

Suicide Postvention

Support for Families, Whānau and Significant Others after a Suicide

A literature review and synthesis of evidence

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OVERVIEW

This report has been commissioned by the Ministry of Youth Development to summarise current evidence based knowledge about bereavement by suicide, and support and services for those bereaved in this way. This information is intended to provide background and context for the enhancement and development of support services for people bereaved by suicide, with this work being undertaken as part of the development of a comprehensive national suicide prevention strategy. This paper has been commissioned to address mainstream issues, explicitly. Companion reports describe:

- i) Cultural perspectives (including those of Māori, Pacific Peoples and Asian populations) about death, bereavement, mourning, suicide, and needs for support following suicide deaths. This report includes a review of Māori, Pacific Peoples and Asian literature and research about these issues ¹.
- ii) Resource materials produced and available in New Zealand, and produced overseas, providing information about suicide for individuals and families bereaved by suicide ².
- iii) Existing support services, and the perceived needs of stakeholders for support services, counselling and related resources in New Zealand for those bereaved by suicide ³.

This review focuses upon health-related research associated with grief and bereavement. Whilst there are other approaches to studying grief and bereavement (including, for example, those which adopt primarily anthropological or sociological perspectives) grief and bereavement may have potential health-related consequences. This may especially be the case for suicide deaths because of the nature of the death. In addition, many of those who die by suicide may have had mental illnesses, and care for these illnesses from mental health providers and General Practitioners. These providers may be the point of contact for those who are bereaved and for those with “atypical” or severe grief reactions. General Practitioners are also the point of contact for those who are bereaved and who need referral for psychotherapeutic interventions and to support groups for the bereaved. A final reason for the focus on health-related research is that postvention is predicated upon the assumption that, if effective, it decreases the likelihood of stressful and adverse health-related outcomes, including suicide ⁴.

The report presented here consists of three related papers all of which bear on the general issue of bereavement by suicide.

Paper 1: Review of the literature and synthesis of evidence

The first paper presents an overview of the literature on bereavement by suicide focussing on the following key points:

- The themes and processes of typical grief reactions after bereavement by any mode of death.
- The acute and longer-term grief reactions, emotional experiences and consequences of a suicide death for those bereaved in this way.
- Key factors likely to influence the nature of grief after bereavement by suicide.
- Identification of special populations that might be affected by suicide.
- Immediate support for those bereaved by suicide.
- Longer-term support and counselling services for those bereaved by suicide.
- Aspects of the coronial inquest process relevant to those bereaved by a suicide death.
- The approaches to provision of support services for those bereaved by suicide that are being taken by other countries.

The paper attempts to synthesise the findings from the review of evidence to develop a tentative series of best practice recommendations about the provision of support for those bereaved by suicide.

Paper 2: Findings from the Canterbury Suicide Project

This paper places the findings from the literature review in the context of an analysis of New Zealand data collected by the Canterbury Suicide Project (CSP). In this study a consecutive series of 105 individuals bereaved by suicide has been studied at 6 months following the bereavement, and 18 months following the bereavement. The overall aims of this study were to examine a series of issues relating to bereavement by suicide. These issues include:

- The acute (6 month) and longer term (18 month) impact of bereavement by suicide on a range of psychosocial outcomes including risks of mental disorder, personal adjustment and suicidal behaviour among close family members.

- Identifying factors that contribute to prolonged and complicated bereavement outcomes, and those that appear to facilitate a positive outcome.
- The extent to which poor outcomes for those bereaved by suicide may be attributed to the mode of death, or may reflect pre-existing vulnerability to the development of psychiatric and adjustment difficulties.
- The extent to which needs for family, social, professional and other types of support of family members following bereavement by suicide were met, and identification of gaps in the provision of support to this population.

Paper 3: Policy recommendations

This paper draws together the key themes emerging in Papers 1 and 2 to lay the foundations for a series of policy recommendations about possible strategies for addressing the issues raised about bereavement by suicide. Major recommendations include:

- Acknowledgement of the need to provide national leadership, help and support for those bereaved by suicide. This could perhaps best be ensured by integrating this theme into the proposed national suicide prevention strategy to secure the political leadership and infrastructure necessary to ensure a. adequate, sustained funding for support initiatives and services; and b. service delivery at a national, regional and local level.
- The need for evidence based research about the effectiveness and efficacy of a range of support services and programmes for people bereaved by suicide.
- Improved generic bereavement support services, and integration into these broader services, of services specifically for those bereaved by suicide.
- Proactive contact and offers of support to bereaved families immediately after a suicide death and at regular intervals within the first year of bereavement.
- Improved training for immediate and first responders after a suicide death.
- Improved training programmes for those professionals who have contact with individuals bereaved by suicide, to enhance professional competency about bereavement, generally, and bereavement by suicide, specifically.
- Public educational campaigns about grief reactions following bereavement, to enhance public knowledge about this issue.
- Consultation with coroners to explore the desirability and feasibility of developing a coronial counselling service attached to coroners' offices in large cities.
- Consultation with coroners to consider ways in which bereaved families can be supported through coroners inquests and court procedures.

- Development and dissemination of a single national information package for those bereaved by suicide which includes information about suicide, practical matters, grieving, strategies to cope with grief, resources, available services, support and related issues.
- Enhanced access to professional services for bereaved individuals.
- Removal of cost barriers to counselling.
- Research to address current gaps in knowledge about bereavement after suicide including: i. the factors contributing to individual vulnerability and resiliency to severe emotional outcomes following bereavement by suicide; ii. the impact of suicide on special populations and their needs for support; iii. the impact of suicide on family functioning including family dynamics and family communications; iv. exploring ways of minimising risk of further suicidal behaviour in families bereaved by suicide; v. development and evaluation of interventions to support those bereaved by suicide.

SUICIDE POSTVENTION

SUPPORT FOR FAMILIES/WHĀNAU AND SIGNIFICANT OTHERS AFTER A SUICIDE

PAPER 1

REVIEW OF LITERATURE AND SYNTHESIS OF EVIDENCE

*There are always two parties to a death;
the person who dies and the survivors who are left behind.*

Arnold Toynbee, *Man's Concern with Death*, 1978

EXECUTIVE SUMMARY

This paper reviews research based evidence and related literature and information about grief and bereavement, bereavement by suicide, and support and services for families, whānau and significant others bereaved by suicide. The information has been summarised and synthesised to present an overview of current knowledge in this area, and to provide a series of recommendations for providing support for those who are bereaved by suicide. Key themes suggested by this review include:

- For most people, grief following bereavement follows a typical, non-pathological process, with a fairly predictable course. Extreme grief reactions appear to occur in no more than a small minority, with these reactions meeting recognised diagnostic criteria for depression, anxiety and post traumatic stress disorder, rather than the range of recently proposed categories of complicated grief.
- Grief following bereavement by suicide has much in common with grief following bereavement by other types of sudden traumatic death, with the common elements of the grief experience arising from the common aspects of the unexpected, traumatic, often violent nature of the death.
- However, grief following bereavement by suicide may differ from grief following other types of bereavement in duration, with those bereaved by suicide perhaps having a slower recovery in the first two years following the death.
- Suicide bereavement may differ from mourning after other types of deaths in the following ways: i. a stronger need to find meaning in the death; ii. higher levels of guilt, blame, and responsibility, and greater feelings of rejection and abandonment; iii. stronger feelings of stigmatisation and social isolation; iv. a particular impact on family systems including family interaction and communication, and increased risk of suicide.
- There is a need for further research about bereavement by suicide. Specific areas for further research include: the extent to which a range of individual, social, and family factors contribute to bereavement outcomes; the impact of suicide on family functioning, family communications, family dynamics, and suicide risk, taking into account premorbid family functioning; the role of cultural, religious and social supports in mitigating adverse family outcomes and suicide risk following suicide; and the impact of various types of support and treatment on bereavement outcomes.
- Those who are bereaved by suicide express clear needs for help. These needs include: professional help; information about suicide and available resources; assistance with practical matters; contact with others bereaved by suicide; assistance and support with the coroner's inquest and official procedures.
- There have been few methodologically defensible evaluations of the efficacy and effectiveness of the range of support services that now exist for people bereaved by

suicide. Consequently, there is a need to evaluate the services that are now provided. Currently there is no body of evidence-based knowledge to guide service delivery and implementation.

- There is public expectation that a range of support services should be provided for those bereaved by suicide, even though there is very limited evidence to show that these services are effective and efficacious.
- Postvention programmes used within schools and other institutions following a suicide death have been poorly evaluated. Systematic reviews of critical incident debriefing (a component of postvention programmes) suggest there is no evidence that it is helpful, and that it may, in fact, not be safe. However, there is now a public demand for critical incident debriefing after traumatic events including suicide, and people like it. In this context withdrawing critical incident debriefing without replacement with an alternative programme is problematic. There is a need for further research of programmes which may be more effective and efficacious.
- Given the small number of suicide deaths each year, it may be useful to consider integrating suicide-specific services with generic bereavement services to provide an adequate infrastructure for training, education, and service provision.

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1. BACKGROUND AND CONTEXT

1.1 Background

In New Zealand there are approximately 500 deaths by suicide each year⁵. Each death is a personal and private tragedy for the families, whānau and other relatives and friends involved. It has been estimated that approximately six individuals are closely affected by each suicide death⁶. This estimate suggests that there may be a population of up to 65,000 individuals who have been bereaved by suicide in New Zealand during the last 20 years, with an additional 3,000 people newly bereaved each year.

To date, much of the research and writing about suicide in New Zealand, and internationally, has tended to focus on exploring the causes of suicide and suggesting approaches to suicide prevention. Recently, however, in New Zealand and overseas, there has been increasing recognition of the need to better understand the responses of those who are bereaved by suicide, and their needs for support⁷. This is acknowledged in the New Zealand Youth Suicide Prevention Strategy which includes, as one of the five major goals of the strategy, “*the provision of effective support to those who are bereaved or affected by a suicide*” (page 18)⁸.

As part of the implementation of the National Youth Suicide Prevention Strategy and the development of a national all ages suicide prevention strategy the Ministry of Youth Development (MYD) has commissioned this report to summarise current evidence based knowledge about: bereavement by suicide; the impact of bereavement by suicide on family members, whānau and significant others; and the implications of this knowledge for the development and provision of support and services for those bereaved in this way.

The specific issues covered in this report are described below.

Chapter 1 provides background and context for the report, discusses terminology and definitions and provides estimates of the number of people bereaved by suicide in New Zealand.

Chapter 2 provides an account of the themes and processes of typical grief and bereavement reactions and discusses factors which may influence the outcome and course of bereavement. Current views about concepts of complicated grief outcomes are also discussed.

Chapter 3 reviews evidence about the ways in which bereavement by suicide may differ from bereavement by other forms of death.

Chapter 4 provides information about the needs for support and assistance that those bereaved by suicide have, and also discusses a series of groups whose needs for support following a suicide death may, for a number of reasons, be hidden.

Chapter 5 discusses a range of options for providing support to those bereaved by suicide, in the immediate aftermath of the death, and in the short and longer term following the death. This section includes discussions of postvention programmes provided for schools, workplaces, mental health settings and other institutions after a suicide death. Current evidence about the value of critical incident debriefing is also reviewed. A series of issues specific to the provision of support for those bereaved by suicide is also reviewed.

Chapter 6 reviews aspects of the coronial inquest process that are relevant to those bereaved by suicide.

Chapter 7 discusses the approaches to provision of support services for those bereaved by suicide that are being taken in other countries.

Chapter 8 draws together information from the previous chapters to develop a tentative model of best practice for the provision of support to those bereaved by suicide.

1.2 Terminology and definitions

There is sometimes confusion about the terms grief, bereavement and mourning. These terms are not equivalent, and may be defined as follows:

Bereavement refers to the loss of a close relationship ⁹. **Grief** refers to the emotional response to bereavement. **Mourning** refers to the social expression (including rituals and customs) of grief.

Although there is still debate about these definitions some people find expansion of the simple definitions given above to be useful. Bereavement has been described as “*a broad term that encompasses the entire experience of family members and friends in the anticipation, death and subsequent adjustment to living following the death of a loved one*”¹⁰. This definition includes individuals' reactions and adaptations to the loss, and more broad changes such as those seen in social relationships and living arrangements.

Grief may be more comprehensively described as “*a complex set of cognitive, emotional and social difficulties that follow the death of a loved one. Individuals vary enormously in the type of grief they experience, its intensity, its duration and their way of expressing it*”¹⁰.

Postvention is a term originally used by Edwin Shneidman, a pioneer suicidologist, to refer to the activities that serve to reduce the consequences and sequelae of a traumatic event, such as suicide. It was Shneidman's view that “*[postvention's] purpose is to help survivors live longer, more productively, and less stressfully than they are likely to do otherwise.*”⁴.

One issue that emerges from review of the literature about bereavement by suicide is what to call those who are bereaved by suicide. American usage has tended to favour calling them 'survivors'. However, this is potentially confusing since the term 'survivors' is also used to refer to those who make non-fatal suicide attempts. To avoid confusion, and because it has been common usage in New Zealand to date, this document will use the term **'bereaved by suicide'** to describe this population. For the purposes of this report we have determined that the population of those bereaved by suicide comprises all those who define themselves in this way.

1.3 Estimation of the number of people bereaved by suicide

Discussions of suicide bereavement often become concerned with estimating the number of people bereaved by suicide, and the size of the national population bereaved in this way. A commonly cited figure is 'six' bereaved people for each suicide. This figure is quoted by McIntosh⁶ as being originally used by Shneidman, without, however, it being based on any objective evidence. Currently, there is general acceptance of the origin of the figure of 'six', but, also, widespread acknowledgement that 'six' is likely to be an underestimate. The extent of underestimation is unclear since it depends upon the context of the discussion and the definition of the survivor population.

It is likely that precision in estimating the number of people closely affected by suicide deaths is, ultimately, an unattainable goal and, perhaps, immaterial: those who are bereaved by suicide are all those who define themselves in this way.

For the purposes of this report, we have attempted to estimate the number of people affected by a suicide death, and the size of the 'bereaved by suicide' population in New Zealand who might, potentially, need support services. These estimates are generated in order to provide a realistic basis for service planning and resource allocation. We made our estimate in the following way: During the last 25 years for which suicide statistics are available (1976-2000) there were approximately 10,500 suicide deaths in New Zealand^{5, 11}. If there were, conservatively, six closely affected individuals for each of these deaths, then, currently, there is a bereaved by suicide population of approximately 65,000. On average, over the last 10 years (1991-2000) there have been 500 suicide deaths each year, suggesting that, every year there are, approximately and conservatively, 3,000 family members, whānau and significant others closely affected by a new suicide death. In addition, it could be argued that, in New Zealand, the extended nature of whānau might increase the number of individuals closely affected by a suicide death. While precise numbers within whānau affected by suicide are difficult to determine, this point underscores the fact that the estimates provided above are conservative.

2. THE GRIEF PROCESS

This section outlines, firstly, components of the 'typical' grief process which occurs in response to deaths from any cause, and, secondly, considers current evidence about ways in which this typical grief process may become complicated for particular individuals. This outline will serve two purposes: Firstly, grief about a death by suicide shares many features with grief following deaths from other causes. Secondly, a review of the typical grief process provides a context for examining, in Section 3, grief reactions and recovery following a death by suicide.

2.1 The 'typical' grief process

Death and bereavement are common events. However, people respond in different ways to losses and bereavement^{9, 12}. This variability in individual response to loss has led to various attempts at explanation. Theories of grief developed in the 1960s have been influential in determining the public understanding of bereavement. These theories tended to conceptualise bereavement in terms of a number of 'stages'^{13, 14}. For example, Kubler-Ross described a five-stages model of grief and bereavement (denial, anger, bargaining, depression, and acceptance) in her popular book "*On Death and Dying*"¹⁴. However, these "stage" theories have not been supported by recent research^{15, 16}. Contemporary research tends to emphasise the dimensions or 'phases' of grief, and the 'tasks' that bereaved individuals have to undertake to recover from the loss¹⁷⁻²³. These views are favoured because they offer a more flexible account of grief and resolution of grief than the 'stages' models allowed.

These current views are typified by recent reviews of the literature about grief reactions after bereavement^{12, 17}. The authors concluded that, despite individual variations, there was remarkable consistency in grief experiences, with the majority (50-85%) of bereaved people experiencing "*a common grief pattern consisting of moderate disruptions in cognitive, emotional, physical, or interpersonal functioning during the initial months after a loss*"¹⁷. For most bereaved individuals, grief was not a lengthy or pathological process, with most returning to pre-bereavement functioning within a year.

These reviews^{12, 17} have concluded that, typically, bereavement may disrupt normal functioning in four ways: Firstly, people may become **cognitively disorganised** in the first months after the death, with these difficulties including: a preoccupation with the loss; a search to make sense of the loss and find meaning in it; a struggle to accept that the loss has actually occurred; a sense of lost identity with the person who died; and uncertainty about the future.

Secondly, most people are **emotionally distressed**, or dysphoric, in the first few months after bereavement. Typical emotional responses include sadness, anger, irritability, fear, guilt, loneliness, and longing or 'pining' for the deceased person. For most bereaved people

this emotional distress dissipates after the first few months, and only a small minority experience extreme or chronic emotional distress.

Thirdly, many people may suffer **somatic distress** in the first months following bereavement, with such problems manifested in an increased number of medical consultations, worsened illnesses, or an increased number of health problems including palpitations, shortness of breath, insomnia, poor appetite, digestive problems, short-term impairment in immune response, changes in endocrine activity and increased mortality from disease (including heart disease), motor vehicle accidents, and suicide. As with cognitive and emotional manifestations of grief, somatic manifestations appear to occur predominantly in the first months after bereavement, and only a small minority of bereaved individuals suffer enduring health problems.

Fourthly, many people suffer **disruptions to their social and occupational roles** in the early stages of bereavement, withdrawing from social activities, and experiencing difficulties in their work or family roles, in existing relationships and in establishing new relationships. For most people most of these problems resolve within one to two years after bereavement, and only a small minority of bereaved individuals appear to suffer enduring and severe social difficulties.

Bereavement also appears to generate **positive experiences** for some individuals. Bonanno and Kaltman²⁴ reported that a significant proportion of bereaved individuals described themselves, as early as the first few months after bereavement, as having benefited from the bereavement experience, and reported that they liked being on their own. Bonanno and Kaltman observed that these responses, rather than being interpreted as evidence of denial or avoidance (as in previous studies), appear to be features of the relatively benign common grief pattern.

The experiences of grief outlined above interact to produce a typical, but not inflexible, pattern of bereavement⁹. Usually, initially, there is a period of intense distress and crying followed by numbness, then by longing for the person who has died. At this time bereaved individuals may be highly anxious, irritable, depressed, despairing and disorganised. They may perseverate in reliving the events that led to the death, searching for meaning and explanation, and opportunities by which the death might have been prevented or avoided. In time, bereaved individuals move beyond distress and despair to accepting or resolving the loss and reorganising their lives.

The usual pattern of bereavement involves a relatively quick (within one to two years) recovery from the experience, with initial adaptation to the loss being a good predictor of later, successful resolution of the bereavement. For most people, it appears that relatively little change in the recovery process occurs after the first year following the bereavement, with people usually acknowledging that they are recovering during the second year¹⁷.

Despite the common occurrence of death and bereavement, and the strong commonalities in grief experiences following bereavement from different modes of death, no clear and well-defined description of normal grief has yet been agreed upon^{12, 17}. Recent reviews

of grief and bereavement have tended to provide support for the DSM-IV¹ position²⁵, i.e. that, for most people, grief is a normal, non-pathological process, with a fairly predictable course. Extreme grief reactions occur in no more than a small minority, with these reactions meeting diagnostic criteria for depression, anxiety and post traumatic stress disorder (PTSD).

The DSM-IV definition of grief acknowledges that societies and cultural groups tend to develop culturally sanctioned approaches to expressing grief, and there may be considerable variability in cultural expressions of grief²⁵ with these expressions still falling within the range of 'typical' grief responses. There are also suggestions that people in those cultures that sanction overt expressions of grief may ultimately cope better with the grief process than those from cultures that encourage strong suppression of grief²⁶.

Further, there have been suggestions that the increasing secularisation of modern societies may provide fewer opportunities for religious rituals and observances associated with grieving⁹. As a consequence the period of mourning 'allowed' those who are bereaved may have become abbreviated with those not permitted a certain period of mourning perhaps being more vulnerable to poorer bereavement outcomes in the longer term.

2.2 Factors which influence the outcome, course and expression of grief

A number of studies have examined the factors that are likely to influence the course and duration of the typical grief process and its outcomes²⁷⁻³². These factors have been assessed by Parkes²⁷, for example, who suggests that the extent of reaction to the bereavement may be influenced by:

- i. **Antecedent factors:** These may include such things as previous experiences of grief, previous mental illness (especially depression), prior life crises, and the nature and quality of the relationship with the deceased. Parkes noted that those most likely to have adverse reactions are those with previous exposure to loss, a history of mental illness, prior life crises, and those who had a difficult or impaired relationship with the person who died.
- ii. **Concurrent factors:** These factors include demographic factors (gender, age,) personality factors, socioeconomic status, religious and cultural factors. Those most likely to have poor grief outcomes include women, younger people, those with avoidant personalities and those with difficulties coping with stresses and separations, and those of lower socioeconomic status.

¹ DSM-IV refers to the diagnostic and statistical manual of the American Psychiatric Association, which provides widely accepted definitions and classifications of mental disorders.

- iii. **Subsequent factors:** The course of bereavement may also be influenced by a number of social and contextual factors that include: the extent of social support or isolation; stresses (e.g. financial difficulties) that may occur consequent to bereavement; and life changes subsequent to bereavement including employment, friendships and partnerships. In general those most likely to have an uncomplicated grief process are those exposed to high levels of social support, few secondary stresses and who have subsequent positive life opportunities subsequent to the bereavement.

In addition, it may be noted that the course of bereavement, generally, and following suicide deaths, specifically, tends to have been more often studied in females than males, and by female, than male, researchers. These (potentially gender-biased) studies have generated findings that have tended to suggest that females, and especially mothers, are more traumatised by family suicides than males. In turn, this perception may lead to females being offered more support. There is a need for further research to examine the extent to which there may be gender differences in the expression of grief, and the extent to which males and females may derive benefit from different types of support³³.

2.3 Complicated grief outcomes

While there is potentially wide variation in responses to bereavement, nevertheless, most experiences of bereavement appear to fall within an expected range of outcomes. However, for a small fraction of bereaved individuals the bereavement process may become complicated by physical or psychiatric outcomes. Physical complications that have been linked to grief include impaired immune response, changes in endocrine activity, psychosomatic illnesses, and increased mortality. Psychiatric effects may include depression, anxiety disorders, panic disorder, and post-traumatic stress disorder (PTSD)^{17, 27, 34}. These disorders may occur comorbidly.

In recent years there has been an increasing amount of research about a range of what have been proposed as complicated outcomes of the grieving process, including *traumatic, absent, delayed, inhibited, avoided, masked, exaggerated, distorted* or *chronic grief*^{13, 20, 27, 35}. However, there is little agreement in the literature about clear definitions, or even the existence, of these phenomena¹².

Reviews of current research have concluded that there is insufficient evidence to support these proposed types of complicated grief^{17, 36}. However, Bonanno and Kaltman¹⁷ acknowledge that there is evidence to suggest that a small minority of bereaved individuals may suffer severe and chronic grief with their enduring symptoms essentially fitting the existing psychiatric diagnostic categories of depression, anxiety and PTSD²⁵. They, and others, have also noted that there is evidence to suggest that a proportion of bereaved individuals show little or minimal grief³⁶. Bonanno and Kaltman suggest that apparently *absent, delayed, avoided* or *inhibited grief* might be better construed as *minimal grief* indicating adaptation to the loss, rather than a pathological response.

3. BEREAVEMENT BY SUICIDE

The preceding section examined the components and processes of the typical grief reaction, and also examined evidence for severe or chronic grief reactions. This section reviews evidence about the acute and longer-term emotional experiences and consequences of a suicide death for the bereaved. These issues include the extent to which bereavement by suicide is a qualitatively and quantitatively different experience when compared with bereavement by other types of death, and particular features of suicide deaths that may influence the grief responses of those bereaved by suicide.

3.1 The extent to which bereavement by suicide differs from bereavement by other types of death

For many years bereavement following a death by suicide was regarded as a particularly severe and extreme experience, and more stressful and disabling than bereavement by other forms of death (see, for example, ^{37, 38, 39}). However, careful examination of the studies that generated this view reveals that many were methodologically limited and flawed ^{6, 29, 40-43}. In particular, they often consisted of interviews with small, convenience, selected samples, with no control or comparison groups. Sometimes these selected groups consisted of individuals with extreme or pathological reactions which were then interpreted as being typical reactions to bereavement by suicide. When these limitations were taken into account reviewers concluded that these studies produced no evidence to support the view that bereavement by suicide is more severe than bereavement from other types of deaths.

However, in recent years a series of methodologically more defensible studies ^{28, 32, 40, 44-48} has suggested the following conclusions:

- i. In comparison to those who are not bereaved, individuals who are bereaved following death from any cause experience poorer psychosocial functioning in the aftermath of the death. These poorer outcomes include the typical grief processes (as described above), poor mental health functioning, notably increased risks of depression, anxiety disorders, PTSD, and other adverse outcomes including impaired cognitive, social and emotional functioning.
- ii. Those bereaved by suicide appear to have similar outcomes to those bereaved by death from other causes. However, there is evidence to suggest that the length of the bereavement process may be longer with those bereaved by suicide perhaps having a slower recovery period.

- iii. In addition, those bereaved by suicide may encounter different emotional experiences of grief including a stronger need to find meaning in the death, higher levels of guilt, blame, responsibility, rejection and abandonment; stronger feelings of stigmatisation and isolation; impaired patterns of family interaction and communication, and increased risk of suicide or suicide attempt.

3.2 Features of suicide deaths which may influence the bereavement process

There is broad acknowledgement that there are some aspects of suicide deaths that may influence the responses of those bereaved by suicide and their recovery after the death^{12, 31, 38, 41, 49-51}. Some of these features may be shared with other types of sudden traumatic deaths, while some may be unique to deaths by suicide. These factors may explain the increased risks of subsequent psychiatric disorder and adjustment difficulties seen among some relatives of those who die by suicide, or may explain why such risks appear to be mitigated or moderated in other families^{41, 49-55}. Some of the features that may influence the grief process following suicide include:

- i. **The circumstances of the death.** Various features of suicide deaths may make these deaths more traumatic than deaths by natural causes. These features include: the sudden and traumatic nature of the death; witnessing a suicide death; discovery of the body; and disfigurement of the body.
- ii. **Emotional reactions to suicide.** Deaths by suicide may have particular features that evoke emotional responses that differ from those evoked by other deaths. These responses may include: searching for a meaning in the death; denial of the cause of death; fear of shame and stigmatisation; fear of further family suicides; guilt, self-blame and responsibility. In turn these reactions may influence the duration and extent of grief reactions following suicide deaths.
- iii. **The characteristics of the individual who died.** Responses to bereavement by suicide may, in part, reflect the characteristics and premorbid functioning of the individual who died. Factors which may influence adjustment include the age and the kinship of the person who died; the extent of mental illness, or physical disability; terminal illness; a history of suicide attempts; the extent to which mental illness may have led to chaotic, dysfunctional and/or difficult family circumstances^{44, 51, 56-58}. In general, research suggests that grief reactions may be more marked when those who died are younger, and less marked when those who died had severe physical or mental health problems or a terminal physical illness^{42, 59-61}, had made suicide attempts prior to the attempt which led to their death, or had contributed to difficult family circumstances^{42, 60}.

- iv. **The characteristics of the individual who is bereaved.** Adjustment to bereavement may be determined, in part, by the social, demographic and personal characteristics of the individual who is bereaved. These features may include age, gender and kinship; personality traits and cognitive styles including personal resiliency, coping and adaptability; personal faith and spirituality. Grief outcomes may be poorer for younger bereaved individuals, for females, and for mothers. Outcomes may be better for those with strong faith, emotional resources, resiliency and adaptability.
- v. **The nature of the relationship between the person who died and the bereaved individual.** Adjustment to bereavement may also be influenced by a series of factors related to the nature of the relationship between the person who died by suicide and the bereaved individual. Such factors may include the nature of the attachment, the quality of the relationship, and the extent to which the relationship was troubled or estranged. For example, in situations where one partner had a long history of mental illness, and then died by suicide, the bereaved partner may have ambivalent attitudes towards the death, feeling relieved that the suffering has ended for the person who died, relieved for themselves that their difficulties in coping have ended, but guilty because the death was by suicide, and guilty for feeling relieved after the death.
- vi. **The psychosocial context.** Features of the psychosocial environment in which the suicide death occurred may influence grief outcomes. These factors include the social and family context of the person who died and of the bereaved individual; media coverage and interest in the death; coronial inquests and official procedures. Outcomes may be better for families with good premorbid functioning, in cases where media coverage is absent or limited, and where official and coronial processes are sensitive and minimally intrusive for families.
- vii. **Extent and quality of support received following the death.** Grief outcomes may be influenced by the extent to which those who are bereaved receive the support they believe they need from their families, and from people, professionals or agencies outside their family. In particular, those bereaved by suicide often seek contact and support specifically from others who have also been bereaved by suicide, in the belief that only others with a similar experience can offer sympathetic, and empathic, support and understanding^{53, 62, 63}. Outcomes may be better for those whose needs for family, social and professional support are met.

3.3 The need to address both bereavement and suicide issues

From a practical point of view, individuals, families and whānau who are bereaved by suicide require responses that attend directly to both the grief and the suicide. Positioning the loss, and bereavement experiences, in the context of common grief reactions is important to facilitate mourning and avoid escalating anxiety. At the same time, however, there is a critical need to attend directly to the fact that the death was by suicide and that there is a need to address issues of shame, guilt, stigma and isolation associated with suicide deaths.

Finally, it should be acknowledged that there may be dimensions of suicide related grief that may not yet have been captured, or may not be able to be captured by research. For example, Dunne⁶⁴ has suggested that *“Even if these experiences (of grief following suicide) turn out to be not statistically differentiable (from responses to other loss) the social and psychological experiences are not equitable in any simple way and clinicians must be able to respond to the specifics of the situation with knowledge and compassion.”*

4. THE NEEDS FOR SUPPORT OF THOSE BEREAVED BY SUICIDE

4.1 The needs of those bereaved by suicide

A number of studies has examined the needs for information and support that those bereaved by suicide may have following a death by suicide^{41, 51, 53, 62, 63, 65-69}. Based upon the findings of these studies, these needs include:

i. **Needs for information.** Studies have variously suggested that those bereaved by suicide have a range of needs for information including: details about the location, manner and timing of the death; information about the rights of families bereaved by suicide; factual information about suicide and mental illnesses with which suicide may be associated; information about how to cope with grief and about how others bereaved by suicide have coped during the years following a family suicide; information about the impact of suicide on families and strategies for enhancing family communication and functioning after suicide; advice about how and what to tell children about the suicide death of a close family member, and how to protect them from risk of suicidal behaviour; ready access to written information, including a reading list of books about suicide, a list of resources including websites, support group meetings, and local and national bereavement and suicide support organisations.

Those who are bereaved by suicide may be functionally and cognitively disorganised in the immediate aftermath of the death, and may forget information that is given to them at this time. Moreover, their needs for information may change over the course of bereavement. They may be hesitant about seeking help for themselves because of shame and stigmatisation. For these reasons they suggest that it is necessary that they be offered support and information at various times following the death and during the bereavement period for at least the first year^{62, 66}. The bereaved also ask for written material to be given to them and to be made available at various locations (including medical centres, community centres and public libraries) that they may readily access without fear of stigmatisation.

ii. **Needs for support.** A series of studies suggest that those who are bereaved by suicide have a variety of needs for social and professional support which span: opportunities to talk about their experience with others who have been bereaved by suicide; access to individual counselling, therapy or psychotherapy as needed, without cost being a barrier; support from their General Practitioner, and from religious leaders and clergy.

Despite a public perception that those bereaved by suicide have a strong need to meet with others bereaved in this way, recent research does not support this view^{66, 69}. A significant proportion of the bereaved felt that they were able to cope without assistance, and those who did want help conveyed that their strongest needs were for professional mental health support. In a study in Norway Dyregrov⁶⁶ reported that local communities lacked the organisational structures to provide the services that the bereaved wanted. She suggested that a national plan for providing support to the suicide-bereaved was necessary to provide the political leadership and infrastructure to ensure adequate service delivery at a local level.

iii. **Help and advice about practical matters.** A number of studies suggest that those who are bereaved by suicide have a wide range of needs for advice and help about practical matters and other forms of assistance. These matters include: assistance in getting a house or property cleaned after a death by suicide; retrieving property from police; arranging and paying for a funeral; insurance matters; information about the process of police investigation, the coroner's inquest, and other official procedures; obtaining the suicide note or message; and related issues. Some studies suggest that needs for assistance with practical matters may have been under-recognised⁶⁹. A comprehensive list of practical matters to be addressed following suicide is included in a guide developed by the Calgary Health Region⁷⁰.

iv. **Other issues.** In addition to needs for information and support and practical assistance, bereaved families may have other needs in the aftermath of the suicide death. These needs may include: an opportunity to view the body, have the body 'lie in state', or have access to photographs of the body; and needs for cultural and religious rituals to be observed.

4.2 Special populations

Most research examining the responses of those who are bereaved by suicide has focussed on family members. However, certain groups have been shown to have an elevated risk of suicide. For example, Brent and colleagues⁷¹ found that the peers of adolescent suicides were more likely to be depressed than the siblings. In addition, Doka⁷² and others have identified a series of groups who differ in their characteristics but who all have the common feature that their circumstances may place them at risk of being disenfranchised in the grieving process, for a variety of reasons^{72, 73}. These groups may include:

- i. **Children and adolescents who lose a sibling to suicide.** In the aftermath of suicide, attention often tends to focus upon adults in the family and less attention is paid to dependent children and the siblings of the deceased. When a sibling is lost to suicide, family structure, family dynamics and family communications may be altered. These considerations suggest that further attention may need to be paid to the impacts on siblings and family functioning of the suicide death of an adolescent or young person, and to the needs for support that the family and siblings might have.
- ii. **Separated, estranged or divorced partners.** In some cases, suicides may follow a recent separation, estrangement or divorce, and these events may be seen by the family of the deceased person as having provoked or precipitated the suicide. The surviving partner, who may have instigated the separation, may be blamed and excluded from the funeral and family functions, and thereby deprived of sources of support.
- iii. **Gay, lesbian, bisexual people who lose friends or partners to suicide.** There appears to be little published research that has examined the impact of suicide on gay, lesbian or bisexual partners and friends. Consequently, it is not clear whether they have specific or additional needs for support than those in the general population who lose partners to suicide.
- iv. **Different socio-cultural and religious groups.** Cultural and religious beliefs may influence responses to death, generally, and to suicide, specifically. However, little research has examined the unique needs for support that various cultural or religious groups may have after suicide. Further, there appear to be no studies comparing bereavement reactions after suicide across cultures. This issue would appear to be of particular relevance to the Māori, Pacific Peoples, and Asian populations in New Zealand. These issues are further discussed in a companion report ¹.
- v. **Immigrants and refugees.** In many countries rates of suicide are higher amongst immigrants and refugees than in the general population. These groups may have less family and social group support, and they may belong to different socio-cultural and religious groups with special cultural responses to death and suicide. There appears to be little research that has explored the needs for support after suicide that such groups may have.

- vi. **Therapists, doctors, professionals who lose patients to suicide.** A group whose needs may often be overlooked are the professionals who are involved in the care, treatment or management of those who die by suicide. A significant proportion of suicides (approximately 1 in 4) occur in people who have been in mental health care within the year prior to their death ⁷⁴. Some suicides occur in inpatients, some amongst those recently discharged and others in community outpatients. Recent research has explored the impact of patient suicides on therapists, doctors and professionals and examined the needs that these groups have for training and support to address what has been described as "*the inevitability, rather than the risk, of patient suicide*" ^{46, 75-80}.

For example, a recent study examined the effect of patient suicide on psychiatrists ⁷⁵. Almost 80% of Scottish psychiatrists participated in the study and, of these, almost 70% had had a patient in their care die by suicide. One third of these reported that they were significantly affected by this event, with poor sleep, low mood and irritability. They reported that family, friends and colleagues provided most support, and that critical incident and team reviews were helpful provided they were not conducted as blame-seeking exercises.

More generally, the responses of mental health staff to the suicides of patients in their care have been shown to include feelings of personal loss, professional failure and fear of litigation, with these responses occurring regardless of level of professional experience. Female therapists tended to feel more guilt about the event, and some therapists were at risk of developing psychiatric problems ⁷⁸. Grad and Zavasnik ⁷⁷ have suggested that the reactions of doctors to the suicide of a patient differed little from their reactions to patient deaths from other causes.

Less commonly, patients may experience the suicide deaths of their therapist or doctors. When this happens, patients need to be advised, transfers of care arranged, and appropriate assistance and access to bereavement support offered.

- vii. **Other special populations.** A series of other groups have been identified as perhaps having needs for support after suicide which may be poorly recognised or hidden. These groups include people with intellectual handicap ⁸¹; families which have lost multiple family members to suicide; the illicit or unrecognised lovers of those who died by suicide; older parents who lose adult children to suicide; and the grandparents of those who die. However, the needs of these groups, like the needs of other special populations generally, tend to be poorly known.

5. SOURCES OF SUPPORT AFTER SUICIDE

There has been widespread advocacy for providing various forms of support to those bereaved by suicide in the immediate aftermath of the bereavement and beyond. Not all of those who are bereaved by suicide will want to seek support outside their close family and social network. However, a significant proportion (approximately one in two,^{41, 66, 69}) of people bereaved by suicide report that the distress and trauma of their loss are such that they need additional support beyond that provided by family and friends. The bereaved ask for both professional help and social support^{41, 66, 69}.

To meet these expectations, a range of support programmes and services for those who are bereaved by suicide has developed in recent years. These services may be classified, by the time after the suicide death that they are offered, as 'immediate' or 'first response', short-term or longer term programmes. However, there has been little evaluation of the effectiveness or efficacy of this array of services^{41, 82, 83}, and there is no body of research-based evidence to guide national, regional or community plans for support services following suicide. A discussion of the array of service options is given below.

5.1 Immediate services

There are a range of occupational groups who find themselves involved in the immediate response to suspected suicide deaths. These groups include emergency service personnel, police, emergency department staff in hospitals, search and rescue volunteers, and funeral directors. However, it is not the specific role of those who perform most of these tasks (for example, police) to provide support to bereaved individuals. Rather, the immediate support to a family following a suspected suicide death tends to be provided by teams of "first responders"⁸⁴ who may often be volunteers, and who may have limited training and knowledge about bereavement, suicide or support for those who are bereaved by suicide. Immediate support following a suicide death may also be provided by a range of other programmes and workers including crisis support services, funeral directors, religious leaders and the clergy, and health professionals such as general practitioners⁸⁵⁻⁸⁷.

In New Zealand, immediate support following a suicide is provided almost exclusively by Victim Support volunteer workers. Victim Support is a national body that provides support for victims of crisis and trauma (www.victimsupport.org.nz). The organisation has a national office, district offices, and branches in most towns and cities to provide national coverage for sudden, traumatic events. Most often, Victim Support² offices are

² Some individuals who have been bereaved by suicide report that they were surprised, confused and distressed, in the immediate aftermath of a suicide, to be approached by Victim Support workers. Until this contact, their perception (and presumably that of the general public) had been that Victim Support provide services to victims of crime. They do not see themselves (bereaved by suicide), as victims of a crime. If Victim Support are to continue in the role of providing support to those bereaved by suicide then perhaps consideration might be given to changing the name of the service to one which is less stigmatising to those bereaved by suicide.

located within police stations and Victim Support volunteers accompany police officers to advise families of sudden deaths. In this way, Victim Support volunteer workers are the immediate support providers for almost every suicide death that occurs. Currently, their role also includes providing crisis intervention in the form of emotional support and information on official procedures and available options, establishing contacts between bereaved families and appropriate support services, and, in some centres, providing support at inquests.

Victim Support workers receive little formal training to assist them in providing support to families bereaved by suicide, and the service they provide has not been evaluated. Parkes⁸⁸ has suggested that it may take up to a year for a volunteer worker to develop skills to enable them to work adequately with the bereaved.

There are a series of issues that need to be considered in regard to first responders and suicide support. These issues include: their voluntary status; personal experiences of bereavement, loss and trauma; training and supervision; quality assurance measures, and fidelity to the programme. There is also a need to explore and clarify whether there is an evidential basis for assuming that first responders can influence emotions, feelings, adjustment and outcomes of those who are bereaved by suicide. Parkes has noted that *"the value of services that lack the support of trained and experienced members of the care-giving professionals remains to be established"*⁸⁸. In many cases, volunteer workers have themselves experienced sudden traumatic losses, and their personal experiences, views and attitudes towards suicide may affect the type of immediate support they are able to provide. There is also a risk that volunteers with histories of personal loss and trauma may become vicariously retraumatised, and there is a need to develop ways of monitoring volunteer crisis and support workers to minimise this risk.

5.2 Short term support and services

Following the immediate response to a death by suicide there is often a need to provide short term support and services to those involved in the death. Such services may be provided to individuals and families (see section 5.3), but may also cater to the needs of those in workplaces, schools and institutions. Although these programmes may differ depending upon the individuals involved and the circumstances, they all encompass similar general principles by providing:

- i. information about the particular suicide, and about suicide in general;
- ii. the opportunity to talk, in a supportive environment, about how the suicide has affected the individuals involved;
- iii. the opportunity to find some personal understanding and acceptance of the suicide, so that individuals can put the death into perspective and continue with their lives.

The basic components of the programmes offered to address these needs are derived from suicide prevention approaches and from traumatic incident response activities. An account of the applications of these programmes in schools and mental health settings is provided below.

5.2.1 School postvention programmes

During the last two decades, school postvention programmes have proliferated, despite the lack of evidence for their effectiveness or safety. A range of programmes is now available, with all programmes having two broad aims. The first is to respond to, and manage, the crisis of the suicide death, in order to minimise distress and the development of psychiatric disorders amongst students. The second is to minimise the risk of suicide clusters. These aims are achieved by a process which seeks to return the school to normal routines as soon as possible; to support staff and students to deal with the suicide death; and to identify those students at risk for suicidal behaviour, depression, and other psychiatric disorders. Many programmes recommend that an external consultant be brought in to the school to help lead a school's postvention efforts. A number of descriptions and manuals of postvention processes in schools are available (see, for example, ^{89, 90, 91}).

In New Zealand, as part of the recommendations contained within national guidelines for schools for management of suicidal behaviour, schools are advised to develop Traumatic Incident Response Plans (TIRPs) which can be implemented in the event of a school suicide death. The approach to establishing these plans is outlined in the School Guidelines ⁹², and these guidelines have been implemented throughout the country.

The advantages and potential adverse effects of postvention programmes in schools have been controversial and debated for several decades (see, for example, ^{93, 94-97}). There are concerns that well-intentioned efforts in schools may have unintended, negative effects (including suicide), but there are also concerns that, after a suicide death, doing nothing in schools may also have negative consequences. Despite widespread expansion during the last two decades, postvention programmes in schools have been subjected to limited evaluation. Jobses and Berman ⁹⁸ have commented that *"the development of these programmes may owe more to our humanitarian spirit than a reasoned approach to suicide prevention"*. However, as noted by Goldney and Berman ⁹⁵ the low base rate of school suicides and the difficulties of not having postvention programmes in schools, when common sense would appear to dictate that they are needed, are the two major factors which have made evaluation problematic.

5.2.2 Mental health settings

Mental health settings are the workplaces and institutions most likely to encounter suicide deaths^{75, 79, 80, 99-105}. A number of common sense recommendations may be made to address the impact of patient suicide on staff and other patients. These recommendations include: providing social, collegial and professional support, including support groups of professionals who have lost patients to suicide; holding debriefing meetings for clinical teams; arranging meetings between the clinical team or clinician and the bereaved family, with these meetings moderated by a therapist or clinician who had no involvement with the case; conducting psychological autopsy review of the case. In addition, risk management procedures should be implemented to minimise risk of further suicidal behaviour amongst the remaining patients¹⁰⁵.

5.2.3 Other settings

The postvention principles outlined for schools and mental health settings described above can be modified and applied within offices or other workplaces affected by the suicide death of an employee. In workplaces it may be appropriate to bring in an external consultant to facilitate a meeting of staff to provide information about the particular death, and about suicide generally, to assess the needs that individuals might have for support and intervention, and to develop a supportive environment within the workplace.

5.2.4 Critical Incident Debriefing

Many school, institutional and community postvention services after suicide now routinely include psychological, or critical incident, debriefing. This debriefing is commonly delivered as a single session in the immediate aftermath of the suicide. Its use is predicated upon the assumption that debriefing will minimise PTSD and other adverse reactions to traumatic situations. The use of this intervention has become extensive despite its benefit to participants having not been clearly established.

Recent reviews of randomised controlled trials (RCTs) of psychological debriefing have suggested that it is not effective in reducing PTSD, psychiatric morbidity, depression, anxiety, or symptoms of distress and may, in fact, increase risk of PTSD¹⁰⁶⁻¹¹⁰. While the methodology of the RCTs to date has been generally poor, and there is a need for further, better designed studies of group debriefing, the evidence thus far has led reviewers to suggest that "*compulsory debriefing of victims of trauma should cease*"¹¹⁰.

This conclusion invites a searching and critical review of practice in this area and, particularly, consideration of the extent to which critical incident debriefing may have harmful effects. However, there is now widespread public expectation that debriefing should be provided for all traumatic incidents, and the victims of such incidents report that they find the process helpful. Given this level of popularity it may be difficult to withdraw the intervention.

5.3 Longer term support and services

There are a range of services which can provide longer term support to those bereaved by suicide. These include: support groups or networks for those bereaved specifically by suicide; General Practitioners; professional counselling; and bereavement organisations offering peer support groups for those who are bereaved by death from any cause. These types of support are described below.

5.3.1 Groups for the bereaved by suicide

Many people bereaved by suicide report that they feel that their bereavement is "different" in some ways from other types of bereavement. They express a wish to meet with others bereaved by suicide in the hope that sharing feelings and experiences with others through group meetings will provide useful reassurance about their own experiences and concerns^{41, 63, 111}. In recent years a range of groups has been developed in efforts to meet these needs.. These groups may take several forms, and a variety of manuals and descriptions of various model programmes are now available (see, for example,^{112, 113}). Groups may vary in terms of leadership, duration, membership, format and structure^{45, 63, 111, 114, 115}, and may follow therapy, or self-help/support models.

Therapy or treatment groups are usually led by a therapist with qualifications and skills in leading group activities. The group focus depends on the theoretical model employed. These groups are usually closed, and time limited. Battle¹¹⁶ provides an example of one such group in which a therapist led a series of group activities designed to help the bereaved group members understand the suicide, their reactions to it, and develop support for each other within the group.

Self-help/support groups are usually led by group members, who, in some cases are mental health professionals who have been bereaved by suicide. Billow¹¹⁷ and Wroblewski¹¹⁴ provide descriptions of such groups. These groups often have no time limits and are usually open to anyone who wishes to attend. However, some authors recommend that people with psychiatric problems, including suicidal behaviour, should

be excluded from such groups, and that such groups work best if there is a relatively homogeneous membership. In self-help groups, members make use of their personal experiences to assist others similarly bereaved. The groups may include a variety of activities including discussion groups, invited speakers and social activities, and may adopt advocacy or political roles. These groups may vary in the level of formality of the programmes offered, ranging from those which offer highly structured programmes aimed at addressing issues related to bereavement by suicide to those offering an essentially social framework for those bereaved by suicide to meet.

Whilst these groups are often oriented to the needs of those bereaved by suicide similar services are also provided by bereavement services for those who are bereaved following deaths from all causes. Some of those bereaved by suicide may prefer to seek support from these more generic services rather than from suicide-specific services.

Despite widespread advocacy for, and recent establishment of, various groups for those bereaved by suicide, few of these interventions have been evaluated using methodologically defensible designs. There are suggestions, however, that some programmes may have benefits for selected subgroups of those bereaved. For example, Murphy and colleagues reported that very distressed mothers gained benefit from a 10-week intervention, but that fathers showed no gains¹¹⁸. These authors also found a four-fold increased likelihood that bereaved parents would find meaning in their child's death if they attended a support group¹¹⁹. A controlled clinical trial of a group intervention for children bereaved by suicide found improved scores on measures of depression and anxiety in the experimental group compared to the control group. The intervention consisted of education about death, grief and suicide, and encouragement of expression of grief, personal competency promoting skills, and forming new relationships¹²⁰.

Research into suicide specific bereavement programmes is also supported by research about general bereavement programmes. While the research studies in this area are generally compromised by methodological limitations, there is tentative support for programme benefits for bereavement interventions such as professionally led individual therapy, group therapy and trained volunteer counselling⁸⁶. For example, benefits have included reduced morbidity¹²¹, reduction in the length of the grieving process¹²², and decreases in anger, subjective stress and use of psychotropic medication¹²³.

5.3.2 General practitioners

Many of those who are bereaved by suicide may turn to their General Practitioner for information, assistance and support^{19, 63}. General Practitioners may be well placed to provide counselling to bereaved patients since they often know the bereaved person, the person who died and the family history. In addition, the bereaved tend to visit their doctor for medical consultations more often than usual in the months following a death. However, while some General Practitioners may be willing to spend time talking to bereaved patients and/or to provide counselling, such counselling sessions require more than a short appointment. Current funding structures do not support General Practitioners who would like to provide such services to their bereaved patients. Moreover, General Practitioners face an increasing workload, and in this context bereavement counselling may not be an appropriate additional activity¹²⁴. Furthermore, the extent to which General Practitioners support is effective in reducing adverse grief outcomes has yet to be examined.

5.3.3 Counselling services

A further approach to addressing issues relating to longer-term bereavement support services is through the use of individual counselling services. Such services may include counselling to address issues relating to bereavement, counselling to address issues raised by suicide bereavement, specifically, and counselling to address mental health problems that may be the sequelae of bereavement by suicide (including, for example, depression and/or anxiety disorders). The need for counselling has been supported by recent research that has examined the needs for support by those bereaved by suicide. This research has clearly identified that the strongest needs are for professional support^{66, 69}.

An important issue in this area concerns the extent to which it is justifiable to develop a. services that are specific to suicide, or, b. general services that aim to address issues relating to bereavement and mental health problems. This issue is being considered by the United Kingdom committee convened to develop bereavement support services. This committee tended to favour the second approach and proposes to provide support for those bereaved by suicide by strengthening referrals to existing counselling services.

5.3.4 Internet based services

An emerging issue relates to the provision of Internet based resources. The advantage of this technology is that it makes material available in a rapidly accessible, reader-friendly form which bereaved individuals can access anonymously and privately. These services may be particularly useful in New Zealand in areas which are geographically isolated, where the small number of suicides precludes establishment of support groups. Internet sites enable resources to be readily updated, may be used to provide online support groups, and are cost effective ways of disseminating information.

However, web-based technology also allows the development of online counselling and chat rooms. The extent to which it is desirable, and/or possible to provide the bereaved and others who access support material in this way, with access to professional commentary to ensure the safety and accuracy of information shared and disseminated online would appear to be a difficult issue. Whilst internet based resources appear to provide a promising approach to bereavement support, to date there appear to be no evaluations of the efficacy of these services or of their possible limitations and drawbacks.

5.4 Generic issues in providing support to bereaved individuals

Underwriting the current proposal to develop postvention and support services for those bereaved by suicide in New Zealand is the assumption that interventions and support groups are helpful and do no harm. However, recent meta-analytic and narrative reviews of generic intervention studies do not provide clear evidence that grief counselling and related services are effective^{12, 125-129}. The findings of recent reviews are summarised below.

5.4.1 Evaluation of bereavement interventions

Allumbaugh and Hoyt¹²⁷ reviewed 35 studies of interventions following bereavement. Their conclusions are outlined as follows:

- The effect size [ie, the extent to which those who receive the intervention have better outcomes from those (control subjects) who do not receive the intervention] was low (.43). (An acceptable effect size for many psychotherapeutic interventions for a wide range of problems is .8)^{130, 131}.
- More highly trained (compared to non-professional) therapists tended to generate better outcomes with counselling. Individual (compared to group) therapy tended to produce better outcomes.
- Interventions with a larger number of sessions tended to produce better results. Interventions which began earlier (rather than later) in the course of bereavement were more effective.
- Participants who sought help (compared to those who were recruited by service providers or research investigators) tended to achieve better outcomes.
- High-risk participants (compared to those of lesser risk) achieved only marginally better outcomes.

Adopting more stringent criteria (random assignment to treatment and control groups) Kato and Mann¹²⁸ reviewed 13 studies and reported the following conclusions:

- Of four studies adopting individual therapy interventions, three achieved slight improvements in physical health, and one study found improvements in stress reactions.
- One family therapy study and 6 out of 8 group therapy studies found no significant benefit. Effect sizes were so low (.052 for a reduction in depressive symptomatology; .272 for a reduction in somatic symptoms; .095 for a reduction in all other psychological symptoms) that the authors concluded that *“psychological interventions for bereavement were not effective interventions”*.

Neimeyer¹²⁵ reviewed 23 bereavement interventions that used random assignment to control and treatment groups, and reported:

- An overall low effect size (.13).
- Younger (rather than older) participants, a longer time after bereavement before entry to therapy and higher-risk participants appeared to achieve better outcomes.
- Number of therapy sessions, professional (rather than non-professional) therapist training), individual (compared to group) therapy, and the theoretical approach of the intervention did not make significant contribution to outcomes.

Schut and colleagues¹²⁹ reviewed 16 bereavement intervention studies and concluded that:

- *“Primary preventive interventions receive hardly any empirical support for their effectiveness”*.
- However, there appeared to be marginally more support for the effectiveness of interventions developed for children, rather than adults.
- While there appeared to be marginally more evidence of efficacy for secondary interventions (targeted at high-risk populations, including those bereaved by suicide), effect sizes were modest.
- Tertiary interventions (for those who had developed a complicated grief response) tended to produce good outcomes perhaps because the individuals involved tended to have self-referred for help, and there was room for them to show improvement. Interventions delivered later in the bereavement course tended to have better effect although this may reflect the fact that it takes time for complicated grief to emerge.

Taken together, the findings of these reviews suggest that current interventions for bereavement have low efficacy, with effect sizes significantly lower than those for other types of psychotherapeutic interventions. Jordan and Neimeyer¹²⁶ suggest that there are several possible explanations for low efficacy. They suggest “*grief counselling may not be needed by most mourners; grief counselling may not work in the form in which it is typically delivered in research studies; and the positive effects of grief counselling may be masked by methodological issues in the design and implementation of the studies*”.

There is a clear need for methodologically improved designs in bereavement intervention studies. In particular, there is a need for: interventions to have strong theoretical underpinnings; for outcome measures to be analysed by gender; larger sample sizes to improve statistical power; improved outcome measures; improved retention rates; analysis by the extent to which the death might have been anticipated or expected; the need to measure pre- and post-intervention changes in both participants and control subjects, to take into account the self-limiting nature of bereavement; the effect of examination of variation in exposure (number of treatment sessions) and timing (early versus later in the course of bereavement) on outcome. In addition, there is a need for research to explore the extent to which there is a need for different types of counselling or support at different times in the course of bereavement, and to explore whether males and females derive benefit from different types of support. The findings from the reviews also suggest it may be useful to focus on studying the efficacy of bereavement interventions targeted at high-risk individuals.

Summarising and commenting upon the findings of the reviews (above), which show limited efficacy for current interventions for most bereaved individuals, Hansson and Stroebe¹³² have suggested that professionals may perhaps be most effective by supporting natural helpers including family, friends, neighbours, and peers within social religious and business groups.

5.4.2 Research needs

While the above findings apply to generic interventions for bereavement (from all causes of death), very little evaluation has been conducted on interventions specifically for those bereaved by suicide. Many of the suggestions for improving the design and methodology of generic bereavement intervention studies (above) apply to suicide-specific interventions also. In particular, no evidence is available about the efficiency or effectiveness of the range of individual psychotherapeutic, and group support programmes currently offered to those who are bereaved by suicide. These gaps in existing research have led several authors and stakeholders to identify areas for research with those bereaved by suicide. These areas include:

- The extent to which kinship, relationship or other attributes best define those who constitute the population of individuals bereaved by suicide who need support and related services.

- Identifying the features which make individuals vulnerable to, or protected from, severe grief outcomes following bereavement by suicide.
- Exploring the impact of suicide on family functioning, family dynamics, and family communication.
- Conducting theoretically justified, well designed, methodologically defensible randomised controlled trials of existing and new interventions for those bereaved by suicide to determine the efficacy and the effectiveness of such programmes.
- Exploring the extent to which the responses of “first responders” including police, volunteers (such as Victim Support), clergy, funeral directors and others are beneficial or helpful.
- Examining the health-related impacts on “first responders” of providing support to individuals bereaved by suicide, and the extent to which “first responders” need and receive supervision.
- Examining the impact of suicide in various subpopulations of those bereaved by suicide, including: those from different ethnic, cultural or immigrant backgrounds; families suffering multiple losses to suicide; gay, lesbian and bisexual individuals bereaved by suicide; siblings of children and young people who die by suicide.
- Developing appropriate methodological approaches to meet the challenges of conducting research with those bereaved by suicide. These challenges include: developing valid outcome measures; privacy issues; defining comparison and control groups; recruiting sufficiently large samples (given suicide is a low-base rate event) for studies to have adequate power.
- Exploring the extent to which interventions prevent suicidal behaviour amongst those bereaved by suicide.
- Examining the extent to which different types of interventions may be needed for different populations of those bereaved by suicide, including whether interventions need to be gender, and age-group, specific.
- Clarification and refinement of concepts such as “traumatic” “chronic” and “atypical” grief amongst those bereaved by suicide.

5.5 Specific issues in providing support for those bereaved by suicide

Although there is a range of services available to those bereaved by suicide, research has suggested that many of those bereaved by suicide do not make use of these forms of support. This raises the important issue about various barriers that may prevent those bereaved by suicide from seeking support. Some possible barriers are discussed below.

5.5.1 Lack of societal guidelines for supporting those bereaved by suicide

Some of the difficulties that the bereaved by suicide may experience in seeking support may arise from a lack of clear societal recognition of, and guidelines for, addressing bereavement by suicide. Many people feel awkward, embarrassed and diffident in relating to those who are bereaved by suicide, feeling that they do not know what to say or do to support them best. Rather than risk saying something that might inadvertently cause distress, they may avoid the bereaved.

One of the ways in which these issues may be addressed is by the provision of information and education about suicide, mental health problems and how to best support those who are bereaved by a suicide death. There are roles for a range of lay and professional groups in disseminating such information. Those that could be involved in such activities include national and local organizations for grief and loss, mental health professionals, destigmatisation programmes and related groups.

5.5.2 Reluctance by the bereaved to seek support

Shame and stigma associated with suicide may make seeking support for those bereaved by suicide more difficult than for those bereaved by other modes of death. These features of suicide bereavement suggest that support and assistance may have to be proactively offered to those bereaved individuals, or brokered for them. Moreover, during the course of recovery from the loss needs for support may change or the need for a different type of support may emerge. In the activities in the immediate aftermath of a suicide people may not recall being offered help, or the details of the assistance. For these reasons it may be useful to offer support at several times, including, for example, in the immediate aftermath of the death, and, then at intervals during the first year of bereavement.

5.5.3 Balancing peer support with professional assistance

For some bereaved individuals there may be a risk that they come to value and depend upon family and peer support. They, and their family, may not seek or may fail to recognise that they need to seek, professional input to help them to progress beyond a “survival” or “coping” mode of functioning. Professional assistance may help them restore or initiate contacts with the wider community. Working out a balance between peer and professional support may be a specific issue for some bereaved people.

5.5.4 Received versus perceived support

A recurrent issue in bereavement support has been the extent to which the bereaved who believe that they are socially isolated or stigmatized and are not offered enough support do, in fact, *receive* inadequate support or, rather, *perceive* the support they receive as insufficient. Research that has examined this issue has suggested both that those who are bereaved by suicide receive less support, and that the bereaved by suicide perceive themselves as being treated differently from other bereaved individuals and receiving less support (see, for example, ³⁸).

5.5.5 Support services in rural areas

In small cities and towns in New Zealand there may be too few deaths by suicide to warrant, or sustain, the establishment of a support group specifically for those bereaved by suicide. However, there are a number of ways in which bereavement support might be enhanced in rural areas. For example, this issue has been addressed by the Victorian Health Promotion Commission in Australia ¹³³. In conjunction with the National Association for Loss and Grief (NALAG) they explored opportunities for enhancing bereavement support in rural areas. Their recommendations are relevant in New Zealand and include: a. improved public understanding and awareness of bereavement issues, by public education campaigns, training programmes, and the provision of written material, videos or virtual resources; b. using volunteer support to enhance natural support networks, with volunteers receiving appropriate training and supervision; c. adequate funding to provide outreach services in rural areas; d. improved collaboration amongst training providers; e. improved community networks to enhance training, education and service delivery; f. exploration of ways to improve the uptake of resources that are made available; g. investigation of ways in which Internet based resources could be used to improve access to information and support for rural residents.

6. THE CORONIAL INQUEST and BEREAVED FAMILIES

Suicide deaths are subject to police inquiry, official procedures and coroner's inquests. There are a series of studies which suggest that the families of those bereaved by suicide may find some aspects of these procedures formidable or distressing. These aspects include: the legal atmosphere; the delay between the date of death and time of the inquest; the fact that inquests are open to the public; the fact that, unless specifically suppressed, details of the death are in the public domain and may be reported by the media; the fact that information given to police after the death is not confidential and may be read and discussed at the inquest; hearing (sometimes graphic) details of the death in the formal, police summary of the death, and in the formal, medical terminology of the pathologist's report of the autopsy^{49, 63, 134-136}.

The coronial process is derived from the time when suicides were considered crimes and an inquest was a criminal trial. While suicide has now been decriminalised, coronial inquests are often still conducted in legal or quasi-legal surroundings in a semi-formal manner based upon a courtroom style. Family members are invited to be present at inquests, may be asked for comment and are given the opportunity to ask questions of witnesses and of the coroner. Inquests have a legal purpose, specifically, to establish the cause of death. They do not have obligations to address the needs of bereaved families, despite the belief of many families that inquests are convened for this purpose.

In addition, some families harbour the (false) expectation that the purpose of the inquest is to determine responsibility for the death and to assign blame. They are disappointed and distressed when this does not occur. For many families, the official procedures associated with police investigation and the coronial system may be the first time they have ever had contact with police, legal and judicial processes, and this increases the feeling of stigmatisation associated with the suicide death.

Many families, feel that they cannot begin to resolve their grief until the inquest has been held. While there are suggestions from some families that an appropriate time for inquests would be 3-4 months after the death, coroners and police may face other constraints in setting inquest dates, and the delay between death and inquest is frequently longer than 3-4 months.

Despite these difficulties, there are some reports which suggest that some bereaved individuals find the inquest process helpful in systematically reviewing the circumstances surrounding the death and providing a sense of closure. Positive experiences have also been reported when the 'courtroom' setting for the inquest was replaced by a more relaxed informal setting; where information about the process and purpose of the inquest was provided prior to the event; and, where coroners limited the presentation of potentially distressing details¹³⁵.

Many of the foregoing issues are encapsulated in a recent study¹³⁵. In this study Biddle calls for recognition of potential threats to grieving families imposed by the requirements of the coronial system, and describes potential benefits, when inquests are conducted in a way which seeks to minimise distress for families. Her study calls for a review of the coronial process: i. to make it more sympathetic and responsive to the needs of bereaved families; ii. to develop protocols for dealing with bereaved relatives; and, iii. to implement training programmes for court staff who interact with bereaved families^{49, 63, 134-136}. In commenting on these issues, Biddle has said:

"It seems that decriminalisation has not been reflected by a change in coroner's practices and the coroner continues to implicitly process suicide as if it were a crime. The need for a public court to broadcast public hazards hardly seems appropriate for suicide cases which are more accurately conceived of as private tragedies, and as far as allaying public gossip, the inquest frequently allows the press to transform the family into a social curiosity. Many suicide cases are evidently straightforward which has led to suggestion that in keeping with uncomplicated deaths from natural causes, coroners should be allowed the discretion to process some suicides without a public inquest".

Biddle goes on to summarise a series of recommendations for revision of the coronial process for suicide deaths developed by consensus by the British Isles Suicide Researchers Group (2003). These recommendations are reproduced here in full (Table 1) since a. they represent the work of an eminent group of suicide researchers, b. within the constraints of time and available expertise, there are no opportunities to repeat this exercise in New Zealand for the present report, c. the common coronial systems in the United Kingdom and New Zealand would suggest the British Isles recommendations have strong relevance to New Zealand.

Summary of Recommendations for changes to coronial inquests (British Isles Suicide Researchers Group). Reproduced from Biddle ¹³⁵

Level	Area	Recommendations
Primary recommendation	Allow coroners to dispense with public suicide inquest	In non-complex cases where there is no dispute over facts with family agreement coroners allowed the discretion to process suicides without a public hearing.
Secondary recommendations	Standards of practice	Existing guidelines should be updated and operationalised as standards of acceptable practice. These to be made public and reviewed.
	Training	Coroners and coroner's officers to receive training on aspects of bereavement, questioning techniques and dealing with the media.
Before the inquest	Pre-inquest briefing	The relatives of the deceased should be briefed face-to-face by court representative/welfare officer with the purpose of: <ul style="list-style-type: none"> Providing full information and preparation on all aspects of procedure. Outlining the rights of the bereaved. Redressing unrealistic expectations at the outset. Establishing a point of contact for the inquiry. Making the inquest multifunctional by allowing the bereaved to state questions they would like answered and relaying these to the coroner if appropriate.
	Written information	Briefing supported by written information to address difficulties the bereaved experience in processing and retaining information.
	Re-definition of coroner's officer role	Coroner's officer role officially widened to encompass information and support giving to relatives to include the proposed briefing and also dissemination of information regarding specific help-sources for those bereaved by suicide. Role to be professionalised and formalised through bereavement training.
	Time scales for completion	Excluding exceptional cases, inquests to be held within 4 months ^b . Where this is not attainable, reasons for the delay to be explained to relatives.
	Scheduling the date	Coroner's office to liaise with relatives regarding inquest date. Relatives not to be informed by "summons".

Level	Area	Recommendations
	Suicide notes	Addressee to be provided with a copy of the note. Where no addressee is stated, the note to be given to the next of kin at the coroner's discretion.
During the inquest	Reduced formality	Inquests to be conducted in comfortable, sensitive surroundings with a minimum formality.
	Press restrictions	Media prohibited at relative's request where no function of public broadcast can be justified (see primary recommendation above re: public inquest).
	Restrictions on graphic evidence	Coroners to restrict graphic details heard by relatives to a minimum. Wherever detailed reporting of post-mortem findings are necessary, coroners are to allow relatives the opportunity to leave the courtroom.
	Relieving relatives of the witness role	Coroners where able to relieve relatives who have given statements from public formal questioning/giving evidence under oath.
After the inquest	De-briefing	Relatives provided with an opportunity to discuss what has taken place and to ask questions.
	Complaints procedure	A formal, established and accessible complaints procedure made available to relatives who are unhappy with the inquest <i>process</i> ^c (including pre-inquest procedure).
	Return of suicide notes	Originals to be returned automatically.

^a These recommendations are the consensus of the British Isles Suicide Researchers Group and have been directly commented upon by: Dr Tim Amos - Specialist Registrar in Forensic Psychiatry, Mr William Armstrong - H M Coroner, Miss Lucy Biddle - Research Postgraduate, Mr John Coopey - Chairman of Coroner's Officers Association, Dr David Gunnell - Senior Lecturer in Epidemiology and Public Health Medicine, Prof Keith Hawton - Director of the Centre for Suicide Research, University of Oxford.

^b The time period recommended reflects the potential delays associated with the *necessary* examination of samples at forensic laboratories.

^c Process refers to how the inquest is conducted and not its outcome, i.e. the verdict.

7. INTERNATIONAL PLANS FOR BEREAVEMENT SUPPORT SERVICES

Several countries (including the USA, the United Kingdom, Australia and Belgium) are currently preparing national plans to provide services and support for individuals bereaved or affected by suicide. It is useful to examine these plans, to provide a context for New Zealand proposals and to assess the 'goodness of fit' of New Zealand plans with those suggested for other countries. This section discusses support services in selected countries that may be relevant to New Zealand's current proposals.

7.1 United States

In the United States, bereaved by suicide support groups have provided strong recent advocacy for the needs of those bereaved by suicide. While a variety of support services have been developed at local and regional levels, the American Foundation for Suicide Prevention (AFSP), together with the National Institute of Mental Health (NIMH) has recently begun to address this issue at a national level. The AFSP and NIMH have acknowledged the dearth of research about issues relating to bereavement by suicide. More specifically, they have also noted that very little evidence-based research has been conducted to evaluate the effectiveness and efficacy of a range of different types of assistance and support for those bereaved by suicide, and that there is a strong need for existing programmes to be evaluated.

These deficiencies are to be addressed jointly by AFSP and NIMH who will establish a proactive agenda for national research into bereavement by suicide, and provide funding support for studies which address the identified gaps in information and research. A report identifying gaps in knowledge and outlining a research agenda will be published in 2004. The AFSP and NIMH have also commissioned a parallel report which will review relevant literature about support services for those bereaved by suicide, and identify existing services and gaps in service provision. A report summarising these issues will also be published in 2004.

7.2 United Kingdom

The intention to develop support services for those bereaved by suicide was outlined in broad terms in the United Kingdom National Suicide Prevention Strategy¹³⁷. A national committee of stakeholders was convened in 2003 to consider existing evidence and to make recommendations in this area. This Committee, advised by United Kingdom suicide researchers, mental health leaders and policy analysts, has clearly accepted that there is currently no research-based evidence about the efficacy or effectiveness of different types of suicide support programmes which can be used to inform the development of best practice in this area. [This view echoes that of the AFSP and NIMH (see above)]. Accordingly, the United Kingdom committee is unlikely to suggest the

establishment of new services or the enhancement of existing services. Rather, their recommendations are likely to focus upon:

- i. Promoting generic bereavement services, including expansion of current services to ensure that all health trusts have staff who are bereavement advisors. Such advisors would be able to provide generic information about bereavement, and about bereavement by suicide, specifically.
- ii. Improving dissemination of information to those bereaved by suicide using current front line staff who deal with the bereaved. Staff identified as well-positioned to disseminate information include: a. bereavement counsellors in health trusts; b. counsellors attached to general practice surgeries; c. police liaison officers who liaise between police, support services and families.
- iii. Encouraging good practice for improving access to psychological therapies for people with common mental health problems, using an existing framework devised for this general purpose.

7.3 Belgium

A national programme for increasing support for people bereaved by suicide has recently been developed in the Flemish region of Belgium¹³⁸. This initiative began with the establishment of a Working Group of representatives of a wide range of mental health institutions, social programmes and bereaved by suicide groups. This committee decided that the best approach to improve services and service delivery was to develop networks amongst services. The committee has: published a directory of available suicide support services; established regular meetings involving leaders of relevant groups to develop networks; generated funding support; promoted postvention issues at local and regional levels; publishing a manual of best practice for the suicide support field; and has held a suicide "survivor" support day.

7.4 Australia

Australia has not yet finalised a national plan for support services for those bereaved by suicide. However, there is one service option which has been developed in Australia to support those bereaved by suicide which is relevant to New Zealand's current plans. This service is the Coronial Counselling Service. It may be described as follows. In most states in Australia coronial counselling services have been established to provide information, counselling and support services to anyone who suffers a death that has been referred to the coroner's office⁶². The coronial counselling services are attached to, or closely aligned with, State Coroner's offices, and/or with university departments of forensic medicine, and are funded by either the coroner's office or the university. These services are staffed by specialist bereavement counsellors, who provide a proactive service, contacting the next of kin of all unexpected deaths, including suicides, to offer immediate support and information. After the death and funeral, the counselling service provides

individual short or longer term counselling, as needed. The counsellors also organise regular support group meetings, and provide information packages and a newsletter, for those bereaved by suicide.

In summary, there is considerable similarity in the articulated needs of those bereaved by suicide in different countries and in the responses developed within different countries to support these populations. There is wide acknowledgement that, currently, there is no body of research evidence about the effectiveness and efficacy of suicide support programmes to inform service development. The need for well designed studies examining various issues relating to the impact of bereavement by suicide is also well recognised. The response of the United States to these matters has been to develop a research agenda for the field and to fund appropriate research to address identified gaps in knowledge. In the United Kingdom the response has been to promote generic bereavement and counselling (rather than suicide-specific) services, and to develop strategic linkages between these services and those bereaved by suicide. In Flanders, the approach has been to develop and promote networks amongst existing service providers.

Finally, as more countries develop national responses to supporting those bereaved by suicide, it will be important for New Zealand to remain aware of the range of national plans, strategies and evaluations that eventuate.

8. TOWARDS A MODEL OF BEST PRACTICE IN NEW ZEALAND

The preceding chapters provided an overview of a number of themes relating to the nature and course of bereavement and grief following a suicide death, and the array of options for providing support to those bereaved by suicide. The aims of this chapter are to draw together the various threads developed in the preceding chapters to develop a (tentative) series of best practice recommendations about the provision of support for those bereaved by suicide. Specifically, this chapter deals with the following issues: a. assessment, recognition and management of grief and needs for support in the immediate aftermath of a suicide death; ii. provision of short and longer term support services for immediate family members; iii. the recognition and management of grief in institutional settings, including schools, following a suicide death; iv. provision of support in rural areas; v. other responses related to provision of support; vi. implications for policymakers.

8.1 Guidelines for the management of bereavement and grief in the immediate aftermath of a suicide death

Review of the research evidence suggests the guidelines listed below. It should be noted that these are not supported by the results of controlled evaluations, although many suggestions have empirical, and common sense, appeal.

- A. At the time of a suicide death, family members, whānau and significant others should be provided with:
- Information about the manner, timing and circumstances of the death.
 - An opportunity to view the body, have the body 'lie in state' at home, a marae or other venue, and/or have access to photographs of the body, or the opportunity to take handprints.
 - Emotional support at a viewing of the body.
 - Information about official procedures, and investigations, including an explanation of postmortem and inquest procedures. Written information pertaining to these issues.
 - A copy of, or the original, suicide note or message.
 - Help with obtaining financial assistance to pay for a funeral or tangi.
 - Help and advice about practical matters.
 - Help and assistance with obtaining compassionate leave from work.

- Help and assistance with informing family and others of the death and the circumstances of the death.
- Assistance with interpretation of the postmortem report.
- A package of written information covering: grief and coping strategies for grief; suicide; available resources; a reading list; contact information for local bereavement, and bereaved by suicide, support groups; and related matters.
- Written information about how to support children bereaved by suicide.
- Advice about responding to media inquiries and requests for information about the death.
- Information, support, assessment and, perhaps, medication, from a General Practitioner.

Not all families bereaved by suicide will need all of these services, but under ideal circumstances all of these services should be available.

B. At the time of a suicide death, opportunities for debriefing should be provided to the resuscitation team; emergency rescue staff (including helicopter and boat rescue crew); Emergency Department staff; police; institutional staff (including, for example, police, prison, mental health units).

There is also a need to provide some mechanism to provide such services. There are at least two approaches to developing these services. The first would be to use an existing model (such as Victim Support) to develop an integrated package aimed at addressing the needs of those bereaved by suicide. Alternatively, such services could be provided by specialist units attached to coronial offices (as is the case in some states in Australia - see Chapter 7).

8.2 Guidelines for the management of bereavement and grief in the short and longer term following a suicide death

In the short and longer-term following a suicide death, families, whānau and significant others should be provided with access to:

- Information about the inquest, including the purpose, context and protocols associated with the process, and social and emotional support during the inquest.

- The inquest held in a timely way (i.e. within four months), as far as official procedures allow.
- Opportunities to talk about their experience of a suicide death with others who have been bereaved in this way, in the context of a bereaved by suicide support group, if available
- Access to professional individual or group counselling, therapy or psychotherapy as needed, without cost being a barrier.
- Support from religious leaders and clergy.
- Access, in a non-stigmatising way, to factual information about suicide and mental illnesses with which suicide may be associated.
- Information about how to respond in social environments to questions about the suicide death in their family.
- Information about how to cope with grief and about how others bereaved by suicide have coped during the years following a family suicide.
- Access to information about the impact of suicide family on functioning, how other families have coped after suicide, and strategies for enhancing family communication and functioning after suicide.
- Advice about how and what to tell children about the suicide death of a close family member, and how to protect them from risk of suicidal behaviour.
- The opportunity for assessment to assist in planning care.
- Links with bereavement services.
- Follow-up contact, at several times during the first year, to reiterate offers of support and assistance, and to provide information.

It is noted that critical incident debriefing is contraindicated by evidence that suggests that it does not decrease risk of psychiatric morbidity, depression, anxiety disorders or PTSD, and may, in fact, increase risk of PTSD. There are suggestions that critical incident debriefing might be able to be adapted for use as a screening tool to identify those at risk of developing adverse responses, or that early cognitive behavioural therapy (CBT) might replace debriefing. However, there is not yet evidence for the effectiveness of early CBT¹⁰⁷.

The services described above could be delivered by a number of groups and agencies which include Victim Support, General Practitioners, religious leaders and the clergy, specialist bereavement counsellors, and mental health professionals.

8.3 Guidelines for the recognition and management of grief in institutional settings following a suicide death

Following a death by suicide in an institutional setting, or involving a member of an institution (such as a mental health unit, school, or prison), or the death by suicide of a workplace employer or employee:

- Use should be made of existing Traumatic Incident Response Plans.
- Consideration should be given to bringing in an external consultant with expertise and experience in leading a response to suicide deaths.
- Staff should be provided with information about the specific suicide death, and about suicide, generally.
- Staff should be provided with the opportunity to talk, in a supportive environment, about how the suicide has affected them, and to have their needs for support assessed.
- Relevant community resources/agencies should be identified and information provided to staff/workers and other bereaved individuals about how to access these services.
- Existing risk management procedures should be implemented to minimise risk of suicidal behaviour amongst staff, patients, inmates, students, and others.
- Effective assessment procedures should be used to identify those at risk of severe grief responses, and at risk of suicidal behaviour.
- Collegial support groups could be provided within institutional settings, including mental health settings, to provide support from staff with experience of suicide deaths.
- A meeting between staff and the bereaved family should be offered, and a facilitator provided.
- A review of the circumstances of the suicide should be conducted, if appropriate.
- Individual staff should be provided with access to professional supervision.
- At the end of the intervention all staff involved should be debriefed and the Traumatic Incident Response Plan revised as needed.

These services could be delivered by counsellors and other mental health professionals, and/or by specialist consultants with expertise and experience in facilitating postvention programmes after suicide deaths.

8.4 Suggestions for the provision of bereavement support services in rural areas

As noted above (5.5.5), in rural regions and in small towns in New Zealand, the number and frequency of suicide deaths may be too low to sustain support services specifically for those bereaved by suicide. The Victorian Health Promotion Commission¹³³ has made a series of suggestions to support the development and delivery of support services in rural and small town regions. These suggestions are appropriate to consider in developing a model of best practice in New Zealand, and are reproduced below.

1. Enhance public awareness of loss and grief issues including economic, social and environmental aspects, and their physical, emotional and social impact on the well-being of communities.
2. Enhance community and professional “literacy” (awareness and understanding) of loss and grief issues by provision of resources, funding for professional education and training and for community education.
3. Provide appropriate resources and training for professionals in health, welfare and community services to enable them to better identify, assess and appropriately refer bereaved individuals who need support and/or professional services.
4. Enhance social support structures and programmes which provide support to bereaved individuals, with these programmes having professional input and co-ordination. Volunteers could play an important role in such programmes. Resources for training and supervision of volunteers are necessary to ensure quality control.
5. Provide adequate funding for counselling services so that counselling can be delivered in a timely, accessible manner.
6. Provide funding to support networking and alliances amongst service providers.
7. Provide funding which recognises the additional costs incurred in providing outreach services in rural regions.
8. Enhance training about loss and grief issues by increasing collaboration among training providers.
9. Develop innovative and collaborative strategies to enable supervision of those professionals who provide support to bereaved individuals.
10. Promote the development of networks amongst service providers.
11. Investigate ways of enhancing access to resources and services by rural residents who are bereaved by, for example, developing appropriate internet resources, and evaluating levels of use, and effectiveness of these resources.

8.5 Implications for Policymakers

Beyond best practice recommendations about the provision of support for those bereaved by suicide which are suggested by review of the literature, a number of specific issues emerge which may be of relevance for developing policy in this area. These issues include the following:

- There is currently no clear research-based evidence about the efficacy or effectiveness of a range of psychotherapeutic interventions or support programmes for individuals who are bereaved by suicide which is available to support decision-making about the development of such services.
- Narrative reviews and meta-analyses of methodologically defensible studies of generic bereavement interventions suggest:
 - i. For adults with uncomplicated grief reactions, interventions are likely to be of little benefit and may, in fact, be harmful to some fraction of this population.
 - ii. For adults at risk of developing complicated grief reactions, interventions may be of some benefit, at least in the short term.
 - iii. For adults with complicated grief reactions psychotherapeutic interventions are likely to be of some benefit ¹².
- The lack of evidence for the efficacy and effectiveness of suicide-specific bereavement interventions, and evidence for the limited benefit of generic bereavement interventions, suggest the need for a prudent and cautious approach to establishing support services for those bereaved by suicide.
- Psychotherapeutic interventions and support services should be theoretically justified and consistent with international best practice in this area. Currently, however, there is no single theoretical model of grief and bereavement which is universally accepted and dominant. Many existing interventions and support services appear to have been developed merely upon the *assumption* that such services are beneficial, and that the provision of these services is desirable within any country. Few existing programmes have been subjected to rigorous evaluation. As a consequence, best practice guidelines are lacking.
- Gaps in knowledge about bereavement by suicide imply the need for research to be conducted to provide information about the needs that those who are bereaved by suicide have, and how these needs can best be met.

- Lack of knowledge about programme efficacy and effectiveness implies the need for evaluation of existing and new intervention and support services. Applications for programme funding should be expected to contain plans for evaluation and requests for a budget specifically to meet evaluation costs. Funding providers should demand regular evaluation reports.
- Volunteers currently play a significant role in providing “first responder” services. There are a series of issues that need to be considered including: their voluntary status; their personal experiences of loss, trauma and bereavement; their needs for training and supervision; quality assurance and fidelity to the programme of support; the risk of vicarious retraumatisation. In addition, there is a need to examine the extent to which the support currently provided by volunteers is helpful and beneficial. To date, the programmes provided by the voluntary sector have, largely, not been subjected to evaluation.
- Reviews of randomised controlled trials of critical incident debriefing suggest it may provide no benefit and may, in fact, be harmful. While there is a need for further research in this area, this conclusion invites a searching and critical review of current practice, especially given public perceptions that such debriefing be provided for all traumatic incidents.
- The relatively small number of deaths by suicide and the lack of evidence to underwrite programme development suggests that one cautious approach to developing postvention support may be to strengthen networks among current service providers, and to improve knowledge and training for current gatekeepers so that they can better refer to appropriate services those perceived to be at risk.

8.6 Other responses

There are also a series of more general guidelines to support the development and provision of services for those bereaved by suicide. These include the following:

- All workers, including volunteer workers, involved in providing support to those bereaved by suicide should receive regular, appropriate training from a recognised and appropriately qualified training programme.
- All workers, including volunteer workers, engaged in providing support to those bereaved by suicide should receive regular supervision from an appropriately qualified supervisor.
- There should be a written agreement between the worker and the supervisor giving details of the supervisory process.
- All staff engaged in providing support to those bereaved by suicide should have annual appraisals.
- There are arrangements in place to make support services available to rural populations (see below).

- Use is made of effective individual interventions.
- Use is made of effective group treatment.
- Best practice guidelines are made available for those who wish to establish a support group for those bereaved by suicide.
- Improved training of mental health and bereavement professionals in bereavement and assessment issues.
- Improved collaboration amongst training providers.
- Adequate funding provision for counselling services to be able to be accessed in a timely way.
- Recognition and funding to support access to professional supervision for those providing bereavement services and support.
- Improve community networks to enhance training, education and service delivery.
- Exploration of ways to improve the dissemination and uptake of resources that are provided.
- Exploration of ways in which Internet based resources could be used to improve access to information and support.
- Research to provide information to address knowledge gaps, to evaluate existing services, changes to services or new services that may be developed.

Many of the activities suggested in this paper would appear to require central government and policy input and it is likely that leadership in this area would need to be provided by existing government agencies with a stakeholding in this area including Ministry of Health, Ministry of Social Development, Ministry of Youth Development, Ministry of Education, Department of Courts, Te Puni Kokiri, Police, ACC and the Health Research Council and other research funding agencies.

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APPENDIX I. SEARCH STRATEGY

The materials used in this review were obtained from a number of sources. These sources included:

i) Searches of computerised databases including:

Clinahl
 Clinspsych
 Current contents
 Embase
 Medline
 Psychlit
 The Cochrane Library

Search terms included:

“absent grief”
 “avoided grief”
 “bereaved by suicide support (group)”
 “bereavement support”
 “bereavement”
 “chronic grief”
 “complicated grief”
 “coronial counselling (service)”
 “counselling”
 “crisis support”
 “critical incident debriefing”
 “critical incident response”
 “death”
 “debriefing”
 “delayed grief”
 “distorted grief”
 “dying”
 “exaggerated grief”
 “first responder”
 “grief support”
 “grief”
 “initiated grief”
 “loss”
 “masked grief”
 “minimal grief”
 “pathological grief”
 “post traumatic stress disorder”
 “postvention”

“psychological briefing”
 “SIDS”
 “sudden infant death syndrome”
 “sudden traumatic loss”
 “suicide”
 “support network”
 “support”
 “survivors”
 “traumatic grief”
 “traumatic incident response plan”
 “volunteer counselling”

ii) Searches of websites and specific journals including those of:

American Association of Suicidology.
 American Foundation for Suicide Prevention.
 Befrienders.
 Bereavement Care (journal).
 CDC (Centres for Disease Control).
 CRISIS journal.
 CRUSE.
 Death Studies (journal).
 Grief Matters (journal).
 International Association for Suicide Prevention.
 National Association for Loss and Grief.
 National Injury Surveillance Unit.
 OMEGA (Journal of Death and Dying).
 SIEC (Suicide Information and Education Centre).
 SOBS (Survivors of Bereavement by Suicide).
 The Compassionate Friends.
 The National Association of Bereavement Services (UK).
 The Samaritans.
 World Health Organisation.

iii) The author’s personal collection of books, reviews, journal articles, collections of conference abstracts and related materials.

iv) Searches of reference lists of publications described in (ii) and (iii) above.

The review attempted to apply broad inclusion criteria for the large number of publications and materials identified during the search procedure. In the case of New Zealand literature, and particularly for Māori, Pacific Peoples and Asian populations within New Zealand, these broad inclusion criteria were relaxed further to allow a comprehensive discussion of New Zealand studies. Regrettably, however, the literature search revealed no studies.