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Exploring the Formal Supports Used by People Bereaved Through Suicide: A Qualitative Study

JANETTE M. McKINNON, BSocWk (Hons)
School of Psychology, Social Work, and Social Policy, University of South Australia, Clarence Park, South Australia, Australia

JILL CHONODY, PhD
School of Social Work, Indiana University Northwest, Gary, Indiana, USA

Approximately seven Australians take their own lives every day (Mendoza & Rosenberg, 2010), which means that thousands of survivors will require support for their unique grief each year. This study seeks to better understand the personal lived experiences of people bereaved by suicide by exploring their use of formal supports and identifying any unmet needs. In this phenomenological study, 14 individuals bereaved by suicide were interviewed. Thematic analysis of the data identified two major themes supports in the immediate aftermath and ongoing supports. *Survivors were inconsistently connected with service providers or provided with information regarding available services. The response of first responders and other professionals influenced the bereavement journey for suicide survivors, and the participants' lived experience ranged from compassionate to cold. Continuing study into postvention is critical to ensure that available supports can meet the needs of those grieving after a suicide. Such efforts may help avert complications associated with the suicide of a loved one.*

KEYWORDS suicide survivors, postvention, formal supports, first responders, peer support group

INTRODUCTION

Suicide has far reaching consequences, and the ultimate victims of suicide are those who survive (sometimes referred to as suicide survivors). Suicide is

Address correspondence to Janette M. McKinnon. E-mail: mckjm009@mymail.unisa.edu.au

one of the leading public health problems in Australia; approximately seven Australians commit suicide each day (Mendoza & Rosenberg, 2010). But the number of people bereaved by suicide is vast. Some studies estimate that for each suicide, six people are directly affected (Clark & Goldney, 2000; Sakinofsky, 2007); however, this likely underestimates the actual impact (Campbell, 1998). Perhaps a more accurate estimate is that 28 different bereavement relationships exist for every suicide (Campbell, 1998), which would mean that 14,520 to 67,760 new suicide survivors are created every year in Australia alone (Australian Bureau of Statistics, 2011). Those bereaved through suicide have unique bereavement needs due to the stigma associated with suicide.

THE IMPACT OF SUICIDE ON SURVIVORS

Knowing someone who has suicided is consistently connected to negative consequences, the most serious of which is an increased risk of suicide (Crosby & Sacks, 2002; Hoffmann, Myburgh, & Poggenpoel, 2010). Heightened physiological, psychological, and/or social anguish for extended periods of time (Jordan & McIntosh, 2011) along with feelings of guilt, shame, and rejection may be felt in addition to grief (Aguirre & Slater, 2010; Andriessen, Beautrais, Grad, Brockmann, & Simkin, 2007; Andriessen, 2009; Feigelman, Gorman, & Jordan, 2009; McMenamy, Jordan, & Mitchell, 2008). In a recent study, relatives or friends of people ($N = 163$) who had suicided were interviewed, and results indicated that 80% of participants suffered such frequent strong emotions that their everyday lives were disrupted (Schneider, Grebner, Schnabel, & Georgi, 2011). A common finding across studies is that those bereaved through suicide will be at risk for a range of psychological problems, including increased rates of complicated grief and suicide (Cerel, Jordan, & Duberstein, 2008; de Groot, de Keijser, & Neeleman, 2006; Feigelman et al., 2009; Latham & Prigerson, 2004; McMenamy et al., 2008; Mitchell, Sakraida, Kim, Bullian, & Chiappetta, 2009). A 2010 study explored the experiences of five South African females between the ages of 17 and 22 who had been bereaved by suicide. Their guilt, anger, depression, and blame were so intense that their bereavement and healing journey was protracted. They were also placed under immense physical and psychological risk, resulting in suicidal ideation (Hoffmann et al., 2010).

Furthermore, the response of others can also negatively impact on those bereaved by suicide. Increased stigmatization, isolation, rejection, guilt, abandonment, and blame may occur, which in turn can slow recovery and lead to complicated grief and even suicide (Botha, Guilfoyle, & Botha, 2009; Maple, Edwards, Plummer, & Minichiello, 2010; Ratnarajah & Schofield, 2008; Sudak, Maxim, & Carpenter, 2008). Feigelman et al. (2009) indicate that stigmatization experienced after a suicide death contributes to increased

depression, difficulties during the grieving process, and suicidal ideation for suicide survivors when compared to those who experience loss through non-traumatic death. A Swedish quantitative study utilized statistics from the death register and concluded that the degree of suicide in families bereaved by suicide is double that of families bereaved by other deaths, and that a family's history of suicide becomes a considerable risk indicator, independent of any acute mental health issues (Runeson & Asberg, 2003). These negative consequences combined with the potentially large numbers of bereaved highlight the need for postvention and the importance of ensuring that these supports can meet their unique needs.

NEEDS AND SUPPORT SYSTEMS

Effective and timely support for the bereaved is a key approach to preventing future suicides (Davis & Hinger, 2004; Jordan, 2001). Research indicates that those who accessed support showed enhanced coping skills (Gaffney & Hannigan, 2010), which suggests that supportive services are important for grief management for those bereaved by suicide (Gaffney & Hannigan, 2010). In a recent study, researchers explored the needs of families from the parents' perspective and found that the primary need was to have people physically present and willing to listen and support the family (Miers, Abbott, & Springer, 2012). On average, a close relative bereaved by suicide will take three to four years to gain enough psychological strength to reach some acceptance of life without their loved one. Even five years after suicide, levels of trauma and distress may still be three times higher than for the non-bereaved, emphasizing the importance of continuing support until they feel they no longer require the service (Begley & Quayle, 2007; Feigelman, Jordan, & Gorman, 2009; Murphy, Johnson, Wu, Fan, & Lohan, 2003).

A needs assessment survey conducted in the United States with adult survivors of suicide found that the bereaved needed different types of supports at different stages in their bereavement journey and that feelings and attitudes associated with the suicide may prevent many bereaved from accessing support (McMenamy et al., 2008). Research findings indicate that some people bereaved by suicide may become stuck—emotionally distanced with intense feelings of guilt—and find it impossible to move forward on their own (Hoffmann et al., 2010). Findings from two separate studies suggest that of those who participate in postvention activities, 65–88% found supports useful; however, those who did not receive professional support showed increased amounts of guilt, grief, and lack of energy (Dyregrov, 2002; Provini, Everett, & Pfeffer, 2000). Negative emotions may be reduced by receiving appropriate, timely, and sufficient support (Schneider et al., 2011). The availability of suitable and informed support for the suicide bereaved is essential, and an awareness of the complicated and distressing bereavement

they face is fundamental in supplying supports of the highest quality (Maple el al., 2010). Unfortunately, postvention services are often underdeveloped (Andriessen et al., 2007; Andriessen, 2009; McMenamy et al., 2008; Wilson & Clark, 2004), especially in rural communities.

PURPOSE OF THIS STUDY

The purpose of this study is to explore the formal supports utilized by those bereaved by suicide, which are referred to as postvention and defined as the provision of planned supports for those bereaved by suicide to aid the grieving process and reduce negative outcomes including copycat suicides (Andriessen, 2009). Better understanding the current postvention services is important as it will allow providers to offer supports that are more relevant and beneficial to those in need of support. The research was guided by the following four research questions:

1. What supports have people bereaved through suicide used during their bereavement journey?
2. Of these supports which were helpful?
3. What are their unmet support needs?
4. How have the supports they used affected their bereavement journey?

METHOD

This study utilizes an interpretive phenomenological methodology to gain in-depth knowledge about those formal supports employed after experiencing the suicide death of a loved one. The rationale for this approach is that it privileges the voices of those bereaved by suicide and allows the researcher to gain insight into the rich experiences of study participants. To achieve trustworthiness of findings, qualitative research should seek to achieve confirmability, dependability, transferability, and credibility (Bryman, 2012; Liamputtong, 2009b; Lincoln, 1990; Mertens, 2012). Confirmability refers to the degree to which the results support the data collected from study participants whereas dependability is related to quality of processes, which requires attention to detail in data collection and analysis (Guba & Lincoln, 1982). Transferability indicates the degree to which findings can be applied beyond the current research (Guba & Lincoln, 1982). Credibility addresses the accuracy of research and can be achieved by methods such as member checking (Guba & Lincoln, 1982).

In-depth interviews were employed for this study, which allowed for a discussion of sensitive issues and created a space for participants to fully explore their experience with the researcher. Guided by an interview

schedule, the primary researcher explored the use of formal supports with participants during a semi-structured interview. The interview schedule detailed the broad topic areas that were to be covered during the interview, but it also allowed the interview to remain conversational and gave the interviewer the ability to probe and ask follow-up questions to gather in-depth responses from participants, which is the chief benefit to this approach (Rubin & Babbie, 2011).

Participants

A purposive sampling framework was employed to recruit participants. Eighteen local social service organizations were contacted to recruit participants, and five organizations agreed to help with recruitment. The primary researcher spoke at two peer support group meetings, articles and flyers were distributed, and information was also included on four websites of suicide prevention and postvention agencies. Participants made direct contact with the primary researcher to schedule an interview. Ten participants were originally sought to achieve data saturation; however, to gain both a metropolitan and rural perspective, a total of 14 participants were interviewed, which included six rural participants and eight metropolitan participants. All of the interviews were face-to-face, except one who preferred to respond via e-mail. Interviews lasted around 90 minutes, and began first with a series of demographic questions (e.g., participant's age, time elapsed since death of loved one and relationship to the deceased). Guba (1990) and Liamputtong (2009b) indicate that demographic information along with rich descriptions may permit the transferability of a study's findings; therefore satisfying one of the criteria for qualitative trustworthiness.

Data were transcribed, and all identifying information was removed during transcription and replaced with pseudonyms to protect participants' anonymity. Once transcription was completed and reviewed for accuracy, the transcript was e-mailed to each participant for member checking along with some clarifying questions. Seven of the 14 participants returned additional information, and five of these were from a metropolitan area. This process ensured that experiences of participants were faithfully represented, maintaining the study's credibility and rigor (Ezzy, 2010). The additional notes were found to be very explicit and a worthwhile addition to the spoken data. This process allowed for confirmability and thus contributes to the trustworthiness of qualitative data.

Coding and Analysis

The primary author conducted thematic analysis. First, data familiarisation was achieved by methodically reading and re-reading transcripts until common words, phrases, and concepts emerged that generated initial codes

(Braun & Clarke, 2006). Next, common themes were identified by analysing specific similarities and differences, which were then sorted into overarching themes (Braun & Clarke, 2006; Liamputtong, 2009a). The primary researcher noted the initial codes onto individual sticky notes, placed them on a large sheet of paper, moving them around and organizing them into themes while thinking about the relationships between codes, sub-themes and main themes. Creating a thematic map provided a visual review of the relationships between themes and resulted in the discarding of some, combining of others and the eventual creation and naming of the themes (Braun & Clarke, 2006). Framing the thematic analysis within an inductive approach supports the constructivist perspective of the study and was achieved by not attempting to fit the data into pre-conceived codes (Braun & Clarke, 2006). It was important to retrieve the meanings within the data and not impose preexisting views on interpretations in order to represent participants' views with reliability (Flick & Gibbs, 2007).

RESULTS

Demographic Characteristics of the Sample

The age of participants ranged from 26–75, and 12 of the participants were women. The average age of the sample was 49, and at the time of the suicide, participants were between 18 and 74 years old. The relationships of the deceased to participants included brothers (5), sons (5), a grandfather, husband, father, sister, and wife. Bereavement periods for participants spanned from 24 years to less than twelve months with an average of 5.93 years.

Thematic Findings

While each participant had a unique experience with the formal supports they encountered, two dominant themes emerged: (1) supports in the immediate aftermath and (2) ongoing supports. Within each theme, helpful and unhelpful aspects of the support were identified as well as unmet needs. First, we discuss the support received in the immediate aftermath of the suicide, such as first responders, funeral directors, and the coroner's office. In Australia, the coroner's office is primarily tasked with investigations, inquests and making findings of deaths that were not the result of natural causes. Second, we explore ongoing supports, such as peer support groups.

Immediate Aftermath

A variety of different professionals may have contact in the immediate aftermath of a suicide. In this study, participants identified police,

paramedics, the coroner's office, funeral directors, and early support workers. Nine participants indicated that they had a number of negative experiences with first responders who did not assist them in the immediate context of the suicide. Specifically, they found that many of these personnel lacked compassion and respect for what they were feeling. They also felt unheard and judged and were not allowed enough time to say goodbye to their loved one. Experiences with first responders are significant because they influence the way the bereaved move through the grief process (Salvatore, 2010). Elizabeth reflects on her experience at the scene of her son's suicide:

> . . . they said "don't hurry, nothing to do here." I shall always remember that, at the top of his voice. . . . I thought good God. It was really bad . . . none of them spoke to him [husband]. I mean they didn't speak to me, but I was still in a coping mode, [but] he had completely collapsed. I would have thought they would have done a bit more.

Helen reflects a similar experience in her encounter with a funeral director, ". . . she said to me 'what a naughty boy.' It was the first thing that she said. . . . I was like my goodness." On the other hand, Deb indicated how her funeral director was generous with his time and linked her to an early support service that she found valuable and supportive: ". . .they would just let you talk and they'd ask you what you were feeling, what you were going through and it was very reassuring that you're on the right path and not going insane."

Of those who had direct contact with police immediately after the suicide ($n = 9$), the majority reported support that was kind, compassionate, caring, and empathetic: ". . . the police were fantastic. They were incredible, very understanding and very supportive, and no pressure. . ." (Deb). Elizabeth was supported by a police liaison officer the day her son suicided and found him "fantastic" and his support was "well over and beyond anything we would of ever expected." However, Elizabeth was the only participant to receive this service from the police.

Written materials were given to three participants during initial encounters with the police and/or the coroner's office as a means of providing information intended to assist in the grieving process. However, participants felt indifferent about this material since the information was generally outdated and often irrelevant to their needs. Two participants (Elizabeth and Margaret) were contacted by a social worker from the coroner's office and were informed about the coronial process. Elizabeth was also connected to an early support service, which she found to be appropriate and helpful.

Seven participants identified frustration with the coroner's office in terms of communication and the amount of time taken to manage the autopsy. These issues may contribute to a prolonged bereavement experience. Six

participants felt unsupported by the coroner's office because they were not kept informed about the progress of coronial processes. They felt frustrated, upset, and angry and it made one participant "feel a whole lot worse" (Helen). While information within the coroner's report may provide closure, an extended reporting framework could draw out the process of closure and make it more painful. This is illustrated by Nicole's comment: "It helps with the sense of closure, to find out what happened . . . it takes a long time . . . eventually . . . six months plus."

Ongoing Support

Nine participants emphasised how their physical and mental health hindered their ability to search for ongoing support services. The physical consequences of grief felt by participants included: insomnia, poor appetite, low energy, increased anxiety, and uncontrollable crying. They also struggled with complicated feelings of anger, self-blame, depression, and guilt. This complex web of mental and physical states highlights the difficulties participants faced in locating and connecting with supports on their own. Participants identified the process of being proactively linked to ongoing formal supports as a major unmet need. Alana exemplifies this: " . . .I think you don't have the energy when you're needing the help the most, you don't have the energy to seek it out. . ."

This issue was compounded for participants from rural areas who could not find formal supports in their local areas and were expected to travel long distances to receive support. Due to those physical and emotional consequences associated with grief, travelling long distances for support is inherently difficult. Catherine states, "I don't want to, I'm stressed enough as it is, I don't want to have to drive to the city."

Peer Support Groups

Eight participants were adamant that attending a peer support group would not help them to better cope with their grief. They indicated that they did not want to listen to others retelling their stories of suicide and would find it difficult to share their own stories. For example, Deb explains why she did not attend a peer support group. "I don't know if I can sit and listen to other peoples' tragic stories; I'll just be heartbroken." Individuals react differently to the distinct feelings associated with a death by suicide, which in turn means that they will require different coping strategies. Hence, they will have different support needs. Five participants felt that overall their experience in a peer support group was unproductive, and four never returned. They felt that peer support groups did not introduce them to new ways of healing. As explained by Lauren: ". . .I needed to do more than just talk around in circles. . . . I needed to know that there were strategies that you could use; there were ways of healing."

Peer support groups may be the only formal support available to assist with their grief, yet some participants felt that these groups needed a professional presence to help direct the group, support the recently bereaved, and keep them up-to-date with new coping strategies. Margaret highlights this when she states, ". . .it would be wonderful with these groups if there was a trained professional there who could, to be the one to sort of direct . . . they have a professional insight into what could be helpful if need be."

Nonetheless, 11 participants identified at least some aspect of support groups could be helpful. The companionship, mutual understanding, and comfort gave the participants a sense of belonging, and the support they received made them feel validated and hopeful. These experiences meant participants did not feel alone or isolated when they attended the group, and they felt the things they were going through were normal. This is illustrated in Alana's comment: "The most helpful thing above all was just being with people who understood . . . there's just something so comforting about knowing that someone else has the similar burden."

Peer support groups can provide a sense of normalization since everyone has been through a shared experience, but some participants indicated a desire for one-on-one support with a person who had personal experience of suicide bereavement. Lauren explained how her connection to someone who had also been bereaved by suicide was invaluable, making her feel "hopeful" and "understood." This experience made Lauren realize that if her support person could survive, then perhaps she could too. This type of support may help ease some of the difficulties associated with complicated grief and give survivors a further sense of normalization. Helen also praises immediate one-on-one support:

> I think for first contact . . . because I think it's a pain that's indescribable . . . you've got that connection. So you might be talking to someone and you can actually feel as well as understand what is happening for them. You know I think that having a peer person like that is essential. . .

Other Professionals

All participants sought some form of clinical support from professionals and semi-professionals in order to identify strategies to help them cope with grieving for their loved one. Counselors, psychologists, and local doctors were the main avenues of assistance. Finding clinical help from someone who was compassionate and experienced in grief and loss was a challenge, as illustrated by Linda's comment: ". . . it is difficult to find a counselor, psychologist, or a psychiatrist that you can build a good rapport with. . ." These difficulties, which were also expressed by other participants, underscore the significant issue of continuity of care for those bereaved by suicide. Six participants reflected how the discontinuity of care actually deterred them from looking for another support. The continual turnover of support staff

resulted in the bereaved having to frequently retell their stories, which they found very difficult.

Three participants were able to locate and connect with counselors that gave them helpful strategies, but local doctors can also be another important support in the bereaved person's network. Nine participants did find their local doctors to be very supportive (e.g., in assisting them to seek support, research and explain things, spending time listening and giving realistic advice, and having a caring attitude). This is highlighted in the comments from Anthony: ". . .our General Practitioner has counselled us. I personally found his chat much more realistic, and helpful than other counselling."

However, Alana had the opposite experience. ". . . she wasn't even very . . . very compassionate actually . . . was quite a clinical approach. . ." From the participants' perspective they understand that they will not always match with every doctor they contact, but they do feel that at a minimum they should receive compassionate and empathetic support so their needs can be assessed.

DISCUSSION

From the participants' lived experiences after the suicide of their loved one, our findings suggest that availability and consistency of formal supports are major issues. For some, they found that supports were unpredictable, awkward, and unhelpful, but for others, they found effective and compassionate support. This variability in support in the aftermath of significant life event played a role in their individual grief processes. To create appropriate supports for suicide survivors, researchers need to work closely with the bereaved, recognizing them as the experts (Andriessen & Krysinska, 2012; Dyregrov, 2011). Their ideas need to be incorporated into policies concerning suicide prevention, postvention design and implementation. Their input into the process could help refine the type of supports offered and the timing of those efforts. Such efforts begin with the first encounter a suicide survivor has—typically that of first responders.

Police and ambulance personnel are most likely to have first contact with the bereaved; therefore, it is important that they are trained to provide the first line of support for the suicide bereaved. Additional education around the specific complications associated with suicide grief might improve first responders' ability to respond to the needs of the bereaved. These findings are consistent with those of a needs assessment survey by McMenamy et al. (2008), which found that first responders needed more specialized training to be able to appropriately assist the bereaved. Their support may help normalize survivors' reactions. Moreover, they may also be able to provide information and referrals to specialized resources.

During the immediate aftermath of suicide, first responders' reactions toward survivors can influence how survivors react to the initial trauma

and grief (Davis & Hinger, 2004). First responders are able to establish the tone for responding sensitively and respectfully to the needs of survivors (Salvatore, 2010). The experiences of this study's participant's suggest that following a suicide death, those bereaved consider themselves to be in the care of first responders. Participants expressed an expectation that first responders would, as part of their duties, consider their well-being. In some cases, this expectation was met, but it is unclear whether this occurred as a result of formal training or simply as a compassionate and personal reaction by first responders. However, survivors' well-being may be a relatively low priority for responders who are trained to focus on the immediate circumstances surrounding a death.

Furthermore, the Community Affairs References Committee (2010) found that coronial processes may cause additional trauma on those bereaved by suicide, and this was consistent with the findings in this study. Participants showed a preference for more information about the coronial process and regular status reports. Only some participants received an information pack, but it was largely out-of-date and thus unhelpful. A survey of people bereaved by suicide in metropolitan Adelaide ($N = 166$) indicated that only half of all participants received support information after the suicide (Wilson & Clark, 2004), illustrating an area still requiring change. Resource materials should be comprehensive, but manageable, and provided in hard-copy because at the time of receiving such information, they are not likely to comprehend important details when presented orally. Support packs need to reflect current information and resources and may need to be replaced with more contemporary material, such as the newly created booklet by the Commissioner for Victims' Rights (2011), which is an all inclusive resource guide for those bereaved by suicide in South Australia. Andriessen et al. (2007) reported on the 1st International Suicide Postvention Seminar, where the English National Bereavement Information Pack was discussed and the primary take home message was that such booklets need to contain complete and current information and be easily disseminated to those who need it most. Hence, the importance of making sure that those bereaved through suicide receive material that gives them a wide and comprehensive range of strategies and contacts to pursue.

Having someone that is available to listen to you is important to those bereaved by suicide (Miers et al., 2012). Effective contact with first responders and other professionals can determine how those bereaved by suicide cope with the death of their loved one (Davis & Hinger, 2004). In this study, many participants found it difficult to find effective, caring, and compassionate formal supports. While not all participants had negative experiences, the unsympathetic responses of some left a lasting impression. This finding contrasts to an Irish study, which found that participants valued the support received from professional structures (Trimble, Hannigan, & Gaffney, 2012).

It is important for first responders and other professionals to assist the bereaved by being "present" with their grief and understanding its intensity, duration, and the associated complications of guilt, shame, blame, anger, rejection, and abandonment (Jordan, 2008). Findings from this study reflect this need and for some participants, this presence and understanding was missing. In turn, this lack of empathy along with inappropriate communication negatively impacted on an already traumatic experience. Those who had the experience of encountering compassionate and understanding support found that they were better able to negotiate a difficult situation. Suicide grief is distinct from other forms of bereavement, thus individual survivors may need assistance to find the supports and strategies that work best for them in their own personal healing journey.

While the responses of first responders elicited a number of negative experiences for participants in this study, a number of positive outcomes were attributed to peer support groups, including: companionship, mutual understanding, and reciprocity. Survivors' who join peer support groups may feel supported by the discovery that they are not alone and that others have similar feelings and experiences (Trimble et al., 2012). Peer support groups for many survivors have proven to be a highly valuable intervention, providing a safe environment where their experiences are normalized, they feel accepted, listened to, understood, receive advice and resources, find companionship, and can assist others in a way that is also meaningful for them (Dyregrov, Plyhn, & Dieserud, 2012; Jordan, 2008). Peer support groups can provide a safe environment where participants can be heard and understood. The findings from this study reflect some aspects of these positive attributes. In fact, for those who attended a group, they found the most helpful aspect to be the unconditional acceptance by other group members and the normalization that occurred by sharing their experience, a finding that is reinforced by past research (Trimble, Hannigan, & Gaffney, 2012).

However, this study also found that for some participants attending a support group did not provide positive intervention. The primary disadvantage was related to the difficulty associated with listening to other peoples' stories. Listening to how and why other peoples' loved ones had suicided was enough of a deterrent for some participants to never attend, and for others, this heartbreaking experience acted to limit their attendance. In addition, participants found that these groups did not provide healing strategies or alternate approaches to coping, and often lacked organization and direction. Feigelman and Feigelman (2008) found similar reasons for withdrawal during their four-year observations of participants attending a support group. Participants who stopped attending the support group stated a number of reasons, such as unhappiness with the facilitation of the group; feeling that the group had negative effects on them; meeting time was dominated by some members; and the groups' focus was not with assisting survivors towards recovery (Feigelman & Feigelman, 2008). Participants of

this study indicated that peer support groups could be improved by a facilitation process that seeks to meet the varied needs of all survivors. Peripheral to that end, a specialized training course for peer facilitators could provide education and training on coping strategies and processes of group facilitation. Alternatively, professionals within the postvention field could serve as mentors for peer facilitators to help improve supports and outcomes by providing various resources, including guest speakers, healing strategies and activities, new research findings, and progress within the postvention field. This unmet need may be remedied by further collaboration and networking within the field.

No matter how good the services are, survivors still need to be aware that they exist and be able to connect to them. One of the main unmet needs identified in this study was the absence of formal methods to consistently connect those bereaved to support services. While some participants in the study were connected to valuable supports, the majority struggled to find support they needed. Participants indicated that this led them to experience complicated grief, increased trauma, anxiety, not sleeping and eating, confusion, and withdrawal. To overcome this problem and ensure those bereaved by suicide are connected to helpful supports, it is imperative that proactive postvention services are available. Those bereaved by suicide may well endure physical, mental, spiritual and emotional reactions, which may result in overwhelming, lifelong and life-altering impacts for survivors (Mendoza & Rosenberg, 2010). These reactions can be debilitating and may significantly affect the ability of bereaved to seek help and support. This was exemplified in our study by Alana's comment: ". . . I think you don't have the energy when you're needing the help the most, you don't have the energy to seek it out. . ." Waiting for those bereaved to connect to supports is ineffective as the bereaved often become isolated and depressed and unable to find the necessary supports on their own (McMenamy et al., 2008).

Furthermore, early connection with support services generally resulted in positive support experiences for participants; however, early connection was not consistent across the sample, possibly as a result of passive postvention by first responders. A more proactive approach by support providers can have significant benefits for those bereaved (Trimble et al., 2012). Past research suggests that those who cannot easily connect find it difficult to find the energy to persist in their search for support, and this can significantly extend the period it takes to find support (Aguirre & Slater, 2010; Cerel & Campbell, 2008). Connecting those bereaved by suicide to an early support service may ensure that they are adequately informed and supported in a way that is compassionate, sensitive, and empathetic (Aguirre & Slater, 2010). Proactive postvention could result in survivors being given information about local resources and possibly being connected to supports sooner, resulting in an improved grief process and reduced risk of suicide (Aguirre & Slater, 2010). Proactive postvention by early support services may

provide home visits, offer reassurance, explain services, answer questions, and/or supply a range of resources (Aguirre & Slater, 2010). Connecting with services earlier can help to normalize emotional reactions and associated stigma (Cerel & Campbell, 2008). Due to the uniqueness of suicide bereavement and the individual nature of coping, future research into the support needs of various groups is warranted. Participants felt that formal supports were significantly deficient in continuity of care and long-term support. These requirements are often clearly identified by survivors as significant support needs, but often underestimated by support providers (Lindqvist, Johansson, & Karlsson, 2008). Many of the participants in this study have been bereaved for a number of years, yet they still struggle with many of the affects of complicated grief, highlighting the need for long-term support. Replicating this study to identify support needs among other groups of survivors (i.e., Indigenous, children/teenagers, and refugees) would be a valuable addition to this body of knowledge.

LIMITATIONS

The findings from this study should be viewed within the context of its limitations. First, the majority of participants for this study self-selected from one support service that they were currently using or from which they had once received support. Another range of responses may have been generated with a more diverse sample of people bereaved by suicide; for example, survivors who utilized other support services or did not use any formal supports. Second, variances in the sociodemographic characteristics associated with those bereaved through suicide, such as men, younger survivors, and diverse cultural backgrounds, may have led to other types of narratives. Studies involving a broader range of participant experiences may result in findings that point to improved postvention for specific groups of the bereaved.

CONCLUSION

Our findings indicate that formal supports were inconsistent with some participants receiving support that helped ease their grief, while others experienced inadequate assistance, which contributed to their grief. Empathy, compassion, and non-judgemental communication in the immediate aftermath of a suicide create an atmosphere for those bereaved to feel supported. Ongoing supports that normalize the experience and offer healing strategies can facilitate the grief journey. This article provides those within the field of postvention with further information regarding the specific needs and the formal supports those bereaved by suicide find helpful. These

findings contribute to the existing wider body of knowledge regarding suicide postvention and, in particular, the personal lived experiences of those bereaved by suicide and may inform future support program design.

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