

Bereavement Experience of Female Military Spousal Suicide Survivors: Utilizing Lazarus' Cognitive Stress Theory



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Lindsey Mitchell

The purpose of this study was to explore the relationship of five variables—primary appraisal, secondary appraisal, coping skills, social support and stigma—to bereavement among women whose military spouses had completed suicide. Four correlations to bereavement (primary appraisal, secondary appraisal, coping skills and stigma) were significant. Hierarchical multiple regression analysis assessed the overall relationship of bereavement (the criterion variable) to the five predictor variables, along with the unique contribution of each predictor variable. In the regression, five of six models (all except Model 4) showed significance. The dissertation on which this manuscript is based has the following practical implications: statistically significant correlations between bereavement and constructs of Lazarus' Cognitive Model of Stress (LCMS), as well as the significance of Lazarus' construct of primary appraisal within Model 6, indicate that LCMS holds promise for understanding symptoms of bereavement in women whose military spouses have completed suicide.

Keywords: suicide, bereavement, military, spouse, Lazarus

Reports indicate that suicides in the U.S. military surged to a record number of 349 in 2013. This figure far exceeds the 295 American combat deaths in Afghanistan in 2012 and compares with the 201 military suicides in 2011 (National Institute of Mental Health [NIMH], 2013). Some private experts predict that the trend will worsen this year (Miles, 2010).

From 2008–2010, the Army reported the highest number of suicides ($n = 182$) among active duty troops; whereas the Navy and Air Force reported 60 and 59 respectively (National Institute of Mental Health [NIMH], 2013). The Marine Corps had the largest percentage increase in suicides in a period of 2 years (Lamorie, 2011). U.S. veterans accounted for 20% of the more than 30,000 suicide deaths in the United States in 2009. Between 2003 and 2009, approximately 6,000 veterans committed suicide annually, an average of 18 suicides each day (Congressional Quarterly, 2010; Miles, 2010). During the 2009 fiscal year, 707 members of the veteran population committed suicide, and another 10,665 made unsuccessful suicide attempts (Miles, 2010). Certain experiences of military service members (e.g., exposure to violence, act of killing the enemy, risk of injury, exposure to trauma) increase suicidal tendencies (Zamorski, 2011).

For every person who completes suicide, an estimated 20 people experience trauma related to the death (NIMH, 2010). This suggests that from the 349 military suicides in 2013, approximately 7,000 people have experienced related trauma. Suicide survivors are family members and friends whose lives significantly change because of the suicide of a loved one (Andriessen, 2009; Jordan & McIntosh, 2011; McIntosh, 1993). Survivors of suicide may have higher risk for a variety of psychological complications, including elevated rates of complicated grief and even reactive suicide (Agerbo, 2005).

Lindsey Mitchell, NCC, is the recipient of the 2015 Outstanding Dissertation Award for *The Professional Counselor* and a licensed counselor in both Texas and Washington, D.C. Correspondence may be addressed to Lindsey Mitchell at lmitch26@gmail.com.

It is also important to note that suicide survivors might not differ significantly from other bereaved groups regarding general mental health, depression, post-traumatic stress disorder symptoms and anxiety (Sveen & Walby, 2008). Examining the impact of suicide on surviving military family members may provide important information on minimizing negative consequences, including possible survivor suicide.

Military deaths are often sudden, unexpected, traumatic and/or violent in nature, and the family is conditioned to anticipate these types of deaths. In contrast, death by suicide is not anticipated and might not be handled well among military families (Martin, Ghahramanlou-Holloway, Lou, & Tucciarone, 2009). Suicide within the military culture is a traumatic as well as a unique experience. Service members and their families struggle with the visible and invisible wounds of war and the aftermath that combat deaths leave for the survivors. When a service member's trauma leads to suicide, the military community is less trained and conditioned to process the grief than when death occurs as a direct result of military service (Zhang & Jia, 2009).

Stress plays a role in the grief process within the military culture when it relates to suicide. The chief identifying feature of military culture is warfare, which in turn leads to the claiming of human lives (Siebrecht, 2011). Siebrecht argued that bereavement can only be overcome if people adopt a more rational attitude and grant death its natural place in life. Association with the military ensures that most families will have to experience some form of bereavement and many forms of loss during times of war (Audoin-Rouzeau & Becker, 2002). Military men and woman are less equipped than the general population when it comes to their culture's acceptance of outward demonstration or sharing of the emotional experience of grief (Doka, 2005).

Stigma

Historically, the stigma of suicide has been present in society (Cvinar, 2005). The biggest obstacles that families with members who have completed suicide confront are acts of informal social disapproval. The surviving family may be suspected of being partly blameworthy in a suicide death and consequently may be subjected to informal isolation and shunning (Bleed, 2007). The stigma of suicide can be subtle. It can be manifested in overt actions taken against the survivors (i.e., placing blame on the family), as well as by omitted actions (i.e., not receiving life insurance), which are probably far more common. When people experience the untimely loss of a family member, there can be feelings of being offended, wounded or abandoned (Neimeyer & Jordan, 2002). The stigmatization experienced by survivors may complicate their bereavement process (Cvinar, 2005; Jordan, 2001; McIntosh, 1993). This complexity results in communication issues, social isolation, projection of guilt, blaming of others and scapegoating (Harwood, Hawton, Hope, & Jacoby, 2002; Lindemann & Greer, 1953). There is a lack of research in the professional literature addressing the grief of surviving military family members impacted by the death, including suicide, of a loved one (Lamorie, 2011).

Suicide and Bereavement

Jordan (2001) researched suicide bereavement and concluded that there are several underlying reasons that it differs from other types of mourning. Jordan summarized that "there is considerable evidence that suicide survivors are viewed more negatively by others and by themselves" (p. 93) and that suicide "is distinct in three significant ways: the thematic content of grief, the social processes surrounding the survivor, and the impact suicide has on family systems" (p. 91). In reviewing the social processes surrounding suicide, Jordan's analysis supports those of Worden (1991) and Ness and Pfeffer (1990), saying that "there is considerable evidence that survivors feel more isolated

and stigmatized than other mourners, and may be viewed more negatively by others in their social network" (p. 93). Most traumatic death survivors will face questions regarding their own culpability in their loved one's decision to take his or her own life. Survivors may find themselves repeatedly pondering missed warning signs and risk factors (Parrish & Tunkle, 2005). Four primary factors that distinguish the complexities of suicide bereavement for families include stigma, questions about reasons, issues of remorse and guilt, and various logistical and legal factors unique to suicide that necessarily influence the events and processes following death (Minois, 1999). The question of *why* often comes up given the pervasive sense that suicide is a preventable event. This line of thought can often define the grief process. Combined with factors of shock from the sudden, often violent nature of the death, these questions are virtually unavoidable. In some cases, answers to questions of *why* may never be forthcoming or satisfactory (Steel, Dunlavy, Stillman, & Pape, 2011). Among military families, bereavement is complex. A military death often has circumstances not normally found in the civilian world. It is most likely unexpected, potentially traumatic, occurring in another country, publicized by the media, and enveloped in the commitment to duty and country. Surviving family members of military personnel are often parents, siblings, grandparents and spouses. Military widows are young, often with young families, and are living at a duty station, far away from family and longtime friends (Katzenell, Ash, Tapia, Campino, & Glassberg, 2012).

Bereavement in the Military Culture

Bereavement is a part of the military culture but is often misinterpreted as a weakness that will elicit limited outside support. Military men and women in general are uninformed about the cultural acceptability of outwardly demonstrating their grief or sharing the emotional experience of the loss (Doka, 2005). Although traditional mental health treatments predominantly encourage emotional vulnerability, the military culture values emotional toughness (Kang, Natelson, Mahan, Lee, & Murphy, 2003) and stigmatizes mental illness (Doka, 2005). These attitudes can often deter service members from seeking assistance that could help them to overcome physical and mental health issues. Military culture affects the impact of suicide on families. Each spouse and family has a different bereavement process, and this process is influenced by stigma, social support and ability to cope. In the U.S. military, these issues can be a hindrance to seeking services and can lead to feelings of isolation, which in turn are a risk factor for suicide (Christensen & Yaffe, 2012).

Conceptual Framework

The conceptual framework of Lazarus' Cognitive Model of Stress (LCMS) was used to frame this study. The underlying construct of this model states that times of uncertainty and difficulty may assist in understanding a person's ability and capacity to cope with the suicide of a loved one. In general, when people encounter a difficult situation, they employ strategies for dealing with and lessening perceived stress (Groomes & Leahy, 2002).

LCMS (Lazarus & Folkman, 1984) has served as a useful lens for examining the interaction between a person and situational demands. Burton, Farley, and Rhea (2009) used LCMS to frame a study of the relationship between level of perceived stress and extent of physical symptoms of stress, or somatization, among spouses of deployed versus non-deployed servicemen. Eberhardt and associates (2006) examined Lazarus and Folkman's 1984 stress theory regarding the ways that stress mediators and perceived social support may affect anxiety (as a stress response). The above studies show the usefulness of LCMS in depicting the impact of stress and coping on perceived anxiety, acceptance, ability to lead mentally and physically satisfactory lives, and perception of social support.

LCMS includes primary appraisal, secondary appraisal, coping and perceived social support. Stress is defined as a person's relationship to his or her environment, specifically a relationship that the person perceives as exceeding his or her resources and endangering well-being. This model supports that the person and the environment are in a dynamic, reciprocal and multidimensional relationship. This conceptualization suggests that people's perception of stress is related to the way they evaluate, appraise and cope with difficulties.

Stress can be measured by the way an individual appraises a specific encounter. Lazarus and Folkman (1984) presented two types of appraisal. The first is primary appraisal, defined as an individual's expressed concern in terms of harm, loss, threat or challenge. Harm and loss appraisals refer to loss or damage that has already taken place; threat appraisal refers to harm or loss that has not yet occurred (i.e., anticipatory loss); and challenge appraisal refers to the opportunity for mastery or growth (Lazarus & Folkman, 1984). The second type is secondary appraisal, defined as the focus on what the individual can do to overcome or prevent harm. Lazarus and Folkman suggested that an appraisal of threat is associated with coping resources that can mediate the relationship between stressful events (e.g., loss of spouse to suicide) and outcomes (e.g., ability to seek mental health services).

Coping resources are the personal factors that people use to help them manage situations that are appraised as stressful (Lazarus & Folkman, 1984). Coping resources can be available to the person during the grief process or can be obtained as needed. This fact suggests that the grief process following a suicide is stressful and imposes demands on coping as the bereavement process evolves. Lazarus and Folkman (1984) defined coping as "constantly changing cognitive and behavioral efforts to manage specific external or internal demands that are appraised as exceeding the resources of the person" (p. 141). Coping is a dynamic process that is called into action whenever people are faced with a situation that requires them to engage in some special effort to manage that situation (Lazarus & Folkman, 1984). The ability to cope impacts a person's bereavement process, and the ways and ability to cope vary with each individual. Stigma and the amount of perceived social support also influence the ability to cope (Bandura, 1997). These variables impact the bereavement process, especially with the added variable of death by suicide.

Social support can strengthen an individual's position against the stressor and reduce the level of threat (Lazarus, 1996). Research suggests there are specific reasons why survivors do not seek out social support. McMenamy, Jordan, and Mitchell (2008) identified depression and a lack of energy as substantial barriers to obtaining social support.

People who experience a traumatic event are more likely to perceive barriers and not request medical and mental health services due to this lack of energy, lack of trust in professionals and depression (Amaya-Jackson et al., 1999). Provini, Everett, and Pfeffer (2000) stated that the stigma and social isolation that survivors experience can interfere with seeking social support and the willingness of social support networks to come to the aid of the survivor. A lack of social support can increase depression, a lack of energy to complete daily tasks and isolation. Limited social support is especially common for suicide survivors. Shame and guilt surrounding a suicide can impact survivors' ability to seek social support; however, high social support can be linked to positive mental health.

Barriers to Bereavement

Many suicide survivors struggle with questions about the meaning of life and death, report feeling more isolated and stigmatized, and have greater feelings of abandonment and anger compared with

other sudden death survivors (Callahan, 2000). Moreover, the feeling of relief from no longer having to worry about the deceased may distinguish survivors of suicide from survivors of other types of sudden death (Jordan, 2001). Experiencing suicide in one's family increases risks for family members' mental health and family relationships (Jordan, 2001). Despite the frequency of suicide, there is limited research focusing on the needs of surviving spouses (Miers, Abbott, & Springer, 2012).

The family system in which the spouses existed as a couple is destabilized by suicide, but the survivor must continue to function. Tasks that were carried out in the relationship must now be carried out by the survivor (Murray, Terry, Vance, Battistutta, & Connolly, 2000). Cerel, Jordan, and Duberstein (2008) stated that because suicide occurs within families, the focus on the aftermath of suicide within families and the impact on the spouse are important areas to investigate in order to determine exactly how to help survivors. Helping survivors to address practical, economic and legal issues, in addition to providing information and therapeutic intervention, is important (Dyregrov, 2002; Provini et al., 2000).

Purpose of the Study

Because of the frequency of suicide in the United States, the increased number of suicides within the U.S. military, and the impact of suicide on the family, the bereavement process among female spousal survivors of military suicides deserves further exploration. The purpose of this study was to explore bereavement in female spousal survivors of military suicides. Using LCMS, the study explored the relationship of bereavement and stigma, social support, primary appraisal, secondary appraisal, and coping skills among women whose military spouse had completed suicide.

Summary of the Study and Methodology

This study investigated the linear relationship between the dependent variable of bereavement and each of five independent variables—primary appraisal, secondary appraisal, coping skills, perceived social support and stigma—among women whose military spouses had completed suicide. The following hypotheses guided the study. Hypothesis 1 stated that there would be a relationship between bereavement and stigma; this positive relationship was significant. Hypothesis 2 stated that there would be a relationship between bereavement and social support; the relationship was not statistically significant. Hypothesis 3 stated that there would be a relationship between bereavement and primary appraisal; this positive relationship was significant. Hypothesis 4 stated that there would be a relationship between bereavement and secondary appraisal; this negative relationship was significant. Hypothesis 5 stated that there would be a relationship between bereavement and coping skills; this negative relationship was significant.

Using hierarchical regression analysis, the researcher examined the relationship of five independent variables—primary appraisal, secondary appraisal, coping skills, social support and stigma—to bereavement. The relationship was statistically significant. The model was a good fit and controlled for time since death (i.e., number of years since the person completed suicide). Therefore, for this sample, the five independent variables are components of a statistically significant model.

Participants and Recruitment

The participants in this study were women aged 18 and older who had lost a military spouse to suicide. Criteria for inclusion were that (a) the service member who had completed suicide had been either on active duty or of veteran status, (b) the survivor was female and 18 years of age or older, and (c) the survivor was considered a spouse. A spouse was defined as legally married to another person

or living and cohabiting with another person in a marriage-like relationship, including a marriage-like relationship between persons of the same gender. Participants were chosen from seven national organizations serving veterans. The researcher recruited participants from these organizations by explaining the study and asking for volunteers. The director or assistant director of each organization distributed study information and materials through listservs and posted them on their Web sites. Once prospective participants received an e-mail, they decided whether they wanted to participate and whether they met the eligibility requirements. If the spouses decided to participate in the study, they would complete the survey through Survey Monkey.

Variables

Demographic variables included age, race/ethnicity, length of relationship with the deceased partner, the decedent's military status (active or retired), the decedent's length of service, and time elapsed since death. The survey also asked about the deceased's rank, education level, surviving children and prior suicide attempts.

A self-report online survey was constructed using the following five instruments: the Core Bereavement Items (CBI; Holland, Futterman, Thompson, Moran, & Gallagher-Thompson, 2013), the Stigma of Suicide and Suicide Survivor Scale (STOSASS; Scocco, Castriotta, Toffol, & Preti, 2012), the Coping Self-Efficacy Scale (CSES; Chesney, Neilands, Chambers, Taylor, & Folkman, 2006), the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, 1988), and the Stress Appraisal Measure (SAM; Peacock & Wong, 1990). The SAM is one measure. However, the variables of primary stress appraisal and secondary stress appraisal within it were separated, and the questions within the SAM regarding primary stress appraisal were referred to as the primary stress appraisal measure (PSAM), and the remaining questions of the SAM were referred to as the secondary stress appraisal measure (SSAM). In addition to these assessments, participants would also answer 11 demographic questions and three open-ended questions. The survey was split into seven sections.

The first section had 11 demographic questions. The second section, comprised of the MSPSS, had 12 questions regarding social support of the participant and used a 7-point Likert scale. The third section, comprised of the CBI, had 26 questions regarding the participant's ability to cope and used a 10-point Likert scale. The fourth section, comprised of the SAM, had 19 questions regarding participant's stress appraisal measures and used a 4-point Likert scale. The fifth section, comprised of the STOSASS, had 17 questions regarding the participant's perceived stigma and used a 4-point Likert scale. The sixth section, comprised of the CBI, had 17 questions regarding the participant's bereavement process and used a 4-point Likert scale. The survey included the three following open-ended questions that were derived from the Grief Evaluation Measure (GEM) and reviewed by three licensed professional counselors working in the field of suicide bereavement: (1) What do you recall about how you responded to the death of your spouse at the time?; (2) What was the most painful part of the experience to you?; and (3) How has this experience affected your view of yourself or your view of your world? To analyze the qualitative responses, the researcher identified the most commonly recurring words or phrases used by participants for each question. Three experts in the field of grief and loss were consulted and confirmed the content and face validity of the survey.

Data Analysis

The Statistical Package for the Social Sciences (SPSS), a statistical software package, generated all of the statistics for this research investigation. A Pearson correlation analysis was conducted to determine whether there was a linear relationship between primary appraisal, secondary appraisal, social support, coping skills, stigma and bereavement for women whose military spouse

had completed suicide. Following this analysis, a multiple regression was used to describe the relationships of the independent or predictor variables to the dependent or criterion variable (Lussier & Sonfield, 2004). Because LCMS states that it is possible to discern the order in which a person experiences each variable with regard to a particular event, the variables were entered into the regression using the following equation: Bereavement = {time since death} + {primary appraisal} + {secondary appraisal} + {coping skills} + {perceived social support} + {perceived stigma}.

Results

Descriptive Statistics

Descriptive statistics provided simple summaries of the demographic characteristics of the sample, as well as descriptors such as means and standard deviations for these characteristics. The sample was a well-educated, racially diverse group of women who had lost their military spouses to suicide. The majority of participants were non-Hispanic White females who had attended at least some college. Most were affiliated with the Army and had been married to the military member who had completed suicide. The majority of the partners had committed suicide while on active duty. The mean age of respondents was 33.48 years ($SD = 5.20$; $SE = .373$); their ages ranged from 23–50 years. The mean number of children aged 17 or under that were a product of the relationship with the service member was 1.12 ($SD = .79$; $SE = .064$); the range was 0–4 children. The mean number of prior suicide attempts by the service member (known/confirmed by the surviving female spouse) was 1.31 ($SD = 1.06$; $SE = .096$); the range was 0–4 prior suicide attempts.

Correlation Results

Using SPSS Student Version 22.0 software, a Pearson correlation coefficient was used to measure the relationship of bereavement, primary appraisals, secondary appraisals, coping skills, social support, and stigma among women whose military spouses had completed suicide. The correlation coefficient measures the strength and direction of the relationship among variables. When conducting a correlational analysis of two co-occurring variables, the researcher can indicate whether change in one is accompanied by systematic change in the other. Examination of intercorrelations among study variables indicated statistically significant correlations between bereavement and each of four independent variables: primary appraisal, secondary appraisal, coping skill, and stigma. The results for each correlation are presented separately and summarized below as well as in Table 1.

Table 1

Correlations for Independent, Dependent and Control Variables

	CBI	TSD	PSAM	SSAM	MSPSS	CSES
1. TSD	.277*					
2. PSAM	-.309*	-.167				
3. SSAM	-.309*	-.151	.602*			
4. MSPSS	-.039	.032	.379*	.172*		
5. CSES	-.174*	-.167*	.494*	.473*	.585*	
6. STOSASS	.252*	.095	-.196*	-.221*	.022	-.253

Note: $N = 194$; CBI = Core Bereavement Items; TSD = Time Since Death (in months);

PSAM = Primary Stress Appraisal Measure; SSAM = Secondary Stress Appraisal Measure;

CSES = Coping Self-Efficacy Scale; MSPSS = Multidimensional Scale of Perceived Social Support; STOSASS = Stigma of Suicide and Suicide Survivor Scale.

* $p < .05$.

Control variable. There was a statistically significant relationship between time since death and bereavement for women whose military spouse had completed suicide, $r(194) = .277, p < .01$. The shorter the amount of time elapsed, the higher the bereavement scores.

Independent variables. Primary stress appraisal, $r(193) = -.309, p < .01$: There is a weak negative linear relationship between bereavement and primary stress appraisal. Secondary stress appraisal, $r(193) = -.309, p < .01$: There is a weak negative linear relationship between secondary stress appraisal and bereavement. Coping skills, $r(193) = -.174, p = .015$: There is a weak negative linear relationship between coping skills and bereavement. Social support, $r(193) = -.039, p = .594$: There is no linear relationship between perceived social support and bereavement. Stigma, $r(193) = .252, p < .01$: There is a weak positive linear relationship between perceived stigma and bereavement.

Multiple Regression

Following the correlational analysis, a multiple regression was utilized. This analysis was appropriate to describe the relationships between the independent or predictor and dependent or criterion variables in an objective manner (Lussier & Sonfield, 2004). The design was appropriate because the purpose of the study was to explain the relationships between variables.

Model 1 (TSD onto bereavement) yielded $R = .277, R^2 = .077, F(1, 125), p < .001$. The portion of the variance explained was 7%. Model 2 (TSD and primary appraisal) yielded $R = .431, R^2 = .186, F(2, 124), p < .001$. The portion of variance explained was 18.6%. Model 3 (TSD, primary appraisal and secondary appraisal) yielded $R = .454, R^2 = .206, F(3, 123), p < .001$. The portion of variance explained was 20.6%. Model 4 (time since death, primary appraisal, secondary appraisal and coping skills) yielded $R = .455, R^2 = .207, F(4, 122), p < .001$. The portion of variance explained was 20.7%. Model 5 (time since death, primary appraisal, secondary appraisal, coping skills and social support) yielded $R = .471, R^2 = .221, F(5, 121), p < .001$. The portion of variance explained was 22.1%. Model 6 (time since death, primary appraisal, secondary appraisal, coping skills, social support, and stigma) yielded $R = .482, R^2 = .232, F(6, 120), p < .001$. The portion of variance explained was 23.2% (see Table 2).

Qualitative Component

There is a growing interest in integrating qualitative data across quantitative studies to discover patterns and common threads within a specific topic or issue (Erwin, Brotherson, & Summers, 2011). The main aim of the qualitative questions within the survey is to gain insight into the participants' world and capture their unique experiences (e.g., naturally occurring events and/or social or human problems) and their interpretations of these experiences (Jones, 1995; Sarantakos, 1993).

A total of 55 (28.4%) participants responded to the question, "What do you recall about how you responded to the death of your spouse at the time?" Of these, 24 stated recalling "sadness" as most frequent. Fifteen participants indicated disbelief, shock, feelings of helplessness or feelings of fear. Other participants' responses included "trying not to think about what had happened," crying, sobbing, physical symptoms, physical pain, collapsing, fainting, being unable to forget what happened, and being unable to recall or process the event. A total of 68 (35.1%) participants responded to the question, "What was the most painful part of the experience to you?" Of these, 50 reported physical and emotional numbness and only partial recollection of learning about the death (e.g., who told them, where they were when notified, immediate responses). These participants indicated that they could recall parts of the experience but struggled with identifying feelings or emotions directly following the event. Other responses included being hospitalized, contemplating suicide, refraining from eating, and feeling that their future had been lost. Although four reported

contemplating suicide following the death of their spouse, no participants reported attempting suicide at any point. A total of 36 (18.6%) participants responded to the question, "How has this experience affected your view of yourself or your view of your world?" Of these, 15 participants indicated that they no longer feared death, while seven reported having a negative reaction to relationships. Eleven participants reported that they perceived stress as more threatening than before the suicide of their spouse and were unaware of the triggers that brought on stress during the bereavement process. Ten participants indicated that their view of love had changed since the loss of their spouse. Nine participants wrote about making an effort to enjoy life after the suicide of their spouse.

Table 2*Hierarchical Multiple Regression*

Model	<i>R</i>	<i>R</i> ²	<i>t</i>	<i>p</i>	<i>B</i>	β	<i>R</i> ² Change
Model 1	.277	.077	61.600	.000	.049	.277	0
TSD			3.228	.002			
Model 2	.431	.186	19.482	.000			.109
TSD			2.696	.008	.039	.222	
PSAM			-4.074	.000	-.406	-.335	
Model 3	.454	.206	19.646	.000			.02
TSD			2.618	.010	.038	.214	
PSAM			-1.947	.054	-.254	-.209	
SSAM			-1.782	.077	-.192	-.191	
Model 4	.455	.207	16.971	.000			.001
TSD			2.622	.010	.038	.216	
PSAM			-1.952	.053	-.262	-.216	
SSAM			-1.788	.076	-.199	-.198	
CSES			.266	.791	.004	.025	
Model 5	.471	.221	12.989	.000			.015
TSD			2.307	.023	.034	.192	
PSAM			-2.359	.020	-.335	-.276	
SSAM			-1.111	.269	-.132	-.132	
CSES			-0.710	.479	-.012	-.083	
MSPSS			1.505	.135	.091	.167	
Model 6	.482	.232	9.026	.000			.010
TSD			2.329	.022	.034	.194	
PSAM			-2.187	.031	-.312	-.257	
SSAM			-1.105	.271	-.131	-.131	
CSES			-0.320	.750	-.006	-.039	
MSPSS			1.107	.271	.069	.128	
STOSASS			1.280	.203	.086	.112	

Note: TSD = Time Since Death (in months); PSAM = Primary Stress Appraisal Measure; SSAM = Secondary Stress Appraisal Measure; CSES = Coping Self-Efficacy Scale; MSPSS = Multidimensional Scale of Perceived Social Support; STOSASS = Stigma of Suicide and Suicide Survivor Scale.

Discussion

This study investigated the relationships between bereavement and primary appraisal, secondary appraisal, coping skills, perceived social support and stigma among women whose military spouses had completed suicide. There are several study findings that deserve further exploration.

First, there was a statistically significant positive relationship between stigma and bereavement, suggesting that as female survivors perceive increased stigma regarding the suicide of their spouse, they present more symptoms of bereavement. Knieper (1999) suggested that bereavement following suicide is not the same as that following natural death. He reported that stigma and avoidance continue to be central issues for suicide survivors. Psychological projection of feelings of rejection and the actual social response to the survivor interact in a complicated manner. Worden (2009) also noted a difference between suicide bereavement and other forms of bereavement, suggesting that suicide is often associated with stigma and a sense of shame. Such shame can result in the complete isolation of the bereaved during the period immediately following the suicide event. Eaton and associates (2008) examined survivors' barriers to seeking mental health treatment after the suicide of their partners and found that spouses were 70% less likely to seek treatment following a suicide, as compared to a natural death, and that stigma was a recurrent theme in the qualitative analysis. However, Eaton et al.'s study did not directly examine the impact of stigma on bereavement. It did show that stigma is an important variable that needs to be investigated further. The present study showed similar results to Eaton et al.'s (2008) research.

The qualitative comments recorded in the open-ended question section of the survey supported the study findings. For example, one participant responded, "I blamed myself for not doing more, not being there enough, or not being there when the death happened." Another participant noted, "Suicide is one of the most difficult and painful ways to lose someone we love, because we are left with so many unanswerable questions." One participant expressed the following:

[I felt] anger at family members for not assisting me with my husband and anger at physicians that treated my husband and were not able to see the warning signs or provide assistance in caring for them properly. I was then left with the scars after the death and had to explain to people what happened. I felt I got blamed and it was not my fault.

Several participants expressed "numbness and isolation." Responding to stigma, people with mental health problems often internalize public attitudes and become embarrassed or ashamed. These feelings can lead them to conceal symptoms and fail to seek treatment (President's New Freedom Commission on Mental Health, 2003). These survey responses assist in understanding the impact of stigma upon the military spouse survivors and imply that unanswered questions, as well as guilt, are important factors to explore in the grief process following a suicide.

Second, a statistically significant relationship between primary appraisal and bereavement was reported, suggesting that survivors who perceive the death of a spouse to be stressful are more likely to experience bereavement. This result is supported by the bereavement literature (Cvinar, 2005; Jordan, 2001; McIntosh, 1993). Lazarus (2005) argued that primary appraisal shows that it is not the situation, but the way a person interprets the situation, that affects the person's experience. The

way a person appraises a situation can impact the way the person reacts to it. Primary appraisal is an important step in processing the stress of bereavement, since grieving is such an individualized experience.

The qualitative comments recorded in the open-ended question portion of the survey supported the statistical relationship between primary appraisal and bereavement. For example, one participant indicated that her worldview had changed when she responded, "My world has become gray; I have made myself closed. I live in a rain cloud and now know that good people do bad things that change lives." The participant had changed her worldview such that her world became a smaller, more restricted place. Another stated, "This death, this loss, makes small things seem insignificant. Material things are insignificant. Relationships with people are more important. I don't have a fear of dying and in fact, feel like I will die at a young age." This concept of primary appraisal is based on the idea that emotional processes are dependent on a person's expectancies about the significance and outcome of a specific event. The same event within the same community (in this case, suicide within the military) can elicit responses of different quality, intensity and duration due to individuality in experiences and personality (Krohne, Pieper, Knoll, & Breimer, 2002). The different kinds of stress identified by the primary appraisal may be embedded in specific types of emotional reactions, thus illustrating the close conjunction of the fields of stress and emotion (Lazarus & Folkman, 1984).

Third, a statistically significant negative relationship was reported between secondary appraisal and bereavement, suggesting that survivors who make a negative appraisal of their ability to control the outcomes of their spouse's death are more likely to experience bereavement. In the future, when examining outcomes of interventions that impact coping, beliefs about a person's ability to perform specific behaviors related to coping would need to be highlighted. This concept is known as specific coping behaviors and is also pertinent to stress, coping theory and secondary appraisal (Chesney et al., 2006). Part of secondary appraisal is the judgment that an outcome is controllable through coping; another part addresses the question of whether or not the individual believes he or she can carry out the requisite coping strategy (Chesney et al., 2006; DiClemente, 1986; Hofstetter, Sallis, & Hovell, 1990).

The qualitative comments recorded in the open-ended section of the survey supported this finding. For example, one participant indicated her appraisal of the situation by stating, "Everyone must learn to face the misfortune, because life on the road will not be smooth." Another stated that "time can dilute all and I must face life and accept my reality;" yet another wrote, "I want to work on longer range goals to give myself some structure and direction to my life and not focus on my loss. I am only interested in rebuilding my life." However, other participants stated that it was harder to assess the loss and to move forward after the suicide. One participant stated the following:

I often find myself complaining to God about what seems senseless or unjust and unfair. I find myself bogged down in fear and even anger at myself or the person who died and "left" me. I do not accept what happen[ed] to me and my children.

Some participants reported not knowing what to do. An example of this feeling is the statement, "I perceive stress as threatening. I feel totally helpless." Perceived self-efficacy, defined as a belief about one's ability to perform a specific behavior, is a salient component of this theory. It highlights the importance of personal efficacy in determining the acquisition of knowledge on which skills are founded (Bandura, 1997; Chesney et al., 2006).

Fourth, a statistically significant negative relationship between coping skills and bereavement was reported, suggesting that survivors who believe they have a low ability to cope with their spouses' death are more likely to experience bereavement. Although it is important for survivors to become familiar with the stress appraisal process, the way they assign meaning to their spouse's death and their past experience with death also are important in their primary appraisal to the overall coping effort. One model of this process is the transactional model of coping (Lazarus & Folkman, 1984). This model of coping implies that a person's appraisal of his or her interaction with a difficult event naturally evokes a coping response for dealing with the situation. Experiencing a suicide or living in a social environment that hinders, stigmatizes or isolates a person who has experienced a suicidal death may cause demands to exceed his or her resources for dealing with certain situations. Few studies have examined the natural coping efforts used by suicide survivors, or have identified specific problems and needs that survivors experience following the suicide of a significant other (McMenamy et al., 2008). Interventions with suicide survivors have limited effectiveness (Jordan & McMenamy, 2004). Provini et al. (2000) presented four categories of concerns for suicide survivors: concerns related to (a) family relationships, (b) psychiatric symptoms, (c) bereavement and (d) stress. Family-related problems were the most frequently mentioned type of concerns (Provini et al., 2000). Examples of family relationship concerns included inability to maintain parenting roles, inability to maintain family routines, existence of different coping styles within the family, and inability to provide appropriate emotional support to family members.

Qualitative comments recorded in the open-ended section of the survey supported this study finding. For example, one participant stated, "I often feel distracted, forgetful, irritable, disoriented, or confused. I try to remember how I got over a death in the past, sometimes it helps and sometimes it does not." Another participant stated, "I know I need to start to form new relationships or attachments in my life but my mind [is] telling me 'there must be some mistake,' or 'this can't be true.'" Regarding bereavement, one participant wrote, "Grief is perhaps the most painful companion to death." Addressing coping, one participant stated, "I must also adjust to working or returning to work after the death. I know things can't go back to the way they were before, very difficult and painful to deal with and I better adjust to life." These statements support the need to further explore the relationship between one's ability to cope with the suicide of a spouse and one's ability to experience and acknowledge feelings and move forward with everyday life activities (e.g., employment, childcare, financial obligations). Ability to cope impacts a person's bereavement process; the ways and ability to cope vary with the individual. Stigma and amount of perceived social support have been correlated with ability to cope (Bandura, 1997). It is important to understand the individual impacts that stigma, social support, primary appraisal, secondary appraisal and coping have on bereavement. However, it is equally important to examine the relationships of these variables within the context of a model in order to establish future interventions for bereavement within the context of a suicide.

Fifth, results indicated that the model is statistically significant in predicting bereavement outcomes and provides considerable support for using the Lazarus model as a means of understanding the relationship between stress and bereavement when placed into the equation in a particular order: $CBI = TSD + PSAM + SSAM + CSES + MSPSS + STOSASS$.

This study suggests that the proposed model, using LCMS and assessment of stress, identifies the constructs associated with bereavement among women whose military spouses completed suicide. Future research could further explore the assessment of primary and secondary appraisal processes,

coping, stigma, and social support enhancement programs and interventions to improve the bereavement process for military spouses. When survivors can identify and address their needs, the bereavement process following a suicide can begin (Christensen & Yaffe, 2012).

Limitations

First, the majority of the sample (54.1%) were non-Hispanic White, or Euro-American. Second, there is limited representation across military branches. Third, the study collected data from a self-administered electronic survey. Fourth, although the social support measure (i.e., MSPSS) has good reliability and measures social support as a general feeling of belonging to a social network that one can turn to for advice and assistance in times of need (Uchino, 2006), it does not delineate various types of social support. Finally, most of the sample consisted of women whose spouses had completed suicide while on active duty. Active duty members typically live on base and are well connected to the military community. When the military spouse dies, these supports are often no longer available, and the stigma of a suicide could strongly affect these women.

Recommendations for Future Studies

There are several practice implications from this study. The statistically significant correlations between bereavement and four other variables (primary appraisal, secondary appraisal, coping skills and stigma), as well as the significance of the LCMS construct of primary appraisal within Model 6, indicate that LCMS holds promise for understanding symptoms of bereavement in females following the suicide of a military spouse. Primary appraisal, the most significant variable within this study, could be highlighted within bereavement research on women whose military spouses have completed suicide. When conceptualizing the responses of these women, counselors and clinicians could use LCMS, examining the three components of primary appraisal (goal relevance, goal congruence and ego involvement) and exploring the ways these components present during the client's bereavement process. The approach would focus on the role of maladaptive cognitions during times of stress (Sudak, 2009).

The reluctance of the military community to seek mental health support contributes to an inability to move through the bereavement process in a healthy way. Within the military community, it can be quite difficult to deal with the ambiguity of bereavement that is typically associated with emotional vulnerability (Lamorie, 2011). However, the current study suggests that four constructs—primary appraisal, secondary appraisal, coping and stigma—are significant when addressing the issues of bereavement in females who have lost a military spouse to suicide. Using LCMS to address cognitions, counselors might be able to assist a population whose members have been reluctant to seek mental health services in the past. Because the components of LCMS are correlated with bereavement, clinicians could use LCMS and cognitive stress research, which together seem to be a promising direction, when assisting women who have lost a military spouse to suicide.

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