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On April 1, 2009, AHS brought together 12 formerly separate health entities in the province: nine geographically based health authorities (Chinook Health, Palliser Health Region, Calgary Health Region, David Thompson Health Region, East Central Health, Capital Health, Aspen Regional Health, Peace Country Health and Northern Lights Health Region) and three provincial entities working specifically in the areas of mental health (Alberta Mental Health Board), addiction (Alberta Alcohol and Drug Abuse Commission) and cancer (Alberta Cancer Board).

Alberta Takes Action on Suicide

Best and Promising Practices in Suicide Bereavement Support Services: A Review of the Literature



Prepared for:

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EXECUTIVE SUMMARY

This literature review highlights the state of suicide bereavement support services and the evaluation processes reflected in the current research. The goal was to review the literature on best and promising practices, and to focus on documentation specific to suicide bereavement support services and evaluation approaches that have been found to be effective, valid, and reliable in applications elsewhere. It also includes specific considerations for target populations.

Two searches of the literature were conducted. The first involve three primary databases, the grey literature, and a small number of key informant interviews including a survivor focus group. The second search investigated further the literature related to complicated grief, coping skills measurement, and services for Aboriginal populations. In total, 74 information sources were deemed to be appropriate and relevant according to the set criteria, and thus have been included in this review.

SUICIDE BEREAVEMENT SUPPORT SERVICES

There is still much to learn about the specific experiences of grieving the loss of someone who has died by suicide. The experience of shame, stigma and isolation, guilt, blame, and meaning-making are factors that result in a unique grieving process for survivors of suicide.

Bereavement groups are the most common form of suicide bereavement support services, but the literature shows varied levels of effectiveness for these services. A co-facilitation model (professional plus a survivor) was noted to be most effective in providing a balanced service to survivors that provides for understanding of similar experiences along with extensive knowledge of potential complications of suicide grief. One-on-one supports can be provided through a variety of approaches and present a less formal route for support, based on when and how the survivor needs a particular service. Survivor involvement in any type of service provision is optimal, as they can be a significant resource for others through better understanding the need for meaning-making and in addressing feelings of isolation.

Regardless of the type of service provided, it is prudent to design links between suicide bereavement support services and a mental health provider, at minimum, for support, advice, and referral. Finally, further program evaluation and research is required.

SURVIVOR SUB-POPULATIONS

In general, not enough is known about the different experiences of children, parents, the genders, Aboriginal, and elderly survivors. In the design and delivery of services, consideration must be given to the unique needs of these particular groups. Those providing services to various sub-populations require adequate training in developmental and experiential factors that may complicate the grieving process. As well, an

understanding is warranted in regard to traditional and acceptable bereavement practices in ethnic subpopulations being served.

EVALUATION TOOLS AND PROCESSES

The evaluation tools and approach findings in the literature are summarized in the following seven key statements:

1. As no standardized means or measures of suicide bereavement support services exist in the literature, a unique approach is necessary to respond to the needs of the Alberta environment.
2. Both quantitative and qualitative designs are necessary and valuable in understanding the impact of suicide bereavement support services.
3. The quantitative tools found to be reliable and valid for survivor programs were the Inventory of Complicated Grief (measure for the grief experience) and the COPE Scale (understanding survivor's coping activities).
4. Multiple data collection sources are necessary in order to fully understand the impact of support services including survivors, referring agencies, and organizational statistics.
5. A balance between the amount of information necessary and collection methods needs to be considered and planned for in the evaluation design.
6. It is important to know whether or not information regarding coping skills and options are a component of the service, not how well participants are coping.
7. A difficulty remains in determining the period of time in which a change is expected specifically as a result of a support service.

LIMITATIONS AND OPPORTUNITIES

- No exploration of research related to suicide contagion which may provide insights that could not be identified through the search parameters applied in this review.
- The lack of pre-defined, reliable, and valid evaluation tools for suicide bereavement support programs creates a potential limitation for any evaluation approach implemented.
- No best practice model for support services (groups or one-on-one) that can be applied unilaterally.
- Evaluating across programs will be difficult if a standard service delivery model does not exist.
- It remains unclear how much time will need to pass before support services impact the lives of survivors.

1. OVERVIEW

In the field of thanatology (the study of grief), a number of assumptions related to suicide bereavement require exploration. First, it is believed that the loss of someone to suicide can create profound grief reactions that are somewhat different in nature to those in other types of death (including sudden death). Vulnerable and at-risk individuals who have lost someone to suicide are at a significantly higher risk for experiencing suicidal thoughts and feelings. Further, certain populations may be more susceptible to the effects of suicide because of the significance and history of suicide within that population. Similarly, children and youth are vulnerable populations due to developmental factors, influences of imitative and contagious elements and, for some, feelings and experiences of isolation.

Consideration of these various factors and the needs of vulnerable populations increase the complexity of suicide bereavement support services and complicate their ability to respond in an appropriate and timely manner. After a death by suicide, specific activities (postvention services) address the traumatic after effects suffered by survivors, including bereavement and trauma recovery needs. They provide education and screening efforts to reduce the risk of further suicides (Dafoe & Monk, 2005). Bereavement support services are important postvention elements in survivor recovery and are a necessary component of a comprehensive suicide prevention strategy.

1.1 Background

Suicide is a national concern. Canada-wide efforts to establish an all-inclusive strategy are evident in the *Blueprint for a National Suicide Prevention Strategy* (2004) prepared by the Canadian Association for Suicide Prevention (CASP). Goal 8 in this national strategy emphasizes survivor services through the following national objectives:

1. *Increase the number of support services, both immediate and longer-term, to those impacted by a suicide.*
2. *Develop standards of competency and care for those who work with people bereaved by suicide.*
3. *Develop education modules for first responders regarding death notification, funeral arrangements, community systems of support, and aftercare.*
4. *Develop guidelines and information packages for funeral directors, churches, schools and other community resources to improve services, education and support to those bereaved by suicide.*

(CASP, 2004, p. 13)

Suicide rates in Alberta have been among the highest in Canada for many years. The recent *Provincial Mental Health Plan for Alberta* (2004) called for the development of a province-wide suicide prevention strategy that is comprehensive in its attention to suicide prevention, intervention, and postvention activities.

The Alberta Mental Health Board (AMHB) led the collaborative effort to develop *A CALL TO ACTION: The Alberta Suicide Prevention Strategy*, which was launched in

September 2006. “The purpose of the Alberta Suicide Prevention Strategy is to prevent and reduce suicide, suicidal behaviour, and the effects of suicide in Alberta over the next 10 years” (AMHB, 2006a, p.13). *A CALL TO ACTION* identified fifteen potential at-risk groups. The *Summary of Available Data and Evidence on Groups at Potential Risk for Suicide* (AMHB, 2006b) was developed, summarizing the data and the research literature for each of these identified groups. A review of this summary led to the identification of the following six priority groups for Phase I Implementation Planning.

- Aboriginal Peoples
- Those Affected by the Aftermath of Suicidal Behaviour or a Suicide Death
- Those Diagnosed with a Mental Illness
- Middle-Aged Males
- Previous Suicide Attempters
- School-Aged Teens and Young Adults

Improving intervention and support for Albertans affected by suicide is Goal 4 of *A CALL TO ACTION*, with the following objectives.

- 4.1 *Enhance community and regional capacity to develop, implement and evaluate services and support programs for those bereaved by suicide.*
- 4.2 *Support the development of programs that offer the choice of using traditional healing practices for Aboriginal peoples bereaved by suicide.*
- 4.3 *Enhance community and regional capacity to develop, implement and evaluate. (p.23)*

The *Summary of Available Data and Evidence on Potential Groups at Risk of Suicide in Alberta* document (AMHB, 2006b) identifies a scarcity of research in the area of suicide survivor risk. The AMHB responded with the development of a number of initiatives to further this knowledge. One of the initial steps in achieving the goal of improving intervention support for survivors was to develop and enhance suicide bereavement support services in the regions through the *Active Postvention Initiative, 2007-2010* (AMHB, 2007). The intent is to build a more proactive postvention response to survivors in order to increase their awareness of, and timely access to, suicide bereavement support services. With strengthened support services in place, more active postvention mechanisms would also be developed in the regions, using appropriate models to fit the needs and geographic diversity across the province.

The current literature review initiates a response to the above objectives as the first stage of a larger evaluation study. The steps involved in the evaluation study process include the following.

1. Literature Review of Best and Promising Practices in Suicide Bereavement Support Services
2. Snapshot of Suicide Bereavement Support Services in Alberta
3. Logic Model, Evaluation Framework and Tools
4. Project Summary Report

The literature review process highlights the state of suicide bereavement support services and the evaluation processes reflected in the current research. Based on this review and analysis of the literature, the AMHB will have information enabling it to better support the appropriate development and enhancement of suicide bereavement support services in Alberta, in collaboration with the many potential partners and stakeholders.

2. GOAL AND OBJECTIVES OF THE LITERATURE REVIEW

2.1 Goal

To review the literature on best and promising practices in suicide bereavement support services.

2.2 Objectives

- Conduct a literature review of best and promising practices in suicide bereavement.
- Focus on documentation specific to suicide bereavement support services and evaluation approaches that have been found to be effective, valid, and reliable in applications elsewhere.
- Identify relevant evaluation data, tools, and processes reflected in the literature.
- Identify specific considerations for target populations.

3. LITERATURE REVIEW METHODOLOGY

3.1 Search methodology

A literature search was conducted to identify key published material regarding suicide bereavement support services and suicide postvention services. Two databases, OVID and EBCOHOST, were used to search article databases. Both included the Cochrane Central Register of Controlled Trials and the Cochrane Database of Systematic Reviews. In addition to the above databases, the OVID search included EMBASE, and the EBCOHOST search included CINAHL, ERIC; Health Source - Consumer Edition; Health Source: Nursing/Academic Edition; PsycARTICLES; PsycCRITIQUES; and PsycINFO databases. A search of the Centre for Suicide Prevention database was also included, along with snowball referencing wherein key articles were identified for consideration when referenced by other authors. Finally, a grey literature search was conducted of international suicidology websites for suicide bereavement support service programs and evaluation descriptions.

A second search process was applied to investigate further the literature related to complicated grief, coping skills measurement, and services for Aboriginal populations. This search involved appraising the literature already accessed for the specific topics of grief measurement and coping skills measurement. The grief measurement tools identified through the literature review were compared against the Kristjanston et al.'s (2006) *Systematic Review of the Literature on Complicated Grief* and Roach's (2000) literature review of potential grief measurement instruments. A further search using Medline (1966-2007) to identify coping skills literature and evaluation tools was conducted; 50 articles were identified. After a review of the abstracts of these articles, 16 were selected for further review. In addition, the *Handbook of Coping* (Zeidner & Endler, [Eds.], 1996) was also reviewed for further information.

See Appendix A for a complete report of the search strategy and outcomes.

3.2 Inclusion criteria

Subject headings were exploded (that is, additional subheadings were incorporated into the search resulting in a broader coverage of the published literature) where possible to include narrower terms. Text words were used to search titles, abstracts, and full-text where available, as well as to search other (non-database grey literature) resources. The search included documents published in all languages, but only English language articles were accessed for the purpose of this review. Other inclusions were as follows.

- Any jurisdictions
- All age groups
- Date coverage: 1996 – present (though earlier articles were not excluded)

3.3 Exclusion criteria

The following terms and programs were excluded from this review:

- community and school postvention crisis response protocols
- psychological debriefing (including Critical Incident Stress Debriefing/Critical Incident Stress Management)
- clinical interventions
- editorials

3.4 Search results

In total, 408 abstracts were reviewed and 182 extracted; 74 were deemed to be appropriate and relevant according to the criteria, and thus have been included in this review. The subject of suicide bereavement support services was found to be relevant on international agendas. Some interesting work from several European countries was found in the search (as was evidenced in the English abstracts). Unfortunately many of these articles were not published in English and therefore were not included in this review.

Documents were first categorized according to type: primary study, literature review, meta-analysis, program description, or expert opinion. The latter generally took the form of website information from national organizations and was chosen based on the recognized credibility of that organization. A small number of key informant interviews were also conducted, including a survivor focus group, and have been included in the expert opinion category. Documents were further organized by descending order of date; in most cases, key studies identified in current articles were also identified through the search strategy performed for this review.

3.5 Status of the research literature

Unfortunately, the status of research on suicide bereavement support services was not strong. This review, like many others before it (AFSP, 2007; Brown et al., 2007; Clark, 2001; Constantino, Sekula, & Rubinstein, 2001; Cvinar, 2005; Gariano, 2006; Jordan & McMenemy, 2004; Jordan, 2001; Mitchell et al., 2007; Sakinofsky, 2007) found a lack of research related to necessary program components, effectiveness of services and most appropriate approaches for various target audiences. Further, where studies had been completed, methodological challenges raise questions about the reliability of study outcomes and the utility of information obtained (AFSP, 2007; Brown et al., 2007; Cvinar, 2005; Jordan & McMenemy, 2004; Sakinofsky, 2007). Methodological issues such as recruiting and maintaining participants, various ethical and practical concerns related to control groups were highlighted.

A review of Canadian research on suicide from 1985 through 2003 conducted by the Public Health Agency of Canada revealed that “very few published Canadian studies examine the issue of suicide bereavement” (White, 2003, p. 7). White (2003) identified five studies within this time period; all five focused on understanding the grief experience of survivors rather than exploring the provision of support services and their effectiveness.

3.5.1 Study quality

In the literature, there was a lack of overall guidance and program guidelines in regard to the provision of services to survivors (Clark, 2001; Cvinar, 2005) and some inconsistencies in study findings that represent a philosophical debate in the field today. Further, virtually no research has been conducted on the impact and applicability of electronic forms of support (Beautrais, n.d.; Linn-Gust, 2005). Consequently, it was not possible through this review to denote best practices in suicide bereavement support services.

Where randomization or rater-blindness strategies were lacking, most studies were uncontrolled and few assessed the long-term impact of services. Similarly, Sakinofsky's (2007) systematic review of the postvention research discovered only a handful of studies and many methodological flaws in their designs. Further, in the literature there is "almost a complete absence of empirically validated interventions that specifically address the thematic, social, and family system problems noted" (Jordan, 2001, p. 99). Comparisons across study outcomes are difficult because of a lack of consistency in target audiences, program descriptions, and service components.

3.5.2 Limited research outcomes

Though suicide bereavement support services are considered to be beneficial, the evidence for their effectiveness tends to be based on small, non-representative samples (AFSP, 2007; Cvinar, 2005; Jordan & McMenemy, 2004). The formal literature revealed bereavement services having a rather low rate of impact overall, possibly reflecting the natural flow of the grieving process (Jordan & McMenemy, 2004).

Although there exists a plethora of programs for survivors of suicide, few have been subjected to rigorous evaluation of their efficacy. Meta analyses of programs that allow this analysis are mixed and show paltry effect sizes. (Sakinofsky, 2007, p. 134S)

Research outcomes may also be impacted by the relief effect that results when the family chaos of living with a suicidal individual is over (Jordan, 2001). In these cases, survivors may actually experience improvements on some psychometric scales that are not sensitive enough to evaluate the environment (Agerbo, 2005; Jordan, 2001; Maple, 2005). "The healing effects of time can not be ruled out" (Constantino, Sekula, & Rubinstein, 2001, p. 439).

Jordan and McMenemy (2004) conducted a review of the literature for studies related to the perceived needs of survivors, research implications concerning general bereavement services, and research on bereavement service efficacy. This review provides a succinct overview of the ten studies from 1982 through 2003 that considered program effectiveness for adult survivors and are summarized below.

- Bereavement services may be effective for high risk populations (such as suicide survivors);
- Gender differences need to be considered in program planning.

- Many bereavement services are not long or strong enough to show impacts.
- Brief interventions following closely after the death are not sufficient alone to address the magnitude of the loss.
- Most programs have high levels of participant satisfaction.

Like others, however, Jordan and McMenemy (2004) express caution in these statements. For example “while there is anecdotal evidence and a general clinical impression that services are helpful, we must conclude that the efficacy of formal interventions for survivors has yet to be scientifically established” (Jordan & McMenemy, 2004, p. 345).

3.6 Suggestions for future research

Other suggested approaches noted in the literature are as follows.

- Monitoring Survivor progress involves the use of tools such as progress notes (Constantino, Sekula, & Rubinstein, 2001), checklists, and surveys so that regular monitoring of health status occurs.
- Sampling issues could possibly be addressed through the use of psychological autopsy-catchment area studies where all Survivor families are interviewed (AFSP, 2007).
- Future research should follow-up those survivors who desired services; this should be done in order to better understand what was most useful in making the decision to seek help (Campbell, 2002).
- Longitudinal and prospective designs with randomized controls are needed (Clark, 2001).
- There is a need for multi-site applications that allow exploration of the particular situational dynamics that make a service beneficial (Linn-Gust, 2005).
- Service-effectiveness studies are needed with those who have not accessed and received services, or studies that attempt to determine the most effective route to reaching newly-bereaved survivors (Linn-Gust, 2005).
- Further research needs to be conducted to clearly understand the implications of kinship and relationship between the survivor and the individual who died, in order to guide the service approach (Mitchell, Kim, Prigerson & Mortimer-Stephens, 2004).

The literature review conducted by Jordan and McMenemy (2004) provides some direction on how to obtain the maximum impact of research in this field. They recommend the following approaches.

- Consider how to obtain better information on the most common course of bereavement after suicide.
- Distinctions in measurement should be made in the thematic content of the grief experience for survivors, differences in social supports survivors have following the death, and specific family processes at play.

- Long-term follow-up studies involving community-based and diverse survivor populations would be beneficial in understanding the challenges associated with the suicide grief process and the most useful coping skills required after a suicide.
- Services need to be able to respond to differences in coping strategies of the genders, different personality types, and cultural implications. Further study is required of these variables in order to respond to differing needs.

Jordan and McMenemy (2004) further suggest that comparative studies are premature given that there is not a strong understanding of the basic elements of suicide survivor grief. They further recommend that research in this area ought to be conducted in two phases.

Phase 1 Naturalistic studies of the effectiveness of existing groups, including data on perceived needs, coping tactics, and sources of support employed by survivors.

- The goal would be to evaluate those common elements (mutual, non-judgmental emotional support, safe setting, and suggestions for coping) of most bereavement support services.
- This could include both quantitative and qualitative study designs moving beyond symptom assessments.
- Qualitative measures assessing the individual's beliefs about the world, quality of life, social adaptation.
- With large enough samples, information related to timing of service, duration, group format (open vs. closed; structured vs. unstructured, psycho-educational vs. support), and type of facilitator training could be assessed.

This more naturalistic, effectiveness-oriented research on existing groups could then lay the foundation for a second wave of more controlled studies of specific intervention techniques for specific types of survivors.
(Jordan & McMenemy, 2004, p. 346)

Phase 2 Controlled studies using random assignment to treatment conditions with control groups; assessing the theoretical basis of bereavement services and program fidelity.

3.7 Summary

Research in the area of suicide bereavement support services is limited. What is available is methodologically questionable, particularly in quantitative design studies. Typical quantitative studies have not found significant changes in overall health indicators, highlighting the need to study those indicators that make suicide grief unique.

The future does hold opportunity for improvement in suicide bereavement research. Many perspectives on how to improve this knowledge-base have been expressed, including a focus on services for specific survivor sub-populations or those considered to be high risk, which may provide information on the need to specialize services for these individuals.

4. INTRODUCTION TO SUICIDE BEREAVEMENT

The *Introduction to Suicide Bereavement* section provides an overview of the information reviewed in the literature and describes the current understanding of suicide bereavement and complicated grief reactions, the status of research on suicide bereavement support services, and the spectrum of service options. This information provides a framework for considering the appropriate and necessary support service needs.

4.1 Grief theories

Normal grief is the emotional state for people following the loss of a loved one. Although this emotional response varies across individuals, it is expected that the grief state continues for a period of weeks or months. It is also expected that intense yearning, intrusive thoughts and images, and a range of dysphoric emotions are observable among the bereaved during the acute grief phase. However, these symptoms are not expected to persist. Persistence of these symptoms (in 10 to 20 percent of those bereaved) are indicators of a complicated grief response (Kristjanson, Lobb, Aoun & Monterosso, 2006).

A number of authors provide succinct descriptions of grief theories over time (see Freeman, 1991; Fielden, 2003; Gariano, 2006; Kastenbaum et al., 2003; Mitchell et al., 2006). The following is a synopsis of these theories. The first two theories are considered intrapersonal models commonly referenced as personal constructs, psychoanalytic or cognitive theories (Gariano, 2006). The latter two are more current views and integrative in nature (though not yet recognized in the field of thanatology); they are able to incorporate and respect unique cultural traditions, and explore the meaning of the death.

Staged grief

Early perspectives of the grieving process identified a series of stages or phases that a person will go through on their path to recovery (Clark, 1992; Gariano, 2006). They provided a means for understanding emotional and physiological experiences, but depicted grief as a linear process with specific timelines.

Grief work

Originally coined by Freud, grief work refers to “the process that an individual goes through during mourning their loss of a loved one” (Gariano, 2006, p. 17) as portrayed through the socially acceptable grief activities of Western societies. This psychoanalytic theory is universal in nature and does not allow individual or unique experiences of grief effects.

Dual process model

This model integrates the concepts of the previous two theories and divides bereavement tasks as either a loss-oriented process (doing grief work, breaking attachments) or a restoration-oriented process (focusing on stressors associated with bereavement such as engaging in new activities, forming new roles, identities, and relationships (Gariano, 2006; Kastenbaum et al., 2003).

Four components model

The reconstruction of life's meaning is a major task of grief that needs to be completed through communication with others (rather than alone and internally) (Mitchell et al., 2006). The four components model identifies the following features as central to one's grief process:

(1) context of loss, risk factors such as type of death, gender, and cultural setting; (2) the continuum of subjective meanings associated with loss, appraisals of everyday matters as well as existential meanings; (3) the changing representations of the loss relationship across time, including the persisting bond with the deceased; and (4) the role of coping and emotion-regulation processes that can relieve or aggravate the stress of the loss.

(Kastenbaum et al., 2003, p. 25; Gariano, 2006)

A current, specific model of grief was not found. Rather, a belief that the staged approach to grief does not reflect individual grief reactions and unique bereavement needs; therefore, understanding grief as a process is more reflective of current thinking (Gariano, 2006; Kastenbaum et al., 2003; Mitchell et al., 2006; J. Wright & T. King, personal communication, July 31, 2007). The consideration of suicide grief as an individualized process will require services to be respectful of the unique journey each survivor will take; as well, it will require service systems to consider what variety of services may be needed in a given community.

4.2 Understanding of suicide bereavement

4.2.1 Definition of a Survivor

The literature presented no consistent, agreed definition of what constitutes survivor status (AFSP, 2007; Campbell, 2001; Jordan, 2007; Jordan & McMenemy, 2004; Linn-Gust, 2005; Maple, 2005; Sakinofsky, 2007). Should the definition be based on kinship lines, the relationship to the deceased, a combination of both, or be left to the individual to decide? Service implications change depending on the definition and which service response is most appropriate given the relationship to the deceased (Mitchell, Kim, Prigerson & Mortimer-Stephens, 2004). Further, study outcomes varied depending on the target population of survivors. Within a family, three to four generations can be affected including siblings, parents, grandparents and, in the case of an adult death, their own children (Maple 2005). Relatives, friends, and the individual's community may also be affected (Campbell, 2002; Gariano, 2006; Maple, 2005); however, those most closely related to the individual who died through kinship were found to be most adversely affected (Mitchell, Kim, Prigerson & Mortimer-Stephens, 2004).

Studies are needed to determine whether the status of Survivor is better defined by kinship ties, by the nature and quality of the relationship one has shared with the deceased, or by other specific characteristics.

(AFSP, 2007)

Similarly, there was a lack of research defining the number of individual survivors for every suicide death. The most common estimation was noted as six survivors for every suicide death (Campbell, 2002; Hoffman, 2006; Gariano, 2006; Jordan & McMenemy, 2004; Mitchell, Kim, Prigerson & Mortimer-Stephens, 2004; Sakinofsky, 2007).

4.2.2 What is suicide bereavement?

There is some indication that suicide death tends to be more traumatic for survivors than those grieving other forms of death and therefore survivors may benefit more from bereavement support services than the general population of bereaved individuals (Jordan & McMenemy, 2004; Jordan, 2001). However, suicide survivors generally received less support than those grieving other types of death. It has been suggested that the quality and type of support may be more important than the quantity (Constantino, Sekula, & Rubinstein, 2001).

Grief responses tend to spiral and impact survivors in waves (Jordan, 2007). Emotional times are triggered by events. Survivors become more skillful at dealing with the triggers as time goes by, but this experience will likely remain vivid for life. Survivors learn to live with the loss and carry on, recognizing that the loss is ever present but able to be borne (Dyregrove & Dyregrov, 2005; Jordan, 2007).

4.2.3 Is suicide bereavement different?

Much of the literature responds to this basic question: Is suicide bereavement different from other forms of grief? There was significant discussion through the mid 1990s in this regard; understanding the unique elements of suicide bereavement is important for setting program targets and services (Clark, 2001; Constantino, Sekula, & Rubinstein, 2001; Jordan, 2001; Pietila, 2002; Scocco et al., 2006). The following outlines current perspectives.

Complicated grief reactions

Though somewhat controversial, there was general agreement in the literature that experiencing a loss to suicide can result in more severe and longer-lasting emotional and physical difficulties as compared to non-suicide death (Bailey, Kral & Dunham, 1999; Campbell, 2002; Clark, 2001; Constantino, Sekula, & Rubinstein, 2001; Gariano, 2006; Jordan, 2001; Mitchell et al., 2007; Sakinofsky, 2007). This was also confirmed by Kristjanson, Lobb, Aoun and Monterosso (2006). They identified survivors of suicide in particular as being at increased risk of complicated grief.

The term *complicated grief* has been defined as a grief response that is typically characterized by intrusive thoughts of the deceased and excessive loneliness, bitterness, and anger related to the death lasting more than six months (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004; Kristjanson et al, 2006; Sakinofsky, 2007). Complicated grief has become associated with suicide grief responses (Campbell, 2002; Clark, 2001; Currier, Holland & Neimeyer, 2006; Gariano, 2006; Mitchell, Kim, Prigerson & Mortimer-Stephens, 2004; Sakinofsky, 2007).

While not experienced by all survivors, and while some studies report no significant differences in psychometric testing between survivors and those who have experienced other deaths, there seems to be a greater potential for complicated grief reactions in survivors (Campbell, 2002; Cvinar, 2005; Jordan & McMenemy, 2004; Jordan, 2001; Mitchell et al., 2006; Mitchell, Kim, Prigerson & Mortimer-Stephens, 2004; Sakinofsky, 2007; Scocco, Frasson, Costacurta & Pavan, 2006).

Complicated grief response can be divided into two components: *separation distress* and symptoms of *traumatic distress*. Separation distress is characterized by the emotions of longing and searching for the deceased, loneliness, and preoccupation with thoughts of the deceased. The symptoms of traumatic distress are characterized by feelings of disbelief, mistrust, anger, shock, detachment from others, and physical symptoms similar to those of the deceased (Kristjanson, Lobb, Aoun & Monterosso, 2006). However, a consistent, agreed definition of complicated grief has not been established in the literature, and framing this form as grief by symptomology versus duration or intensity of grief varies (Gariano, 2006). Furthermore, although there are proposals to include in the DSM-V complicated grief as a disorder; these have not yet been accepted.

Predisposing factors for complicated grief among bereaved individuals include insecure attachment styles, childhood abuse and serious neglect, childhood separation anxiety, close kinship relationship to the deceased, marital closeness, support and dependency (Kristjanson, Lobb, Aoun & Monterosso, 2006). Preliminary studies suggest that complicated grief is found as an independent risk factor for suicidal ideation; however, these studies are inconclusive and further longitudinal studies have been recommended to confirm these early findings (Kirstjanson et al., 2006)

Specific grief reactions

Those surviving a suicide death report more profound experiences of feelings such as stigma, shame, self-recrimination, and search for meaning (Bailey, Kral, & Dunham, 1999; Cain, 2002; Campbell, 2002; Clark, 1992; Cvinar, 2005; Fieldmen, 2003; Gariano, 2006; Jordan & McMenemy, 2004; Jordan, 2001; Kovac & Range, 2000; Maple, 2005; Mitchell, Kim, Prigerson & Mortimer-Stephens, 2004; Sakinofsky, 2007) and may require mental health treatment (Jordan, 2001; Mitchell, Kim, Prigerson & Mortimer-Stephens, 2004). Further, the increased risk for suicidal behaviours after losing someone to suicide was considered to be significantly higher than among other mourners (Campbell, 2002; Jordan, 2001).

Bailey, Kral and Dunham (1999) found that suicide survivors experienced more frequent feelings of rejection, responsibility for the death, and grief reactions than those grieving other modes of death. In particular, increased feelings of shame and stigmatization were noted in suicide survivors.

Unique to suicide bereavement was dealing with the recurring issue of *why?* Making sense of the death was a complicating factor for survivors (Bailey, Kral, & Dunham, 1999; Clark, 2001; Clark, 1992; Currier, Holland & Neimeyer, 2006; Fielden, 2003; Gariano, 2006; Jordan, 2007; Jordan, 2001) and can be magnified in children grieving a

suicide death (Black, 2005; Dyregrov & Dyregrov, 2005; Sakinosfsky, 2007). In fact, Currier, Holland and Neimeyer (2006) found that the inability to make sense of the death was more indicative of a complicated grief response than the cause of death. Consideration of the impact of this death on one's core belief system must be attended to (Jordan, 2007). The unnatural nature of the death was considered to be a variable that made sense-making more difficult in a violent and traumatic death. This was further compounded when the death was particularly gruesome, or when the survivor had witnessed the scene because memories were imprinted resulting in flashbacks, terror, helplessness, and other Post Traumatic Stress Disorder (PTSD)-like symptoms (Currier, Holland & Neimeyer, 2006; Jordan & McMenemy, 2004).

In summary, recent perspectives based on controlled studies indicate that the grief experience is not necessarily more severe than among other types of bereavement. Rather, there are certain themes that may be more prominent in suicide grief that can make coping with the loss more difficult (Hawton & Simkin, 2003). The common thematic experiences noted in the literature for suicide survivors are as follows.

- stigma
- shame
- guilt/blame
- rejection
- inability to understand why

The experience of these negative responses both internally and externally compounds the grief effects and often undermines the social support networks previously in place, increasing feelings of isolation in survivors. This then makes seeking help more difficult (Hawton & Simkin, 2003) and the grief experience more complicated.

4.3 Understanding of suicide bereavement support

4.3.1 Postvention versus bereavement support

The term *postvention* was coined by Edwin Shneidman (Campbell, 2002; Constantino, Sekula, & Rubinstein, 2001; Dafoe & Monk, 2005; Gariano, 2006; Jordan & McMenemy, 2004; Leenaars & Wenckstern, 1998) to represent all those activities that occur following a suicide death aimed at reducing the impact and long-term effects of the death (Hoffman, 2006). The term itself seems to have recently been focused on those activities that follow immediately after the death, whereas bereavement services refer to treatment and support services that follow over time to assist the individual in their grieving process. It was also difficult to find a common definition for *support services*. In some of the literature *support groups* were more clinically therapeutic in nature with a psycho-educational/cognitive component and therefore were facilitated by clinicians.

Psycho-educational programs are interventions that assist individuals and/or groups to cope with the challenges of daily living...to empower individuals and groups with skills, insights, awareness, and

competencies... it promotes health, prevents problems, and reduces the magnitude and severity of the problems' consequences.
(Hoffman, 2006, p. 463)

4.3.2 Social support/networks

The literature is in agreement that suicide survivors perceive a lack of empathy and judgmental attitude from those not grieving a suicide death (Cvinar, 2005; Jordan, 2001; Mitchell et al., 2007). Consequently, they report feeling their natural relationships and environment are no longer safe places for them to share their confusing and daunting grief reactions (Cvinar, 2005; Mitchell et al., 2007). It may be that those in one's social network may wish to provide support, but are ill-equipped emotionally or are too uncomfortable to do so (Jordan, 2001; Kovac & Range, 2000). Further, survivors may be self-stigmatizing and therefore may not make themselves available for assistance from others (Jordan, 2001).

Maple (2005) highlights that social supports are considered to be of critical importance in the grieving process, yet for suicide survivors these natural allies often become unavailable and inaccessible. Bereavement supports need to be more than social groups Constantino, Sekula, and Rubinstein (2001) found that while such groups were somewhat beneficial to survivors, bereavement groups were better able to address other concerns associated with suicide grief, not simply the social variables.

4.3.3 Family considerations

The role of the family in bereavement services is unclear in the literature. Some indicate that given the impact of suicide death on the family environment and the functioning of family members, services must work to help restore relationships and a sense of order (Cvinar, 2005; Dyregrov & Dyregrov, 2005; Jordan, 2001; Jordan & McMenemy, 2004). Others caution against the involvement of more than one family member in support services as some members may experience increased levels of stress, guilt and stigma that will inhibit group participation and this could ultimately be detrimental (Brown et al., 2007). This dilemma speaks to the need for support services to be flexible in how they respond to the unique needs of survivors, to be considerate of family functioning and dynamics when planning service options, and to be cognizant of potential confounding elements that may inhibit participation and perhaps cause greater distress.

Family functioning before and after the death is also a consideration (Brown et al., 2007; Cerel et al., 2000; Clark, 2001; Cvinar, 2005; Dyregrov & Dyregrov, 2005; Gariano, 2006; Jordan, 2001; Sakinofsky, 2007). Some research shows that the families of those who have died by suicide tend to withdraw from their social networks due to stigmatization (real or perceived) and that "shaky family dynamics may become even more dysfunctional" (Sakinofsky, 2007, p. 131S; Cvinar, 2005; Jordan, 2001). Further, in families where the individual who died may have suffered from a long-standing mental illness, survivors may experience conflicting feelings of relief or isolation once the pain and chaos (for both the individual and the family) is over (Agerbo, 2005; Jordan, 2001; Maple, 2005). This may further complicate their grieving process or, on the other hand, make it more manageable.

Suicide bereavement approaches with child survivors

As has been noted, the literature is limited in specific information assessing the use and effectiveness of bereavement services for children and youth who have lost a parent to suicide (Brown et al., 2007; Hoffman, 2006; Mitchell et al., 2007; Mitchell et al., 2006). This review found some recent work with this sub-population, though there still is much to learn. Working with children does require the ability to accommodate the varied cognitive developmental levels of child group participants – age appropriate supportive education and communication concerning the grieving process is critical (Cain, 2002; Mitchell et al., 2007). Further, some literature suggests that children surviving the suicide of a parent, experience psychological distress and often require clinical services (Dowdney et al., 1999). For example, the Children's SOS group described by Mitchell et al. (2007) employed a clinical nurse-practitioner facilitator who had expertise in working with children and an understanding of the cognitive and developmental variables.

Therefore, it seems particularly important that primary-care or mental-health professionals be involved in suicide bereavement work with children. Mitchell et al. (2007) suggests that through a therapeutic support group

The child develops satisfying relationships and gains potential benefits such as lessened social anxiety, increased self-esteem, and a decreased need for self-concealment through realization that disclosure does not result in abandonment or ridicule....a positive feedback loop is established through which a growing sense of approval and acceptance improves self-esteem, encouraging improved communication with parents, siblings, and peers and discouraging problematic behaviors. (p. 6)

With children, secrecy concerning the death is not an uncommon response. While it is often difficult for adults to talk to a child about suicide, secrecy increases feelings of shame and guilt, and may compound a child's the grief reaction (Cain, 2002; Gariano, 2006; Mitchell et al., 2006). Effective communication allows for an understanding of the death and facilitates movement by way of three grieving tasks: recognition, reorganization and reinvestment (Cain, 2002; Dyregrov & Dyregrov, 2005; Mitchell et al., 2006).

*The telling must be a process, not an event. For most the tale will need to be retold and retold, and for virtually all, understandings will be repetitively reshaped as influenced by development, life experiences, and accrual of new information about the death.
(Cain, 2002, p. 135)*

The child's developmental level will impact how he or she understands the death, recognizes which services will be most effective, and why. Children do not fully understand the concept of death much before age seven (Black 2005; Cain, 2002 Mitchell et al., 2006).

The effect of age upon children's understanding of death, level of cognitive development is also important to their ability to understand the concept of death...children begin to develop an understanding of death only after reaching the stage of concrete operational thought, between the ages of 7-12 years...children's understanding of the concept of death is a function of age, verbal ability, and cognitive development.
(Mitchell et al., 2006, p. 133)

Therefore, a child's refusal to listen to or inability to understand a discussion about how the parent died may be quite independent of the surviving parents' refusal or inability to inform the child (Cain, 2002).

Finally, a key element in assisting children in resolving grief reactions is to reassure them that someone will take care of their physical and emotional needs (Cain, 2002; Mitchell et al., 2006). This is a basic instinctual need for the young and can be achieved through open and honest communication. This includes using words that represent the permanency of death and not using euphemisms or metaphors that can be misunderstood. Further, as children grow and their cognitive abilities improve, they will likely require new skills to help them deal with their emotions concerning the death.

Dowdney et al. (1999) found that children and families grieving a suicide were provided with more services when the family was previously known to health providers. As well, services were less likely to be provided to younger children. Key findings in this study include the following.

- Children grieving a parent's suicide show high levels of psychological disturbance and boys tended to be more vulnerable than girls.
- Mothers surviving the suicide death of a child present more psychiatric difficulties than do surviving fathers.
- There is a relationship between the levels of psychological distress in bereaved parents with psychological difficulties in their children.
- Parental wishes and mental health status of family members did not impact whether or not services were provided to children following a death; type of death (e.g. natural causes, accidental, and suicide) and age of the child did influence service provision.
- As services are not necessarily being provided to those who need them, General Practitioners and other primary-care workers need to take a more active role in identifying and referring distressed families to services.

They summarize by indicating that "given resource limitations, service provision should be targeted at psychologically disturbed children or psychiatrically disturbed parents wanting parenting support, or both" (Dowdney et al., 1999).

4.3.4 Coping skills

In the literature, a common element of bereavement support work related to children and parents concentrates on the coping skills of suicide survivors (Clark, 1992; Hawton &

Simkin, 2003; J. Wright & T. King, personal communication, July 31, 2007). Consistent factors in of suicide bereavement support groups and one-on-one supports include the following.

- Create a safe and sharing environment.
- Ensure there is an understanding of the grief process.
- Teach coping strategies to deal with grief effects (interpersonal, emotional, and cognitive).
- Encourage the development of new relationships.

(AFSP, 2007; Clark, 1992; Hawton & Simkin, 2003; J. Wright & T. King, personal communication, July 31, 2007)

Coping skills are specific practices that suicide survivors use to master, tolerate, reduce, or minimize the stressful effects of losing someone to suicide. In Schwarzer and Schwarzer (1996), coping is broadly defined as “cognitive and behavioral efforts to manage specific external or internal demands (and conflicts between them) that are appraised as taxing or exceeding the resources of a person” (p.107).

In this review, most articles identified that development of coping skills is important for suicide survivors, but literature identifying a link between specific coping skills and the prevention of suicide ideation among survivors was not available. A small number of articles introduced coping-skill interventions for bereaved people or those with terminal or chronic diseases. The research indicates that the development of coping skills improves outcomes in these populations; measures such as the reduction in symptoms of depression and anxiety were often identified as the primary outcomes. Coping-skills measurement has also been used to identify links between selected conditions (eating disorders among adolescent girls or burn-out among palliative care nurses) and their models of coping. Further, research on programs that teach coping skills fall short of investigating changes in those skills before and after an intervention.

Although desirable, current research does not establish a causal relationship between the coping skills and the outcomes but highlights that coping-skill training may be an effective component in cognitive and behavioral therapies (Zeidner & Skalofske, 1996). These authors concluded that there is no consensus in research about which coping strategies are most effective and adaptive in promoting positive outcomes. Research provides information about which sub-populations tend to use which coping skills more often. Further research is required to determine how coping strategies resolve problems, relieve emotional distress, and prevent future difficulties (Zeidner & Saklofske, 1996).

It is difficult to measure how people cope. Each person responds to stress differently and their reaction changes depending on the trauma and the emotional state they are in. In the context of suicide bereavement, coping strategies vary depending on the relationship to the deceased and the survivor’s personality characteristics, age and gender (Jordan & McMenemy, 2004). Furthermore, coping responses would be different in the days immediately following the suicide, compared to weeks or years after the loss. Therefore it is neither possible to prescribe nor predict a particular way of coping. The assessment of

coping skills may identify coping-support needs at the individual level; however, it is unlikely that information would be gained on changes or improvement in coping capabilities. More detail regarding the difficulties in measuring coping skills is provided in Section 5 of this report.

In the case of a traumatic event, both short-term and long-term emotional reactions result from a significant change in the individual's perception of their invulnerability, which stems from the following fundamental assumptions: the world is a benevolent place; it has meaning; and the self is worthy (Frieze & Bookwalla, 1996). Therefore, after the traumatic event, individuals must cope not only with the direct consequences of the event, but also with the threat to their invulnerability. Compared to other traumatic events, loss is different in several ways:

(a) loss is a specific event that has occurred, which has an element of immediacy; (b) loss involves an object of referent, the disappearance of a significant object or person; (c) adaptation of a loss is a long lasting process that may have consequences for the entire life span.

(Mikulincer & Florian, 1996, p. 554)

Bereaved persons identified coping strategies such as seeking release of tension, avoiding painful thoughts and feelings, ruminating about the deceased, using a cognitive framework to understand the loss, seeking emotional support, and relying on religious beliefs (Mikulincer & Florian, 1996). The process of coping with loss involves confronting negative feelings, recollecting thoughts about and analyzing the causes, meaning and consequences of this experience, and reframing their understanding of themselves, and the changed reality within which they must live (Mikulincer & Florian, 1996).

Coping strategies can be grouped under problem-focused strategies (for example, seeking support from family and friends), reappraisal (for example, redefinitions of the event), reorganization (for example, acceptance, working through the grief, and restructuring inner structures), and avoidance (for example, denial, relocation) (Mikulincer & Florian, 1996). Problem-focused coping attempts to eliminate the external sources of stress through a vast array of cognitive and behavioral approaches that attempt to make changes in the environment. Reappraisal involves redefining the event, focusing on positive information, creating positive illusions and denying negative aspects. Reorganization involves moving through a series of steps of psychological processing. Avoidance involves preventing the intrusion of disturbing thoughts and disengaging from the stressful situation through active withdrawal or using substances like alcohol and drugs (Mikulincer & Florian, 1996).

Reorganization was noted in the literature as the preferred coping approach for the bereaved. However, reorganization requires revisiting loss-related painful feelings and pondering over the causes and the meaning of loss. Coping through reorganization is a long-term, never-ending process. The adaptation outcomes of reorganization coping should be examined over much longer periods of time. Although it may lead to short-

term emotional problems, encouraging reorganization coping may lead to long-term positive effects (Mikulincer & Florian, 1996).

In the process of coping, actual social support (reduced isolation) and perceived social support play important roles. In addition to promoting more accurate appraisals of personal resources, perceived social support may also enable individuals to confront challenges more effectively because they believe others will help them if the challenge exceeds their personal resources (Pierce, Sarason & Sarason, 1996). Individuals who feel they have high levels of support approach others with the belief that others are likely to provide help; people who feel isolated may avoid asking others for assistance because they fear aid will not be forthcoming. Those who possess the perception of highly-perceived support as a personal characteristic are led to “(1) structure situations so that stressful life events are relatively unlikely to occur, (2) develop effective personal coping skills, and (3) seek and obtain assistance when it is needed (Pierce, Sarason & Sarason, 1996, p. 438).” Secure attachments, developed through social support enhance exploratory behaviour from which coping skills will develop.

4.3.5 Timing of service

The timing of service provision is a common theme in the literature. “Different kinds of support are more beneficial at different stages of the crisis” (Forde & Devaney, 2006, p. 55). For example, crisis-management supports are likely most necessary upon learning of the incident, whereas access to a trained expert in the field may be needed during the transition stage where the survivor is seeking out specific information.

Some survivors attend a support group almost immediately, some wait for years; others attend for a year or two and then go only occasionally.
(AFSP, 2007)

The literature speaks to the need to allow survivors to access the service when they are ready. The process of becoming ready takes time and bereavement group services are unlikely be helpful earlier than from three to six months after the suicide death (Clark, 1992; Jordan & McMenemy, 2004). Often, programs are designed in such a way that survivors themselves are required to make the initial contact and request services (AFSP, 2007; Constantino, Sekula, & Rubinstein, 2001; J. Wright & T. King, personal communication, July 31, 2007).

Predetermined, time-limited therapy and quick-fixes are not likely to be useful to individuals experiencing complicated grief reactions, who often require longer-term assistance in addressing the overwhelming feelings of hopelessness (Cutcliffe, 2006; Jordan & McMenemy, 2004). The survivor’s grieving process can take as long as three to four years before experiencing some feeling of resolution (Murphy, 2000) and anniversaries are particularly difficult (Constantino, Sekula, & Rubinstein, 2001). Some programs have responded to this need by providing survivors with the option of follow-up services in the form of telephone contacts, drop-in groups, and survivor-organized activities should they feel the need (AFSP, 2007; Farberow, 1992; J. Wright & T. King, personal communication, July 31, 2007).

There is value in providing services immediately following the death (the active or outreach model), but this does not predispose the need for support services that must be available for long-term support (three to four years). Finally, it is important to note that not all survivors will need support. Some are able to move through the grieving process without a great deal of difficulty (Farberow, 1992). Therefore, choice what services a survivor receives, and when, are foundational to any service.

Finally, understanding the impact that time has on the decrease of grief response is important. Research indicates that as time goes on, there is a natural decrease in grief effects (Sakinofsky, 2007). This natural result of the passage of time may be responsible for some of the perspectives in the literature that indicate suicide grief is not different from other forms of grief. To sum up, the experience of complicated grief, the length of time grieving, and the intensity of the grief reaction seem to be important factors in understanding survivor grief.

4.4 Summary

There is still much to learn about the specific experiences of grieving the loss of someone who has died by suicide. No definitive perspective was found as to which grief theory is most acceptable in thanatology today. Further, in many studies the theory behind the service was often not articulated clearly enough to allow for consideration in this review. The key elements that were noted are as follows.

- While no common theory was identified, services need to be based on some theoretical perspective.
- Grief is a process rather than a series of stages or tasks to be completed.
- The loss will eventually become a component of the survivor's new life.

Agreement on definitions of terms and services is a challenge. It is agreed that survivors are those who are affected by the loss of someone to suicide. The individual nature of the relationship and unique impact of the death means that a broad definition is likely most appropriate, allowing individuals themselves to identify their survivor status.

There is agreement that the suicide grief experience is unique, but it is difficult to establish whether that affects the long-term trajectory of the bereavement process and if so, in what ways. Some of the literature argues that suicide bereavement cannot be considered the same as the general bereavement processes. There seem to be five consistent grief experiences for survivors of suicide that make their grief process unique from those grieving other forms of death and these are as follows.

- shame
- stigma and isolation
- guilt
- blame
- meaning-making

The available literature does provide advice as to how services could be developed and the components that need to be included. The existence and nature of social supports following a suicide are critical to survivors in regard to their perception of stigma and isolation and in their ability to connect with others in a supportive manner. Many survivors experience a loss of natural social supports after the death and need to be assisted in developing new networks that feel safe and helpful in working through the grief process.

The function of family in suicide bereavement is complex. Family may be a major support for survivors or a further cause of stress. Variables such as relationships prior to the death, the existence of mental health issues and past suicide attempts, as well as internal family dynamics make it difficult to define the most common family response or effective means for addressing the surviving family member's concerns. "The suicide death, or psychiatric illness of a family member can have a huge impact on the wellbeing of other family members" (Agerbo, 2007, p. 411). The only common perspective related to family is that it is a factor that should be assessed and considered in suicide bereavement support service delivery.

Enhancing coping capabilities and recognizing the variety of individual grief responses are goals of any suicide bereavement support service. However, the range of individual experiences results in an inability to identify appropriate coping tools that need to be in the survivor's tool-box. No evidence was found linking specific coping skills to bereavement. Thus, it is important to explore with survivors how they are coping, whether or not their current approach is working for them, and enhance their knowledge about other options they may find useful.

Perspectives are mixed on which is the most appropriate approach to service access; these depend on the type and timing of service, and are based on limited empirical evidence. Immediately following the death, pro-active contact with survivors in order to provide short-term support and information is considered the most appropriate approach because of the chaos that surrounds the death.

However, more involved services, which assist survivors in working through the grief experience, should be decided upon by the individual survivor. The key is to ensure that survivors are well informed, so that they are able to access the services they want, when they want.

Finally, suicide survivors are unique in their service needs and therefore a variety of service options should be made available. Jordan's 2001 summary of the literature reflects five clinical considerations in providing suicide bereavement support services that may advise future service designs.

1. Whenever possible, provide support services that are specific to suicide survivors; at the least, ensure survivors are connected with other survivors.
2. Ensure systematic monitoring of survivor reactions and behaviours.

3. Provide psycho-educational resources through a variety of formal and informal venues.
4. Target coping skills with the survivor's larger social network.
5. Facilitate family resolution.

5. TYPES OF SUICIDE BEREAVEMENT SUPPORT SERVICES

Document terminology in the literature often proved challenging, in light of the intent and scope of this review. The term *intervention* was used in reference to formal therapy (outside the scope of this review) as well as to support groups. Further, *support groups* took the form of survivor-facilitated, professionally-facilitated, or co-facilitation models of delivery, with more or less psycho-educational content. As well, a variety of *support services* were identified. This section provides an overview of this spectrum of suicide bereavement support services, descriptions of what was typically included in the service, along with highlights from the literature. Example programs are included in Appendix B.

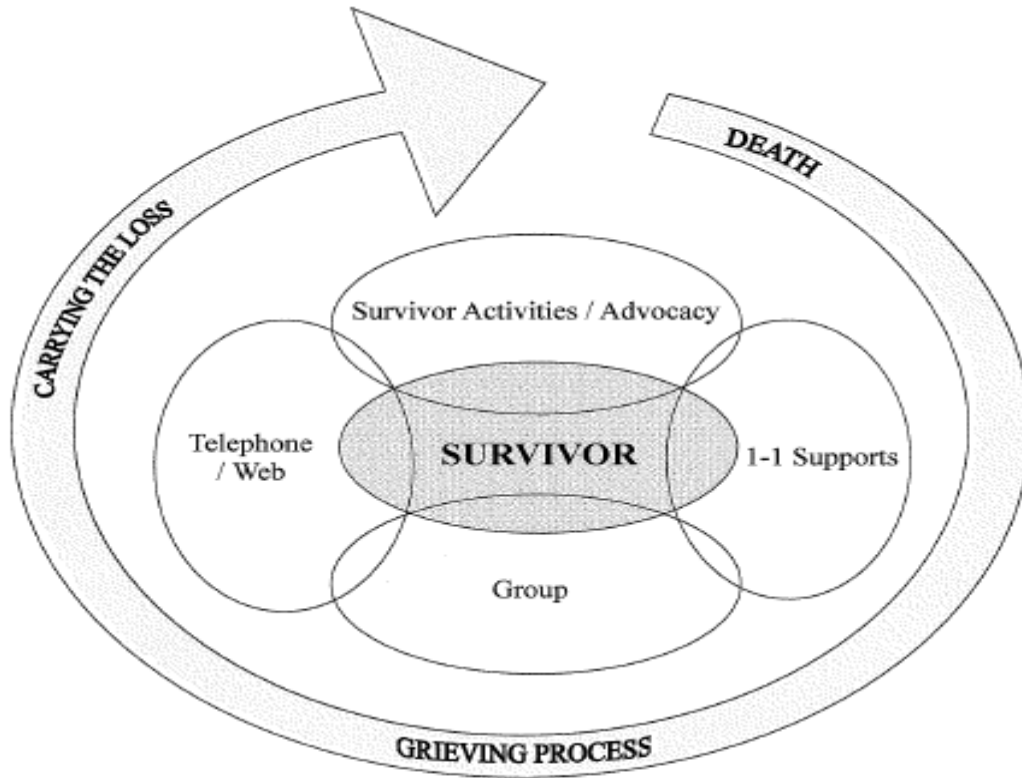
Many of the national suicidology organizations (for example, Canadian Association for Suicide Prevention [CASP], American Association of Suicidology [AAS], American Foundation for Suicide Prevention [AFSP]) provide website links to support services that are either a part of their association or have come to their attention through various activities. For instance, the CASP website provides a listing of Canadian services by province, with a brief description and contact information (see www.casp-acps.ca/supportgroups.asp)¹. These lists may be useful to survivors and service providers attempting to seek-out reputable suicide bereavement support services.

As noted earlier, a variety of services need to be available because not every survivor will need the same service, provided in the same way (Jordan, 2007). Flexibility in service design and provision is required. Services included in the spectrum of suicide bereavement support services are as follows.


- one-on-one support
- psycho-educational groups
- drop-in
- survivor activities

These services are described in detail in Section 5. If we accept the earlier notion of Jordan (2007) in section 4.2.2 of carrying the loss through the grief process, and impose the service options across this experience, then a visual depiction of the suicide bereavement support services may be similar to that represented in the following graphic.

¹ Note that these programs should not be considered as the only suicide bereavement programs available to survivors nor are they screened by CASP in any way. They are listed purely for information and should not be considered as sanctioned programs by CASP.



 Grieving Process over time

 Types of support services Survivors may access (may access all or portion of these services over time)

5.1 Active postvention/outreach services

5.1.1 Service description

Outreach services or active-postvention services, are those typically offered to survivors, immediately following the suicide death, and often through a team approach. The primary purposes of such programs are to provide support for the immediate trauma being experienced, to assist survivors in maneuvering through the process and questions associated with the death (usually involving the Medical Examiner and police), and to provide information about resources the survivor may require.

Active postvention will be a component of further review in the *Active Postvention Initiative, 2007-2010* (AMHB, 2007). Given the specific focus of this review on suicide bereavement support services, outreach-based services was not included. However, it is important to note that outreach may be an important element in the overall spectrum of suicide bereavement services.

5.2 One-on-one supports

5.2.1 Service description

One-on-one supports involve counseling provided through telephone, electronic and individual support sessions. Because of the search criteria applied and the exclusion of clinical therapy services, little was found in the support realm related to one-on-one supports other than those provided via telephone and email contacts.

Supportive counseling

Specific information related to the effectiveness of individual counseling was not found through this review process. This may be because of some of the terminology problems identified earlier in this review. Essentially this service involves a non-clinical intervention on an individual basis, with a similar intent as that of group processes (J. Wright & T. King, personal communication, July 31, 2007).

Telephone and electronic supports

Help lines have existed for many years and have provided invaluable service to those in need. It is not surprising that survivors may look to an anonymous means to talk with someone about their grief experience, taking into consideration the variety of environmental impacts already noted in this review.

When one runs a search on the Internet for *suicide survivor on-line support* over a million hits come up, including a number of individual web resources in the form of chat rooms and bulletin boards (remembering specific individuals who have died by suicide), and some geared for specific target populations (for example, fathers), as well as various host organizations and individuals.

A significant challenge in web-based services is the lack of assurance that the website is reputable. Some national and international organizations have either published lists of known sites or provided links to their webpage. For instance, CASP has posted a Listserve that has become an important and well-used venue for survivors and others (for example, researchers, policy makers, program staff) across Canada to share information. This Listserve can be accessed at <http://groups.yahoo.com/group/SurvivorAdvocates/>

Similarly, the AFSP has posted a listing of eight email support groups and discussion boards, along with another five potential web sites of interest to survivors (see www.afsp.org/index.cfm?fuseaction=home.viewpage&page_ID=1). The AFSP has established its own survivor e-network, with the goal to provide instant communication with survivors in order to empower them to become active in suicide prevention. Services include sharing information of new resources and initiatives, upcoming conferences, research developments, and advocacy activities (AFSP, 2007) that are clearly directed at those survivors who are no longer submerged in the grieving process.

Email support groups have also been implemented in areas of the US where survivor support groups are unavailable (AFSP, 2007). The use of Internet services may be particularly helpful to those in geographically isolated communities or those who do not

desire more traditional services (Clark, 2001). Similarly, survivors relate that this ability to communicate with a stranger can have a great impact (Johnson-Berns, 2000). A survivor can access these services whenever needed. However, this is an area of bereavement support that has not been evaluated (Clark, 2001).

5.2.2 Review of the literature

With the availability of Internet-based survivor support sites, it was interesting to find only one article that specifically considered the applicability of this mode of service. The Hoffman (2006) article describes their comprehensive web-based psycho-educational program for youth suicide survivors; however, no evaluative data was available on the efficacy of this approach. Beautrais (n.d.) also notes the increasing use of technology for grief support in New Zealand and echoes the lack of research on this topic.

The lack of research on the effectiveness and utility of such websites is not surprising. Many social services have expanded into their use of technology in an attempt to address accessibility concerns, improve networking and the sharing of information, and the provision of supports to individuals who, for various reasons, may not be accessing other forms of supports, or may be augmenting those supports with this anonymous communication tool (M. Horton, personal communication, May 22, 2007). Research has not kept up with this expansion of technology and significant methodological challenges exist. This mode of service provision is likely to be of greater importance to the next generation of researchers who will have grown up with the Internet as a vital component of their everyday social lives. As well, this mode of service delivery may have benefits for those who are geographically isolated and those who do not desire the more traditional services. It may also be a cost-efficient means of serving survivors (Beautrais, n.d.; Clark, 2001).

In summary, there is little advice in the literature related to whether or not one-on-one supports as a service delivery mode is appropriate; however, the relevance of accessibility concerns may direct more services providers to consider alternate approaches to providing grief support. Therefore, the lack of current empirical knowledge should not prohibit the use of technology for service provision, in spite of the fact that mechanisms to evaluate such services need to be addressed.

5.3 Support groups

5.3.1 Program description

Support group services have existed within social services for many years and have been applied to various physical, mental, and social problems. However, some countries have experienced a reluctance to establish support groups for suicide survivors (Andriessen, 2004; Defauw & Andriessen, 2003; Grad, Clark, Dyregrov, & Andriessen, 2004).

For some, Yalom's (1985) 12-point therapeutic approach for psychotherapy with the bereaved has become a basis for many group model designs, including length of program (Constantino, Sekula, & Rubinstein, 2001; Freeman, 1991). While program length

(usually 8 or 10 weeks) differed somewhat, as well as the session activities reviewed, generally, groups included the following components.

- intake process
- group orientation and establishing a safe environment
- develop of new relationships
- understanding the grieving process
- identifying feelings
- remembering the deceased
- discussing coping strategies for difficult times (special dates, activities, events)
- socializing strategies
- group closure and future steps

Support groups essentially provide an opportunity for suicide survivors to talk with others who have experienced a similar loss in a safe and accepting environment (AFSP, 2007; Archibald, 2005; Clark, 1992; Farberow, 1992; Hall, 1990; Jordan & McMenemy, 2004; Mitchell et al., 2007; Pietila, 2002; Sakinofsky, 2007; J. Wright & T. King, personal communication, July 31, 2007). Support groups focus on “the instillation of hope, emphasizing universality and interpersonal learning, facilitating group cohesion and catharsis, as well as imparting information” (Mitchell et al., 2007, p. 5) and have been considered a critical support element at international suicidology tables for family members bereaved by suicide (Archibald, 2005; Grad, Clark, Dyregrov, & Andriessen, 2004; Scocco, Frasson, Costacurta & Pavan, 2006).

Pietila (2002) speaks to the role of the support group as providing a venue for sharing with fellow-sufferers, and as the more traditional and accepted route of supporting survivors (rather than therapy): “the most significant aspect about bereavement support groups may be the realization that, in the given situation, people share similar experiences and ‘go through’ more or the less the same process” (p. 403). Groups that provide therapy and support may be the most effective and efficient for survivors and group leaders (Constantino, Sekula, & Rubinstein, 2001).

Facilitators and group leaders

Strong opinions were noted in the literature regarding the qualifications of group facilitators (Andriessen, 2004; Campbell, 2002; Constantino, Sekula, & Rubinstein, 2001; Farberow, 1992; J. Wright & T. King, personal communication, July 31, 2007). Mitchell et al. (2007) describe the role of the group facilitator as follows:

- to provide information (explanations and clarification);
- to establish and maintain group expectations for a safe environment (caring, respectful, empathic, active listening); and
- to model a firm belief in the value of the group process and its healing capabilities.

Group facilitators are also responsible for the systematic monitoring of survivor reactions and behaviours (Jordan, 2001). This is a critical element in any service as a means to

gauge how participants are dealing with discussion matters and information, and allows for ongoing assessment of suicidal risk in survivors. The facilitator is not responsible for healing but is the group's guide (Archibald, 2005; Constantino, Sekula, & Rubinstein, 2001) and monitors the group discussion to allow for the free sharing of information in a safe and healthy environment.

Little specific information was found in the literature regarding training requirements for facilitators. Clark (2001) identifies that many educational packages are available to those wishing to increase their skills and Constantino, Sekula, and Rubinstein (2001) conclude that "training bereavement group leaders in that specific bereavement training may not be as important as the fact that any type of group support, even social may be equally beneficial" (p. 439) and, further, that their skills in expressing interest, caring, and understanding are important healing factors.

Four approaches were noted in this review.

A. Clinician-led

In the literature, clinician-led groups were most commonly noted in connection with particularly high-risk populations or children. These were not psychotherapy groups, which would be considered as treatment services, but were intended to provide participants with access to the specific skills and in-depth training clinicians possess.

As discussed in a later section on the sub-population of children, there are specific suicide bereavement concerns that would benefit from a clinical facilitator. For example, Jordan and McMenemy (2004) note that clinical skills are required to address a "need for help with supporting minor children after the suicide, as well as targeted help in dealing with posttraumatic experiences of intrusive memories and images" (p. 338).

Widow support groups studied by Constantino, Sekula, and Rubinstein (2001) were facilitated by a Master's-level mental health nurse because female survivors often have more symptomatic grief responses (described in more detail below).

B. Co-facilitation (one clinician and one trained survivor)

There was an emphasis in the literature on the value of the co-facilitation model involving both professional and survivor: "professionally led groups have been shown to have added advantages...the greatest benefit was gained when using a professional and a Survivor as co-leaders" (Constantino, Sekula, & Rubinstein, 2001, p. 431; Farberow, 1992). This link with a mental health professional was considered to be critical because of a high risk for complicated grief reactions, suicide, and a possible need for psychiatric intervention (Jordan, 2001).

The involvement of survivor facilitators seems critically important in program design. It allows group participants to talk with someone who has been there, and this has been noted as an important element for survivors in the development of trust and relationships. Survivor facilitators are also able to model effective coping mechanisms to deal with such trauma (Archibald, 2005; Campbell, 2002; Constantino, Sekula, & Rubinstein,

2001; Farberow, 1992; Mitchell et al., 2007; Pietila, 2002). Not only do these facilitators instill hope for the future, they are also able to enhance coping skills in group participants (Mitchell et al., 2007). This seems particularly important for children who often struggle to make sense of their new world, which is further compounded by the cognitive and developmental changes they experience (Cain, 2002; Campbell, 2002; Mitchell et al., 2007; Mitchell et al., 2006).

The survivor-facilitator served as role model of someone who had experienced the same trauma and survived the experience, giving them hope. The professional leading the group was found to be a source of security, information, and education for the members, particularly if there were expressions of emotional disturbance, suicidal feelings, or severe depression among participants.

(Constantino, Sekula, & Rubinstein, 2001, p. 431)

C. Survivor-facilitated

Others have spent a great deal of time training and supporting volunteer survivors to facilitate groups, usually in pairs and often with access to guidance and support from a clinician (J. Wright & T. King, personal communication, July 31, 2007).

It should be noted that many of the peers (or volunteers) are paraprofessionals, indicating some formal training or some level of experience, or both. Also, many of the peer-facilitated initiatives employ a mental health professional back-up.

(Andriessen, 2004, p. 27)

A specific list of consistent qualities, skills or training needs for survivor-facilitators was not found in the literature. Examples of some of the qualities noted are as follows.

- open, non-patronizing, compassionate, non-judgemental, good listening skills, able to acknowledge their own feelings (Grad, Clar, Dyregrov & Andriessen, 2004; J. Wright & T. King, personal communication, July 31, 2007)
- caring, respectful, empathic, active listener, possess a firm belief in the group process (Mitchell et al., 2007)
- able to provide practical and appropriate information related to the grief process and mental health issues (Farberow, 1992)
- excellent group facilitation skills (for example, able to use silence, guide conversations, control self-disclosure, interpret participant responses, know when to provide support, and breaks when appropriate) (Archibald, 2005)

D. Other-facilitated

Due to the very nature of their work, other bereavement-related service providers have made available general grief recovery groups that would involve suicide survivors as well as those grieving other types of death. Examples of these service providers are funeral homes and churches. These organizations have a natural link with those grieving, and an

established relationship based on the death; these are organizations and institutions whose employees or members are compassionate individuals who are knowledgeable and comfortable talking about grieving (Hall, 1990). This allows communities to respond to bereavement needs, using already established and respected community institutions and thereby alleviating access concerns for those who are comfortable with such service providers and wish to receive services close to home (Hall, 1990). The training of facilitators and their comfort and ability to deal with suicide deaths was not explicit in the literature.

Group structure

The demographic make-up of groups was also considered. Jordan (2001) recommends that support services be provided to homogenous cause-of-death groups. There is recognition that this may not always be feasible in all communities (Jordan, 2001). The opportunity to interact with other survivors is an important healing factor, and could be integrated through other means (for example, while those in the support group may not all be survivors, facilitating links to survivor volunteers, telephone, and email supports could meet this need).

There are two types of groups, open (membership changes) and closed (a specific group or intervention) (Andriessen, 2004; Campbell, 2002; J. Wright & T. King, personal communication, July 31, 2007). Closed support group services tend to be limited in time and number of sessions and services to build upon the need to develop safety, trust, and new social networks. Often, these services are followed by an open drop-in group that any survivor can access for ongoing support and follow-up (Farberow, 1992 [SAS Program]; J. Wright & T. King, personal communication, July 31, 2007 [The Support Network]).

5.3.2 Review of the literature

It became evident through this review (as it has for others) that no guidelines have been established to advise on the duration of a group or the type of facilitator (Sakinofsky, 2007), nor has there been adequate research to enable comment on the overall effectiveness of suicide bereavement support groups (Gariano, 2006; Linn-Gust, 2005). Programs tend to be based on either one grief theory or an integration of a number of theories or grief concepts, but considering the efficacy of these approaches there are little empirical data and few studies.

Farberow (1992) studied the impact of the Los Angeles Survivors After Suicide (SAS) support group and found that more women access this group and approximately 77% of members accessed the group within the first six to eight months after the death. The factors most helpful to participants in dealing with their loss were as follows.

- talking to friends and family
- reviewing pictures and mementos
- visiting the grave
- re-arranging and storing the belongings of the deceased

This study assessed for self-reported change involving nine emotions: depression, shame, anger at the deceased, grief, guilt, puzzlement, anxiety, anger at oneself or others, and one's own suicidal feelings.

Participants indicated that they found help in facing the reality of the loss, were reassured their feelings were normal, and felt they had regained control of their lives after a severe disruption. Almost all stated they would recommend the program to others.

(Farberow, 1992, p. 32)

Finally, a strong recommendation was made to use a co-facilitation model with a professional and a survivor because both types of facilitators fulfill different but very necessary functions in the group process.

The Constantino, Sekula, and Rubinstein (2001) study of bereavement versus social group impact applied four instruments at four different time periods, one including a pretest and final measurements taken one year following the completion of the program. They found that “participants in the combined postventions experienced a significant reduction in overall depression, psychological distress, and grief, and an increase in social adjustment” (p. 437). This impact was not noted immediately following completion of the group but rather between six to twelve months later.

Groups for children have also been recommended in the literature (Dyregrov & Dyregrov, 2005; Jordan & McMenemy, 2004; Mitchell et al., 2007, Mitchell et al., 2006; J. Wright & T. King, personal communication, July 31, 2007) as well as for teen survivors (Black, 2005). Pietila (2002) conducted a qualitative review of parent and child reactions to a family member's suicide. Survivors indicated they perceived a sacred significance to the death that no outsider could completely understand which resulted in a safety net being formed around the group. They felt safe enough to speak about this intimate experience only in support groups, a setting in which their understanding of their own experience was enhanced by the process.

Constantino, Sekula, and Rubinstein (2001) found that both bereavement and social support groups held some positive outcomes; Jordan and McMenemy (2004) suggest that “any group format that allows survivors to interact with other survivors in a professionally led group may be beneficial” (p. 342). It seems apparent that support groups have been beneficial to the majority of survivors seeking help (Campbell, 2002; Farberow, 1992).

In their review of the literature related to facilitator skills, Constantino, Sekula, and Rubinstein (2001) note that while there are benefits to the use of survivor facilitators, many authors recommend that professionally led groups or co-facilitation models are likely the most effective. Therefore, it may be prudent to consider the integration of professional roles into survivor services.

5.4 Survivor activities

The ability of society to respond appropriately to survivor experiences lies in knowledge and understanding. Survivor advocates provide many vital roles in suicide bereavement support services from educating, to informing research questions and using knowledge generated from the research, to informing and influencing policy, to advocating for programs and services. These functions are particularly helpful in areas where current research is limited. Therefore, bereavement support services and survivor activities and advocacy can play a large role in educating the community, as well as providing an ongoing network of social supports for survivors. The Survivor Advocates Listserve referred to earlier is one venue that allows for national and international communications concerning such activities as well as networking across jurisdictions.

As the diversity and form of survivor activities varies significantly, no attempt to document sample programs was undertaken. Various national and international suicide prevention organizations (for example, AAS, AFSP, CASP, International Association of Suicide Prevention [IASP]) have dedicated Divisions to survivor concerns and advocacy. Typical approaches include community awareness events (walks, promotional days and weeks), media communications, the establishment of survivor social networks, and sharing information through presentations, written materials and newsletters.

5.5 Summary

A variety of suicide bereavement support services are necessary because a single approach cannot meet the needs of all survivors. Accommodating a spectrum of services for suicide survivors seems prudent because each approach serves a different need (for example, outreach programs connect, therapy treats, support groups educate and support, telephone and websites support the isolated and long-term survivors, and activities empower survivors).

Bereavement groups are the most common form of suicide bereavement support services, but the literature shows varied levels of effectiveness for these services. Those who are experiencing the most difficulty in their grief process do experience the greatest benefit from bereavement groups. The bulk of the literature suggests the co-facilitation model to be most effective in providing a balanced service to survivors that provides for understanding of similar experiences along with extensive knowledge of potential complications of suicide grief.

One-on-one supports can be provided through a variety of approaches and present a less formal route for support, based on when and how the survivor needs a particular service, but this area, too, lacks a strong direction that indicates which components of the service are most beneficial for suicide survivors. Further exploration is needed concerning the potential role telephone and web-based services might play.

Survivor involvement in any type of service provision is optimal, as they can be a significant resource for others in addressing feelings of isolation and through better understanding the need for meaning-making, but there was little found in the literature

regarding how to measure a survivor's individual capabilities and performance as providers of services.

Regardless of the type of service provided, it is prudent to design links between suicide bereavement support services and a mental health provider, at minimum, for support, advice, and referral. With child survivors, a clinician-led facilitation should be employed preferably with two facilitators wherein services are provided to parents as well; no definitive indication of a need for survivors as co-facilitators was identified specifically for children. Finally, further program evaluation and research is required to understand the potential of these approaches to suicide bereavement service delivery.

6. SURVIVOR SUB-POPULATIONS

A number of high risk populations to be considered are identified in *A CALL TO ACTION: The Alberta Suicide Prevention Strategy* (AMHB, 2006a). It was therefore important to explore particular considerations for different sub-populations of survivors. Unique needs and approaches are important in program planning and service delivery. Different service needs may exist among individuals, within families, and among peers and friends of the deceased (Maple, 2005). This section presents information from the limited literature related to the sub-populations of children and families, gender, Aboriginal populations, and the elderly.

6.1 Suicide grief in children

The literature contained research in regard to the child survivor's relationship to the deceased. This section discusses the research related to children grieving the suicide death of a parent or sibling and suggests approaches to bereavement support services.

Those referred to as children in the literature were generally aged 5 to 12; those aged 13 to 20 were identified as either adolescents or youth. However, clear delineations were often lacking and therefore these age ranges should not be considered definitive. Components of services were related to age developmental level, and comprehension of death. Accessibility and the lack of participation of youth also impact how services to this population are delivered. Articles specific to youth populations tend to explore alternative modes of connecting with these survivors, such as electronic means (Hoffman, 2006) or strategic postvention responses (Maples et al., 2005)

6.1.1 Child survivors of a parental suicide

As previously noted, child grief is complicated by developmental changes, cognitive abilities, and their perspective of self as it relates to the world around them (Cain, 2002; Campbell, 2002; Mitchell et al., 2007; Mitchell et al., 2006). Given this, children are possibly a population that experience even higher risk for complicated grief reactions when surviving the death of parent (Brown et al., 2007; Mitchell et al., 2006).

When planning interventions with this population in the form of a support group, it is important to consider the question of a child's readiness to respond to the traumatic loss of a parent by suicide...many children may want to avoid dealing with issues that cause them to experience upsetting feelings, and so it is reasonable to expect that they may require time before they are ready to express their grief.

(Mitchell et al., 2007, p. 4)

The Brown et al. (2007) literature review speculates that children bereaved by parental suicide have more mental health problems than demographically comparable non-bereaved children, possibly as a result of stigma, house-hold disruption, and trauma. The studies they reviewed indicated limited or emotion-specific empirical support for this claim. The subsequent study that Brown et al. (2007) conducted presents the following three primary conclusions.

1. The cause of parental death, either by suicide or other violence, is a modest indicator of the need for bereavement services. Other variables that need to be considered and are likely better indicators for a need for services include: child's level of functioning, coping capabilities, beliefs about themselves (self-worth) and their world (for example, fear of abandonment), and the family environment including parent approach and skills, stress factors in the home, and the mental health status of parents.
2. Children who lose a parent to suicide experience similar difficulties dealing with the death as do children whose parents die from illness. Risk and protective factors are the same; therefore, it is likely that program components of a service would be the same regardless of the type of death.
3. The unique elements associated with suicide death (for example, shame, guilt, and stigma) need to be addressed through the service. A focus on strengthening protective factors and supporting healthy grieving activities are recommended for bereaved children of any parental death.

Children who lose a parent due to suicide “tend to experience even higher rates of anxiety, depression, poor school performance, and decreased social adjustment than children whose parents died of natural causes” (Mitchell et al., 2006, p. 130). Black (2005) highlights that:

6-12 year olds who lost a parent or sibling to suicide experienced significant emotional and behavioral problems such as anxiety and depression. The children suffered intense sadness, longing for the deceased, worry about losing another relative, guilt, and concern about explaining the death-by-suicide to others (p. 30).

The complexity of the grief response in children who were grieving a parent's suicide death depended on the stability of the home environment prior to the parent's death (Sakinofsky, 2007). Therefore, programs need to be able to respond to a child's unique service needs that will change over time (Black, 2005; Mitchell et al., 2006).

Cerel et al. (1999) compared children who had lost a parent to suicide to those who were grieving a parent's death that was not suicide. They found timing of treatment to be an important consideration as “suicide bereaved children are more likely to experience anxiety immediately after the death, followed by anger at 6 months and shame by 1 year after death” (p. 678). They further found that PTSD symptomology did not differ between the two study populations, but the long-term adjustment to losing a parent to suicide is an important treatment element.

In a follow-up study, Cerel et al. (2000) compared the parental and family dynamics of these same populations of children for family and relationship functioning before and after the death of a parent. Those families where the death was a suicide had higher

degrees of family disruption or chronic medical illness before the death than families where the parental death was due to another cause. While the surviving parent seems to deal with the death quite well, their children do not. Programs need to consider providing services to parents to assist them in dealing with their child's grief reactions to suicide.

There is much to learn about the impact of losing a parent to suicide. There is some indication that as these children age they experience negativity associated with that suicide. Similar to the benefits expected for adults, there is a belief that the support group model is beneficial for children because this gives them an opportunity to talk with others who have experienced similar and disruptive family circumstances (Jordan & McMenemy, 2004; Mitchell et al., 2007). Further, when child survivors were interviewed as adults, they reported a strong belief that being able to talk with someone about their experience would have been helpful (Campbell, 1997; Mitchell et al., 2007).

6.1.2 Child survivors of a sibling suicide

Similarly, little is known about sibling response to suicide (Maple, 2005). A national research project from Norway was noted as one of the few studies attempting to understand sibling impact from suicide (Dyregrov & Dyregrov, 2005). This study revealed that the siblings of a person who died by suicide had suicidal thoughts, along with feelings of stigma, blame, rejection, and guilt. These feelings were compounded when the surviving sibling was dealing with having kept secrets about their sibling's suicidal thoughts and triggers. The typical meaning-making process of grieving a child's suicide became even more complex for some children in these circumstances. Parents were trying to understand the death, often with no resolution while siblings held important risk information that they did not feel they could share due to loyalties to the sibling or fear of further blame (Dyregrov & Dyregrov, 2005). These circumstances create a family dynamic that support providers must prepare for.

The experience of losing a sibling to suicide may create a significant change in emotional growth in child survivors. "The event had changed their social roles, identity, life expectations, and daily activities" (Dyregrov & Dyregrov, 2005, p. 720) and therefore past friends and social networks no longer seemed to fit a survivor's current needs. Hence, siblings were not only experiencing the withdrawal of social networks as is common with suicide but also, those networks were no longer relevant to their new vision of life.

Children who were grieving the suicide death of an older sibling seem to be vulnerable to complicated grief effects. "Siblings who were younger than the decedent had somewhat more difficulty" (Sakinofsky, 2007, p. 131S; Dyregrov & Dyregrov, 2005). Further, a question arises around the availability and accessibility of services for siblings. Dyregrov & Dyregrov (2005) found that only 40% of children in their study received services following the death of a sibling. Only six percent of sibling survivors were provided with services for more than three months.

Cvinar (2005) and Dyregrov and Dyregrov (2005) strongly recommend greater consideration and availability of services earlier on for parents as well as sibling

survivors. Some suggest family-based services given the interface of various home and environmental dynamics (Cvinar, 2005; Dyregrov & Dyregrov, 2005; Jordan & McMenamy, 2004).

Further research is needed (Dyregrov & Dyregrov, 2005; Hoffman, 2006; Maple, 2005; Mitchell et al., 2007), but the preliminary perspective is that siblings are a vulnerable population (Campbell, 2002; Clark, 2001; Dyregrov & Dyregrov, 2005; Hoffman, 2006; Maple, 2005; Mitchell et al., 2007). Dyregrov & Dyregrov (2005) conclude by advising:

Assistance to siblings needs to be provided both as direct help to siblings and parents, as well as to the family as whole. Follow-up procedures should include both supportive and psycho-educational components to enable parents and siblings to continue their lives as individuals and as a family while at the same time being able to maintain the positive memories of the person that they have lost. In order to ensure help for all families that need it, such support should be provided by local authorities through systematic outreach assistance (p.723).

6.2 Parental suicide grief

Some investigation has occurred related to understanding parental responses to a child's suicide and to the suicide of a spouse who is also a parent. Gender differences were also noted in responding to suicide bereavement support services.

6.2.1 Parent survivor of a child's suicide

Parents who lost a child to suicide felt isolated by their experience. There was general agreement that the death of a child was the most traumatic grief experience (Maple, 2005; Murphy, 1996; Murphy, Johnson & Lohan, 2002). Couples may experience increased support or protection, as well as stress and aggravation within the relationship following the death (Maple, 2005). However, little research has been conducted on the specifics of the parent bereavement process following a death of a child by suicide (Maple, 2005).

Mothers seem to have greater difficulty than fathers in grieving for the child who died by suicide (Clark, 2001; Maple, 2001; Murphy, 1996; Murphy, Johnson & Lohan, 2002; Sakinofsky, 2007). "Mothers of adolescent suicide victims...continued to struggle with prolonged depression, and it was more likely to recur" (Sakinofsky, 2007, p. 131S). In fact, mothers seem to experience more distress, trauma, difficult loss adjustment, poor physical health, depression, marital dissatisfaction (Maple, 2005) and may take years to get over the death (Constantino, Sekula, & Rubinstein, 2001; Maple, 2005; Murphy, 1996; Murphy, Johnson & Lohan, 2002; Sakinofsky, 2007).

Regarding the concern for increased risk for suicide, Agerbo (2005) reports that "being a parent was a protective factor against suicide, especially to more than one child" (p. 408). This was only relevant for women.

6.2.2 Parent survivor of a spousal (other parent) suicide

In their randomized study of sixty widowed suicide survivors, Constantino, Sekula, and Rubinstein (2001) found that participants experienced a significant reduction in mental health symptoms as a result of participating in bereavement groups that involved both psycho-educational and social supports. “The few studies that have been conducted in this population overwhelmingly support the postvention approach to assist the surviving spouses in working through their resultant depression, psychological distress, social adjustment, and grief” (p. 432). Mothers seem to experience greater difficulties with a spousal suicide than fathers (Brown et al., 2007; Dowdney et al., 1999).

6.2.3 Gender differences

Though not definitively researched, there is cause to consider gender differences in the design of suicide bereavement support services. In the literature related to children and family survivor services, there was little reference to gender. Murphy, Johnson and Lohan (2002) found that both mothers and father’s experienced significant mental health issues following the violent death of a child, but that overall, mother’s grief responses were more profound. They found that bereaved parents who lost a child to accident, suicide or homicide described the impact of the death on their lives as “lasting’ and report that there is no ‘recovery’” (p. 218).

Program statistics and examination of study populations reveal the majority of survivors accessing bereavement support groups are female (Currier, Holland & Neimeyer, 2006; Jordan & McMenemy, 2004; J. Wright & T. King, personal communication, July 31, 2007). The lack of male participants in researched programs results in a knowledge gap regarding which services are desirable and effective for male survivors.

Men and women may use different coping styles to deal with loss...the typical structure of support interventions (e.g., self-disclosure and sharing of feelings) may be less effective, or perhaps even deleterious, for people with an instrumental and more avoidant orientation to coping, which is generally more characteristic of males.
(Jordan & McMenemy, 2004, p. 341)

Therefore, such supports may not be as effective or sought out by grieving men. Brown et al. (2007) reports that family bereavement programs designed to prevent mental health problems in bereaved children may have more relevance for girls because boys did not seem to gain benefit from these services. Bereaved mothers tended to experience great improvement from group sessions, particularly when they showed high levels of distress and complications in their grief experience. However, group support may actually increase post-traumatic stress symptoms in males (Jordan & McMenemy, 2004; Murphy, 2000; Murphy et al., 1998). Campbell (1997) expresses support for Bland’s 1994 findings that men and women experience different numbers of problems with activities of daily living but specific areas of concern were not identified. Dowdney et al. (1999) found that boys were more symptomatic than girls particularly in acting out or aggressive behaviours. Consequently, program providers may need to consider alternative approaches to access and service provision for male survivors.

6.3 Suicide grief among Aboriginal peoples

The recent focus on understanding the experience of suicide within Aboriginal populations has resulted in a number of studies primarily in Canada and Australia (White, 2003). Unfortunately, a review of national websites related to Aboriginal suicide prevention efforts, along with the published literature, revealed little guidance on the most appropriate or effective suicide bereavement support services. Similarly, in their systematic review of complicated grief, Kristjanson, Lobb, Aoun and Monterosso (2006) were not able to find any studies focused on complicated grief among Aboriginal populations and concluded that this gap in research is a concern. The desire to understand the survivor experience in Aboriginal populations is not unique to Canada, but has also been identified in the Australian context (Maple, 2005).

Recent initiatives in understanding Aboriginal perspectives may reveal some insight into this lack of research. Robinson (n.d.) reports on a panel discussion related to research on mental health issues in Aboriginal communities and suggests that the lack of attention to ethical processes, respectful communications with Elders and community leaders both before and after research activities may have resulted in a lack of trust and a lack of interest in participating since these communities have not benefited as a result. In many cases, the outcome of research activities was not even shared with these communities. Current practices recommend more involvement of researchers local to the community of interest. Robinson (n.d.) presents two types of research that would be helpful for practitioners in Aboriginal communities:

1. focus evaluation research on understanding the specific components of the services that are helpful and those which do not work well, and
2. apply research approaches that are concerned with understanding and respecting the unique characteristics, community culture, and protocols in the communities

While there is significant recognition for the application of traditional healing practices in supporting the grief process, little was found that reflected specifically on the best way to apply these practices or under what conditions they were found to be most beneficial to survivors. Healing in many Aboriginal traditions involves more than the individual; it entails different activities and processes for the immediate family, extended family, and the community (Waldram, n.d.). It is from this multi-perspective approach that service providers must consider what services are delivered and in what manner.

The work entitled *Promising Strategies, Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies* (White & Jodoin, 2003) provides a comprehensive approach for addressing the complexities of youth suicide among Aboriginal peoples. The cumulative, multi-generational trauma experienced in some Aboriginal communities not only places members of the community at significant risk for suicide, but means their grieving process involves multiple layers and sources of grief. For many, the grieving process is often interrupted or magnified by new losses. While this manual does not directly address the needs for suicide bereavement supports, it does identify that youth and family support groups can be particularly important in Aboriginal youth suicide prevention, and this includes addressing bereavement needs. These programs focus on

life-skills and coping-skills development with real-life applications. The group structures involve a professional facilitator and graduates of the program are encouraged to be involved in the planning and provision of these services.

In their development of the *Suicide Postvention is Prevention* a proactive planning workbook for communities affected by youth suicide, Dafoe and Monk (2005) found support for the need to consider the unique traditions and meanings related to the population of concern. This environmental element may play a significant role not only in the suicide bereavement support services ultimately provided, but also who provides them. For example, Dafoe and Monk (2005) speak to considerations for some communities that have experienced many suicide deaths where "...the cumulative nature of the exposure to traumatic stress for the caregivers is an important consideration when developing a suicide postvention..." (p. 45). In such cases, implementing survivor-facilitated supports may not be the most appropriate or effective ones for anyone in the community.

What we do know from this body of knowledge is set out in the following points.

- The best resources related to suicide prevention services come from within the community itself.
- Service providers are most helpful when they respect local knowledge, culture, wisdom, tradition, and healing practices.
- Various protective factors related to cultural continuity (land claims, self-government, education services, police and fire services, health services, and cultural facilities) within Aboriginal communities have the potential to improve resiliency to suicide and the effects of suicide.

(Chandler & Lalonde, 1998; Dafoe & Monk, 2005)

Australian studies examining suicide risk and suicide rates with Aboriginal populations found similarities with North American Aboriginal peoples, along with the same lack of research exploring the unique history and cultural interpretations of suicide (Maple, 2005). Maple (2005) also found that the size and nature of the cultural community, linguistic barriers, and social networks may further isolate survivors. More information is necessary to understand the ways culture, ethnicity, socio-economic status, religion and spirituality impact the experience of suicide survivors (AFSP, 2007).

Masecar (2007) has compiled a valuable collection of community-based suicide prevention initiatives in Canadian Aboriginal communities. This report provides the reader with first-hand experiences voiced by community members and ways they have incorporated local traditional practices, creating relevant and successful strategies. Masecar (2007) further provides guidance for program planning from a community development perspective that is respectful of Aboriginal history and healing processes. While this document provides a basis from which discussions may emerge around suicide bereavement support services for Aboriginal survivors, it does not provide a succinct direction.

Based on this knowledge, it is reasonable to suggest that the most promising practice in suicide bereavement support services for Aboriginal peoples may be to respect and support traditional healing practices and ceremonies along with other service options. Given the variety of traditions and beliefs across differing Aboriginal populations, it is not likely that a singular approach could be defined or be appropriate.

6.4 Elderly

Complicated grief in the elderly often has significant impact on their physical and psychological health, and therefore may place elderly survivors at higher risk for major grief effects (Clark, 2001; Mitchell, Kim, Prigerson & Mortimer-Stephens, 2004). Currier, Holland and Neimeyer (2006) report that elderly survivors often find the grieving process for suicide to be more complex as well, and severe depressive feelings will often remain for over a year after the death. Elderly individuals who survive the suicide of their peers often receive less support than those who have lost someone to a natural death (McIntosh, 2005) and the fact that these individuals often have experienced multiple losses other than suicide, may add further complexity to bereavement support needs for elderly survivors. Little research has been conducted in recent years on this vulnerable population (McIntosh, 2005). There may be a need to consider further how to respond to the unique suicide-bereavement needs of this population.

6.5 Summary

In general, not enough is known about the subgroup survivor experiences of children, gender, Aboriginal survivors, and the elderly and the best direction for suicide bereavement support services to take. In the design and delivery of services, consideration must be given to the unique needs of these particular groups.

Children and younger siblings are particularly high-risk populations who, due primarily to developmental stages, will require a more clinical approach to adequately address grief responses. Mothers are another group of survivors who seem to experience more complicated grief reactions.

Gender-specific approaches may also need to be a consideration. Limited research was identified in this review related to the differences in grief responses between men and women; however significant anecdotal evidence was presented through the expert opinion approaches undertaken in this process. Men were less likely to access conventional suicide bereavement support services (such as groups or survivor activities) and therefore, further investigation specifically into male survivors is required to understand the type of services needed and how those services should be delivered.

Knowledge regarding Aboriginal suicide bereavement support service delivery needs is growing, however little is known about specific cultural implications for support services and this should be investigated further. The best practice noted through this review is that service providers need to understand and assist survivors and communities to incorporate traditional healing practices into suicide bereavement support services. The most promising approach to this is when services are provided through resources internal to the community.

The elderly are another under-studied population. Given the large number of losses these individuals experience at this stage of life, the elderly were noted as vulnerable people who may require specialized approaches.

Those providing services to various sub-populations require adequate training in developmental and experiential factors that may complicate the grieving process. As well, an understanding is warranted in regard to traditional and acceptable bereavement practices in ethnic subpopulations being served.

7. EVALUATION TOOLS AND PROCESSES

Section 7 provides a basis to inform and support the evaluation of suicide bereavement support services in Alberta. While a variety of measures had been utilized in studies of bereavement services, most were clinical in nature and measured various symptoms from a quantitative perspective. The following presents the findings of qualitative and quantitative approaches for evaluating suicide bereavement support services found in the literature followed by an overview of tools for coping-skills assessment.

7.1 Quantitative approaches

Methodological research concerns in this field, such as recruiting and maintaining participants and the ethical use of control groups were highlighted in section 3. Quantitative approaches that were applied most commonly utilized pre-post test designs (Brown et al., 2007; Farberow, 1992; Kovac & Range, 2000; Murphy et al., 1998). Further, individuals may experience stigma that prevents them from accessing services (Clark, 2001).

Kristjanson, Lobb, Aoun and Monterosso (2006) reviewed complicated grief measurement tools as follows.

- Texas Revised Inventory of Grief
- Hogan Grief Reaction Checklist
- Grief Evaluation Measure
- Revised Grief Experience Inventory
- Core Bereavement Items
- Inventory of Complicated Grief
- Inventory of Complicated Grief –Revised
- Parkes Bereavement Risk Index

In addition to complicated grief measures, the following represent a variety of other measures more generally referenced in the literature for grief (Roach, 2007).

- 10 Mile Mourning Bridge, Anticipatory Grief Scale
- Bereavement Experience Questionnaire
- Bereavement Phenomenology Questionnaire
- Bereavement Response Scale II
- Brief Symptom Inventory
- Complicated Grief Symptom Questions
- Composite International Diagnostic Interview
- Grief Measurement Scale
- Grief Resolution Index
- Hogan Grief Reactions Checklist
- Impact Event Scale
- Monologue Questionnaire

- Psychological Adjustment to Physical Illness
- Satisfaction with Bereavement Experiences Questionnaire
- Semantic Representation of Others Scale

The literature review indicated that the following were used by authors who researched suicide bereavement services: Texas Inventory of Grief, Impact of Event Scale, Inventory of Complicated Grief, Grief Experience Inventory, Brief Symptom Inventory, Grief Experience Questionnaire, and Core Bereavement Items. Below are short summaries of these instruments as presented in Kristjanson, Lobb, Aoun and Monterosso (2006).

7.1.1 Texas Inventory of Grief and Texas Revised Inventory of Grief

The Texas Inventory of Grief questionnaire is a seven-item scale that measures the extent of unresolved grief. Items are rated on a 5-point Likert scale. The measure is intended to serve as a brief screening tool.

The Texas Revised Inventory of Grief is a 21-item scale designed to measure the extent of unresolved or pathological grief. It is a 5-point Likert scale instrument that gauges two points in time: past (immediate or shortly after the death) and present (the time of data collection). The tool measures feelings and actions at these two time periods. A criticism of the tool is that the scale for the past depends on the memory of the individual and there is a potential that memories are influenced by the respondent's current state. Reliability and internal consistency of the tool were measured and found to be at acceptable levels.

7.1.2 Impact of Event Scale

This tool is a 15-item questionnaire intended to assess the response to stressful life events, including the death of a loved one. The data is collected based on a 4-point scale; two subscales of intrusion and avoidance were proposed and factor analyses supported both.

7.1.3 Inventory of Complicated Grief and Inventory of Complicated Grief-Revised

Prigerson and colleagues developed this tool and the revised version (Prigerson et al., 1995; Prigerson & Jacobs, 2001). The Inventory of Complicated Grief is a 19-item questionnaire for the assessment of symptoms of complicated grief. The items describe an emotional, cognitive, or behavioral state associated with complicated grief. The Revised Inventory of Complicated Grief is based on the same 19-item questionnaire but measures a single underlying construct of complicated grief. High internal consistency and test-retest reliability estimates were reported for this tool.

Based on the good convergent criterion, validity and ease of administration, Kristjanson, Lobb, Aoun and Monterosso (2006) recommended the use of this tool in the assessment of individuals for complicated grief in the Australian context. This tool has also been used as a primary measurement in suicide survivor studies (see Currier, Holland & Neimeyer, 2006; Dyregrov & Dyregrov, 2005; Mitchell, Kim, Prigerson & Mortimer-Stephens, 2004).

7.1.4 Grief Experience Inventory and Revised Grief Experience Inventory

The Revised Grief Experience Inventory is a 22-item, 6-point scale that focuses on four domains (depression, physical distress, existential and tension and guilt). There is evidence of the tool's construct validity. Kristjanson, Lobb, Aoun and Monterosso (2006) identified that the extent of this instrument's ability to discern complicated grief response has not been reported, and they have suggested that the severity of response over an extended period of time may be a useful way of indexing some level of complicated grief reaction.

7.1.5 Brief Symptom Inventory

Presented by Derogatis and Mlisaratos in 1983, this tool has 53 items. Bereaved individuals report their emotional status through nine dimensions (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism) and three global indices of distress.

7.1.6 Grief Experience Questionnaire

Originally published in 1989, the Grief Experience Questionnaire is a 55-item self-administered questionnaire representing 11 dimensions of grief (somatic reactions, general grief reactions, search for explanation, loss of support, stigmatization, guilt, responsibility, shame, rejection, self-destructive behaviour, and unique reactions). This instrument is the only specific one developed for bereavement experiences of suicide survivors versus those grieving other forms of death. Initial results of the tool confirm its ability to differentiate these two groups. In 2000, Bailey, Dunham, and Kral conducted a factor analysis of the Grief Experience Questionnaire and recommended that three items required revision, and that the tool needed to be updated to allow for easy comparison across subscales. They also suggested that further studies are required to assess validity and potential clinical use of the instrument.

7.1.7 Core Bereavement Items

The Core Bereavement Items were developed by Burnett et al. in 1997. This is a 17-item time questionnaire that was developed through the qualitative data from a longitudinal study of three groups: bereaved spouses, bereaved adult children and bereaved parents. The tool includes three scales (images and thoughts, acute separation, and grief) and demonstrated high reliability and validity.

7.1.8 Summary of quantitative tools

Most of the above tools were developed to be applied in clinical assessment, and in a clinical environment, and most have been used with general bereaved populations. These tools have not been tested for implementation in a community environment through lay facilitators. Furthermore, the capability of the community organizations to analyze this data and apply it in decision making and service improvements may be limited. Among the grief instruments, the Grief Experience Questionnaire is the one most suited to identify grief experiences of suicide survivors. Although this instrument shows the ability to separate the grief experiences of survivors from other forms of grief, the ability of the

tool to show differences between test-retest have not been assessed. Therefore, it was not recommended to be used in clinical applications.

The Inventory of Complicated Grief was the tool most commonly used to assess the grief responses of the bereaved. This tool has high internal consistency as well as test-retest reliability. As mentioned earlier, although complicated grief is more likely among survivors than the general bereaved population, not all suicide survivors show symptoms of complicated grief. Therefore, the Inventory of Complicated Grief is useful to identify survivors that do show symptoms of complicated grief, but may not be useful in identifying the changes in grief reactions of the survivors over time.

Prigerson and colleagues (2005) investigated complicated grief further in order to develop a criterion to identify complicated grief reactions. In addition to consensus criteria developed based on the Inventory of Complicated Grief tool, they have added symptoms of traumatization, impairment and functioning, and the continuation of the symptoms for at least two months from the time of onset.

Prigerson's (2005) Criteria for Complicated Grief Proposed for DSM-V (p.11)

Criterion A:

Chronic and disruptive yearning, pining, longing for the deceased.

Yearning & Longing – “Do you feel yourself yearning and longing for the person who is gone?”

Criteria B:

The person must have four of the following eight remaining symptoms at least several times a day or to a degree intense enough to be distressing and disruptive:

1. **Trouble accepting the death** – “Do you have trouble accepting the loss of ___?”
2. **Inability to trust others** – “To what extent has it been hard for you to trust others since the loss of _____?”
3. **Excessive bitterness or anger related to the death** – “Do you feel angry about the loss of ___?”
4. **Uneasy about moving on** – “Sometimes people who lose a loved one feel uneasy about moving on with their life. To what extent do you feel that moving on (for example, making new friends, pursuing new interests) would be difficult for you?”
5. **Numbness/Detachment** – “Do you feel emotionally numb or have trouble feeling connected with others since _____ died?”
6. **Feeling life is empty or meaningless without deceased** – “To what extent do you feel that life is empty or meaningless without ___?”
7. **Bleak future** – “Do you feel that the future holds no meaning or prospect for fulfilment without _____?”
8. **Agitated** – “Do you feel on edge or jumpy since _____ died?”

Criterion C:

The above symptom disturbance causes marked and persistent dysfunction in social, occupational, or other important domains.

Criterion D:

The above symptom disturbance must last at least six months.

Complicated Grief Diagnosis:

Criteria A, B, C, and D must be met.

Taking into consideration that complicated grief increases the risk of suicide ideation and that identifying people with symptoms of complicated grief is useful for timely referral, the Inventory of Complicated Grief could be a useful tool. Recognizing and reporting the existence of the above symptoms to community organizations should initiate action necessary to prevent suicide ideation among suicide survivors.

Caution is raised however in relying solely on quantitative approaches as “studies that compare suicide bereavement to other types of losses by using only quantitative (as opposed to qualitative) measures, and that assess only general aspects of functioning (as

opposed to suicide specific domains) may fail to detect differences that emerge with measures and research methods intended to specially assess suicide grief” (Jordan, 2001, p. 97). The several factors listed below need to be considered in selecting a tool for measuring the grief experiences of suicide survivors.

- Long-term recovery process.
- Various types of service delivery.
- Need for support decisions regarding the survivor or service design.
- Cultural differences.
- Individual grief experiences.
- Need to measure perceptions of change throughout the relationship between survivor and service provider(s).

It is desirable to establish the foundation of grief measurement based on a validated and reliable tool. This approach provides a good basis for the questions to be asked and improves the quality of evaluation outcomes. Based on what was learned through the review of the above tools, a suggest approach is the use of the Inventory of Complicated Grief (Prigerson et al., 1995) to assess the grief experience and changes in that experience. While the application of this tool in its current form may not be adequate for the current task, it could be considered a foundation for a standardized measurement of survivor experience.

7.2 Qualitative approaches

A more useful approach to the evaluation of suicide bereavement support programs might be through qualitative designs. Cvinar (2005) and Jordan (2001) encourage the consideration of different ways of evaluating suicide bereavement services given the large number of confounding variables and methodological challenges that exist in conducting traditional quantitative research.

Taking into account that the narrative is such an integral part of bereavement support groups (Jordan, 2001; Pietila, 2002), should the evaluation also involve a narrative element that allows survivors to share their experiences in their own words? Narrative methodologies have been employed to learn more about parent experiences with a child’s suicide and may provide important information and understanding. Multiple methodologies are necessary to truly understand the multidimensional experience of survivors (Maple, 2005) and therefore qualitative approaches should not be considered secondary-level evidence. Participatory-action research techniques have been noted as beneficial when working with Aboriginal populations as this respects their specific community needs, values the participation of all involved, and is also more respectful of local traditional practices than quantitative designs (Robinson, n.d.).

The web-based program that Hoffman (2006) describes uses a phenomenological approach to understand the meaning-making and coping patterns of survivors. Evaluation needs to cover two bases: first, to assess the program’s instructional design and content and second, to ensure the program involves continuous, systematic assessment of

concepts, content, design, instructional material effectiveness, user friendliness, and implementation.

The primary challenge in applying a qualitative approach to community service delivery is the means by which data is collected, analyzed, and reported. For methodological soundness to be maintained, consideration of the following elements must be addressed.

1. Who will conduct the interviews? Interviewers detached from the service would resolve the notion of bias in accounts of both respondent and interviewer. Respondents may be reluctant to criticize a service if they believe it may impact their ability to access services in the future. However, survivors may feel more comfortable in speaking with someone familiar.
2. Is the process anonymous? Anonymity improves response reliability, but does not allow for tracking changes over time.
3. Inter-rater reliability can be a concern if interviews are conducted by more than one individual. If information across sites is to be collapsed together, this element needs to be addressed.
4. Understanding the meaning of the data is dependent on consistent data collection and analysis processes. If more than one interviewer or data analyst is used, the interpretation of responses could be contravened.

7.2.1 Summary of qualitative approaches

Qualitative evaluation approaches provide an opportunity to learn more in-depth information from program recipients than that which is typically collected in quantitative tools. Further, it allows for exploration of specific information of particular relevance to informants that come forward, which a clinical control trial would be unable to accommodate. Qualitative approaches are consistent with the way information is generally shared in suicide bereavement support services and therefore respects the processes that have been developed through the various services. Narrative data collection is also considered to be the more appropriate means for use with Aboriginal survivors and this also allows the survivor's voice to be heard. This perspective is critically important to the overall understanding of the uniqueness and complexities of suicide grief and has a profound effect on current knowledge today.

While qualitative designs will provide a deeper understanding of the survivor's grief journey, there are some barriers to this form of data collection that need to be considered. Small, community-based programs may not have the resources (human and financial) to address such methodological elements. Analysis of qualitative data requires skilled thematic organization and is difficult to consolidate across different programs service providers. While subpopulation of Aboriginal survivors may prefer the narrative approach, others such as male survivors may not be as comfortable with this form of sharing, consequently limiting the amount of information that can be collected. Qualitative data collection generally takes more time than a quantitative survey. This time allocation needs to be planned for in programs and the importance of the information explained to participants. Finally, some survivors may tire of telling their

story multiple times (through the course of services and evaluation) which may limit the amount of information they wish to share.

While there are significant benefits to qualitative data collection in the field of suicide bereavement support services, the implications for conducting such evaluations and the lack of standardized questions means an organization must be thoughtful in its evaluation design. It is recommended that qualitative approaches be incorporated into any program evaluation for survivor services.

7.3 Measurement of coping

The difficulty with attempting to measure coping begins with the conceptualization of what coping entails. Three conceptual elements have been noted. The information in this section is summarized from Schwarzer and Schwarzer's book chapter entitled *A Critical Survey of Coping Instruments*, in *Handbook of Coping* edited by Zeidner and Endler (1996).

1. An effort to cope must be made but this does not need to be a completed "successful" act.
2. This effort must be led cognitively, but does not need to be apparent in actual behaviour.
3. The prerequisite for coping attempts is the cognitive appraisal of the stressor.

In addition, when an individual appraises a situation, this can also be considered a coping mechanism and the line becomes blurred between the end of appraisal and the beginning of coping. There were attempts in the literature to define the difference between appraisal and coping. Lazarus's definition is presented by Schwarzer and Schwarzer (1996) as "coping refers to what a person thinks or does to try to manage an emotional encounter; and appraisal is an evaluation of what might be thought or done in that encounter" (p. 107).

Another problem in measurement is separating coping from coping resources such as hardiness, dispositional optimism, self-efficacy, or social support. These resources support both the appraisal and the coping processes (Schwarzer & Schwarzer, 1996). For example, an individual with a large social support network may appraise a stress factor as less threatening than an individual who has a small social network. This larger network may increase the survivor's ability to cope through better problem solving, or positive self-talk techniques.

The coping assessment identifies the cognitions and behaviours used at the time of the assessment, while dealing with the stressful encounter. People deal with stressful situations by using different cognitions and behaviours over time (different stages of the stressful encounter) and also with each new stressful encounter (depending on the nature of the situation and coping resources available at the time) (Schwarzer & Schwarzer, 1996). Therefore, measuring the coping with standardized instruments assumes that there are preferred ways of coping and ignores the uniqueness of situation-specific coping

responses. Furthermore, because each individual's coping responses for the same situation might be dramatically different, comparative measurement of coping across individuals is significantly undermined. These two factors reduce the stability and general usefulness of any coping measurement.

The coping responses of individuals also have dimensions. While some people react to stressors more actively (such as instrumental, attentive, vigilant, or confrontative coping), others react more passively (such as avoidant, palliative, and emotional coping). Various authors qualified these dimensions as (Schwarzer & Schwarzer, 1996) as follows.

- Khrono's vigilance versus cognitive avoidance.
- Billings and Mos' assimilative versus accommodative coping.
- Taylor's mastery versus meaning.
- Rothbaum, Weisz and Snyder's primary control versus secondary control.
- Lazarus and Folkman's problem-focused versus emotion-focused coping.

Most coping-assessment instruments measure processes, not dispositions or styles. To assess coping styles with the instrument, the investigator would need to assess an individual's coping processes in a range of stressful encounters then evaluate consistencies in those processes across encounters. The following is a summary of the findings on coping instruments of Schwarzer and Schwarzer (1996).

7.3.1 Coping Instruments

The Miller Behavioral Style Scale: Monitoring and Blunting

This instrument measures whether individuals choose to work with the stressor or to avoid it. The instrument provides four hypothetical situations in which two are physical threats and two are ego-threats. Each hypothetical example is followed by an 8-item questionnaire. This is a validated tool; the main criticism is its restriction to only those stress situations that elicit anxiety. It is not applicable to other stress situations such as a challenge, harm, or loss.

The Mainz Coping Inventory: Vigilance and Cognitive Avoidance

Similar to the Miller Behavioral Style Scale, this instrument provides hypothetical cases that test responses to physical and ego threats. Each case is followed by 18 coping acts that are subdivided into those reflecting vigilance and those reflecting cognitive avoidance. This tool provides more detailed assessment by presenting results in four groups: vigilance in ego-threat situations, cognitive avoidance in ego-threat situations, vigilance in physical threat situations, and cognitive avoidance in physical-threat situations. This tool is validated on German samples and awaits cross-cultural validation. It has the same limitation of questionable applicability in other stress situations.

Billings and Moos Coping Measures

This tool measures 19 coping statements with yes or no answers based on a recent life crisis. The authors developed a 32-item and four-point Likert scale version of the tool. This tool groups coping responses into three categories: appraisal-focused, problem-

focused, and emotion-focused. It was noted that the scales do not show satisfactory internal consistencies.

Ways of Coping Questionnaire

The Ways of Coping Questionnaire sets the standard in the field. This tool consists of 50 items (plus 16 narrative questions) falling under eight empirically-derived scales. The instrument extracts factors depending on the sample and stressor, and this is identified as a limitation but one which is not unique because most coping measurement tools suffer from the same problem. The coping scales included in the tool are as follows.

1. Confrontive coping (6 items) Example: “I stood my ground and fought for what I wanted.”
2. Distancing (6 items) Example: “I went on as if nothing had happened.”
3. Self-controlling (7 items) Example: “I tried to keep my feelings to myself.”
4. Seeking social support (6 items) Example: “I talked to someone to find out more about the situation.”
5. Accepting responsibility (4 items) Example: “I criticized or lectured myself.”
6. Escape-avoidance (8 items) Example: “I hoped a miracle would happen.”
7. Planful problem solving (6 items) Example: “I made a plan of action and followed it.”
8. Positive reappraisal (7 items) Example: “I changed or grew as a person in a good way.”

The internal consistencies of the scales were not always satisfactory and test-retest reliabilities were not reported. The original tool is available free of charge; however, Mind Garden has a similar tool with some updates and it is commercially available.

Broad Range of Coping Responses for Different Coping Appraisals of Stress

This tool is focused on situational coping responses rather than dispositional coping styles. The developer of the tool, McCrae (as cited in Schwarzer & Schwarzer, 1996) argues that the nature of the stressor would fundamentally determine how people cope. The tool includes 118 coping items (68 from the Ways of Coping Questionnaire) and 50 added by the author. Although this instrument correctly incorporated the relationship between the stress factor and an appropriate coping response to the stressor, the tool lacks the reliability and validity necessary in order to be widely implemented with confidence.

The Coping Strategy Indicator

This tool was developed by asking a large number of people to identify their coping strategies. Several iterations were used to distill those strategies. However, the resulting tool was not able to achieve high levels of correlation with other scales and statistical indicators do not warrant widespread use.

Life Events and Coping Inventory (LECI)

In consideration that children may have different responses to stress, this tool focuses on coping responses in children. It was developed empirically through interviews with children. The tool identifies aggression (7 items), stress recognition (13 items), distraction (11 items), self-destruction (8 items), and endurance (9 items) as coping strategies in a 49-item questionnaire. Although it is a well-developed tool and specific to children, the lack of categories that match those of other tools and the possibility of cross-validation failure in different samples undermines its usefulness.

The Adolescent Coping Orientation for Problem Experiences Inventory (A-COPE)

Similar to the Life Events and Coping Inventory, the authors of A-COPE began by interviewing high school students and identifying their coping responses. They developed a 54-item questionnaire and identified 12 factors with high internal consistencies. The factors included the following.

1. Ventilating feelings
2. Seeking diversions
3. Developing self-reliance and optimism
4. Developing social supports
5. Solving family problems
6. Avoiding problems
7. Seeking spiritual support
8. Investing in close friends
9. Seeking professional support
10. Engaging in demanding activity
11. Being humorous
12. Relaxing

The tool measures the responses to general life stress at a specific development stage. The limitation of the tool is that the collection of the coping strategies is based on 30 adolescent responses. Due to this limitation, the level of evidence is not strong enough to warrant widespread use.

Life Situation Inventory (LSI)

This tool asks respondents to identify an experience in five conflict areas (decision making, defeat in competition, a frustration-producing situation, difficulty with an authority figure, and general disagreement with a peer). Respondents complete a 28-item questionnaire for each one of the identified situations. The tool offers a well-balanced and reasonable approach to identifying stressful situations. However, the variations in self-identification of stress situations undermine the possibility of comparing coping strategies across individuals because the stressors might be different.

Coping Inventory for Stressful Situation

The Coping Inventory for Stressful Situation instrument was developed following a rigorous methodology and resulted in a robust tool. The tool consists of a 66-item questionnaire and identifies three factors (task oriented, emotion oriented, and avoidance

oriented coping, with sub-factors of distraction and social diversion). High construct validity and high correlations with the Ways of Coping Questionnaire are reported.

The COPE Scale

The instrument identifies 13 measurements with four categories, each consisting of more than 60 items. A short version of the COPE Scale with 28 items was also released. These two versions include the following.

1. Active coping: "I do what has to be done, one step at a time."
2. Planning: "I make a plan of action."
3. Suppression of competing activities: "I put aside other activities in order to concentrate on this."
4. Restraint coping: "I force myself to wait for the right time to do something."
5. Seeking social support for instrumental reasons: "I talk to someone to find out more about the situation."
6. Seeking social support for emotional reasons: "I talk to someone about how I feel."
7. Positive reinterpretation and growth: "I learn something from the experience."
8. Acceptance: "I learn to live with it."
9. Turning to religion: "I put my trust in God."
10. Focus on and venting of emotions: "I let my feelings out."
11. Denial: "I refuse to believe that it has happened."
12. Behavioral disengagement: "I just give up trying to reach my goal."
13. Mental disengagement: "I daydream about things other than this."

In addition to the above, alcohol and drug use were added as additional coping strategies. The tool was found to have satisfactory psychometric properties, and validity. The authors (Schwarzer & Schwarzer, 1996) suggest that the COPE Scale is a well-designed and balanced tool that addresses the disposition versus situation problem, and they suggest the use of the COPE instrument for further research in coping responses.

The Measure of Daily Coping

This instrument is designed as a structured, written interview. Respondents choose appropriate coping categories and write down their coping strategies. This approach allows for omitting unnecessary items and provides better results of coping strategies linked to specific situations. However, wide-scale implementation of this tool is limited due to the data-collection methodology.

Stress and Coping Process Questionnaire

The data for this tool is collected in three stages. In each stage there is an increase in the intensity of the stressful situation described in the questions. The data is collected in a two-page questionnaire. Although this tool measures various responses provided by individuals to varying degrees of theoretical stress situations, the intensive data collection methodology limits the use of this tool.

Coping Scale for Adults (CSA)

Based on the knowledge gleaned from adolescents through the A-COPE tool, Frydenberg & Lewis (2001) developed a Coping Scale for Adults (CSA). This tool aims to measure specific and general coping strategies used by adults by measuring their responses to 74 items in a self-report inventory. These items measure the following 19 distinct coping strategies (Frydenberg & Lewis, 2001, p. 64).

1. Seek Social Support - Sharing the problem and enlisting the support of others.
2. Focus on Solving the Problem - Tackling a problem systematically.
3. Work Hard - Commitment to work.
4. Worry - Concerns about the future and one's happiness.
5. Improve Relationships - Improving a particularly close relationship.
6. Wishful Thinking - Hoping for a positive outcome.
7. Tension Reduction - Releasing tension to feel better.
8. Social Action - Enlisting support by writing petitions or organizing a meeting.
9. Life Situations Inventory (LSI)
10. Ignore the Problem - Consciously blocking out the problem.
11. Self-Blame - Blaming oneself for being responsible for the concern.
12. Keep to Self - Desiring to maintain a concern from others.
13. Seek Spiritual Support - Seeking the assistance of a spiritual leader.
14. Focus on the Positive – Positive perspective on the situation.
15. Seek Professional Help - Using a professional advisor such as a counselor.
16. Seek Relaxing Diversions - General relaxation.
17. Physical Recreation - Playing sport and keeping fit.
18. Protect Self - Supporting ones' self concept
19. Humour - Using humour as a diversion.
20. Not Cope (Optional) - Unable to cope; occurrence of psychosomatic illness

The Coping Scale for Adults instrument provides a profile of an individual's coping strategies and through discussion or self-exploration enables a change in coping behaviours. Rather than clinical research, this instrument focuses on psychological well-being and adaptive strategies. The authors argue that the tool has reliability and good internal consistency. However, there is no indication that this instrument can be used in the bereavement context.

7.3.2 Summary of Coping Instruments

There are several tools available to assess the individual's use of coping skills. None were designed for the suicide survivor population, though a few include loss as a stressor. Most include several scales and subscales, and interpretation of the results requires specific education in the tools and a data-analyses capability. Among these tools, the Ways of Coping and COPE Scale are those most used by researchers in order to analyze the responses of individuals to stressors. In terms of use in community-based suicide bereavement support programs, the COPE Scale seems to be the most appropriate.

Although it has been identified that the ability to cope varies, depending on many factors, and there is no particular appropriate or effective mode of coping, it is important for

survivors to have knowledge of a variety of options and make their selections based on this information. The impact of coping-strategy knowledge has been identified in the survivor focus group data collection component of this review. A survivor participant mentioned that when she was overwhelmed with grief, she used the active planning tool to compartmentalize her emotions and develop an action plan to manage them. This anecdote supports the expectation that knowledge of coping skills is useful for survivors and may lead to the use of more active coping methods rather than passive ones.

Furthermore, the COPE tool identifies sharing emotions and seeking help as important coping strategies. It is expected that with the help survivors receive from a suicide bereavement support service, these coping strategies would be used more often. Therefore, it is important to ensure that survivors are educated in coping strategies, and that opportunities for emotional support are provided. The measurement of coping strategies must focus on whether the strategic knowledge has been provided and whether the survivors' preferences have changed.

7.4 Summary

There are specific purposes and benefits for the use of both quantitative and qualitative evaluation designs. Quantitative tools allow for standardized data collection across a number and variety of programs that can be amalgamated into a larger analysis. Quantitative designs allow survivor voices to be heard, and a deeper understanding gained of the survivor's grief experience and the impact of support services on that journey. Therefore, the use of both quantitative and qualitative study designs was found to be necessary when evaluating suicide bereavement support services. The findings in regard to evaluation tools and approach literature are summarized in the following seven key statements:

1. As no standardized means or measures of suicide bereavement support services exist in the literature, a unique approach is necessary to respond to the needs of the Alberta environment.
2. Both quantitative and qualitative designs are necessary because they collect different types of information, both of which are valuable in understanding the impact of suicide bereavement support services.
3. Quantitative tools have been found to be reliable and valid. Through this review, the Inventory of Complicated Grief was found to be the most appropriate measure for the grief experience, and the COPE Scale was determined most useful for understanding survivor's coping activities.
4. Multiple data collection sources are necessary in order to fully understand the impact of support services. These data sources include survivors, referring agencies, and organizational statistics.
5. A balance between the amount of information necessary and collection methods needs to be considered and planned for in the evaluation design.
6. There is no right way to cope with the loss of someone to suicide. Therefore, it is important to know whether or not information regarding coping skills and options are a component of the service, not how well participants are coping.

7. Because changes occur over the natural course of time and through each individual's unique experience, a difficulty remains in determining the period of time in which a change is expected specifically as a result of a support service.

8. LIMITATIONS AND OPPORTUNITIES

Concerning this review, a number of limitations and potential opportunities must be noted.

First, the scope of this review did not allow for an exploration of research related to suicide contagion, a term that reflects the phenomenon whereby susceptible individuals are influenced towards suicidal behaviour through the knowledge of another person's suicidal acts. This body of research may provide insights into the prevention of suicide via bereavement support services that could not be identified through the search parameters applied in this review.

Second, the lack of pre-defined, reliable, and valid evaluation tools for suicide bereavement support programs creates a potential limitation for any evaluation approach implemented. Any approach will likely require modification respective of the survivor populations. The universal nature of most tools is limited or unknown. However because of this, an opportunity arises for the AMHB to contribute to closing a clearly identified gap in the suicide bereavement support service knowledge.

Further, there is no best practice model for support services (groups or one-on-one) that can be applied unilaterally. The scope of this review, has not allowed the determination of the types of suicide bereavement support services that are most beneficial to survivors, nor what specific components of support services are most effective. Therefore, evaluating across programs will be difficult if a standard service delivery model does not exist. It is therefore recommended to measure overarching, consistent components of suicide bereavement support services that would be applicable to all services rather than assessing for specific elements of a service (such as particular activities or modules of information). That is, regardless of the type of suicide bereavement support service one receives, the service must consider the following elements.

- Service accessibility: Does the community know about the available services; how would a survivor become aware of a service, and what would that first contact experience involve?
- Service provision: Suicide bereavement support services currently fall in the realm of one-on-one (in-person, telephone, electronic), psycho-educational groups, drop-in groups and programs, and survivor activities. Services should have a theoretical basis and be provided through a means that is appropriate to survivor needs.
- Objectives and outcomes of service provision: These provide direction to programs; expected short- and long-term outcomes should be identified and measured.
- Infrastructure and staffing: The organization must have an infrastructure that ensures appropriate and skilled service provision (either through staff or volunteers), adequate training, and a mechanism through which feedback from survivors on this particular service delivery is available.

It remains unclear how much time will need to pass before support services impact the lives of survivors. For some, the ability to absorb the loss may take many years and the passing of time may be more of a factor in that survivor's grief experience than any support service provided. This time element must be reflected in the evaluation schedule. It needs to be recognized that the healing process is multi-faceted and that participation in a suicide bereavement support service may be just one of many helpful components a survivor experiences over time.

ACRONYMS & DEFINITIONS

Acronyms

The following list of acronyms is presented to provide a common understanding of how various terminologies are used in this report.

AAS	American Association of Suicidology
AFSP	American Foundation for Suicide Prevention
AMHB	Alberta Mental Health Board
CASP	Canadian Association for Suicide Prevention
CISD	Critical Incident Stress Debriefing
CISM	Critical Incident Stress Management
IASP	International Association of Suicide Prevention

Definitions

The following are descriptions of terms that are consistent with definitions previously applied by the Alberta Mental Health Board (AMHB, 2006a). A more detailed discussion of these elements as they relate to suicide bereavement support services is included in *Section 4* of this report.

Aboriginal	In section 35 of the Constitution Act, 1982, Aboriginal Peoples of Canada are identified as the “Indian, Inuit and Métis peoples of Canada”.
Best Practice	The provision of care and service utilizing evidence-based decision making and a continuous quality improvement approach focused on best outcome within the context of available resources. It operationalizes evidence-based practice.
Bereavement Support	Bringing together vulnerable individuals in a caring and comfortable environment where they receive the support of peers and practice valuable life skills. Services are psycho-educational in nature and provide opportunities for participants to explore their response to the loss with the assistance of an individual experienced in the grief process.
Postvention	Activities that occur after a suicide death or attempt, aimed at supporting those bereaved by suicide or the family and friends of someone who has attempted suicide.
Promising Practice	Incorporates the philosophy, values, characteristics, and indicators of other positive and effective public health interventions.

- Is based on guidelines, protocols, standards, or preferred practice patterns that have been shown to lead to effective public health outcomes.

Is a process of continuous quality improvement that:

- Accumulates and applies knowledge about what is working and not working in different situations and contexts;
- Continually incorporates lessons learned, feedback, and analysis to lead toward improvement and positive outcomes; and,
- Allows for and incorporates expert review, feedback, and consensus from the public health field.

Has an evaluation component or plan in place to move towards demonstration of effectiveness; however, it does not yet have evaluation data available to demonstrate positive outcomes.

Screening	The routine administration of an instrument or procedure in order to find those individuals who are in need of a particular treatment or service. By directly asking people about their emotional state, screening actively seeks out suicidal individuals and ensures that everyone has an equal chance of being identified as to their potential risk status. Screening programs have been designed to identify and refer to treatment or other assistance for individuals at high risk of suicide.
Stigma	An object, idea, or label associated with disgrace or reproach.
Suicidal Behaviour	A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and suicide death.
Suicide Attempt	A potentially self-injurious behavior with a non-fatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some level to kill himself or herself. A suicide attempt may or may not result in injuries.
Suicide Survivors	Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide.
Support Groups	Support groups serve the purpose of counteracting a number of early risk factors experienced by vulnerable people, while enhancing important protective factors.

The following definitions are used by the Kirstjanson et al. (2006) in their work of *A Systematic Review of Literature on Complicated Grief* (p. 10).

Bereavement	The death of a loved one and in its broadest terms 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.
Grief	Grief is normal reaction to loss and refers to the distress resulting from bereavement. Grief is multidimensional with physical, behavioural and meaning and spiritual components and is characterized by a complex set of cognitive, emotional and social adjustments that follow the death of a loved one.
Complicated Grief	Complicated grief occurs when integration of the death does not take place. People suffering from complicated grief experience a sense of persistent and disturbing disbelief regarding the death and resistance to accepting painful reality. Intense yearning and longing for the deceased continues, along with frequent pangs of intense, painful emotions. Thoughts regarding the loved one cause the Survivor to limit their life to avoid painful feelings and their interest and engagement to life diminishes. It is estimated that 10 to 20% of bereaved people experience complicated grief.
Thanatology	The study of bereavement and grief.

REFERENCES

- Agerbo E. (2005). Midlife suicide risk, partner's psychiatric illness, spouse and child bereavement by suicide or other modes of death: A gender specific study. *Journal of Epidemiology & Community Health, 59*(5), 407-412.
- Alberta Mental Health Board (AMHB). (2004). *Advancing the Mental Health Agenda: A Provincial Mental Health Plan for Alberta*. Edmonton: Author.
- Alberta Mental Health Board (AMHB). (2006a). *A CALL TO ACTION: The Alberta Suicide Prevention Strategy*. Edmonton: Author.
- Alberta Mental Health Board (AMHB). (2006b). *Summary of Available Data and Evidence on Potential Groups at Risk of Suicide in Alberta*. Edmonton: Author.
- Alberta Mental Health Board (AMHB). (2007). *Alberta is Taking Action on Suicide Prevention. An Overview of the Active Postvention Initiative 2007-2010 (DRAFT)*. Edmonton: Author.
- American Foundation for Suicide Prevention (AFSP). (2007). *Survivor Research. AFSP and NIMH Propose Research Agenda for Survivors of Suicide*. Retrieved July 28, 2007 from:
http://www.afsp.org/index.cfm?fuseaction=home.viewpage&page_id=2D9DF73E-BB25-0132-3AD7715D74BFF585
- Andriessen, K. (2004). Suicide survivor activities, an international perspective. *Suicidologi, 9* (2), 26-27, 31. Retrieved July 26, 2007 from:
www.med.uio.no/iasp/files/papers/Andriessen.pdf
- Archibald, L. (2005). Support group leader tips and hints for a long-lasting group. *Surviving Suicide Newsletter*. American Association of Suicidology. Retrieved July 28, 2007 from:
<http://www.suicidology.org/associations/1045/files/supportgroupleader.pdf>
- Bailley, S.E., Dunham, K., & Kral, M.J. (2000). Factor Structure of the Grief Experience Questionnaire. *Death Studies, 24*(8), 721-738.
- Bailley, S.E., Kral, M.J., & Dunham, K. (1999). Survivors of suicide do grieve differently: Empirical support for a common sense proposition. *Suicide and Life-Threatening Behavior, 29*(3), 256-271.
- Beane, R.H. (1987). Westchester crisis counseling program. *American Journal of Public Health, 77*(6), 739.

- Beautrais, A.L. (n.d.). *Support for Families, Whanau and Significant Others After a Suicide. A Literature Review and Synthesis of Evidence*. Christchurch: Christchurch School of Medicine & Health Services.
- Black, S. (2005). When children grieve. *American School Board Journal*, August, 28-30.
- Brown, A.C., Sandler, I.N., Tein, J.Y., Liu, X., & Haine, R.A. (2007). Implications of parental suicide and violent death for promotion of resilience of parentally-bereaved children. *Death Studies*, 31(4), 301-335.
- Cain, A.C. (2002) Children of suicide: The telling and the knowing. *Psychiatry*, 65(2), 124-136.
- Campbell, F.R. (1997). Changing the legacy of suicide. *Suicide & Life-Threatening Behavior*, 27(4), 329-338.
- Campbell, F.R. (2002). The influence of an active postvention on the length of time elapsed before survivors of suicide seek treatment. *Dissertation Abstracts International Part A: Humanities & Social Sciences*, 63, 753.
- Campbell, F.R., Cataldie, L., McIntosh, J., & Millet, K. (2004). An active postvention program. *Crisis*, 25(1), 30-32.
- Canadian Association for Suicide Prevention (CASP). (2004). *The CASP Blueprint for a Canadian National Suicide Prevention Strategy*. Edmonton: Author.
- Canadian Association for Suicide Prevention. (CASP). (2007). *Support Groups across Canada*. Retrieved July 28, 2007 from: <http://www.casp-acps.ca/supportgroups.asp>
- Cerel J., Fristad, M.A., Weller, E.B., & Weller, R.A. (1999). Suicide-bereaved children and adolescents: A controlled longitudinal examination. *Journal of American Academy of Child and Adolescent Psychiatry*, 38(6), 672-679.
- Cerel J., Fristad, M.A., Weller, E.B., & Weller, R.A. (2000). Suicide-bereaved children and adolescents: Parental and family functioning. *Journal of American Academy of Child and Adolescent Psychiatry*, 39(4), 437-444.
- Chandler, M. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry*, 35(2), 191-219.
- Clark, S. (1992). The role of the Bereaved through Suicide Support Group in the care of the bereaved. In: *Preventing Youth Suicide*. Canberra: Australian Institute of Criminology, 289-296.
- Clark, S. (2001). Bereavement after suicide – How far have we come and where do we go from here? *Crisis*, 22(3), 102-108.

- Constantino, R.E., Sekula, L.K., & Rubinstein, E.N. (2001). Group intervention for widowed survivors of suicide. *Suicide & Life-Threatening Behavior*, 31(4), 428-441.
- Currier, J.M., Holland, J.M., & Neimeyer, R.A. (2006). Sense-making, grief, and the experience of violent loss: Toward a mediational model. *Death Studies*, 30, 403-428.
- Cutcliffe, J.R. (2006) The principles and processes of inspiring hope in bereavement counselling: A modified grounded theory study - part two. *Journal of Psychiatric & Mental Health Nursing*, 13, 604-610.
- Cvinar JG. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care*, 41(1), 14-21.
- Defauw, N. & Andriessen, K. (2003). Networking to support suicide survivors. *Crisis*, 24(1), 29-31.
- Dafoe, B. & Monk, L. (2005). *Suicide postvention is prevention: A proactive planning workbook for communities affected by youth suicide*. Vancouver: BC Council for Families.
- Dowdney, L., Wilson, R., Maughan, B., Allerton, M., Schofield, P., & Skuse, D. (1999). Psychological disturbance and service provision in parentally bereaved children: Prospective case-control study. *British Medical Journal*, 319(7), 354-357.
- Dyregrov, K. & Dyregrov, A. (2005). Siblings after suicide - 'The forgotten bereaved'. *Suicide & Life-Threatening Behavior*, 35(6), 714-724.
- Farberow, N.L. (1992). The Los Angeles Survivors-After-Suicide program. An evaluation. *Crisis*, 13, 23-34.
- Fielden, J.M. (2003). Grief as a transformative experience: Weaving through different lifeworlds after a loved one has completed suicide. *International Journal of Mental Health Nursing*, 12, 74-85.
- Forde, S & Devaney, C. (2006). Postvention: A community-based family support initiative and model of responding to tragic events including suicide. *Child Care in Practice*, 12(1), 53-61.
- Freeman, S.J. (1991). Group facilitation of the grieving process with those bereaved by suicide. *Journal of Counseling & Development*, 69, 328-331.
- Frieze, I. H. & Bookwala, J. (1996). Coping with unusual stressors: Criminal victimization. In Zeidner, M. & Endler, N.S. (Eds). *Handbook of Coping*. New York: Wiley.

- Frydenberg, E. & Lewis, R. (2001). Coping Scale for Adults. *Application of Occupational Psychology to Employment and Disability*, 4(1), 63–71.
- Grad, O.T., Clark, S., Dyregrov, K., & Andriessen, K. (2004). What helps and what hinders the process of surviving the suicide of somebody close? *Crisis*, 25(3), 134-139.
- Hall, T. (1990). Solace after bereavement: Counseling services grow. *ProQuest Historical Newspapers: The New York Times* (1857 – Current file), May 20.
- Hawton, K. & Simkin, S. (2003). Helping people bereaved by suicide. *British Medical Journal*, 327, 177-178.
- Hoffmann, W.A. (2006). Telematic technologies in mental health caring: a web-based psychoeducational program for adolescent suicide survivors. [Review] *Issues in Mental Health Nursing*, 27(5), 461-474.
- Johnson-Berns, S. (2000). Reaching out through the darkness. Survivors drawn together in grief. *Surviving Suicide Newsletter*. American Association of Suicidology. Retrieved July 28, 2007 from: <http://www.suicidology.org/associations/1045/files/ReachingOut.pdf>
- Jordan, J.R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide & Life-Threatening Behavior*, 31(1), 91-102.
- Jordan, J. (2007). *Traumatic Death: New Understanding, New Direction*. Proceedings from the Alberta Funeral Services Association Grief Conference, October, 25 & 26. Edmonton: Author.
- Jordan, J.R. (2007). After suicide loss: What can we learn from grief research? *Surviving Suicide Newsletter*. American Association of Suicidology. Retrieved July 28, 2007 from: <http://www.suicidology.org/associations/1045/files/aftersuicidloss.pdf>
- Jordan, J.R. & McMenemy, J. (2004). Interventions for suicide survivors: A review of the literature. *Suicide & Life-Threatening Behavior*, 34(4), 337-349.
- Kastenbaum, R., Doka, K.J., Beder, J., Scwab, R., Farberow, N.L., et al. (2003). Grief. *Macmillan Encyclopedia of Death and Dying*. Retrieved Nov. 26, 2007 from: http://www.findarticles.com/p/articles/mi_gx5214/is_2003/ai_n19132155
- King, S., Khadjesari, Z., Golder, S., Eichler, K., & Sowden, A.J. (n.d.). Interventions for persons bereaved by suicide: A scoping review. *Centre for Reviews and Dissemination*. Retrieved June 1, 2007 from: <http://www.york.ac.uk/inst/crd/pdf/prpsuicide.pdf>.

- Kovac, S.H. & Range, L.M. (2000). Writing projects: Lessening undergraduates' unique suicidal bereavement. *Suicide & Life-Threatening Behavior*, 30(1), 50-60.
- Kristjanson, L., Lobb, E., Aoun, S., & Monterosso, L., (2006) *A Systematic Review of the Literature on Complicated Grief*. Common Wealth of Australia.
- Leenaars, A.A. & Wenckstern, S. (1998). Principles of postvention: Application to suicide and trauma in schools. *Death Studies*, 22, 357-391.
- Linn-Gust, M. (2005). Survivor research: Has the time finally come? *Surviving Suicide Newsletter*. American Association of Suicidology. Retrieved July 28, 2007 from: <http://www.suicidology.org/associations/1045/files/research.pdf>
- Maple, M. (2005). Parental bereavement and youth suicide: An assessment of the literature. *Australian Social Worker*, 58(2), 179-187.
- Maples, M.F., Packman, J., Abney, P., Daugherty, R.F., Casey, J.A., & Pirtle, L. (2005). Suicide by teenagers in middle school: A postvention team approach. *Journal of Counseling & Development*, 83, 397-405.
- Masecar, D. (2007). *What is working, what is hopeful. Supporting community-based suicide prevention strategies within indigenous communities*. Health Canada. Retrieved Oct 15, 2007 from: <http://www.communitylifelines.ca>
- McIntosh, J. (2005). Survivors of elderly suicide: Opportunities lost. *Surviving Suicide Newsletter*. American Association of Suicidology. Retrieved July 28, 2007 from: [http://www.suicidology.org/associations/1045/files/Survivorsofelderly suicides.pdf](http://www.suicidology.org/associations/1045/files/Survivorsofelderly%20suicides.pdf)
- Mikulincer, M. & Florian, V. (1996). Coping and adaptation to trauma and loss. In Zeidner, M. & Endler, N.S., (Eds). *Handbook of Coping*. New York: Wiley.
- Mitchell, A.M., Kim, Y., Prigerson, H.G., & Mortimer-Stephens, M.K. (2004). Complicated grief in survivors of suicide. *Crisis*, 25(1), 12-18.
- Mitchell, A.M., Wesner, S., Brownson, L., Gale, D.D., Garand, L., & Havill, A. (2006). Effective communication with bereaved child survivors of suicide. *Journal of Child & Adolescent Psychiatric Nursing*, 19(3), 130-136.
- Mitchell, A.M., Wesner, S., Garand, L., Gale, D.D., Havill, A., & Brownson, L. (2007). A support group intervention for children bereaved by parental suicide. *Journal of Child & Adolescent Psychiatric Nursing*, 20(1), 3-13.
- Murphy, S.A. (1996). Parent bereavement stress and preventive intervention following the violent deaths of adolescent or young adult children. *Death Studies*, 20(5), 441-452.

- Murphy, S.A. (2000). The use of research findings in bereavement programs: A case study. *Death Studies*, 24(7), 585-602.
- Murphy, S.A., Johnson, C., Cain, K.C., Gupta, A.D., Dimond, M., et al. (1998). Broad-spectrum group treatment for parents bereaved by the violent deaths of their 12- to 28-year-old children: A randomized controlled trial. *Death Studies*, 22(3), 209-235.
- Murphy, S.A., Johnson, C., & Lohan, J. (2002). The aftermath of the violent death of a child: An integration of the assessments of parents' mental distress and PTSD during the first 5 years of bereavement. *Journal of Loss and Trauma*, 7, 203-222.
- Pierce, G.R., Sarason, I. G., & Sarason, B.R. (1996). Coping and social support. In Zeidner, M., & Endler, N.S. (Eds). *Handbook of Coping*. New York: Wiley.
- Prigerson, H.G. & Maclejewski, P.K. (2006). A call for sound empirical testing and evaluation of criteria for complicated grief proposed for DSM-V. *Omega: Journal of Death and Dying*, 52(1), 9-19.
- Prigerson, H.G., Maclejewski, P.K., Reynolds, C.F., Bierhals, A.J., Newsom, J.T., et al. (1995). Inventory of Complicated Grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research*, 59, 65-79.
- Pietila, M. (2002). Support groups: A psychological or social device for suicide bereavement? *British Journal of Guidance & Counseling*, 30(4), 401-414.
- Roach, M. J. (2007). Grief and bereavement. In *Annotated Bibliographies Toolkit of Instruments to Measure End-of-Life Care*. Retrieved October 9, 2007 from: <http://www.chcr.brown.edu/pcoc/Griefa.htm>.
- Robinson, E. (n.d.). *Panel discussion: Research on mental health issues in native communities: How can it be useful?* Public Health Module, Cree Region of James Bay.
- Sakinofsky, I. (2007). The aftermath of suicide: Managing survivor's bereavement. *Canadian Journal of Psychiatry*, 52 (6 Suppl 1), 129S-136S.
- Schwarzer, R. & Schwarzer, C. (1996). A critical survey of coping instruments. In Zeidner, M. & Endler, N.S. (Eds). *Handbook of Coping*. New York: Wiley.
- Scocco, P., Frasson, A., Costacurta, A., & Pavan, L. (2006). SOPRoxi: A research-intervention project for suicide survivors. *Crisis: Journal of Crisis Intervention & Suicide*, 27(1), 39-41.
- Waldram J. B. (n.d.). *But Does it Work? Traditional Healing and Issues of Efficacy and Evaluation*. Saskatoon: University of Saskatchewan

White, J. (2003). *Suicide-related research in Canada: A descriptive overview*. Ottawa: Public Health Agency of Canada. Retrieved Oct. 1, 2007 from: http://www.phac-aspc.gc.ca/publicat/mh-sm/suicide-research/a2_e.html

White, J. & Jodoin, N. (2003). *Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies*. Calgary: Centre for Suicide Prevention.

Zeidner, M. & Sakalovski, D. (1996). Maladaptive and adaptive coping. In Zeidner, M. & Endler, N.S. (Eds). *Handbook of Coping*. New York: Wiley.

APPENDIX A: SEARCH METHODOLOGY

Literature Review Methodology for Suicide Postvention Support Services

Issues to address:

Key issues: suicide, bereavement, postvention, and support

Type of information:

Key articles, discussion and background papers, reports, policy papers

Inclusions:

Language: Not limited

Jurisdictions: Not limited

Age groups: Not limited

Date coverage: 1996 - present

Exclusions:

None

Search Methodology

A literature search was conducted to identify key published material discussing suicide bereavement support services. Specifically, the search attempted to identify existing key literature addressing any written material regarding suicide bereavement support services.

Two databases OVID and EBCOHOST were used to search article databases. Both included Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews. In addition to the above databases, the Ovid search included EMBASE, and Ebcohost search included CINAHL, ERIC; Health Source - Consumer Edition; Health Source: Nursing/Academic Edition; PsycARTICLES; PsycCRITIQUES; and PsycINFO databases.

Following the first draft of the literature review, an appraisal of the literature already accessed was conducted for the specific topics of grief measurement and coping skills measurement. There was insufficient information within this body of knowledge resulting in the need for a second search process.

The grief measurement tools identified through the literature review development were compared against the Kristjanston et al.'s (2006) *Systematic Review of the Literature on Complicated Grief* and Roach's (2000) literature review of potential grief measurement instruments. A further search using Medline from 1966 – 2007 to identify coping skills literature and evaluation tools was conducted; 50 articles were identified. After review of the abstracts of these articles, 16 were selected for further review. In addition, the *Handbook of Coping* (Zeidner & Endler [Eds.], 1996) book of was also reviewed for further information.

Core Search

Table 1: Search Terminology/Strategy for Core Search

Bibliographic databases searched included Medline and EBCOHOST. Subject headings were exploded² where possible to include broad terms in the search. Text words were used to search titles, abstracts, and full-text as available. Example subject headings below were used in Medline. Text words were used to search the other (non-database grey literature) resources.

Duplications excluded through abstract review.

Textwords (keywords):

Textwords: Suicide, bereavement, postvention, grief, mourning, service, and support

Textwords: coping, coping scale, evaluation

Table 2: Conventional (Commercial) Database Search Summary

Database	Date Coverage	Comments
OVID: ACP journal Club, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, EMBASE, Ovid Medline	1996-2007	<ul style="list-style-type: none"> • Suicide – 39,003 • Bereavement or postvention – 3883 • Grief or traumatic grief – 114 • Services – 238,609 • Suicide and (bereavement or postvention) -334 – 140 were selected based on abstract reviews for further review. • Suicide and services and (bereavement and postvention) – 46 – all article abstracts were reviewed (33 potentially relevant)
EBCOHOST: Academic Search Elite, CINAHL with Full Text; Cochrane Central Register of Controlled Trials; Cochrane Database of Systematic Reviews; ERIC; Health Source - Consumer Edition; Health Source: Nursing/Academic Edition; MEDLINE; PsycARTICLES; PsycCRITIQUES; PsycINFO	1996-2007	<ul style="list-style-type: none"> • Suicide – 106,805 • Bereavement - 16015 • Postvention – 238 • Bereavement or postvention – 16,376 • Service – 1,651,833 • Suicide and (bereavement or postvention) -1260 • Suicide and services and (bereavement and postvention) – 188 – all article abstracts were reviewed (11 potentially relevant)

² Where appropriate, multiple MeSH Subheadings can be logically grouped together. Such related groups of subheadings include other related terms. Exploding a subject heading includes these additional subheadings into the search resulting in a broader coverage of the published literature.

Table 2: Conventional (Commercial) Database Search Summary

Database	Date Coverage	Comments
EBCOHOST: Academic Search Elite, CINAHL with Full Text; Cochrane Central Register of Controlled Trials; Cochrane Database of Systematic Reviews; ERIC; Health Source - Consumer Edition; Health Source: Nursing/Academic Edition; MEDLINE; PsycARTICLES; PsycCRITIQUES; PsycINFO	1996-2007	<ul style="list-style-type: none"> • Suicide – 106,805 • Bereavement - 16015 • Postvention – 238 • Bereavement or postvention – 16,376 • Service – 1,651,833 • Suicide and (bereavement or postvention) -1260 • Mourning – 7,283 • Grief – 28,669 • Support – 1,305,056 • Suicide and (mourning or grief) or (bereavement or postvention)) – 2,240 • Suicide and (mourning or grief) or (bereavement or postvention) and support – 488 • Suicide and (mourning or grief) or (bereavement or postvention) and support and service – 80 – all article abstracts were reviewed (19 potentially relevant)
Suicide Information & Education Centre	None specified	<ul style="list-style-type: none"> • Bereavement and support and services; all types all locations – 44 – all abstracts were reviewed (20 potentially relevant) • Includes program information, brochures, policy manuals (grey literature)
EBCOHOST Medline	1966-2007	<ul style="list-style-type: none"> • Coping skills and death – 29 all abstracts reviewed • Coping scale – 217 • Bereavement – 3666 • Coping scale and bereavement – 5 abstracts and articles reviewed • Evaluation and coping instruments – 0 • Evaluation and coping scale – 16 all abstracts were reviewed

Table 3: Grey Literature Search Summary

Source	Date Coverage	Comments
King, S., Khadjesari, Z., Golder, S., Eichler, K., and Sowden, A.J. (2004). Interventions for persons bereaved by suicide: A scoping review	1982 - 2004	<ul style="list-style-type: none"> • Studies that described an intervention – 4 possible relevant • Studies that evaluated an intervention for persons bereaved by suicide – 8 possible relevant
International Association of Suicide Prevention		<ul style="list-style-type: none"> • 1 article
Canadian Association of Suicide Prevention		<ul style="list-style-type: none"> • List of bereavement services in Canada • 1 document retrieved
American Association of Suicidology		<ul style="list-style-type: none"> • Survivors of Suicide Handbook • 6 articles retrieved
The Support Network		<ul style="list-style-type: none"> • 6 articles retrieved • 2 key informant interviews
Safe OnLine Outreach Society		<ul style="list-style-type: none"> • 1 key informant interview

Table 3: Grey Literature Search Summary

Source	Date Coverage	Comments
Aboriginal resources: - National Aboriginal Health Organization - Aboriginal Healing Foundation - AMHB		<ul style="list-style-type: none"> • 3 articles retrieved • 4 articles retrieved • 3 articles retrieved • 1 key informant interview
Public Health Agency of Canada		<ul style="list-style-type: none"> • 1 article retrieved
American Foundation for Suicide Prevention		<ul style="list-style-type: none"> • 6 articles retrieved • 1 key informant interview
Brown University – Toolkit of Instruments to Measure End-of-Life Care		<ul style="list-style-type: none"> • Grief and Bereavement – Literature Review

APPENDIX B: SAMPLE PROGRAMS

1. *Active Postvention/Outreach Services*

Local Outreach to Suicide Survivors Program (LOSS) (Campbell, 1997; Campbell, 2002; Campbell, Cataldie, McIntosh & Millet, 2004)

A first-response team of the Baton Rouge Crisis Intervention Center, the “LOSS team reaches out to survivors to let them know that they are not alone, provides immediate contact and support, informs them of the resources available to them in the community, and provides an installation of hope that they too, can survive this traumatic loss” (Campbell, Cataldie, McIntosh & Millet, 2004, p. 30). Team members are staff and survivor volunteers who have received specific training on crime scene procedures, blood-borne precautions, and supportive counseling training. The team is activated on the decision of the Coroner and connects with survivors at the scene and is intended to decrease the time lapse between death and the survivor seeking services (Campbell, 2002).

Inclusion of survivor volunteers is considered critical as it provides an immediate connection to someone who has had a similar experience and was able to cope with the trauma, thereby not only attempting to facilitate a bond but modeling some hope that one can move ahead. The key purpose of the team is to:

- provide immediate support and resources;
- establish a connection to the newly bereaved;
- negotiate with other first responders on the individual’s behalf; and
- provide referrals.

The impact of the team reported by Campbell, Cataldie, McIntosh & Millet (2004) includes the growth in relationship and understanding between the team members and other first responders resulting in a more concerned and caring environment for survivors. Further, team members are able to assist with the task of working with survivors, which can be uncomfortable and thereby alleviating the pressure on other first responders. Finally, the endorsement of the Coroner improves the the team’s credibility, particularly if the team is responsive and reliable in their response.

AFSP Survivor Outreach Program (AFSP website, 2007; J. Harpel, personal communication, August 15, 2007)

The Survivor Outreach Program is a recent development for the AFSP wherein trained survivor volunteers visit and provide support to newly-bereaved survivors. Two volunteers team up to listen, share their experiences, and provide resource information (support groups, counseling, helpful reading material) to the newly bereaved. Visits are made upon the request of the survivor and are often followed up with telephone contact; it is made clear that their assistance is not a mental health or counseling service and referrals to such services are provided when needed.

The SOPRoxi Project (Scocco, Frasson, Costacurta & Pavan, 2006)

The SOPRoxi Project is an Italian survivor program that provides counseling through collaboration across community agencies (for example, General Practitioners, Mental Health professionals, and schools). Clinical assessment, diagnosis and treatment, information and education, and research are included.

- Stage 1 - Identification and contact of survivors (via GPs, police, community organizations)
- Stage 2 - Determine those who need assistance (2 assessment sessions; assessing for interpersonal relationships, suicidality, perceived stigma, depression, complicated grief, personality and global psychopathological assessment for pre/existing psychiatric disorders)
- Stage 3 - Intervention program devised
 - explanatory session
 - self-help group
 - psychiatric and pharmacological interventions
 - psychotherapeutic interventions (crisis intervention and interpersonal psychotherapy)

2. One-on-One Supports

The Support Network (J. Wright & T. King, personal communication, July 31, 2007)

The Support Network in Edmonton, Alberta provides a variety of services to individuals, groups, and communities. Survivors requesting service through the suicide bereavement program participate in two one-on-one interviews, providing support, information and determining which service will best address the survivor's needs. Individual supportive counseling is an option for those survivors who are not comfortable or appropriate for a group modality, or for the interim before another group is scheduled to begin. This approach has a similar purpose to that of a support group, but does not address developing new social ties with other survivors. Should a survivor desire that link, they may be referred to an upcoming group or a survivor activity. As well, occasional supportive counseling sessions are available to past clients on an as-needed basis.

Web-Based Psycho-Educational Program for Adolescent Suicide Survivors (Hoffman, 2006)

Hoffman (2006) identifies that in the development of any psycho-educational program, there are four stages to be completed:

1. Situation analysis
2. Program development
3. Program analysis
4. Implementation

At the time of their program development, Hoffman (2006) found no other psycho-educational websites for youth survivors. The goals of this program is to correct

misinformation and myths, provide a cognitive framework for survivors to work within, encourage and support healthy coping and grieving behaviours, normalize and legitimize survivor experiences, facilitate appropriate social supports, and enhance survivor's long-term quality of life. Some of the benefits noted in a web-based approach are as follows.

- you can reach a large number of individuals
- there is high level of flexibility and creativity
- youth are familiar with and readily use web-based sites

The WebCT learning management system provided for intensive web design and support options, as well as a means to conduct evaluations. There are essentially four program components that mirror elements of group support.

1. Survivor Stories – facilitate interaction and relationship building with others who share similar experiences through hearing from other youth survivors that there is hope (for example, survivor facilitators)
2. Experiences – opportunities to post a wide array of emotions, thoughts and behaviours that youth survivors are experiencing (for example, group sharing and empowerment)
3. Resources – provide lists of resources targeting survivors and recommended reading lists for care providers (for example, information and resource links)
4. About Author – professional credentials of the web manager (facilitator training)

Some promotional elements need to be considered for a web-based service. Hoffman (2006) recommends a variety of approaches promoting and educating the community about the service, including: poster presentations, media interviews, presentations to high schools and universities, proactive training workshops for care providers, and distribution of program information flyers. Such a program could operate as a stand-alone service or as a part of a survivor support group program (Hoffman, 2006) or may augment counseling services being provided.

3. Support Groups

Children's SOS Bereavement Support Group (Mitchell et al., 2007)

Designed for children age 7 to 13 who have lost a parent or other family member to suicide, two to six months prior. The 1.5 hour, 8-week group is facilitated by an advanced practice registered nurse and is progressive in design. Group activities include games and drawing to encourage talking about feelings, with a fun activity to close of each session. Each week's activities build upon the last. The therapeutic goals of the weekly modules involve:

- Session 1 – orientation (to group, purpose, each other)
- Session 2 – sharing feelings
- Session 3 – instillation of hope and exploration of the universality of experience
- Session 4 – effects on the child

- Session 5 – continued focus on instilling hope, universality, group cohesion, interpersonal learning
- Session 6 – catharsis and the integration of feelings about the parent who died
- Session 7 – continued therapeutic, curative catharsis
- Session 8 - closure, sharing feelings regarding the group ending and relationships developed

AFSP Support Groups (AFSP website, 2007)

The AFSP maintains a directory of support groups around the United States but does not recommend or endorse any of them. A description of an open group is described by a facilitator as follows.

We sit in a circle, with each person giving a brief introduction: first name, who was lost, when it was, and how it happened. I then ask the people who are attending for the first time to begin, because they usually have an urgent need to talk. The rest of the group reaches out to them by describing their own experiences and how they are feeling. The new people realize that are not alone with their nightmare. By comparing their situation with others, they also begin to understand that they don't have a monopoly on pain.
(para.4)

Community-Based Family Support (Forde & Devaney, 2006)

The family support model operates from a preventative strengths-based perspective to “ensure social support for families experiencing tragedy, with the long-term goal of preventing stagnation by ensuring that families are linking with and aware of support services needed for the future” (p. 54). The principles of family support are as follows.

- listening to service users
- inter-agency working
- provision of needs-led services
- prevention and early intervention

“It can be argued that the principles of family support as applied to this initiative have lead to the development of a family support model of good practice in dealing with tragic events. Therefore, the principles of family support equate to standards of best practice and quality” (p. 54), but have not necessarily been proven to be a best practice for suicide bereavement.

Further, “social support can act as a stress-buffering factor by providing help or support at moments of particular need...informal support arises out of a person’s own network of family and friends, whereas formal support is provided by paid persons or services outside of this network. Natural informal support is crucial.” (p. 55) Cutrona (as cited in Forde & Devaney, 2006) argues that a support worker’s “first priority should be

facilitating the flow of support within existing social networks of family and friends, rather than trying to ‘graft on’ new sources of support” (p. 55).

A key role the family support worker plays is as a facilitator linking the survivor to needed services. This may involve direct referrals, coordinating an interagency response plan, or attending appointments with the survivor.

The family-support model was devised through the direction of an advisory group involving program staff and community representatives; families were involved in an interview process. The model is structured, practical and has a clear pathway that guides the worker’s role. Within the program there are two categories of families – those known to the program and those unknown. This delineation is important as “it is not appropriate for family support workers to enter a family system for the first time, particularly at a time of tragedy, without invitation and agreement from the family” (Forde & Devaney, 2006, p. 58). In the case of unknown families, the link begins by the worker contacting those service providers already involved in the family’s support network. The model further respects the value of the family’s informal networks and works to rebuild or enhance those, rather than automatically constructing new networks. Overall, the family’s desires and wishes drive what, if any, services are provided and how.

Psycho-Educative Intervention Program (Dyregrov & Dyregrov, 2005)

A manual-based grief support service for children grieving a suicide of a parent or sibling based on attachment, grief and loss, and cognitive management theories. This weekly, 10-session group is 30 minutes long and includes psycho-educational and support services. The psycho-educational component aims at providing information and assisting children in understanding the meaning of the death, while the support component facilitates the child’s expression of grief, management of the traumatic experiences, and memories of the lost family member, as well as encourages the development of interpersonal relationships. A parent group is run alongside the children’s group.

Bereavement Group Postvention (for widows) (Constantino, Faan, Sekula, & Rubinstein, 2001)

This 90-minute, 8-session, weekly group was facilitated by a Master’s-level mental health nurse who took an active role in directing the group discussions. The length and structure of the group was based on Yalom’s (1995) therapeutic principles and designed to facilitate group development and enhance the therapeutic environment.

Survivors After Suicide (Farberow, 1992)

The Los Angeles Suicide Prevention Center hosts a survivor support group consisting of 8-90 minute sessions, weekly, co-facilitated (one clinician and one survivor volunteer with specific training). A variety of reading resources are distributed. Monthly drop-in meetings are available to members following completion of the program. The group is mixed in gender, age, and kinship of the loss.

Family Support Team (Beane, 1987)

In 1980, the Westchester County, New York Department of Community Mental Health established a special family support team whose purpose was to make direct contact with family members after a suicide or homicide death. The program planning, training and implementation took approximately five months. The service was free and team members were clinicians with specific training in death, suicide & bereavement. The links between the team and the survivor was through the Coroner's office. Weekly contacts provided the team member with names and contact information of recent survivors. A letter offering their services was sent to the nearest relative and followed up with a telephone call offering a one-on-one session in either their home or at the Centre. Of those contacted, 42.5% accepted help, and a significant number of individuals who initially declined services requested them later.

Bereaved Through Suicide Support Group (Clark, 1992)

These groups are between 10 and 20 members in size and are facilitated by a counselor and trained support workers. The group provides a safe venue for working through grief responses due to a suicide death, along with educational elements related to the grief process, stress management and coping, and relationship building with others who have had similar experiences, as the support workers are survivors who have completed a grief management training program. The service is guided by a Professional Advisory Council, including a psychiatrist, bereavement educator, funeral director, coroner, and a physician. This program also offers 24-hour telephone assistance, as well as individual counseling. Healthy lifestyle and stress management are encouraged.