.

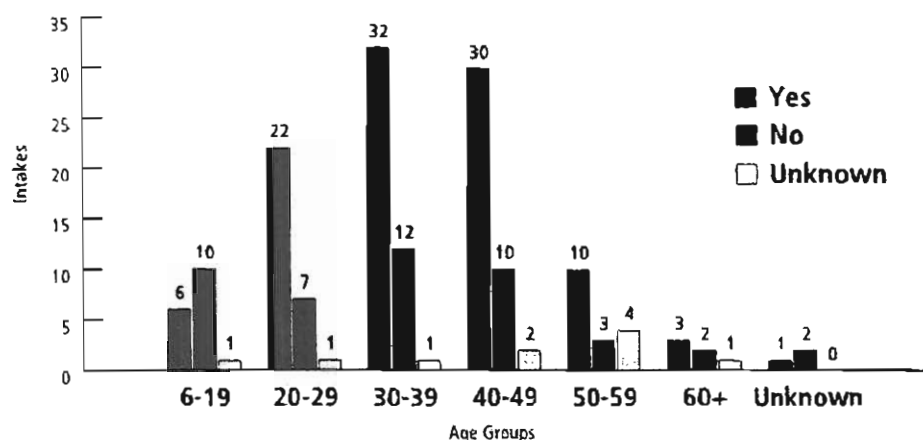


Figure 4. Prior counseling - females, by age. From Bland, D. (1994). *The Experiences of Suicide Survivors: 1989-June 1994*. Reprinted by permission.

as currently offered (Figure 8). Although reasons that are acceptable and appropriate can be offered for this disparity by race, the most difficult aspect to determine is if African American survivors even knew the resource existed. It may be culturally inappropriate to seek help for such a loss; it may be that existing supports are adequate. However, of those African Americans who sought support and participated in the survivors program, the stated benefits were consistent with Caucasians and with other minorities. The impact of suicide and isolation from supports was universal and not ethnically bound.

The first obstacle to overcome in referring survivors to resources is to ensure that *all* identifiable survivors are provided the opportunity to receive services through an active community postvention model. Because of the data already collected by the Baton Rouge Crisis Intervention Center, comparisons can be made to determine if referrals made at the time of death impact minority participation in future survivor referrals. Currently, referrals come from word of mouth, newspaper stories, and sometimes from gatekeepers in the community. However, it is a passive model of postvention, one that requires the survivor to discover and make contact with the resource (Figure 9). This passive

model fails to identify the true number of survivors who are appropriate for some level of postvention.

Presently the number of survivors wanting or needing services remains unclear because the primary referral systems for survivor services are unstructured and vary by community. The number of survivor groups and survivor-sensitive clinicians in existence in the United States indicates a poverty of resources for survivors and a flawed entry system for those services. In a survey mailed to the 350 programs listed in the AAS Directory, Rubey and McIntosh (1995) found that the 141 groups who responded had been meeting for an average of 8.6 years. Meeting size averaged 10 people and frequency varied from weekly to once a month. Some groups were time-limited and met for 8-10 weeks, while the majority were open-ended, allowing survivors to come for as long as they wished. The group leadership also varied from peer to professional facilitator, and some used a combination of both. Significant to the proposed model is the fact that the majority of referrals to the groups came from doctors ( $n = 131$ ), hospitals ( $n = 107$ ), and church ( $n = 102$ ), sources to which some survivors will not be exposed.

When suicides occur that do not result in transporting the deceased to a hospital,

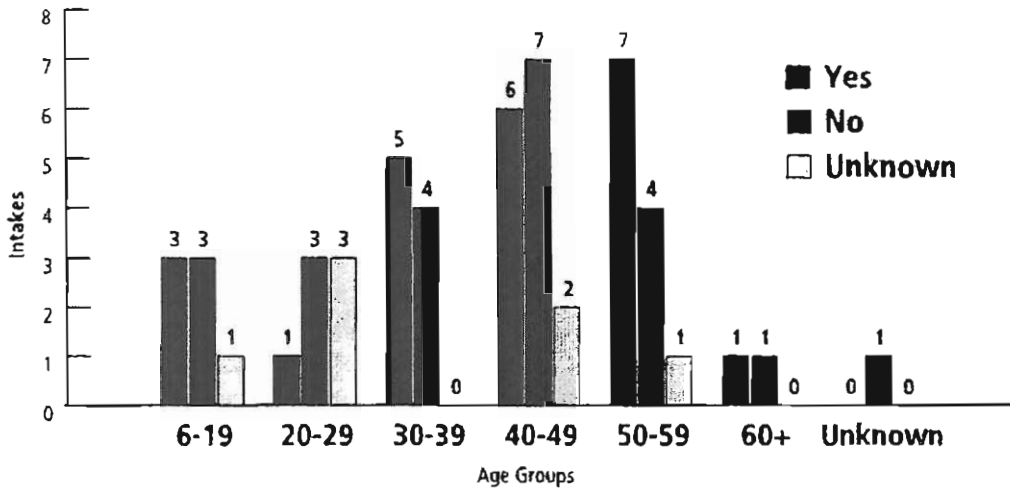


Figure 5. Prior counseling - males, by age. From Bland, D. (1994), *The Experiences of Suicide Survivors: 1989-June 1994*. Reprinted by permission.

the opportunity to speak with doctors or hospital staff is bypassed. Churches as referral sources are often underutilized by survivors because of a variety of theological and stigmatizing issues. Other referral sources mentioned in the study were mental health agencies, crisis intervention services or therapist and community re-

source guides ( $n = 13$ ), media ( $n = 11$ ), police and other officials such as coroners ( $n = 7$ ), funeral directors and mortuaries ( $n = 4$ ), and the public library ( $n = 2$ ). When reviewing the sources of referrals made to service providers, it is clear that persons with the greatest access to survivors at the time of death (police, coroners,

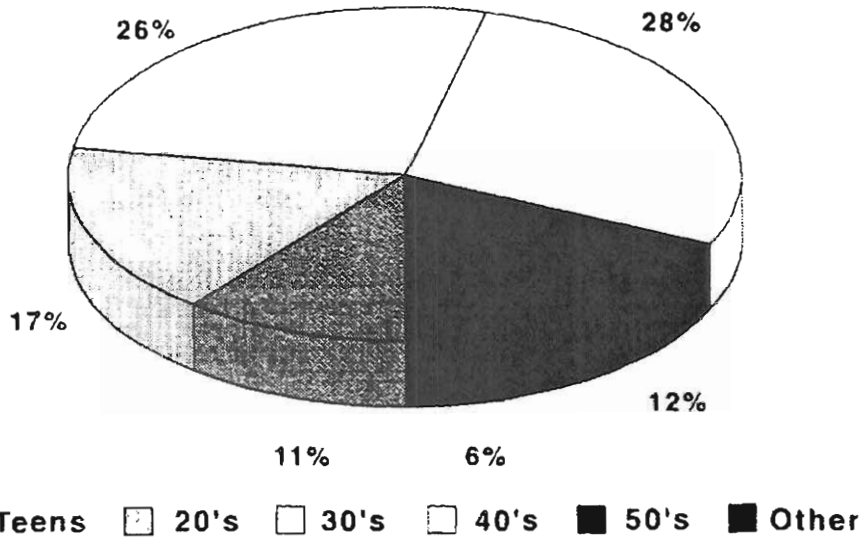


Figure 6. Age of survivors. From Bland, D. (1994), *The Experiences of Suicide Survivors: 1989-June 1994*. Reprinted by permission.

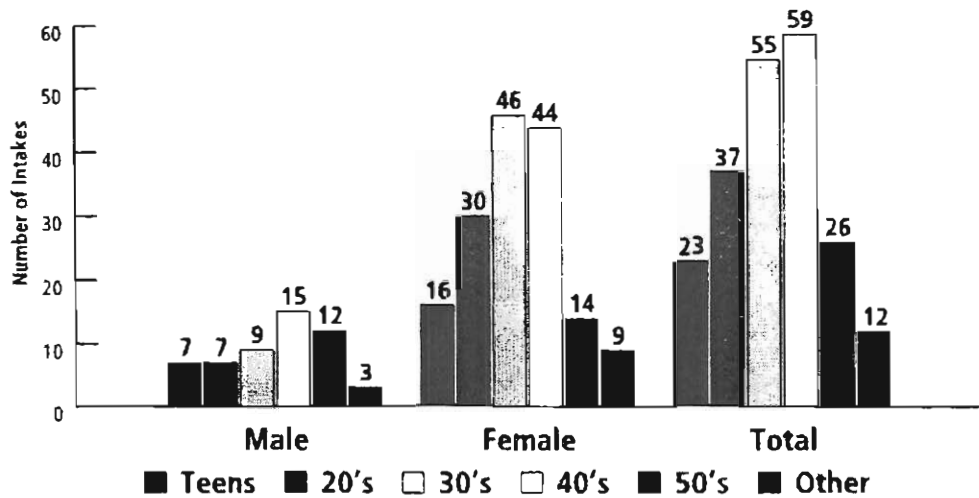


Figure 7. Gender and age of survivors. From Bland, D. (1994), *The Experiences of Suicide Survivors: 1989-June 1994*. Reprinted by permission.

and funeral directors), are among the least credited for referring.

Rather than challenge a system that has consistently underutilized the opportunity to make referrals for postvention services, I propose a more structured and achievable method for providing postvention services and referrals. The problem of access to resources for survivors has been

compounded by an inadequate referral system that breaks down for many who experience a loss to suicide. The informal and noninclusive nature of referrals leaves a large segment of the population without awareness of what help is available; by the time services are connected, many disturbing consequences may have already occurred.

TABLE 1  
Survivors Who Found/Witnessed the Suicide

Age	Male			Female			Totals
	Yes	No	Unknown	Yes	No	Unknown	
6-12	-	-	-	-	1	-	1
teens	2	3	2	-	16	-	23
20s	2	4	1	5	22	3	37
30s	2	7	-	13	32	1	55
40s	5	10	-	13	29	2	59
50s	5	7	-	4	10	-	26
60+	-	2	-	1	3	1	7
Unknown	-	1	-	2	1	-	4
Total	16	34	3	38	114	7	212

Note. If the 10 unknown cases are not considered, the statistics indicate that (1) a minimum of 32% of the males who came to the Baton Rouge Crisis Intervention Center (BRCIC) for an intake either found the deceased or witnessed the suicide, and (2) a minimum of 25% of the females who came to BRCIC for an intake either found the deceased or witnessed the suicide.

From Bland, D. (1994). *The Experiences of Suicide Survivors: 1989-June 1994*. Reprinted by permission.

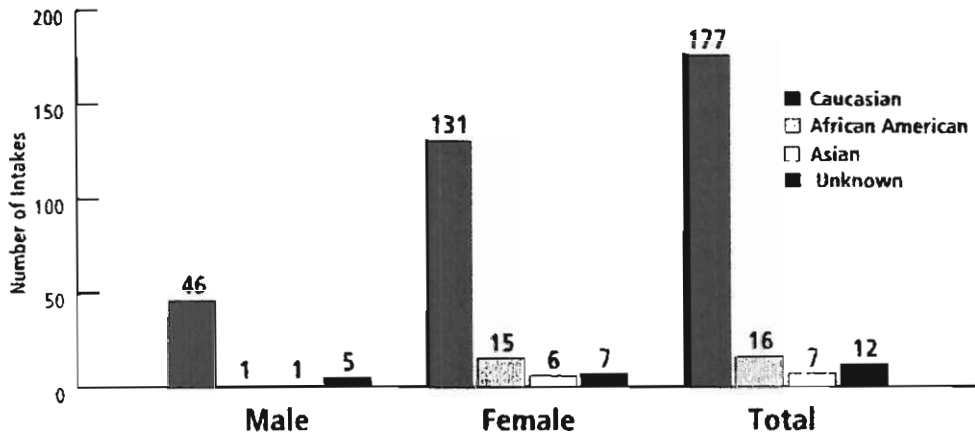


Figure 8. Gender and race composition of survivors. From Bland, D. (1994), *The Experiences of Suicide Survivors: 1989-June 1994*. Reprinted by permission.

Adequate and early postvention services may normalize the grief process after suicide, identify more at-risk survivors, and reduce contagion. Access to services for survivors will be enhanced by implementation of an active model of postvention rather than a passive one (Figure 10). By increasing access to survivors through postvention teams, the impact of postvention services can facilitate the grief process while providing information about resources in the community. The long-term consequences of suicide may be averted if the problems of access

for survivors to services and awareness of resources is overcome.

Postvention is an appropriate area for the AAS to invest the considerable talents of its membership. There are 1,074 members across the country and 1,253 as of 1996, around the globe, and five divisions with which members can affiliate (Survivors, Prevention, Crisis Centers, Research, and Clinical). Membership is composed of individuals (79%) and organizations (21%); most individual members hold advanced degrees and specialties in the areas of suicidology that can greatly

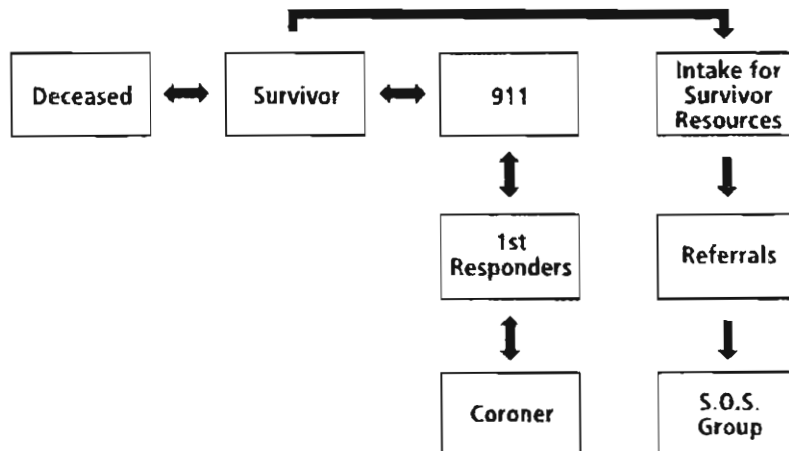


Figure 9. Community passive postvention model.



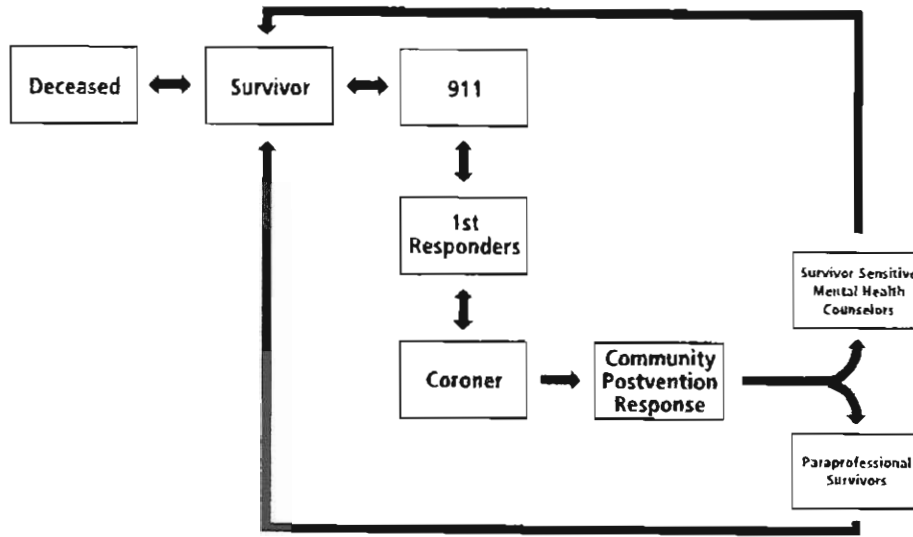


Figure 10. Community active postvention model.

impact postvention development and research. The most formidable obstacle to collaboration could be the AAS divisional structure. It is critical that the membership metaphorically install windows in the "walls" that divide us in order to reduce the danger of professional regression for the association. If we continue to see our divisions as boundaries (Figure 11) we

will miss the opportunity to learn from the rich diversity that is AAS. The current paradigm installs boundaries and reduces cross-divisional collaborations. Although it is historically accurate and representative of major areas of interest, it has failed to develop the hoped-for interactions and dialogue. The proposed paradigm (Figure 12) will allow for prevention.

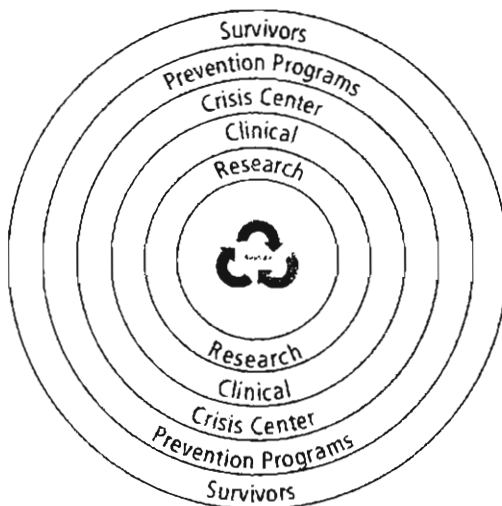


Figure 11. Current paradigm.



Figure 12. Proposed paradigm.

intervention, and postvention to be addressed by any member of the association without restrictions that are real or perceived. The paradigm shift I am suggesting celebrates the contributions of all our members and reduces the risk of elitism or professional regression.

It is my hope that members of this association will seize the opportunities that are available within this organization and set aside their egos and professional desires to help those who are being affected by the legacy of suicide. I hope that when the AAS has its 50th conference, in 20 years, that we will be able to look back with pride to the work that has been accomplished on behalf of survivors by developing, researching, and implementing effective models of postvention.

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