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The Impact of Surviving Suicide Loss on Adolescent Psychosocial Development

Sophie Leonard
sleonard14@winona.edu

Sophie L. Leonard

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Sophie L. Leonard

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Capstone Project Supervisor: ___Mary Fawcett, Ph.D._____
Name

_____
Signature

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Abstract

There has been extensive research in the areas of the impact of suicide and human development over the past several decades. Researchers continue to examine the role that experiencing suicide loss plays in terms of the formation of a healthy identity and overall development. The purpose of this paper is to examine the impact of suicide loss on adolescent development. Specifically, this paper will address the potential impact of surviving a significant suicide loss on adolescent development during the identity versus role confusion stage of Erikson's theory of development. Based on a thorough review of professional literature, the long-term effects and implications of surviving suicide loss will be discussed in relation to Erikson's theory of psychosocial development.

Keywords: suicide, suicide loss survivors, adolescents, Erikson, identity, development

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Impact of Surviving Suicide Loss on Adolescent Psychosocial Development

One of the most difficult clinical problems facing the mental health professional is the prediction and prevention of youth suicide. Suicide is currently the second leading cause of death for young people, ages 10 to 24, in the United States (National Vital Statistics Report, 2020). In broad terms, in the United States, we lose 87 people a day to suicide. For every suicide at least six people will be left to make sense of it. At least six people will grapple with feelings of loss, despair, and guilt. Each year, over 180,000 individuals become suicide loss survivors (Suicide Prevention Action Network USA, 2007). Suicide impacts families, communities, and societies. That's why suicide is a public health problem. That's why we all need to be part of the solution.

Review of Literature

Erikson's psychosocial theory has influenced all contemporary ideas about lifespan development and identity formation. According to his theory, Erikson contended that individuals move through a sequence of eight stages of personality development, characterized by a particular crisis at each stage that requires resolution (Erikson, 1968). Erikson understood that each stage of development presents its own set of unique challenges, which he labeled crises. As a result of biological development and social demands, individuals are pushed from one stage into the next regardless of whether the conflict in each stage is successfully resolved (Sigelman & Rider, 2015). Thus, successful completion of one stage depends on the successful crisis resolution in each preceding stage. If a conflict is not resolved, an individual's development during subsequent stages will be hindered.

Each stage requires the resolution of a crisis, which allows the individual to acquire the necessary qualities for successfully moving on to the next stage of development (Erikson, 1968). Identity development during adolescence is an essential stage that lays the foundation for all other stages into adulthood and beyond. The extended period that occurs between childhood and adulthood is a critical time of development that emphasizes identity formation and role exploration (Sigelman & Rider, 2015). According to Erikson (1968), individuals who have achieved competency during childhood are fully prepared to advance to the next stage of development into adolescence, namely, the identity versus role confusion stage.

Individuals who have resolved the childhood conflict of industry versus inferiority are better prepared to resolve the conflict of identity versus role confusion that occurs during the adolescent years, specifically between the ages of 12 and 18 (Sigelman & Rider, 2015). This is a major stage of development where adolescents must learn the roles they will occupy as an adult.

This psychosocial stage emphasizes an individual's ability to search for a sense of self and personal identity, through an intense exploration of personal values, beliefs, and goals. Failing to establish a positive identity and gratifying life role often results in unhappiness and displacement, which define the principal characteristics of this stage (Erikson, 1968).

Erikson (1968) believed that achieving identity was only possible when a person had developed a strong sense of competence and self-confidence, which results in fidelity; the "achievement" for successfully completing this stage. However, we know that during many of the developmental stages the significance of fitting in with one's social group is high, and self-confidence fluctuates throughout the formative years which often determines an individual's level of self-esteem and confidence. According to Bee (1992), by the end of the identity versus role confusion stage "a reintegrated sense of self, of what one wants to do or be, and of one's appropriate sex role" (p. 245) should be present. During this stage, adolescent body image is ever-changing and feedback from their peers and social circle can either be extremely boosting or detrimental to building up character. Young adults who have developed a strong identity during adolescence are more likely to experience greater intimacy and become involved in a deep, committed relationship during adulthood (Bee, 1992). Given this, many adolescents who enter the identity versus role confusion stage have not achieved the level of maturity required to express themselves and their place in life in its entirety. As a result, successfully progressing through the identity versus role confusion stage can take many years for some individuals as they continue forming their identity and solidifying their path.

While it may take some individuals longer to form a true and individual identity for themselves, other individuals may never experience identity formation to the maximum degree which leads to rebellious tendencies and a negative identity establishment that can last into

adulthood. Erikson (1968) argued that difficulties during childhood often interfere with a person's ability to reach the level of identity formation for minimal role confusion. Individuals who fear the future or experience severe identity crises will continue to have difficulties during subsequent developmental stages. Additionally, these individuals may experience feelings of loneliness and unhappiness demonstrated by difficulty forming a positive identity and sense of self (place in the world) (Sigelman & Rider, 2015). There are many variables that can impact a person's ability to successfully resolve the adolescent conflict of identity versus role confusion. As previously mentioned, many of these variables occur during childhood because of unsuccessful resolution of a conflict from a previous psychosocial stage of development.

While there are many variables that interfere with an individual's development, research confirms that the effects of surviving a significant personal loss to suicide are damaging and potentially persistent throughout development and the potential long-term consequences of being a young suicide loss survivor can be devastating (Cerel, et. al., 1999). When adolescents are close to a person who complete a suicide, their emotion regulation skills for this occurrence are likely not developed enough to grasp and understand these new inner emotions and the emotions can impede their developmental process and result in a variety of psychosocial complications (Cerel et. al., 1999). This paper will address the potential impact of experiencing the loss of someone special to suicide on adolescent development during Erikson's psychosocial stage of identity versus role confusion. Specifically, this paper will discuss various areas of development that are impacted by surviving a significant loss from suicide based on an extensive review of professional literature. These areas include mental health implications, familial implications, building interpersonal relationships, the sexual and occupational identity, LGBTQIA+ community suicidality, trauma recovery implications, and lastly, substance use and suicidality.

Mental Health Implications

Suicide is a complex problem with ideology or beliefs as a common element that interacts idiosyncratically with any number of emergent identities pressing on the individual. One factor underlying suicide concerns the failure to construct a healthy identity (Longwell-Grice et al., 2002). Other causes of suicidal distress include psychological, environmental, and social factors (Achilles et al., 2004). Adolescents who have experienced the loss of someone special to suicide are at greater risk for developing antagonistic psychological problems (Achilles et al., 2004). It is estimated that 400,000 youth younger than age 25 will experience the death of a family member each year (Children's Bereavement Center of South Texas, 2008). Also, statistics indicate that 1.9 million children younger than age 18 have lost one or both parents (Children's Bereavement Center of South Texas, 2008).

Mental health concerns influence many other areas of development, making it difficult for suicide loss survivors to successfully transition through each psychosocial stage. For example, young suicide loss survivors of are more likely to develop mental disorders, which makes it more difficult for them to manage healthy relationships and effectively regulate negative emotions (Brent et. al., 1992). In the same study it was also found that a strong support system decreases the likelihood of developing depression and other psychological disorders in adulthood (Brent et. al., 1992). Consequently, failure to develop healthy relationships and coping strategies leads to an increase of mental health symptoms. The long-term effects of surviving a significant suicide loss are interconnected, thus creating a cycle of developmental barriers that is difficult to break. Some of the long-term effects that are associated with experiencing the loss of someone special to suicide include higher levels of anxiety, CTG & PTSD, depression, relationship and sexual issues, dissociation with reality, and denial (Brent et. al., 1996b).

Although different types of childhood/adolescent trauma have many common characteristics and mental health outcomes, traumatic loss in adolescents have several distinctive features. Most importantly, the leading long-term affect that adolescents who experience a traumatic loss may develop is childhood traumatic grief (CTG), which is the violation of trauma symptoms on the grieving process (Cohen & Mannarino, 2011). This prevents the adolescent from navigating through the typical steps associated with normal bereavement and grief and lends itself to further psychological issues (Cohen & Mannarino, 2011). Another way that CTG is different from normal bereavement is regarding the presence and severity of PTSD symptoms. Some PTSD symptoms include sleep difficulties, loss of interest in peer and other social activities, and trouble concentrating, which can normally be expected in bereaved adolescents. However, major PTSD symptoms such as intrusive re-experience of the deceased's death, persistent avoidance of death reminders, angry outbursts, or even avoidance of reminders of the loved one are less typical of normal bereavement but very characteristic of CTG (Cohen & Mannarino, 2010).

Another leading long-term effect for older adolescents experiencing a significant loss from suicide is depression (Cohen & Mannarino, 2010). Depression interferes with healthy development, making it difficult for young adults to build a strong network and navigate their way through the identity versus role confusion stage of development. Environmental stressors such as parental pressure for academic achievement, family mobility, the availability of drugs, and peer pressure can also lead to depression (Capuzzi, 1994). Since many survivors often place blame on themselves for this loss too (i.e., "*I should have noticed*"), they often develop distorted thought patterns and destructive belief systems (Capuzzi, 1994). Suicide loss survivors who blame themselves experience high amounts of guilt, fear, and shame which interferes with the

development of self-esteem and efficacy further lending itself to role confusion. As these loss survivors enter adulthood, the effects of that earlier loss are exhibited through depression and other mental disorders (Capuzzi, 1994).

Although depression and other mental health diagnoses are common among loss survivors of suicide, researchers have identified several other factors at play between experiencing suicide loss and psychological health. Longwell-Grice et al., (2002) examined these potential variables between experiencing suicide loss during adolescence and psychopathological functioning during adulthood utilizing a meta-analysis. The results of this meta-analysis indicated that conducting post traumatic interventions while the loss survivor is still young inspired increased levels of positive and healthy identity development which resulted in a better psychopathological outcome for loss survivors in adulthood (Longwell-Grice et al., 2002).

In 2018, suicide ranked as the second leading cause of death in the 10-to-24-year-old age group (National Center for Health Statistics, 2020). As well, it is concerning that the rates of adolescent suicide have increased significantly over the past four decades. The national suicide rate among persons aged 10–24 increased 57.4% between 2007 and 2018 (National Center for Health Statistics, 2020). Researchers have established that the best predictor of a suicide attempt is a previous suicide attempt (Leon et al., 1985). However, since only 10% to 40% of those adolescents who die by suicide have made a previous attempt, it is necessary to assess for other risk factors (Brent et al., 1988; Marttunen, et al., 1993). In a longitudinal study, researchers found that most of the suicide attempts reported by participants were made by young adults who were older than 18 and who had a previous suicide attempt which would indicate that their first suicide attempts would have occurred in adolescence (Velez and Cohen, 1988). Also, suicidality

tends to escalate with intent and lethality of means with age, and decreasing time between successive attempts (Goldston et al., 2015).

The assessment of suicide risk in adolescents is particularly difficult because teenagers may provide evaluators with discrepant information and have a reluctance to disclose personal information to adult authority figures (Brent et al., 1988; Velting et al., 1998). Some research suggests that suicidal patients are more likely to disclose current suicidal ideation on a self-report measure than in a clinical interview (Kaplan et al., 1994; Velting et al., 1998). In the New York Adolescent Suicide Study, researchers found that among adolescent suicide victims in their sample, 21% of boys and 50% of girls met diagnostic criteria for major depression (Shaffer et al., 1988). Kovacs et al. (1993) found a four-to five-fold increase in suicidal ideation and behavior among adolescents with affective disorders as compared to teenagers with other psychiatric illnesses.

Familial Implications

Family climate has also been found to play a role in suicide risk among adolescents. Parental psychopathology, including abuse and neglect of children, family history of suicidal behavior, nonintact family composition, familial stress (e.g., deaths, separations), family conflict, and, more recently, impaired communication and low levels of emotional support and expressiveness are the familial factors most consistently associated with adolescent suicidal behavior (Campbell et al., 1993; Garber et al., 1998; Keitner et al., 1990; King, et al., 1993; Martin & Waite, 1994; Pfeffer, 1989; Wagner, 1997). Studies report a higher rate of mental disorders in the family history of suicide attempters than in control groups (e.g., Garfinkel et al., 1982; Wagner, 1997). However, when suicidal subjects are compared with non-suicidal psychiatric samples, levels of parental psychopathology do not differ (Brent et al., 1990). This

suggests that psychiatric disorders in family members may not be a direct risk factor for adolescent suicidality per se, but rather it puts adolescents at risk for psychopathology.

Building Interpersonal Relationships

There is a high prevalence of interpersonal difficulties among young adults who have experienced the loss of someone special to suicide during adolescence (Brent et. al., 1996b). Adolescents who have experienced the loss of someone special to suicide may demonstrate difficulty establishing and maintaining close relationships with others. The symptoms associated with experiencing the trauma of losing someone special to suicide may impede the development and growth of positive relationships and identity during the identity versus role confusion psychosocial stage of development (Cerel et. al., 1999). An inability to form connections with others, the self, and an occupation to a greater degree often results in feelings of isolation and loneliness. Furthermore, adolescents who fail to successfully resolve the conflict of identity versus role confusion will have even more difficulty progressing into the subsequent stages of development (Sigelman & Rider, 2015).

As adolescent suicide loss survivors develop, they may believe that other people they love and care about will disappear too. After entering the identity versus role confusion stage of development, young suicide loss survivors may experience a variety of interpersonal communication and relationship building issues because of this trauma that has occurred. Common communication and relationship issues that adolescents may experience during the identity versus role confusion stage are difficulties with social interactions, fear of commitment, difficulty with emotion regulation, submissive behaviors, and an involvement in unhealthy codependent relationships (Brent et. al., 1996a). Research has shown that experiencing a substantial loss to suicide in adolescence increases difficulties in interpersonal functioning for

these individuals during early adulthood. Adolescents who enter the identity versus role confusion stage of development encounter difficulties establishing and maintaining a positive identity after having suffered the trauma of losing someone (Erikson, 1968). One explanation of these findings is the inability for adolescents to successfully resolve the conflict of industry versus inferiority during childhood. As previously noted, Erikson's (1968) theory of development emphasizes the importance of resolving conflict in each psychosocial stage before moving into the next stage, which would decrease the likelihood of difficulties in the following stages. Suicide loss survivors may not have had the opportunity to successfully resolve conflict during the earlier developmental stages, therefore hindering their ability to successfully form an identity during adolescence. Failing to establish a strong identity in adolescence makes it more difficult to form intimate relationships during adulthood (Sigelman & Rider, 2015).

Long-term effects of experiencing a significant personal loss to suicide are evident throughout the identity versus role confusion stage of development. As adolescents and young adults seek out their place in life and attempt to a positive identity, difficulties may arise for loss survivors of suicide that may impede their ability to successfully maneuver through this stage. A study conducted by Bhargava and Sethi (2003) examined the relationship of psychiatric symptoms and outcomes to social adjustment in adolescents that had experienced the suicide of an immediate family member. The results of this study indicated that adolescents who had experienced losing someone special to suicide were found to have more negative attitudes and feelings about themselves, higher amounts of emotional and social withdrawal, and elevated risk for psychiatric disorders compared to adolescents who had not experienced this trauma (Bhargava & Sethi, 2003). The fear of losing someone else and the guilt and shame that many suicide loss survivors experience can impact the success of development during Erikson's

identity versus role confusion stage. Experiencing the loss of someone special to suicide at a young age can leave many adolescents feeling isolated and unsure of themselves and others when it comes to building healthy connections.

Sexual & Occupational Identity

A key aspect to the identity versus role confusion stage in Erikson's Theory of Psychosocial development is the idea Erikson proposed about identity itself. Erikson (1968) established that he believed an identity had two counterparts, the sexual/gender identity and the occupational/vocational identity. It is also important to acknowledge that the effects of experiencing a significant loss to suicide impact adolescent and young adult perception and contemplation about themselves.

First, it is important to consider the sexual/gender aspect to one's identity during this developmental stage. Throughout early adolescence, learning how to identify determines the type of roles and activities that one participates in as well as future places in society (Erikson, 1968). During the identity versus role confusion stage, there is much experimentation as adolescents find who they are in relation to sexual attraction, gender identification, and the roles with which they feel most comfortable identifying. This, however, can cause great cognitive stress and leads to role confusion if they are not supported by family or friends in their pursuit. Many also choose heteronormative labels with or without consideration for their deeper meaning (Striepe & Tolman, 2003). Additionally, the impact of experiencing a significant loss to suicide may determine the role these adolescents and young adults play in an intimate relationship when they start to seek out those relationships in early adulthood/adulthood. In their later development, adolescents who have experienced a substantial loss to suicide often play a passive role in intimate relationships because of this trauma at a young age (Erikson, 1968). Not only does this

reinforce loss survivors' tendency to withdraw emotionally and physically, but it also increases the likelihood that these young adults will be subject to a fear of commitment and loss of their current significant other which could further push their partners away if the partner does not understand this behavior. According to the next stage of Erikson's theory of development - intimacy versus isolation, young adults need to engage in relationships that are mutually gratifying and encompass the values and interests of both individuals involved (Berk, 2009). If a loss survivor of does not play an active role in the relationship, he or she may experience feelings of isolation and have difficulty establishing emotional intimacy with another person.

According to Meyer et al. (1993) "occupational identity refers to an individual's positive assessment of the occupation he/she is engaged in, and it indicates the importance of the occupational role to the individual's self-identity" (Meyer et. al., pg. 539, 1993). During the early stages of this developmental phase, the occupational identity is formed by finding hobbies that can transfer into a career, volunteering in the community/school, and through open communication with family or guardians (Meyer et. al., 1993). This, much like with the sexual identity, can cause great cognitive stress, and leads to role confusion if decisions about their occupational role are made for them (Meyer et. al., 1993). The effects of suicide loss trauma are noticeable as adolescents begin forming interpersonal relationships and thinking about their occupational role in life throughout the identity versus role confusion stage of psychosocial development (Berk, 2009). The impact of experiencing the loss of someone special to suicide and one's development during the identity versus role confusion stage represents itself through feelings of guilt, shame, and fear which also leads to confusion about the self and identity crisis (Berk, 2009). Also, as previously discussed, loss survivors encounter greater difficulties establishing and maintaining positive identity and relationships (Harvard University, 2019).

Therefore, the effects of experiencing a significant personal loss to suicide becomes ubiquitous throughout development, resulting in an inability to form a positive, healthy identity and build positive relationships with others. It is important to note that the occupational and sexual identity can and is often reassessed at any time in the lifespan after the successful completion of this stage of psychosocial development.

LGBTQIA+ Community Suicidality

In their study of 137 gay/bisexual males, Remafedi et al., (1993) found one-third of their sample reported at least one intentional self-injurious act, and nearly half of that group repeatedly attempted suicide. However, it was not homosexuality per se that heightened the likelihood of suicidal behavior. Instead, it was gender non-conformity and precocious psychosexual development that were predictive of self-harm. The younger these subjects were when they identified themselves as homosexual/bisexual, the more likely they were to report suicidal behavior. The authors suggested that the reason for this may be that early and middle adolescents may be less able to cope with the isolation and stigma of a homosexual identity than older adolescents who may have better developed coping skills. In a more recent article, Remafedi et al., (1998) examined the relationship between sexual orientation and suicide risk in a population-based sample of adolescents. They conducted a cross-sectional statewide survey of 7th through 12th-grade public school students. Among the 394 students who described themselves as bisexual/homosexual and 336 gender-matched heterosexual students, suicide attempts were reported by 28.1% of bisexual/homosexual males, 20.5% of bisexual/homosexual females, 14.5% heterosexual females, and 4.2% of heterosexual males. Thus, for males, but not females, bisexual/homosexual orientation is associated significantly with suicide attempts. Similarly, in another population-based sample of 3,365 9th through 12th-grade public high

school students, Garofalo et al. (1999), found that self-identified gay, lesbian, and "not-sure" youth were 3.41 times more likely to report a suicide attempt than their peers (Garofalo et al., (1999). Like Ramefedi et al.'s (1998) results, Garofalo et al. (1999), found sexual orientation to have an independent association with suicide attempts for males. For females, the association of sexual orientation with suicidality may be mediated by drug use and violence/victimization behaviors (Garofalo et al., (1999).

Trauma Recovery Implications

Adolescents are exposed to many experiences throughout the developmental process that determine how they will interact with others and make sense of the world around them. This process includes the formation of personal boundaries and coping strategies. After a death, adolescents are confronted with the reality of going forward with their lives without their loved one. Wolfelt (1996) used the term "reconciliation" to describe this process. Childhood bereavement experts Wolfelt (1996) and Worden (1996) have identified several tasks as significant in the reconciliation process, including accepting the reality of the loss; fully experiencing the emotional distress of the loss; adjusting to one's environment and sense of self without the loved one; finding meaning in the loved one's death; and becoming engaged with other adults who can provide ongoing comfort, security, and nurturance (Wolfelt, 1996; Worden, 1996). As a result, the adolescent that does not or cannot take part in these tasks often experiences confusion and uncertainty about how to move on from this trauma that may continue into adulthood (Brent et. al., 1996b). Adolescents who have experienced the loss of someone special to suicide usually haven't gained an adequate understanding of how to create a path forward from this event which majorly requires the use of professional help in the form of family therapy or support groups of those that have also been affected by the same trauma of

experiencing a significant loss to suicide. The developmental stage of identity versus role confusion is compromised when loss survivors are not able to set a proper plan in place for their foreseeable future such as starting high school, or for older adolescents, beginning to think about college or a job, and graduating high school. Instead of forging this path, adolescents who demonstrate social and/or emotional unavailability, familial isolation, or turn away from this progress are at an increased risk for suicide ideation or attempts to their own life (Brent et. al., 1992).

Another area of development that is often impacted by experiencing the loss of someone special to suicide is the adolescent's ability to form coping strategies to effectively regulate negative emotions. Experiencing this level of loss and bereavement, such as the loss of a parent, close friend, or sibling during adolescence disrupts predictability in the child's life, leaving the child feeling alone, confused, and fearful (Brent et. al., 1996b). Early on, after this type of loss occurs, many older adolescent loss survivors may not wish to discuss what has happened to them for the fear that it will happen again or that it was their fault for not noticing the symptoms of the suicide victim up to the point of said trauma. This creates a sense of isolation as they draw away from those who could offer support and provide care for them. As a result, older adolescent loss survivors must learn how to manage their emotions self-reliantly as they develop. Later, these individuals may choose to reach out for professional help about their earlier trauma in adulthood to clear their conscious.

Brent et. al (1996a) conducted a study to investigate the relationship between experiencing a significant loss to suicide and coping strategies. The results of this study indicated that individuals who experienced this type of loss tended to utilize avoidance coping strategies to regulate their emotions during stressful situations. Adolescents who had experienced this type of

loss were more likely to use problem avoidance and social withdrawal strategies during adulthood compared to their non-loss counterparts (Brent, et. al.,1996a). Loss survivors of suicide may be using avoidance as a coping strategy to escape feelings of pain and to make their lives more manageable. In addition, loss survivors may withdraw because of a rigid family system and limited sources of support to discuss the loss that had occurred. Due to the negative stigma associated with the topic of suicide, loss survivors tend to find avoidance as a more effective way of coping throughout the developmental process due to the lack of understanding from others. Once the formation of dysfunctional coping strategies is developed during adolescence, Erikson's (1968) theory would predict that these strategies will transfer into adulthood, thereby making it difficult for loss survivors to maneuver various life problems during the intimacy versus isolation and generativity versus stagnation stages of development.

The death of a loved one is never easy to experience, whether it comes without warning or after a long struggle with illness. Suicide can isolate survivors from their community and even from other family members. There's also still a powerful stigma attached to mental health substance use (both factors in many suicides), and many cultures specifically condemn the act as a sin, so survivors may understandably be reluctant to acknowledge or disclose the circumstances of such a death (Harvard University, 2019). Family differences over how to publicly discuss the death can make it difficult even for survivors who want to speak openly to feel comfortable doing so.

This poses questions on how to support suicide loss survivors. Research suggests that suicide survivors find individual counseling and suicide support groups to be particularly helpful regardless of age (Harvard University, 2019). There are many general grief support groups for a variety of age groups, but those focused on suicide appear to be much more valuable. Some

support groups are facilitated by mental health professionals, others by survivors themselves (Harvard University, 2019). If an individual goes and feel comfortable and safe and feel that they won't be judged — that's probably more important than whether the group is led by a professional or fellow survivors. As well, for those who don't have access to a group or feel uncomfortable attending meetings in person, internet support groups are a growing resource. Additionally, it is essential to note that there is no time limit on when one can join a support group. Some find it beneficial to engage in a group soon after the death, when an individual feels ready to be social, or even long after the suicide if they feel they could use support, perhaps around a holiday or an anniversary of the death (Harvard University, 2019). When it comes to attending individual counseling, suicide loss survivors should look for a skilled therapist who is experienced in working with grief after suicide or utilized a trauma-informed approach to address this grief in meaningful ways (Harvard University, 2019). Even if a survivor isn't bringing up the subject, you can ask how they are coping with the death and be ready to listen (or respect a wish not to talk about it). Be patient and willing to hear the same stories or concerns repeatedly. Acknowledging emotional days such as a birthday or anniversary of the death — by calling or sending a card, for example — demonstrates support and ongoing appreciation of the loss.

Substance Use and Suicidality

Alcohol and other drug abuse are a major risk factor in suicide, both for those with co-occurring mental disorders and for the general population. According to a study done by Blumenthal (1988), it was found that alcohol abuse is associated with 25% to 50% of suicides; with between 5% and 27% of all deaths of people with substance use disorders are caused by suicide, and a lifetime risk for suicide estimated to be 15% (Blumenthal, 1988). A

particularly strong relationship between substance abuse and suicide among young people was also found, the study finding that as many as 70% of adolescent suicide victims had alcohol or substance abuse problems. An additional important insight is that, for people with substance use disorders, the incidence of suicide is 20 times greater than the general population (Blumenthal, 1988). According to the National Survey on Drug Use and Health (2018) 916,00 adolescents aged 12-17 reported a substance use disorder (including either alcohol or drugs). This comes out to approximately 1 in 27 adolescents (National Survey on Drug Use and Health 2018). In addition to an increased risk of overdose, substance abuse during adolescence can adversely affect physical and mental health, academic performance, and relationships. Many studies have shown that adolescent substance is a major risk factor for suicide (Wolitzky-Taylor et al., 2010; Wang & Yen, 2017).

It is also important to note that comorbidity of alcoholism and depression increases suicide risk, because they exacerbate personality and cognitive problems, and add to environmental stressors (Clark & Fawcett, 1992). In fact, suicide is a leading cause of death among people who misuse alcohol and drugs (Centers for Disease Control and Prevention, 2018). Toxicology tests on adolescent suicide victims indicate the presence of substances that include: 75% of suicides involve one or more substances, 69% of suicides involve alcohol intoxication, 33% of suicides involve benzodiazepine, 30% of suicide deaths involve opiates (including heroin and prescription painkillers), 21% of suicides involve marijuana, 6% of suicides involve cocaine, and 3% of suicides involve amphetamines (Substance Abuse and Mental Health Administration, 2016).

Finally, there is the need to also understand that alcohol and substance use/abuse exacerbate other environmental problems and lessen an adolescent's ability to cope in a healthy

manner (Westefeld et al., 2000). As it can be seen, the role that alcohol/substance use plays in adolescent suicide is striking. Studies with adolescents and young adults have found evidence of alcohol/substance abuse in 38 to 54% of suicide victims (Brent, et al., 1987; Hoberman & Garfinkel, 1988; Marttunen et al., 1991; Shafii et al., 1985). Abel and Zeidenberg (1985) found that in their sample of 15 to 24-year-old suicide victims, 35% of the subjects had medical records indicating significant blood–alcohol levels at the time of death. Hawton et al., (1989) had similar results in their study of 1,973 adolescents and young adults presenting to a hospital emergency room. They reported that 38% of suicide attempters had consumed alcohol within six hours of their attempt. One recent study evaluated 89 consecutive admissions to a specialty outpatient clinic for depressed and suicidal inner-city teens. Of the 49 subjects that had histories of self-injurious behavior, 18.4% met diagnostic criteria for cannabis abuse or dependence (Velting & Miller, 1999).

Applications to Program Area (Clinical Mental Health Counseling)

Every year in the United States, more than 45,000 people take their own lives (Harvard University, 2019). Every one of these deaths leaves an estimated six or more "suicide survivors" — people who've lost someone they care about deeply and are left with their grief and struggle to understand why it happened (Harvard University, 2019). Given these statistics and the information discussed thus far, education for families, children, and routine screenings done by clinicians are ways to help reduce the risk of suicide in youth as well as support adolescent suicide loss survivors.

The grief process is always difficult, but a loss through suicide is like no other, and the grieving can be especially complex and traumatic. Individuals coping with this kind of loss often need more support than others but may get less (Harvard University, 2019). There are various

explanations for this. Suicide is a difficult subject to contemplate. Survivors may be reluctant to confide that the death was self-inflicted. And when others know the circumstances of the death, they may feel uncertain about how to offer help (Harvard University, 2019).

Given this, psychoeducation about grief and loss, especially in cases of surviving suicide loss, is important for clinicians, clients, and families alike. Without a proper understanding of grief, clinicians can over-treat grief that's healthy, or miss the warning signs when someone needs help. The bereaved will benefit by learning that the pain they are feeling serves a purpose—it will help them heal. They are not alone, their grief isn't bad, and the process requires time. One thing to be mindful of is to not over-diagnose normal grief and bereavement, but to also not miss warning signs of deeper issues such as Persistent and Complex Bereavement Disorder (Worden, 2018).

A helpful model for grief to utilize when providing psychoeducation to clients is the Tasks of Grief Model. This model by Worden (2018) describes grief as an active process that individuals can work through, rather than a passive experience that happens to them. The tasks include accepting the reality of the loss, processing the pain of grief, adjusting to a changed world, and remembering the deceased while moving forward (Worden, 2018).

Task 1: To accept the reality of the loss. Oftentimes after a death, survivors struggle to accept the reality of what has happened. They may also deny the significance of the loss. Accepting the reality of the death means coming to terms with the loss both emotionally and intellectually.

Task 2: To process the pain of grief. This task involves confronting emotions, even painful emotions. This means recognizing you are experiencing pain, naming your emotions, and learning how to cope with them.

Task 3: To adjust to a world without the deceased. After a loss, survivors must face a world without their loved one. This task involves making internal, external, and sometimes spiritual adjustments to the loss. Internal adjustments are changes to one's identity. Survivors must ask themselves, "Who am I now, without my loved one?" External adjustments including taking on different roles and responsibilities. For example, a spouse who was previously responsible for childcare may now have to seek employment outside the home. Spiritual adjustments involve changes to a person's worldview, beliefs, and assumptions. For example, someone who believes "the world is a fair and kind place" may no longer feel this way after a loss.

Task 4: To find a way to remember the deceased while moving forward in life. This means keeping a place in your heart for the person you lost, while being willing to move on with your own life. This may also mean allowing yourself to be happy and to love again.

Because grief is a beneficial reaction to death, it is not a belief that there is a problem to be "fixed" within a client, but rather a new reality to learn to live with. The hope is that adolescent clients feel safe to share their story and to find support from others who are grieving (Worden, 2018).

Additionally, interventions that emphasize the importance of teaching adolescents how to communicate about suicidality would be beneficial since lack of knowledge or lack of comfort communicating suicidality is an issue for youth (Cigularov, et al., 2008). Younger adolescents may not have the abstract thinking skills to think about the consequences of attempting suicide like their older counterparts and one study suggested that only 25-45% of children express suicidal ideation that they can identify (Tishler, Reiss, & Rhodes, 2007).

Finally, given adolescence covers a wide age range, the content of the psychoeducation would need to differ by age to provide age-appropriate guidance. Promoting protective factors for adolescent suicide loss survivors, such as sense of connectedness with family, teachers, and counselors increase coping skills can reduce risk for suicidality amongst this age group as well as for loss survivors (Steele et al., 2018).

Conclusion or Discussion

Although the professional literature has presented a significant relationship between experiencing the sense of bereavement and a significant personal loss to suicide on an adolescent's development, everyone's reactions and experiences will vary. As a result, it is important for counselors to assess the individual needs of the client. As research has illustrated, experiencing the loss of someone special from suicide has significant implications on the development of loss survivors. Since the impact of experiencing a substantial personal loss from suicide is evident throughout the professional literature, it is important to continue studying the impact this traumatic event has on development. Additionally, researchers should focus on how counselors can best assist individuals struggling with the long-term effects of experiencing a significant loss from suicide, specifically in relation to healthy cognitive development.

After completing an extensive review of professional literature, experiencing a significant personal loss to suicide interferes with the development of adolescents during the identity versus role confusion stage of development. As described earlier, experiencing the loss of someone special to suicide not only impacts adolescent psychological/cognitive development, but their interpersonal relationship and intimacy building skills during adulthood as well. Failing to establish a sense of identity and learned role can increase the likelihood of developing a psychological disorder, which hinders loss survivors' development and interferes with their

ability to form a healthy relationships and connections with others as well as recover from the trauma. The effects of losing someone special to suicide last into adulthood and counselors need to be competent and knowledgeable to best assist these individuals through their past and present struggles as well as help navigate them towards a healthy and happy path for the future.

Author's Note

When I was 16 years-old, my best friend died by violent suicide. After this traumatic experience, I felt very alone and didn't really have anyone that I felt comfortable speaking to about it. It was also hard for me to interact with others after this loss because I had been outcast by many of my classmates. Therefore, counseling is so important to me, because it is a profession that works with people battling with struggles, no matter how big or small and helping them to find clarity in their life again. To work through those struggles knowing that someone is fighting in their corner for/with them. Many people do not have the support system that is needed to work through these types of tough times, and we can be there to lift them up. I was personally lucky to have had a great emotional support system when I was dealing with my struggles, but the type of trauma I experienced had never happened to my family, so I didn't have the right resources (coping strategies I needed to prosper after pain, etc.) This paper culminates the research, the lived experiences, and the light from the torch I carry as I journey into the professional realm of counseling.

This one is for you, Ad.

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