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Suicide postvention; coping, support and transformation

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It has been estimated that for every death by suicide, there are at least six bereaved people left behind. Ten participants, five male and five female bereaved by the suicide of a close family member, completed a qualitative questionnaire on postvention experiences. Postvention activities are defined as those which are helpful, supportive and appropriate for individuals bereaved by suicide. Postvention is regarded by some as prevention for the future. Losing a close friend or family member by suicide is often one of many features which are considered risk factors in assessing suicidality in an individual. Survivors are susceptible to a range of mental health difficulties, including further suicidal ideation. Many studies on postvention have focused on grief and pathologies, as opposed to highlighting the aspects of impact, coping and latterly, the potential for psychological survival and transformation. Based on survivor accounts, factors have been identified which contribute towards the experience of bereaved individuals in accessing social, community and professional supports. Key themes include: helpfulness of social supports, support groups as a vehicle to contextualise and normalise feelings, desire for understanding and knowledge from professionals, acknowledgement of traumatic nature of bereavement. These findings lead to important and much needed empirical and clinical practise-informed recommendations for mental health professionals engaged in service provision and treatment with individuals, families and organisations. The study finds that trauma focused interventions may benefit survivors who also report the desire for greater access to networks and the further development of proactive networks of support. It is clear from the foregoing that postvention supports, using protocols developed from key research, can go some way in reducing the impact of suicide.

Keywords: suicide; suicide postvention; suicide prevention; suicide bereavement

Introduction

The study of suicide has been historically broken down into three distinct, but interrelated areas: prevention, intervention and postvention (Shneidman, 1981). Postvention efforts are those made to provide support, assistance and crisis intervention in the aftermath of a completed suicide.

Some findings suggest that the reactions of those bereaved by suicide do not differ substantially from other types of bereavements (Muller & Thompson, 2003; Van der Wal, 1989). However, bereavement by suicide has been shown to encompass qualitative differences when compared with more typical bereavements, with the bereavement process including different aspects (Bailley, Kral, & Dunham, 1999),

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unique themes (Jordan, 2001), proving to be more complex and taking more time to move forward (Fielden, 2003). Those bereaved by suicide often struggle with guilt, shame, self blame, isolation and may be at heightened risk for complicated grief and suicidal ideation in future (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004). Furthermore, research has shown that suicide can be contagious in nature (Gould, Jamieson, & Romer, 2003), especially in younger age groups.

Partially in response to increasing numbers of suicide completions, the International Association for Suicide Prevention (Andriessen, 2004) formed Taskforce Postvention in 1999 to increase the public's awareness of issues facing those dealing with the aftermath of suicide and encouraging postvention activities. It has been suggested that effective management in the aftermath of a suicide includes interplay of various strategies on multiple levels, such as professionals, community groups, youth agencies and political support (Hacker, Collins, Gross-Young, Almeida, & Burke, 2008).

Researchers have called for the generation of hypotheses in the areas of postvention (Leenaars & Werckstern, 1998) and particularly for more detailed accounts on the bereavement experience as theory and evidence-based intervention are lacking in this area. Professionals can benefit from examining the interaction between the individuals and the wider system through which they attempt to cope with their loss. The aim of this study is to explore the postvention experiences of individuals bereaved by the suicide of a close family member.

Method

Participants

A semi-structured qualitative questionnaire was administered to five males and five females in Dublin, Ireland. Participants' age ranged from 18 to 60+ with a mean age of 38. Inclusion criteria for participants was the loss of a partner or close family member by suicide a minimum of one year previously, which occurred in the Republic of Ireland.

Procedure

Questions guided participants to report on experiences accessing social, community and professional support networks (see Table 1).

Prior to commencing the research, the questionnaire was piloted for length and clarity of items and subsequently revised. Participants were recruited through two

Table 1. Researcher-constructed questions.

Demographics recorded and qualitative questionnaire
Participant age range, nationality, gender and urban/rural living
Experiences in community/professional support
How did you feel the community responded to your loss?
Please describe your experience with professional support services
Please list reasons a person might decide not to seek professional support
What do you think can be done to better support those bereaved by suicide in Ireland?
What do you think counsellors should know about working with individuals bereaved by suicide?

bereavement support services which were accessed locally. The groups were roughly representative of suicide bereavement services operating in Europe at the time as indicated by the IASP (Andriessen, 2004). One was a closed support group and the other was an open support group. Ethical approval was obtained from the University of Dublin, Trinity College Ethics Committee.

Analysis

Analysis used descriptive and interpretative thematic analysis (Elliot & Timulak, 2005). Steps of this approach include: (1) data collected are assigned into domains which represent a conceptual framework that the researcher brings to or unearths in the data; (2) meaning units are delineated; (3) categories are generated through the comparison of meaning units that link and are interrelated on the basis of conveying similar meaning (4) the main findings are abstracted in the form of narratives. The analysis involves several credibility checks to ensure its validity. All data from this study were independently analysed by two researchers and compared for consensual agreement.

Results

Length of time since the bereavement ranged from 1 to 24 years. Participants had accessed a broad variety of professional support and community services between them, including support groups, counselling, psychotherapy, group therapy, general practitioners (GPs/MDs), psychiatrists, family support services and pharmacological treatment. All participants have been given pseudonyms to protect anonymity. Thematic domains from the analysis appear in Table 2.

Table 2. Experiences in community and professional support.

Thematic domains relating to experiences in the community
Initial support – receiving practical, emotional and financial support from family, neighbours, friends, teachers, clergy
Gradual detachment – gradual lack of openness about deceased person and cause of death, distancing and isolation
Thematic domains relating to experiences with professional support services
Emotional expression and sharing – talking about bereavement experience, hearing others' experiences, emotional expression, normalising element of sharing
Lack of understanding – feeling uncomfortable, not understood, professional services did not know how to help
Need for better access to services – more availability, promotion, expansion, low cost, more specialised services, proactive services
Minimising stigma – increasing awareness, providing information, breaking silence, particularly with older generations and schools
Knowledge of the traumatic impact – desire for professionals to know and recognise pain, strong feelings, expression and acceptance difficult to cope with
Subjectivity – uniqueness of context, individual, grief, coping and needs
Fear of judgement/stigma
Do not think it is necessary
Do not think the professional will understand unless the professional has personal experience
Access and/or cost
Not ready to face the issue

Participants described *Initial support* from people in the local community as being most helpful following the loss. Participants did not appear to avail of professional support structures during the initial bereavement period, but mentioned exchanges like callers coming in and out of the home and assistance with practical matters such as finances. This experience waned for some participants, who described an experience of *Gradual detachment* involving a lack of openness about the deceased person and the cause of death as time went on. This experience seemed to contribute towards feelings of isolation and a disconnection from individuals who initially had seemed supportive. 'Immediately I got good community support as I lived in a small town . . . but soon after the death people drifted away and didn't know what to say to me anymore' (Brian). Another participant echoed this sentiment, 'The community showed great care in the beginning and then detached themselves as they did not want to mention (relative's) name' (Kate).

When describing experiences with professional support services, participants frequently mentioned *Emotional expression and sharing.* Most participants described experiences in support groups, as opposed to other professional services. Participants described being able to express feelings and feel accepted, to share their own stories and to hear the stories of others '. . . met people who I could speak all personal feelings to and they did not think I was going mad'(Jane). The sharing element seemed very important for participants, and helped individuals to contextualise and normalise their feelings. '. . . listening to other people's experiences helped me understand my own feelings better' (Sarah).

Many survivors mentioned a *Need for better access to services.* Greater access to services, expansion of services and better promotion of existing services were recommended. Some suggested proactive support networks, such as 'One professional assigned to liaise with the bereaved family to offer support' (Kate). Others felt that low cost and free services and specialised services (lesbian, gay, bisexual, transgendered or teenager specific) were needed.

Participants felt that *Minimising stigma* was important for survivors to feel supported. From professionals, service users wanted *Knowledge of the traumatic impact* that suicide has on survivors. Participants described the importance of feeling understood and of the depth and complexity of the feelings they brought to professional services. The cognitive component of processing the finality and the method of the death was also an area participants found difficult to verbalise. The act of speaking about these things with another person was a risk for some. Other participants noted that survivors might be more apt to talk to someone with personal experience of bereavement by suicide.

Subjectivity captures a thread that ran throughout the responses, particularly in relation to what participants wished professionals would know about their experience. Participants spoke of the suicidal context of the bereavement being unique, along with the bereavement process, the individual personalities of the mourners and the individual coping experience. Developmental stages of the bereaved were mentioned '. . . because of age, status, and personality, we had to accept (partner's) death at different levels. So no two people had the same sense to it all' (Anne).

Discussion

The support participants described as most helpful during initial stages of bereavement was generally not professional support, but community based support. This

may indicate that education and training on community levels are important aspects of any postvention programme, particularly focusing on the fact that while initial support is important that follow up may be necessary on a longer term basis. These findings are consistent with conclusions drawn by Hacker et al. (2008) that effective management in the aftermath of a suicide includes integration of strategies on multiple levels, such as professionals, community groups, youth agencies and political support. This type of follow up may be achieved by enhancing interconnectivity between community agencies, youth groups, schools, mental health services and families.

Participants mentioned receiving practical social support, emotional support and assisting others as helpful during the bereavement process. Van der Wal (1989) maintained that keeping relationships and supports was an essential task following a bereavement by suicide. It has been suggested that despite being at higher risk due to experiencing bereavement by suicide, that effective social support can offset this risk (Joiner, 1999).

Participants also valued support they received through more professional structures. While evidence on the effectiveness of bereavement support groups has been challenged (Wortman & Silver, 2001) survivors often indicate that talking in support groups is helpful, both to be heard and to learn to accept social support. Participants in this study seemed to greatly benefit, both from support they received within the community and from the opportunity to share their feelings and hear the stories of others within bereavement support groups. These effects of support groups with suicide survivors have been documented in other research (Pietila, 2002).

It has been suggested that there may be a dissonance between the experience the survivor feels in the initial few weeks following a death by suicide and what the survivor may expect to feel (Gaffney & Hannigan, 2010). The process of coping with bereavement by suicide is characterised by fluctuations between expression of emotions and loss with regulatory strategies (Gaffney & Hannigan, 2010), such as distancing, avoidance and focus on daily tasks. Bereaved individuals may meet criteria for Acute Stress Disorder as defined by the diagnostic and statistical manual of mental disorders (DSM IV-TR; American Psychiatric Association [APA], 2000) and later on for post traumatic stress disorder. The process described by survivors is often not linear and involves an oscillation between cognitively and emotionally processing the suicide and returning to routine day to day living (Gaffney & Hannigan, 2010). Models such as the dual process model (Stroebe & Schut, 1999) may be useful for clinicians conceptualising this type of bereavement.

When asked why survivors may not access professional support, the most common answer in this sample was fear of judgement or stigmatisation. Culturally, stigmatisation is worth giving consideration, as suicide was only decriminalised in Ireland as recently as 1993. The participants in this study spoke of the continuing importance of de-stigmatisation of suicide. Stigma reportedly added to their burden of grief and decreased their sense of being understood.

Considering the relative risk for suicide once exposed to the suicide of another person may be great (Gould, Jamieson, & Romer, 2003) and that a person may be impacted by relationships of a more distant nature than previously thought (De Leo & Heller, 2008), using screening and other risk assessment procedures for individuals impacted by death due to suicide is important. Individuals who are linked in any way with a suicidal attempt or completion by someone else may benefit from such an assessment, particularly with adolescents.

Limitations

The findings here serve as an initial step towards informing postvention in an evidence-based manner, grounded in the experiences of bereaved individuals. Due to the small sample size and cultural context, these findings provide a starting point for further exploration of intervention and community service development but may not generalise to other contexts. As participants were sourced from bereavement support services, findings do not include experiences of those bereaved by suicide who received no intervention or who received intervention from local mental health services. Further exploration into these groups and how experiences compare with those in bereavement support services is needed.

Conclusion

Phenomena which occur in the aftermath of a suicide are difficult to study and conceptualise and depend on a variety of complex factors on individual, family and community levels. Services should be prepared to operate on multiple levels and offer short and long term supports. Those bereaved of a person close to them have reported social support and experiences in support groups as helpful to the bereavement process. Trauma focused interventions may benefit these individuals during treatment. These survivors also report desiring greater access to networks and further development of proactive networks of support. It is clear from the foregoing that postvention supports, using protocols developed from key research, can go some way in reducing the impact of suicide.

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