

## GRIEF AFTER SUICIDE: THE EVOLUTION OF SUICIDE POSTVENTION

Like a tornado that sweeps through a community, a suicide can leave in its wake a wide swath of psychological wreckage: shock and confusion, horror, profound guilt, anger and blame, and, of course, sorrow. Suicide survivors (people who are grieving after the loss of someone important to them to suicide) are left to wonder “Why did they do this? Whose fault is it? Could we have done something to see it coming or prevent it? How could they do this to me/us?” And the survivors can be more than just the immediate family of the deceased—friends, neighbors, coworkers, and entire communities can be devastated when suicide happens.

In this chapter, I hope to accomplish several things. First, I would like to briefly describe my involvement in the field and then offer the reader some background on the impact of suicide, and the domain of postvention (the term coined by Edwin Shneidman for the efforts after a suicide to help the survivors and to mitigate its deleterious impact; Shneidman, 1972). I will identify many of the key figures and landmark intellectual events in the development of suicide postvention in the United States. Next, I will discuss current interventions for survivors across different therapeutic modalities, including organizational postvention, and group, family, and individual therapies. Last, I will discuss some future directions and developments that I believe are likely for the field of postvention in the 21st century.

### PERSONAL EVOLUTION

I would like to explain briefly my own involvement with suicide prevention and postvention. Personally, I had a great uncle die by suicide in 1987, at the age of 87. Likewise, I had one patient die by suicide—a man who took his life about 3 months after stopping couples therapy and ending the marriage with his wife. Although initially disturbing and sad for me, neither event significantly influenced the course of my personal or professional life.

What did have a major impact was an event in my private practice. I had a number of survivors in my practice with whom I was meeting individually. One day, I had a realization that there was something that these individuals could offer to each other that I, as a mental health clinician and a “distant survivor,” could not. So, I began a survivor support group that ran, in various formats, for more than 13 years. Over the course of that group, I was moved by the amount of suffering in the group, yet inspired by the tremendous resilience that survivors showed when they were provided a setting that offered nonjudgmental support, compassion, and hope.

From this experience, I began to specialize in working with suicide survivors. I also became actively involved with the American Foundation for Suicide Prevention (AFSP), helping them to develop a training for survivors (and professionals) who wanted to run bereavement support groups for survivors. More recently, I have helped AFSP and the American Association of Suicidology develop a training for mental health professionals about providing grief therapy for survivors. At this point, about 90% of my writing, research, clinical practice, and training activities are related to suicide postvention.

## EVOLUTION OF THE RESPONSE TO A PUBLIC HEALTH PROBLEM

There is a cultural shift going on in the United States (and around the world) in which suicide is coming “out of the closet” and increasingly viewed as an important public health problem. As the **tenth leading cause of death** and third leading cause of death for adolescents, significant strides are being made to reduce the incidence of suicide in America (U.S. Department of Health & Human Services, Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Along with this shift, there is a growing appreciation of the psychological damage that suicide may cause to those left behind and therefore of the importance of postvention efforts after a suicide occurs. There is now compelling evidence that people exposed to suicide, particularly those who are emotionally close or biologically related to the deceased, are at elevated risk for suicide themselves (Qin, Agerbo, & Mortensen, 2002). Suicide-prevention leaders are recognizing that postvention is not just the morally correct and compassionate response to such a tragedy, but a crucial component of suicide prevention with a population of people known to be at elevated risk for suicide.

Beyond this elevated risk, there is also substantial evidence that survivors may experience high levels of psychiatric morbidity, social alienation, and stigmatization, and longer term mental health consequences (De Groot & Killen, 2013; Jordan, 2001; Jordan & McIntosh, 2011c; McIntosh & Jordan, 2011b). The literature on whether and in what ways bereavement after suicide is different from other types of death has been the source of some controversy and confusion, because the studies comparing populations bereaved by different causes of death have shown mixed results (Jordan, 2001; Sveen & Walby, 2008). In a recent review of the studies in question, Jordan and McIntosh concluded that suicide bereavement shares universal elements of grief after any type of loss (e.g., yearning for the deceased); elements of grief after sudden unexpected losses (e.g., shock and disbelief); and elements of grief after other sudden, violent deaths, such as homicide (e.g., PTSD; Jordan & McIntosh, 2011b). They also suggested that some elements of bereavement are likely to be more prominent after a suicide than after most other types of death. These include increased levels of guilt, stigmatization, anger, perceived abandonment by the deceased, and blaming. Also prominent is the difficulty in making sense of the suicide. For those who are blind-sided by the death, a suicide may seem inexplicable and incomprehensible (“he could never have done this”). In this sense, suicide may entail a powerful rupturing of the mourner’s assumptive world, including the belief that we can fully know other people or that we can always keep those we love safe from harm. For other survivors, however, particularly when the deceased suffered from a serious psychiatric condition, the death may not have been unexpected or seen as out of character. Instead, such a “feared suicide” may elicit more prominent themes of helplessness, relief that the suffering is over, and guilt for feeling that relief.

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## INTERVENTIONS FOR SURVIVORS—HISTORY

The effort to help survivors has become a social/political movement, often driven by activists who found themselves bereaved, isolated, and with nowhere to turn for support. Many survivors also feel that the mental health system in America has failed both their loved one before the suicide, and now themselves. As such, much of the “resource infrastructure” available to the bereaved by suicide in the United States consists of services begun by, and often run by, survivors themselves. By far, the most common services are open, drop-in bereavement support groups that are facilitated by a survivor (Cerel, Padgett, Conwell, & Reed, 2009; Cerel, Padgett, & Reed, 2009). In addition to groups, other services may include annual memorial services, fund-raising efforts, outreach to new survivors, newsletters, community education, and the creation of other venues by which survivors can find and interact with one another. Examples of such survivor-initiated programs include Heartbeat, begun by LaRita Archibald in Colorado, Friends for Survivors begun by Marilyn Koenig in California, and The LINK Counseling Center begun by Iris Bolton in Georgia (Jordan & McIntosh, 2011a). Another striking example of a survivor–professional partnership is the Baton Rouge Crisis Intervention Center, begun by Dr. Frank Campbell. This center offers a full range of interventions for suicide survivors: professional therapy, peer-led support groups, and a groundbreaking outreach program called the LOSS Team. The latter consists of a mental health professional and a trained survivor volunteer who go with the police or medical examiner to visit newly bereaved families on the day of the death, often at the scene of the suicide (Campbell, 2011). This pattern of intimate involvement of survivors in providing help to other survivors has played a much larger role in developing suicide postvention services than in most other nations around the world.

Also central to the development of postvention in the United States have been three national organizations. The first is the American Association of Suicidology (AAS; Linn-Gust, 2011). AAS was founded in 1968 by clinical psychologist Edwin Shneidman, considered the father of modern suicidology. The organization is a multidisciplinary membership organization that creates a nexus for clinicians, researchers, and academics to exchange ideas, findings, and concerns. Within the annual AAS meeting, a “conference within a conference” called the Healing After Suicide Conference has been introduced, specifically for suicide survivors. This gathering has become a focal event for the postvention community, along with the newsletter published by AAS (*Surviving Suicide*), an online searchable database of support groups, and other activities sponsored by AAS. Also unique is an online support resource for clinicians who are survivors of either patient or family suicides. For more information about AAS and its postvention resources, see [www.suicidology.org](http://www.suicidology.org).

A second important national organization is the American Foundation for Suicide Prevention (Harpel, 2011). This group, originally founded in 1987 to raise funds for research into suicide prevention, has expanded its mission to become the largest U.S. organization concerned with the needs of suicide survivors. AFSP’s services include International Survivors of Suicide Day, an event that gathers survivors at more than 300 sites within the United States and more than two dozen nations around the world. AFSP also trains survivor volunteers and mental health professionals in the skills necessary to facilitate bereavement support groups for survivors, provides informational home visits for newly bereaved survivors through its network of local chapters, and partners with AAS to offer a new training for mental health professionals focused on clinical work with suicide

survivors. AFSP also sponsors “Out of the Darkness” fund-raising walks that serve as a venue for survivors to take positive action together to prevent suicide and help new survivors. Beyond postvention, AFSP sponsors several million dollars’ worth of research into the causes and prevention of suicide and maintains an active advocacy effort on behalf of suicide prevention and postvention. For more information on AFSP, see [www.afsp.org](http://www.afsp.org).

Third, the recently formed National Action Alliance for Suicide Prevention (NAASP) is a public–private partnership dedicated to reducing suicide in America. Among its activities have been the issuing of an updated U.S. National Strategy for Suicide Prevention (U.S. Department of Health & Human Services, Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012), and the formation of a Survivors of Suicide Loss Task Force. The task force is currently writing postvention guidelines for the United States. When completed, this groundbreaking document will provide recommendations for communities, tribes, states, and the nation as a whole for the development of comprehensive and effective postvention services. For more information on NAASP, see [www.actionallianceforsuicideprevention.org/](http://www.actionallianceforsuicideprevention.org/).

There have been several important milestones in the expansion of our theoretical understanding of the impact of suicide and the role of postvention. Arguably, the field of survivor studies can be traced back to the publication of Albert Cain’s landmark book, *Survivors of Suicide* (1972). This pioneering publication was the first clinically oriented volume to describe some of the problematic reactions to a suicide experienced by many survivors. A second major contribution was the book *Suicide and Its Aftermath: Understanding and Counseling the Survivors* (Dunne, McIntosh, & Dunne-Maxim, 1987). This comprehensive volume offered chapters on the social context of suicide, personal accounts of survivors, the impact of patient suicide on professional caregivers, and interventions for both first responders (clergy, police, funeral directors, etc.) and mental health clinicians. A subsequent book by Mishara followed a similar track by examining the impact of suicide on individuals, families, helping professionals, and society as a whole (Mishara, 1995). A long hiatus followed, until the publication in 2011 of Jordan and McIntosh’s broad update of the knowledge base about survivors and interventions to help them. This work surveyed the considerable body of new research produced in the last two decades on suicide bereavement in both adults and children, addressed key questions in the field (e.g., Is suicide bereavement different? What is a working definition of a survivor?), offered chapters on clinical work with individuals, families, groups, and organizations after a suicide, presented capsule summaries of 19 U.S. and international survivor support programs, and concluded with detailed recommendations for advancing both research and clinical/programmatic agendas within the field (Jordan & McIntosh, 2011a). Currently, this book stands as the most complete and up-to-date summary of the “state of the art” in suicide postvention.

## INTERVENTIONS FOR SURVIVORS—CURRENT STANDING

Despite the widespread negative impact of suicide, little has been studied about the mitigation of its effects and assistance for those affected by this significant public health problem. Recent reviews of the literature on interventions for suicide survivors concur on the paucity of studies on interventions for survivors (Cerel, Padgett, Conwell, et al., 2009; Jordan & McMenemy, 2004; McDaid, Trowman, Golder, Hawton, & Sowden, 2008). Of the research that has been conducted (primarily on group or family interventions), the results have been mixed about

the efficacy of the interventions, although most studies have found small positive effects for the treatments studied. Regrettably, most of the research has suffered from a number of methodological limitations that make evidence-based conclusions very tentative (McIntosh & Jordan, 2011a). There have also been a number of clinical descriptions of interventions published, using group, individual, and family methods (Jordan, 2008, 2009, 2011a, 2011b; Kaslow, Samples, Rhodes, & Gantt, 2011; Mitchell & Wesner, 2011).

## Organizational Postvention

Suicide can have a shocking effect on organizations and groups—schools, workplaces, churches, and so forth. Historically, the tendency has been to simply ignore the “elephant in the room” after a suicide, avoiding public discussion of the event and its impact on members of the group. This is changing, however, as organizations recognize that a community-wide response is required after a suicide. This is true not only because suicide is disturbing to the equilibrium of the community, but also because within settings that are populated by adolescents and young adults (e.g., schools, the military), there is a danger of suicide contagion—the spread of suicidal behavior among other vulnerable young people in that setting (Gould, Greenberg, Velting, & Shaffer, 2006).

Postvention typically includes a multipronged response that begins with providing active support and education for the leadership of the community so that they in turn can respond appropriately and openly to the reactions of students or employees. Postvention also includes helping members of the community find safe and appropriate ways to express and share their grief, while also using the event as a “teachable moment” about the causes of suicide, resources that are available to suicidal persons, and suitable ways of reaching out to community members who might be suicidal themselves. Last, comprehensive postvention responses help the organization to develop well-thought-out plans for dealing with the longer term fallout from the suicide and the implementation of efforts to prevent suicide in the future. For more information about organizational postvention after suicide, see Berkowitz, McCauley, Schuurman, and Jordan (2011) and the excellent toolkit for schools developed by AFSP (<http://www.afsp.org/content/search?SearchText=toolkit>).

## Support Groups

Support groups have become a major source of intervention for suicide survivors in the United States. Most groups are open, “drop-in” groups, often led by survivors. Sometimes they are run by a professional through a local organization (typically a hospice), and sometimes they are coled by a hybrid team of a survivor volunteer and a professional. Unfortunately, there has been very little systematic research about the efficacy of participation in support groups, although anecdotal evidence suggests that for people who participate in groups, they are quite helpful (Cerel, Padgett, Conwell, et al., 2009; Feigelman, Jordan, McIntosh, & Feigelman, 2012).

Unlike formal, therapy groups, support groups do not typically focus on changing dysfunctional behaviors or attitudes among the participants. Rather, they make available an emotionally safe and nonjudgmental setting in which members can tell their story, receive empathic support, and exchange ideas about coping and resources. They also provide a venue in which “veteran” survivors help themselves by helping others who are new in their grief—a process of reempowerment

that may counteract the helplessness often engendered by suicide. Last, support groups can reduce the tremendous isolation and estrangement that many survivors feel from their regular social networks, while offering hope for a restoration of one's life (Feigelman et al., 2012).

Although their number has been growing, finding an accessible support group still continues to be a major problem for many new survivors (McMenamy, Jordan, & Mitchell, 2008). In addition, the format of a support group may feel uncomfortable for many people, particularly men. Thus, other types of support resources are needed (Jordan, McIntosh, et al., 2011). One possibility is the growing number of online support groups and other forms of survivor-to-survivor interaction, which may better meet the needs of survivors (Beal, 2011). For more on suicide bereavement support groups, see Feigelman et al. (2012) and Jordan (2011a).

### Family Interventions

Suicide impacts the entire family, in complex and sometimes devastating ways (Cerel, Jordan, & Duberstein, 2008). To begin with, suicide may be an outcome that is embedded in family conflict and distress. There is evidence that families with a suicide often display more dysfunction, abuse, substance abuse, and psychiatric disorder before the death than families without a suicide (Cerel et al., 2008). When the family has had significant problems before the death, issues of guilt and blame are likely to be at a high level after the death. The scapegoating that may follow a suicide can be toxic to family cohesion, sometimes leading to a permanent fracturing of the relationships in families. It is important to note that the majority of families with a suicide do not manifest excessive levels of family problems, other than the problems caused by a member with a psychiatric disorder. Emerging from societal ignorance about suicide, the popular public perception that a suicide is "proof" that the family is dysfunctional is simply wrong.

A suicide can contribute to tension within a family, even when members are not caught up in anger and blaming around the death. Any type of traumatic death tends to produce "coping asynchrony," a mismatch of individual family members' coping styles that may create relational strain. For example, parents who lose a child to suicide may employ very different ways of managing the intense pain associated with their grief. In a similar fashion, a deeply bereaved and traumatized parent may be considerably less emotionally present for their remaining children, sometimes for an extended period of time. Likewise, the family's collective assumptive world—its collective belief system about the predictability and controllability of events and the availability of members—may all be shattered by the suicide (Jordan, Kraus, & Ware, 1993).

Interventions to mitigate some of these negative effects for families bereaved by suicide have not been extensively studied, although family-oriented models of postvention have been proposed in the literature (Kaslow et al., 2011; Mitchell & Wesner, 2011). Several clinically based guidelines have also been offered (Dunne & Dunne-Maxim, 2004; Kaslow & Gilman Aronson, 2004; Parrish & Tunkle, 2003). In the only randomized controlled trial of a brief family intervention specifically designed to reduce complicated grief, de Groot found that her intervention helped to reduce blame and maladaptive grief reactions in participants, but did not reduce the incidence of complicated grief or depression (de Groot et al., 2007). In general, recommendations for family interventions call for the creation of a psychologically safe setting for family members to share their grief and support one another; provision of extensive psychoeducation of family members about suicide, grief, and posttraumatic stress disorder (PTSD); extension of help in dealing with the

stigmatized social reactions of others; and assessment of developing psychiatric morbidity among members (depression, substance abuse, and suicidal ideation). It should also be noted that several family-focused and evidence-based bereavement interventions have been developed (Kissane & Hooghe, 2011; Sandler et al., 2003). Although not specifically developed for or tested with suicide survivors, these therapies could potentially be helpful after a suicide as well.

### Individual Grief Therapy

Perhaps the most common form of intervention for suicide survivors is individual grief therapy, with a significant number of survivors seeking mental health consultation at some point in their recovery process (Dyregrov, Plyhn, Dieserud, & Oatley, 2012; McMenamy et al., 2008). As with family interventions, individual therapy has not been studied specifically in the context of suicide.<sup>1</sup> However, there are a number of reports of promising general treatments for complicated grief (Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen, 2011). There have also been a number of clinical descriptions of individual treatment of survivors (Pearlman, Christine, Rando, & Wortman, *in press*), with perhaps the most recent and comprehensive ones being offered by Jordan (Jordan, 2011b). Jordan has identified a number of “tasks of healing” that are relevant for most suicide survivors and can become the agenda for individual grief therapy with survivors (Jordan, 2009). These tasks include the following:

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- *Containment of the trauma*—Suicide often produces PTSD-type symptoms in survivors (physiological arousal, “flashbacks,” disruption of biorhythms, irritability, emotional numbing, etc.) that are both intrusive and highly distressing. These typically need to be addressed early in the treatment because the horror of the death and accompanying trauma symptoms make attending to grief work much more difficult. Effective trauma-reduction techniques may include eye movement desensitization and reprocessing (EMDR) and other forms of exposure therapies that help to habituate the trauma response (Pearlman et al., *in press*).
- *Learning skills for dosing grief, finding sanctuary, and cultivating psychic analgesia*—Traumatic bereavement entails intense psychic pain, and a major task for survivors is to gain some regulatory control over that pain so that it can be absorbed in manageable pieces. Imparting these skills can empower the mourner to make the grief more “voluntary,” with the time and place of experiencing the grief more under the control of the bereaved. These skills can include the development of self-soothing activities (meditation, massage, etc.) and distraction and avoidance skills (recognizing and avoiding unnecessary “triggers” associated with the loss, and cultivation of positive affective experiences that produce relief). These skills can then be alternated with exposure skills that are necessary for confronting the loss (visiting the grave, looking at photographs or videos, etc.). This alternation between moving toward and away from the loss fits well with the dual-process model of grieving proposed by Stroebe (Stroebe & Schut, 1999).
- *Creation of a complex, realistic, and compassionate narrative of the suicide through a personal psychological autopsy*—Suicide can be described as the “perfect storm”—a complex convergence of multiple factors in just the “wrong” way that allows suicide to happen (genetics, neurobiology, psychiatric disorder, life stressors, difficult access to treatment and easy access to a means for suicide, and decision making on the part of the deceased; Stillion & McDowell, 1996). Conversely, suicide is rarely, if ever, the result of just one event, problem, or

factor. Most survivors know little about what contributes to suicide. They tend to feel that the suicide could and should have been prevented, if someone had done something different—and for most survivors, that someone starts with themselves. Over time, survivors often need to conduct a kind of psychological autopsy to understand the state of mind of the deceased and to piece together a narrative of why the suicide happened and what role various people (including themselves) played in the suicide. The path to successful coping with this crucial “why” question often involves acquiring the capacity to “hold complexity” (Sands, Jordan, & Neimeyer, 2011). This means being able to see the many elements in the perfect storm, to realistically sort out what was and was not under the survivor’s control, to accept the limitations on their ability to influence the outcome, and to forgive themselves for actions that, in hindsight, might have been taken differently.

- *Learning skills to manage changed social connections*—Suicide frequently disrupts the social bonds between people, both within the family and with the larger social network. Survivors have to deal with what has been called the “social incompetence” of parts of their social networks (Dyregrov et al., 2012). Survivors may sometimes encounter anger, blame, and outright shunning from some people in their family or community (Range, 1998). They may be the recipients of insensitive and intrusive comments from others (“Didn’t you know they were depressed?” “What a selfish thing they did to you!”). Perhaps more commonly, survivors encounter avoidance behaviors from other people due to what can be called “social ambiguity”—avoidance behavior that is not necessarily the result of outright condemnation of the suicide or survivor, but more of awkwardness and confusion about how to appropriately interact with the survivor. Nonetheless, this social distancing can be experienced as abandonment and can greatly contribute to the isolation that suicide may generate. The management of these altered social connections becomes a new skill set that survivors are forced to learn in the midst of their need to mourn their loss, adding to the difficulty of navigating in a postsuicide interpersonal landscape.
- *Repair and transformation of the bond with the deceased*—Suicide almost always entails a rupturing of the relationship with the deceased. If it comes at the end of a long, downward trajectory of psychiatric illness, the rupturing may have begun long before the actual suicide. Conversely, the suicide may be a stunning event, one that is experienced as an utterly unforeseen abandonment and betrayal by the loved one. Thanatology has advanced in the last two decades by recognizing that many people continue a psychological relationship with their deceased loved one (Klass, Silverman, & Nickman, 1996; Stroebe, Schut, & Boerner, 2010). Just as relational repair might be needed if the deceased had emotionally injured the person while alive (e.g., a husband running off with another woman), this psychological healing work often needs to be accomplished between the mourner and their loved one after a suicide. This is a task for which a skilled grief therapist, equipped with the right clinical technique, at the right time, can be particularly helpful to a survivor (Jordan, 2012; Neimeyer, 2012).
- *Memorialization of the deceased*—Memorialization is a universal practice among human beings. However, this important process can be more difficult after a suicide, a type of death that is often stigmatized, disenfranchised, and experienced by the mourner as a personal rejection or a publically dishonorable action. A significant task for survivors is to find ways to remember and honor the *whole* life of the deceased, while putting the suicide in the context of that



life. Just as we do not define people by their mode of death if they die of cancer or heart disease, we do not need to do that with suicide. Survivors often need support for reviewing and valuing the entire life of the deceased, rather than just their manner of death.

- *Restoration of functioning and reinvestment in life*—As with all bereavement, survivors have to “relearn the world” that may have been profoundly changed by the suicide (Attig, 2011). This involves transforming the attachment to the deceased and learning to find meaning, pleasure, and purpose in a changed but still satisfying way of life without the deceased.

A skilled grief therapist can be instrumental in helping a traumatized survivor work on all of these healing tasks. The core of all grief therapy is an empathically attuned and skillfully applied use of the therapeutic relationship as an attachment bond that helps the bereaved and traumatized individual to reregulate their physical, cognitive, and emotional life (Jordan, 2008, 2011b; Winokuer & Harris, 2012). Various techniques are evolving in thanatology that allow the survivor and clinician to work on each of these tasks of healing activities (Neimeyer, 2012; Pearlman et al., *in press*). For example, a technique described by Jordan (2012) involves the use of a guided-imagery conversation with the deceased that includes visualizing them as completely physically and, in the case of suicide, psychologically healed. The deceased is imagined as an empathic and attuned listener, ready to hear whatever the mourner needs to tell them. The mourner can then proceed to talk with the loved one about any aspect of the ruptured relationship that remains problematic, as well as the impact of the suicide on the mourner. Although this technique can most obviously be helpful with repair of the bond with the deceased, it can also be useful for working through the traumatic aspects of the death, the elaboration of a narrative for the death, and memorialization of the deceased.

## INTERVENTIONS FOR SURVIVORS—FUTURE DIRECTIONS

There are a number of promising directions in which survivor services are moving. There are also a number of recommendations that have been made for expanding survivor services in the United States that I will briefly summarize to conclude this chapter (Jordan, McIntosh, et al., 2011; McIntosh & Jordan, 2011a).

### Closer Integration With Suicide-Prevention Efforts

Suicide bereavement has traditionally been the “caboose” in suicidology, even though much of the support for prevention efforts results from the fund-raising, political advocacy, and hard work of survivors. There is considerable evidence that exposure to suicide is both more widespread than generally understood (particularly if one includes exposure to suicide attempts) and that exposure carries with it many negative mental health consequences, including an elevated rate of suicidality. Despite this, the field of suicidology has generally failed to recognize that postvention services should be an integral part of suicide-prevention programs. One important development in this regard is the work of the Suicide Loss Task Force of the National Action Alliance for Suicide Prevention (see <http://actionallianceforsuicideprevention.org/task-force/survivors-suicide-loss>). This working group of experts in postvention expects to release national guidelines for suicide postvention in 2014, an action that should help to accelerate this awareness of the need for effective postvention.

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## Training of First Responders and Clinicians Who Work With Survivors

People who are traumatized by the suicide of their loved one are in a vulnerable psychological state of mind. For better or worse, the actions of caregivers who have early contact with survivors (police, emergency medical professionals, clergy, funeral directors, etc.) can have a lasting impact on the newly bereaved. Likewise, mental health professionals can play a pivotal role in the longer term healing process of survivors (Campbell, Simon, & Hales, 2006). Regrettably, the great majority of first responders and clinicians receive little or no training in how to respond to survivors. Indeed, many times these professional caregivers reflect the larger societal attitudes of fear and condemnation of anything connected with suicide. Recognition of the vital need for training in the provision of psychological first aid and grief therapy with survivors is growing, driven in part by survivors who have had damaging experiences with one or both groups of caregivers. An excellent example of a statewide program that provides this kind of discipline-specific training is the Connect Program in New Hampshire (see <http://www.theconnectprogram.org/new-hampshire-suicide-prevention-resources-and-links>). Likewise, a new, collaborative training developed by the American Association of Suicidology and the American Foundation for Suicide Prevention will provide a day-long training in grief therapy for suicide survivors for interested mental health professionals (see <http://www.afsp.org/coping-with-suicide/education-training/aas-afsp-suicide-bereavement-clinician-training-program>). AAS/AFSP will also develop a searchable, online database of clinicians who have completed the training so that survivors can have an accessible resource for finding a “survivor knowledgeable” therapist in their area.

## Development of Culturally Competent Postvention Services

Suicide is no respecter of race, ethnicity, or religious affiliation. Anecdotal evidence suggests that there are commonalities in the psychological experience of survivors across different cultural groups. Still, the way in which grief is processed by diverse cultures, along with the differing social attitudes toward suicide, mean that postvention services that are culturally sensitive and specific need to be developed. In the United States, most postvention services have been designed by and tend to service Caucasian people of European descent. With a few notable exceptions, services for African Americans, Latinos, Asians, and other ethnic minorities in this country are yet to be developed. The expansion of such culturally competent programs must include the active input of people from the communities for whom the services are being established (Kaslow et al., 2011).

## Expansion and Innovation of Postvention Services

Many new survivors report great difficulty locating services when the need arises (Jordan, Feigelman, McMenemy, & Mitchell, 2011; McMenemy et al., 2008). Even when survivors are able to find services, they may be very limited in nature and unsuitable for the emotional needs and desires of some survivors. For example, a twice-a-month, face-to-face bereavement support group may work well for some individuals, but will be actively rejected by others who feel they are too public, too psychologically threatening, or just not sufficient for their needs. This suggests a pressing need to create multiple pathways by which new survivors can find the support they need and multiple interventions once they find a provider of such services (Jordan, McIntosh, et al., 2011).

For example, the literature suggests that in the first year after bereavement, many survivors are too traumatized and depressed to seek out community services. Outreach teams of trained survivors and/or mental health professionals who visit new survivors in their homes can often provide both immediate, crisis-oriented support and also serve as a bridge to increase their willingness and capacity to find needed services (Cerel & Campbell, 2008). The Baton Rouge Crisis Center (Campbell, 2011), Grief Support Services of the Samaritans in Boston (Hurtig, Bullitt, & Kates, 2011), and the outreach program of the American Foundation for Suicide Prevention (Harpel, 2011) are all outstanding examples of this type of innovative service.

Other examples of groundbreaking services for survivors can be mentioned. Schwartz has described an innovative facilitated family retreat for survivor families (Schwartz, 2011). This intervention is a 1- or-2-day networking meeting of the immediate and extended family members of the deceased to share perspectives on the suicide, provide mutual support, and identify and deal with the effects of the suicide on the family. Beal has developed a pioneering Internet-based support service for survivors that includes multiple forms of message boards where survivors post their experience and receive feedback and support from other survivors, a memorial website to honor loved ones, and an e-newsletter (Beal, 2011). Beal's group also has begun holding face-to-face retreats for survivors who have met through the website. Last, programs are experimenting with the facilitation of other forms of survivor-to-survivor contact. These might include matching survivors one-on-one in person or on the Internet with another survivor with a similar experience (e.g., a bereaved mother with another bereaved mother). All of these pioneering efforts are built on the common principle of creating an emotionally safe venue where survivors can share their experience, learn from others, and receive inspiration and hope that surviving the death of a loved one to suicide is, indeed, possible.

Suicide is a major public health problem in the United States. This is true not only because of the direct loss of almost 40,000 lives a year to suicide, but also because of the tremendous damage suicide leaves in its wake. Historically, the survivors of suicide loss have been a highly disenfranchised group of mourners, being isolated and left to grieve and rebuild their lives on their own. This tragic set of circumstances is changing, however, as suicide survivors become more public in their grief and more active in their push to receive the services they need from their communities and the mental health system. With time, effort, and perseverance in the development of suicide-prevention and postvention programs, the hope is that the United States will be able to reduce the number suicide deaths in its soil and to provide effective, accessible, and compassionate help for those left to carry on when suicide occurs.

## NOTE

1. At the time of this writing, there is underway a multisite randomized controlled trial of Shear's Complicated Grief Therapy with suicide survivors with complicated grief (Shear, Frank, Houck, & Reynolds, 2005).

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