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Suicide and Family Survival

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Suicide and Family Survival

Abstract

Early one beautiful summer morning, a twenty-two-year-old young man, who was loved by his family and liked by many friends, went to his place of employment in the town where he was attending college, and for reasons known, or perhaps not known, only to him, chose to kill himself by means of hanging. His decision not only ended his life; it impacted the lives of others in a way that will have an effect on them, and those with whom they associate, for a long time, if not forever. His family was left not only with the task of dealing with his death, but needing to come to terms with how he died. The "worst" had happened, and they were not sure they would be able to handle it, let alone know how. They had many questions and very few answers, especially in regard to why the seemingly rare and unthinkable had happened to their youngest son and brother and what could have been done to have prevented it. Their outlook on the world had changed, and the days were no longer quite as beautiful.

Suicide and Family Survival

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Early one beautiful summer morning, a twenty-two-year-old young man, who was loved by his family and liked by many friends, went to his place of employment in the town where he was attending college, and for reasons known, or perhaps not known, only to him, chose to kill himself by means of hanging. His decision not only ended his life; it impacted the lives of others in a way that will have an effect on them, and those with whom they associate, for a long time, if not forever. His family was left not only with the task of dealing with his death, but needing to come to terms with how he died. The "worst" had happened, and they were not sure they would be able to handle it, let alone know how. They had many questions and very few answers, especially in regard to why the seemingly rare and unthinkable had happened to their youngest son and brother and what could have been done to have prevented it. Their outlook on the world had changed, and the days were no longer quite as beautiful.

Unfortunately, this devastating, life-altering, and possibly crippling experience, occurs all too often at an increasing rate. In the United States alone, at least 30,000 people end their lives in suicide each year (Smolin & Guinan, 1993). This averages out to 83 suicides per day or one suicide every seventeen minutes. It is this nation's eighth leading cause of death for people of all ages, and the third leading cause of death for young people between the ages of 15 and 24 (Heckler, 1994). There is also an increasing rise in suicide

in young African American men and other minority youth (Matsakis, 1996). And as the baby boom generation continues to move into mature adulthood, the number of elderly people who now commit suicide, fifteen each day in the United States, is predicted to more than double by the year 2010 (Heckler, 1994). Because it is estimated that each of these suicides strongly affects six to eight people, more than a quarter of a million Americans become suicide survivors each year (Smolin & Guinan, 1993). With the increasing number of suicides, the number of survivors will only continue to multiply into even larger numbers, and, therefore, have an increasing impact on the mental health needs of communities.

Most, if not all, of these survivors are members of the decedent's family. Their response as a family and as individuals within the family to this type of death can be traumatic and problematic, allowing for the emergence of unresolved grief issues and other unhealthy psychological conditions. It has only been in recent years that mental health professionals have begun to recognize the impact that suicide has on the remaining members of a family and to address the needs of this specific population (Smolin & Guinan, 1993). While there are various opinions as to how, why, and even if, suicidal grief differs from other forms of bereavement, there is a growing consensus that survivors of suicide could likely encounter greater difficulties in a variety of ways as they work through the grieving process (Dunne, McIntosh, &

Dunne-Maxim, 1987). Even if the suicide survivor is recovering at about the same pace as someone whose relative died of another type of unexpected death, "suicidal mythology" indicates he or she should grieve longer and quite differently (Robinson, 1989). Therefore, important in the healing process for all family members is the availability of support and appropriate therapeutic interventions from within the mental health community immediately following the suicidal death as well as in the months to follow (Dunne, McIntosh, & Dunne-Maxim, 1987; Hatton & Valente, 1981; Kovarsky, 1989).

The purpose of this research paper will be to illustrate that the grieving process for most suicidal survivors is one of the most stressful of life's experiences, and can be quite different from and more complex than the grieving related to other forms of death. Common diagnoses that often result from this form of grief will be described, including those symptoms pertaining to complicated bereavement, depression, and certain anxiety disorders. How a suicidal death can impact the family as a whole as well as the various relationships within the family will also be examined. The therapeutic needs of the family members will be defined, along with suggestions for appropriate forms of therapy. The last issue to be addressed will be the ways in which the mental health professionals as a group can better meet the needs of those in the community who have been impacted by the suicide of one of its members.

Grieving Process and Factors Involved

The loss of or disconnection from a family member due to death is difficult under any circumstances. A suicidal death is probably the most profound kind of disconnection that a person can undertake as it is a disconnection from one's own self and life, as well as from those who have been a part of that life. The disconnection is usually done in secrecy and isolation, and, therefore, makes the grieving process much more difficult and complex (Alexander, 1991). Disconnection that cuts off communication and support from others can also be experienced by the suicide survivor while he or she is in the grieving process (Chance, 1992).

Bereavement for the suicide survivors is not in lieu of the grief process experienced by most people. They may have many of the same reactions and go through similar stages as those used in the Kübler-Ross model (Barrett, 1989). They may, however, probably experience these reactions or stages more intensely and over a longer period of time (Lukas & Seiden, 1987). They also may more than likely experience some of them differently (Demi, 1984). The differences may be due to an accumulative effect similar to that described by Hewett (1980), in which the suicidal survivor's grief reactions come from factors related to general grief, unexpected grief, and unique grief. Calhoun, Selby, and Faulstich (1982) suggested there were three components of suicidal grief that separated it from other forms of grief: (a) increased

feelings of guilt, (b) a more intense search for the meaning of the death, and (c) a lessened amount of social support than those grieving deaths by other causes.

It is important, however, to not automatically consider these reactions to be atypical or abnormal just because they are different. Because suicide is considered by the Western culture to be abnormal, it is often assumed that the typical, more intense, longer lasting and different reactions to suicide are also abnormal or atypical (Barrett, 1989). Many survivors of suicide will actually recover in very much the same way as other survivors do to other forms of death, and cannot be distinguished from these other survivors two to four years after the deaths have occurred (Barrett & Scott, 1990; Robinson, 1989). There are some survivors, however, who seem to be more vulnerable. This group of people is at a greater risk because they may have suffered many losses, have few material resources, poor personal and social skills, and little belief in their own abilities (Mishara, 1995; Séguin, Lesàge, & Kiely, 1995).

Stages of Grief/Related Factors

Regardless of a survivor's life experiences, coping skills, and resources, the first stages of grief immediately following a suicide death are extremely difficult, and can include feelings of shock, denial, helplessness, relief, and blame (Hiegel & Hipple, 1990; Lukas & Seiden, 1987). The shock and denial occur because the death is sudden. The violence of the act and its

accompanying stigma make these feelings even more intense with suicide.

Denial often plays an important part in the suicidal grieving process. There are some survivors who either just cannot comprehend the enormity of the situation, and as a result will refuse to accept the suicide itself, or just need more time before they are ready to accept reality (Hiegel & Hipple, 1990).

Shock is most evident and may last longer for those survivors who discovered the body of the deceased (Barrett, 1989).

For many survivors, the strongest reaction after shock is feeling like they have been personally rejected. The absolute inability to have had any opportunity to do anything to change what has happened results in feelings of helplessness and regret. The response may be similar to the one experienced by Chance (1992) when she stated "By the time I knew he was dying, he was dead" (p. 28). In addition, those survivors that had become extremely anxious about past behavior by the decedent may feel temporary relief (Wroblewski, 1991). However, this usually quickly changes to blame toward self and blame toward others.

The second stages can involve feelings of anger, guilt, shame, and anxiety (Hiegel & Hipple, 1990; Lukas & Seiden, 1987). Anger and guilt are fairly common responses to death, but they are usually more intense and persistent after a suicide. The anger is oftentimes directed at others, oneself and even the suicide victim. Guilt can be thought of as society's automatic

response to suicide. The most destructive kind of guilt is a result of the survivor believing that he or she is responsible for the death. (Hiegel & Hipple, 1990). The resultant guilt that they feel can seriously undermine their self-esteem. In the North American culture, in particular, problems are considered to be the cause of suicide, and survivors of a suicide feel compelled to determine whether he or she was part of that problem (Cain, 1972; Rosenfeld & Prupas, 1984).

The tendency to blame is often connected to feelings of shame, and the survivor will often think that society blames them (Robinson, 1989; Séguin, Lesàge & Kiely, 1995; Smolin & Guinan, 1993). There is a stigma often associated with suicidal deaths in North America, and survivors are likely to experience at least some social isolation and even to be judged unfairly (Calhoun & Allen, 1991; Moore & Freeman, 1995). Two myths associated with suicide that can cripple families are that "nice" people do not kill themselves, and that suicide does not happen in "nice" families (Van Dongen, 1993; Wroblewski, 1984).

The social stigmatization that takes place could actually be a self-fulfilling prophecy, and something that is to be expected or projected by the survivor, rather than something based on reality. (Hewett, 1980; Van der Wal, 1990; Van Dongen, 1993). Some research has also indicated that the seemingly negative public reaction to suicide might be due to there being

different, less clear, and perhaps more restrictive "social norms" in regard to interacting with the survivors (Calhoun, Abernathy, & Selby, 1986). In fact, not all suicide survivors feel the social stigma, and not all of those who do are overly troubled by it (Barrett, 1989; Solomon, 1983). If, however, these feelings of shame and humiliation are felt, they can reach a point that the family ends up isolating itself, choosing not to discuss the circumstances of the suicide death with anyone outside of the family (Rosenfeld & Prupas, 1984). Whether it is due to social stigma or self-inflicted, the isolation felt by survivors and other reactions typical with a suicidal death can lead to disturbed grief reactions and other mental conditions (Kovarsky, 1989).

Diagnostic Impressions

Depression and Complicated Bereavement

Depression is usually the main component of the grief process for the suicidal survivor (Smolin & Guinan, 1993). It is hard, however, to determine if depression is experienced more deeply or in a more severe form by suicide survivors than by survivors of other types of death. One reason for this is the similarity between depressive symptoms and symptoms pertaining to bereavement (Barrett, 1989).

All of the reactions, including depression, that seem to be typically experienced with suicide grief need to be watched. While there has been a recent emphasis on the normalcy of the intensity and duration of certain

reactions to suicidal death, the grieving process is still difficult and can result in complicated bereavement. According to Mishara (1995), a combination of an inability to find meaning in the loss, severe depression, agitation, strong feelings of guilt and anger, and a focus on blaming others are found to be present with those people who seek therapeutic help. When children and adolescents are the suicide victims, there is an increased risk for both parents and siblings to develop major depression within six months subsequent to the death (Brent, Moritz, Bridge, Perper, & Canobbio, 1996).

Dunne (1992) suggested the presence of certain psychological themes with most suicidal survivors that seek out therapeutic assistance. These survivors' symptoms include "an obsessive search for the 'why' of the suicide, a sense of stigmatization, an incomplete or unusual grieving pattern, an invasion of conscious thought by the idea of suicide as an acceptable solution, a sense of helplessness, low self-esteem, reduction in the size and complexity of social contacts, and, most troubling for the therapist, an erosion of basic trust" (p. 37).

Anxiety Disorders

Chance (1992), a psychiatrist and survivor of a son's suicide, stated that she had the symptoms of "three great plagues" that usually affect survivors: depression, post-traumatic stress disorder, and psychosomatic

illness. For a time after her son's suicidal death, she felt disconnectedness and experienced nightmares, not unlike her clients suffering from PTSD.

Acute Stress Disorder or Post Traumatic Stress Disorder (PTSD), as with major depression, is currently a concern of many researchers and clinicians in regard to suicide survival (Barrett, 1989; Brende & Goldsmith, 1991; Dunne-Maxim, Dunne, & Hauser, 1987; Lukas & Seiden, 1987; McIntosh, 1987). They are seeing that the reactions of suicide survivors have many similarities to those being experienced by people after other traumatic life events. Often the feelings of shame and guilt felt by suicide survivors are similar to those felt by those who have been physically and sexually abused (Robinson, 1989). It can afflict both individuals and entire families, especially those members who witness the suicide or discover the body of the deceased (Brende & Goldsmith, 1991; Brent, Perper, Moritz, Liotus, Schweers, Roth, Balach, & Allman, 1993; Matsakis, 1996; Ragaisis, 1994).

Lukas and Seiden (1987), reported that suicide survivors are victims of PTSD, regardless of whether they were direct witnesses to it, because they have experienced a trauma. The anger, fears, and guilt experienced by the survivors are evidenced in the reported nightmares and panic attacks. The severity and duration of these symptoms can be lessened with subsequent therapeutic treatment. Those at highest risk for developing major depression following suicide are those individuals who already suffer from PTSD and

other depressive symptoms as a result of a previous trauma (Brent et al., 1993; Matsakis, 1996; Rappaport, 1994).

Impact on Families

In assessment of diagnosis, it is also important to recognize that suicide survivors grieve in different ways and are influenced by many factors (Barrett, 1984). The most important factors seem to be the family relationship between the survivor and the deceased, the survivor's social support network, his or her personality and coping abilities, the emotional attachment or closeness to the deceased, and the ages of both the survivor and the deceased. Each of these factors will have an effect on how a family and its surviving members respond to the suicidal death (McIntosh, 1987).

Suicide can occur in both healthy and unhealthy families. However, whatever the health of the family before the suicide, this kind of traumatic loss does not do much for family cohesion. Acute grief rarely brings out the best in people, and it is guaranteed to accentuate problems of longstanding (Chance, 1992). These families often share similar kinds of guilt, blame, and even rage. The members may feel abandoned or desire to distance themselves from other family members. Demi and Howell (1991) reported several themes within families experiencing difficulties as a result of the suicide death of one of its members. Along with feelings associated with a suicide death, they may experience anger, family disintegration, stigmatization, lowered self-esteem,

and worries about mental health. They often deal with these painful experiences by denying, avoiding, being secretive, leaving the home, working in excess, and choosing addictive behavior. Hatton and Valente (1981) saw four basic family reactions to suicide as "(a) prohibition of mourning by social networks, (b) disruption and inadequacy of usual coping devices, (c) isolation of bereaved family from friends and family, and (d) crisis in parental identity and personal control" (p. 147).

There was a time when suicide was considered by most people as a family secret that needed to be kept in the "family closet" at all costs. Researchers and clinicians now recognize that the greatest need of the survivors is to be able to talk about the suicide death and their resultant feelings (Colt, 1987). These survivors consistently mention that having the opportunity to talk openly, freely, and as long as need be about their grief is very important in their grieving process (Barrett, 1989).

Hewett (1980) listed secrecy, silence, scapegoating or blaming, denial and idealization of the decedent, and extended mourning as examples of how "games" are played out in surviving families. He saw these forms of maladaptive interaction to be eliminated with more effective forms of communication. Interactions within the family are often described as either supportive or hostile and blaming, and even when a break in communication

does not occur, there is still oftentimes an inability to talk about the suicide (Kovarsky, 1989).

In many cases, the reason why family members do not talk to each other about the suicide is because they are afraid that if they bring the subject up, it will just make things worse. Everyone in the family is likely to be in shock and feeling such intense pain that they are just trying to protect themselves and one another (Rosenfeld & Prupas, 1984; Van Dongen, 1993).

Parents

Guilt and depression among parental survivors seem to last longer and to be more intense than with other survivors (Lukas & Seiden, 1987). In fact, the degrees of grief and loneliness for these parents have tended to rise rather than decrease over time (Kovarsky, 1989). A major reason for the strong guilt feelings is because it is the role of the parents to raise and protect their children (McIntosh, 1987). Psychologically, the mourning process for one's own child not only involves grieving for the loss of that child, but also the loss of a part of oneself. In addition, they are also grieving for the hopes, dreams, and expectations that they had for their child (Rando, 1985).

The parents may blame each other and, therefore, be unable to support each other. As a result, the marriage may not survive (Hiegel & Hipple, 1990; Lukas & Seiden, 1987). Oftentimes, there is conflict within the marriage because of the differing way each of the partners is grieving. Each

of them may have a different perception of the suicide and, therefore, could likely respond in different ways (Robinson, 1989). Miles and Demi (1992) reported that while parents experienced much guilt, the most distressing emotion they felt was loneliness. The parents may not even be able to share their grief with each other (Rosenfeld & Prupas, 1984).

There is also often a great deal of parental fear that if one child died through suicide, then it is a possibility for any of the rest of their children to also choose suicide. For this reason, the parents often become overly protective (McIntosh, 1987; Smolin & Guinan, 1993). One of the scariest things, and a cause of much anxiety, for parents of a suicide victim are the statistics indicating that there is a much greater chance of suicide among survivors, and over one-third of the families will have more than one suicide among its members (Chance, 1992; Lukas & Seiden, 1987).

The parental reaction to the suicidal death can be even more stressful because of the increased social stigma, perceived or otherwise, associated with a child's self-destruction. It does appear that people are more likely to form negative impressions of the surviving parents when a child commits suicide rather than if the victim is an adult (Calhoun, Selby, & Faulstich, 1982; Rudestam & Imbroll, 1983). For this reason, the parents are often unsure about how they should respond in regard to their child's death and with whom they should share this information. They describe being painfully uncertain as

to how to answer the often asked question of "How many children do you have?" (Van Dongen, 1993).

Children

The age and development level of each child survivor are important to how he or she is likely to respond to the suicidal death of a family member. However, three specific aspects pertaining to children and a suicide death in the family seem to stand out (McIntosh, 1987). One of them involves the receiving of distorted information because the child often is not given accurate or enough information about the suicidal death. The second aspect, heightened guilt, may be a result of the distorted information. It may also be due to the responsibility the child feels in regard to death because of a childhood developmental way of "magically" thinking that he or she has the power to control the behavior of another. The third aspect involves identification with the deceased, to the point that the child takes on the dead family member's role within the family. This could eventually lead to a repetition of the suicidal act (McIntosh, 1987; Rosenfeld & Prupas, 1984).

Siblings

Depression seems to be more pronounced for siblings who were close to the decedent, and guilt to be more a part of the bereavement process for those siblings who had a more distant relationship (Balk, 1983; McIntosh, 1987). In addition, school-age sibling survivors oftentimes are unable to

concentrate in the classroom. They may also be at a greater risk for drug and alcohol use, sexual promiscuity, or other acting-out behaviors (Gaffney, Jones, & Dunne-Maxim, 1992). Rosenfeld and Prupas (1984) saw siblings as "growing up faster" and assuming greater responsibility within the family following the suicidal death of a brother or sister, oftentimes to the point of ignoring their own needs. This can be due to an all-consuming over-concern for the remaining members of their family (Gaffney, Jones, & Dunne-Maxim, 1992).

Spouses

The social stigma is particularly felt by the spouse of a suicide victim. Connected to the stigma are feelings of guilt and blame, social isolation, embarrassment, shame, and loneliness (McIntosh, 1987). The increased feelings of resentment and guilt are due to the fact that the surviving spouse may see the suicide as a form of intentional desertion. The surviving spouse may wonder if the deceased was actually desperately trying to get away from him or her (Cain, 1972). The surviving spouse will therefore often question whether he or she is "lovable," which can result in a lowering of self-esteem (Rosenfeld & Prupas, 1984). Oftentimes, when marital separation has taken place before the suicide, feelings of guilt or relief can occur (McIntosh, 1987; Rosenfeld & Prupas, 1984).

Therapeutic Interventions

It is important for therapists to remember that, while each individual, couple, and family grieves differently and their needs will vary, there are specific issues that will differentiate suicide survival from other forms of grief (Barrett, 1989; Bolton, 1995; Dunne, 1987). If they are not knowledgeable about these different issues, mental health professionals and other care givers may not be adequately prepared to deal with the needs of suicide survivors. It is also crucial that therapists look at their own attitudes about suicide and survivors that could have a negative effect upon therapeutic work (McIntosh, 1987).

As stated before, not every suicide survivor will need psychotherapy. In addition, there are some survivors who may not seek out assistance from the mental health community due to several other reasons, including feeling the increased stigma of mental illness or anger at the mental health profession for "failing" to save the suicide victim (Dunne, 1987). It is clear that outreach programs are needed to help those too immobilized to seek help. Those that do choose to get therapeutic help will do so for a variety of reasons, including believing that they are not grieving properly or fearing that another family member may be suicidal. Some may require only short term grief or crisis type counseling, and others may need more extensive therapy (Dunne, 1987). Regardless, therapists need to remember that intervention following a suicide

death is not limited to the initial stage of shock. It can extend over months during the first critical year and can include talking, ventilation, interpretation, reassurance, direction, and even mild confrontation (Hiegel & Hipple, 1990).

Timing of interventions seems to be particularly important in recovery for suicide survivors. By implementing early intervention, suicide survivors can be made more aware of the particular grieving process they are going through in a way that they are helped to withstand the shock of their traumatic loss and to begin to work effectively through the grieving process (Kovarsky, 1989). Surviving family members have indicated that they would have liked to have been seen by a professional counselor within hours of the death (Brownstein, 1992; Hatton & Valente, 1981). This kind of early intervention not only helped them with their need to talk about the death, they also were able to specifically address their feelings of guilt and to reassess their responsibility, reach out to help others, mark anniversaries, and respect each member's own timetable for healing (Rosof, 1994). Through early diagnosis and prompt and effective treatment, the needs of those survivors who are entering into complicated bereavement will be met in a way that assists them in a quicker recovery period (Stone, 1972). When the victim is a child or young adult, there is an even stronger need for prompt therapeutic intervention (Cain, 1972).

Bolton (1994) stated that the best advice that her family received from a psychotherapist and friend upon the suicide death of her 20-year-old son was to make every decision together as a family, discussing each problem openly and treating each family member as an equal, regardless of age or experience. It seems to be especially important for the surviving family members to be part of the decision-making process, and to see that they have choices and a sense of control at a time when things seem so out of control (Praeger & Bernhardt, 1985). This kind of family consensus-building needs to include the making of funeral arrangements. How the service is to be handled appears to be an important way for the family to maintain a sense of dignity for both itself and the deceased (Van Dongen, 1993).

Individual and Group Therapy

According to Schuyler (1973), there are certain issues brought to therapy by most suicide survivors, regardless of each of their unique situations and responses, including a need to reach an understanding of the suicidal death that preserves his or her own self-worth and satisfies his or her search for meaning, and a need to have an opportunity to express his or her feelings in a nonjudgmental atmosphere. The survivor is very likely to question his or her self-worth due to the rejection of the deceased, the blaming by society, and by the self-doubts concerning his or her role in the death (Kovarsky, 1989). The survivor should also be encouraged to mourn the loss of the deceased victim,

in addition to dealing with the suicidal nature of the death, and be assessed as to his or her own suicidal ideation. Since the social response to a survivor is often dominated by the stigma attached to suicide, he or she may need assistance in receiving the much needed social support within his or her own environment (Schuyler, 1973). The clinician can help the survivors by letting them know that feelings of shame are normal reactions to suicide, and helping them to prepare for negative societal reactions if they should occur (Calhoun, Selby, & Faulstich, 1980).

It is important for mental health professionals who work with survivors to recognize that (a) therapeutic goals need to reflect the fact that survivors may never resolve their feelings entirely, (b) they may respond well to therapeutic or support group experiences, (c) they may not necessarily share family history of suicide, and (d) they need to be contacted as soon as possible (Ness & Pfeffer, 1990). Stone (1972) and Praeger and Bernhardt (1985) noted that there are three kinds of intervention that need to be made available to suicide survivors. Primary intervention focuses on assisting the survivor in just dealing with the traumatic loss itself. The secondary interventions look at ways to reduce the further possibility of complicated bereavement and other maladaptive psychological conditions. Important at this level is the introduction of both individual and group counseling. Group counseling is especially helpful in assisting survivors to normalize what may seem to them,

and to others, to be abnormal reactions (Moore & Freeman, 1995). Survivors often fear that they are all alone in how they feel because they do not have the opportunity to share these feelings with other survivors (Smolin & Guinan, 1993). The third or tertiary level of interventions involves the whole community in the efforts to assist suicidal survivors. These efforts can be made in a variety of ways, and those in the mental health community need to be involved.

Community Outreach

Education in the community needs to be focused on de-stigmatizing suicide, teaching healthier coping skills in regard to grief, and putting in place a support system that includes crisis intervention for suicide survivors (Demi & Howell, 1991). It is important for the mental health professional to assist in efforts to educate the rest of the community as to the needs of suicide survivors and the social barriers that hinder their recovery (Dunn & Morrish-Vidners, 1987). Social attitudes and behavior toward suicide victims and their survivors can only change with education and public awareness (Kovarsky, 1989).

Conclusion

A suicidal death is difficult for all survivors. It is devastating for family survivors and can be debilitating. How they deal with this kind of loss in the days and months following the death, both as individuals and as a

family, will be determined, in part, by their own relational and "survival" skills as well as the kind of response they receive from others. As difficult as it may seem to the survivors, as well as society, it is important for them to discover the positives that can come as a result of living through this kind of experience, to create a new perspective on life, rebuilding one's self-esteem in the process, and most important, to find new meaning or purpose in their lives (Bolton, 1994; Chance, 1992; Clark & Goldney, 1995). Perhaps by being assisted by mental health professionals and other people in the community as they begin to work through their unique grieving process, surviving family members of suicide victims will be able to find this new meaning in their lives, learn to cherish the memory of their loved one in the process, and once again enjoy a beautiful summer day.

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