

Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines

**Survivors of Suicide Loss Task Force
April 2015**



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Acknowledgements

The National Action Alliance for Suicide Prevention,¹ a public-private partnership that is advancing the cause of lessening suicide's toll in the United States, is to be commended and heartily thanked for providing a cornerstone for the work of the Survivors of Suicide Loss Task Force.

Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines (National Guidelines) is the work of a dozen dedicated volunteers serving on the Task Force, whose names and affiliations are listed on the page that follows. Collectively, the Task Force represents a vast amount of experience in postvention: learning, teaching others, and advocating on behalf of compassionately attending to the needs of those left behind in the aftermath of suicide. Another 20 volunteers, also listed on the following page, served as expert reviewers, and their thoughtful criticism and suggestions strengthened the guidelines in important ways—and proved that this truly is only a work in progress. These volunteers—and leaders—for the field of suicide postvention have spent countless hours during their careers in the company of survivors of suicide loss and others affected by suicide, and there is no doubt that their work on the guidelines truly has been in dedication to everyone who has suffered because of a suicide and to all who labor to sustain those who suffer.

The most earnest hope of the Task Force members is that the *National Guidelines* help to create an historic opportunity for fundamental, meaningful change in the reach and effectiveness of postvention in America. If that is to happen, it will come about through the efforts of a new generation of advocates, caregivers, and leaders who will build on the 50 years of foundational work by pioneers such as LaRita Archibald (HEARTBEAT), Eleanora Betsy Ross (Ray of Hope), Iris and Jack Bolton, Adina Wroblewski (SAVE), Marilyn Koenig (Friends for Survival), Mary Douglas Kroust, Stephanie Weber, Lois and Sam Bloom, Fred and Gail Fox, Leah and Scott Simpson, Father Charles Rubey, Karyl Chastain Beal (POS/FFOS), Edward Dunne, Karen Dunne-Maxim, Jerry and Elsie Weyrauch (SPAN USA), Judy Meade, Dale and Dar Emme (Yellow Ribbon), Sandy Martin (Lifekeeper Foundation), Frank Campbell (BRCIC), Clark Flatt (Jason Foundation), Donna and Phil Satow (JED Foundation), Carla Fine, Mike Myers, and Mark and Carol Graham. More recently, the efforts of organizational staff and board leadership—through the work of Michelle Linn-Gust and Sally Spencer-Thomas (AAS), Joanne Harpel (AFSP), Kim Ruocco (TAPS), Alison Malmon (Active Minds), Ronnie Walker (Alliance of Hope), and Ken Norton (Connect/NAMI-NH)—have helped thousands of loss survivors and built momentum for systems change focused on postvention. These champions and many more—including those in crisis centers and grief support groups across the country who are, day in and day out, touching the lives of people affected by suicide—have laid the foundation for accomplishing the Task Force's vision: *A world where communities and organizations provide everyone who is exposed to a suicide access to effective services and support immediately—and for as long as necessary—to decrease their risk of suicide, to strengthen their mental health, and to help them cope with grief.*

Please join us to make this vision a reality.

Franklin Cook, John R. Jordan, & Karen Moyer,
Task Force Co-Leads

¹ The National Action Alliance for Suicide Prevention (actionallianceforsuicideprevention.org), established in 2010 with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), is the public-private partnership working to advance the *National Strategy for Suicide Prevention* and make suicide prevention a national priority

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Preface

More than a decade ago, I attended a meeting of survivors of suicide loss who were testifying about how the most devastating event imaginable in their lives had motivated—or inspired or perhaps even *driven*—them to try to change how communities respond to people at risk of dying by suicide and to those who are left behind when suicide ends a precious life.

I will never forget the introductory comments of one of the panelists that day, Pam Harrington, a SPAN USA volunteer from Florida, who was notably anxious about her role as a public speaker—even though her entree onto the panel was the fact that she had leveraged the signatures of thousands of advocates to persuade then-Florida Governor Jeb Bush to make addressing the toll of suicide a high priority in his state. Pam gripped both sides of the podium and began to tell the story of her determination to meet with him, saying how difficult it had been for her to find her voice in that weighty moment but that ultimately she had spoken to the governor with all of the conviction for her cause that she could muster. She felt similarly anxious in the present moment, she said, because she had never imagined herself in such a role. But, she continued, “Whenever I find it hard to speak out like this, I remember *in my heart* that I speak for Beth,” and her voice cracked, and she briefly struggled not to cry, then she went on with her talk. Beth, of course, is her daughter, whose suicide had launched Pam on the road to advocacy and caregiving that tens of thousands of survivors have embarked upon over the years.

I share that poignant scene because it is the only personal account of suicide loss you will find in this document, and I worry that those who have been personally touched by suicide will find the omission of survivor stories baffling or perhaps even hurtful. Please know that everyone who had anything to do with the creation of these new *National Guidelines* has their own story, and *in our hearts*, we have brought the voices of loss survivors into every word that is written.

Another force that lies behind all that these guidelines assert is our belief that there is a profound lack of awareness—among the public, certainly, but also among many who provide care to the bereaved—about the damage that suicide can cause to people who experience the finality and the pain of its impact. The claims put forth in this document rely on the facts, so let me begin with this one: In the 37 years since 1978, when my father killed himself, 1.2 million more people have died by suicide in America (data from J. McIntosh, personal correspondence, April 3, 2015). Using the oft-quoted and unquestionably conservative figure of six people seriously affected by each fatality, that adds up to more than 7 million people among us who have personally experienced the tragedy of suicide. The research findings delineated in the pages that follow present the cumulative argument that the severity and duration of suicide’s damage for many of our friends and neighbors is far worse than is recognized, and that our society is not even close to responding adequately or effectively to lessen this damage or to help people recover from the tragedy that has befallen them.

I believe that creating awareness about the number of people affected, the nature of the damage they suffer, and the extent to which their needs are not being met is extraordinarily important, but to truly succeed, these guidelines must change not only our awareness. They also must compel us to take the bold and drastic action necessary to reinvent postvention in a way that focuses our compassion—and our resources—on answering the call to meet the needs of everyone exposed to a suicide.

A handwritten signature in black ink, reading "Franklin Cook". The signature is fluid and cursive, with the first name "Franklin" written in a larger, more prominent script than the last name "Cook".

April 13, 2015

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Responding to Grief, Trauma, and Distress after a Suicide: National Guidelines

National Action Alliance for Suicide Prevention: Survivors of Suicide Loss Task Force

Executive Summary

Responding to Grief, Trauma, and Distress after a Suicide: National Guidelines—developed by the Survivors of Suicide Loss Task Force of the National Action Alliance for Suicide Prevention—calls for the creation and sustainment of the resources, infrastructure, services, and systems necessary to effectively respond to any incidence of suicide in the United States. The vision that guided the Task Force in its work is of *a world where communities and organizations provide everyone who is exposed to a suicide access to effective services and support immediately—and for as long as necessary—to decrease their risk of suicide, to strengthen their mental health, and to help them cope with grief.*

The Task Force was established in 2012 to focus attention on providing—in communities throughout the nation—effective support to the suicide bereaved and others exposed to suicide who may need help recovering from grief, trauma, or other distress. Its members include national experts in the field of suicide bereavement, survivors of suicide loss, clinicians, and other key stakeholders engaged in suicide response or postvention efforts. The *National Guidelines* are a call to action for everyone engaged in suicide prevention to strengthen and expand their response to every fatality in order to both reduce the risk of suicide and meet the needs of the bereaved and of others who suffer from the range of negative effects related to exposure to a suicide.

The guidelines are intended to reach anyone who is in contact with, cares about, or wishes to help those impacted by a suicide loss. This includes first responders (police, fire, and emergency rescue personnel); mental health clinicians; medical professionals; public health professionals; faith leaders; funeral professionals; and many others. Key audiences also include organizations such as hospitals, social service agencies, bereavement support organizations, faith communities, state and local offices of public health or suicide prevention, schools and colleges, military and veteran service providers, loss survivor support organizations, and others whose work is focused on trauma and traumatic loss. Last but not least, the guidelines are intended for suicide loss survivors themselves who are ready to become involved—locally or nationally—in the efforts under way to reduce suicide and to help those affected by the tragedy of suicide.

The guidelines provide a unified, far-reaching blueprint for the development of suicide postvention at all levels of U.S. society. The overarching goal is to reduce the deleterious effects of exposure to suicide and facilitate the process of healing from a suicide loss. The guidelines call for an integrated and compassionate community response to deaths by suicide in every kind of community in the country.

More specifically, the *National Guidelines*:

- Provide readers with an overview on what is known about suicide exposure and suicide bereavement, including a review of the professional literature

- Use the public health framework from the *National Strategy for Suicide Prevention* (NSSP) to delineate goals and objectives that focus on universal, selective, and indicated responses to the aftermath of suicide
- Present research evidence demonstrating that numerous negative outcomes are linked to exposure to suicide, including an increased risk of suicide, mental health issues, substance abuse, posttraumatic stress disorder (PTSD), and social isolation
- Augment the effectiveness of research and program development by conceptualizing the aftermath of suicide for individuals along a continuum that includes four “categories:” exposed, affected, short-term bereaved, and long-term bereaved
- Treat the experience of a suicide death as a potential crisis event that, for some, does not end with exposure to the death but continues afterward, requiring a mental health response to address individual and community needs
- Address the postvention needs of schools, workplaces, and organizations
- Provide an organized yet flexible and multifaceted structure for the delivery of services to those affected by suicide—focused on effective crisis response and the overlapping and ongoing goals of support and treatment for all who need it
- Outline fundamental research priorities related to the impact of suicide on individuals and organizations, with special attention on how research would inform postvention practices
- Provide linkage to additional resources for those engaged in suicide postvention efforts or who wish to develop a more comprehensive suicide response in their community

The goals and objectives recommended in the guidelines are structured around the framework used by the NSSP in keeping with the principles of a public health response to suicide.

The goals in Strategic Direction 1 (Healthy and Empowered Individuals, Families, and Communities) are *universal* strategies, which are interventions on behalf of the entire population:

1. Integrate and coordinate effective suicide postvention activities across jurisdictions, organizations, and systems through increased communication, collaboration, and capacity building.
2. Communicate accurate and useful information about the impact of suicide on individuals, organizations, and communities; the availability of services for people affected by suicide; and the nature and importance of suicide postvention.
3. Work to ensure that media, entertainment, and online communications about suicide and its aftermath do not contribute to the distress of people bereaved by suicide or to the risk of suicidal behavior among people exposed to a fatality.
4. Create the infrastructure and delivery systems for training a wide array of service providers in suicide bereavement support and treatment, and in minimizing the adverse effects of exposure to a suicide.

The goals in Strategic Direction 2 (Clinical and Community Preventive Services) are *selective* strategies, which are interventions on behalf of people who are at risk for negative mental health or other unhealthy outcomes in the aftermath of suicide:

5. Develop and implement protocols in communities and across caregiving systems for effectively responding at the scene and in the immediate aftermath of all suicides.
6. Ensure that people exposed to a suicide receive essential and appropriate information.

7. Develop and implement effective postvention practices in organizational, workplace, and school settings.

The goals in Strategic Direction 3 (Treatment and Support) are *indicated* strategies, which are interventions on behalf of people who are currently experiencing negative outcomes as a result of a suicide:

8. Ensure that all support and treatment services delivered to the suicide bereaved are accessible, adequate, consistent, and coordinated across systems of care.
9. At the level of support services, provide an array of assistance, programs, and resources that help bereaved individuals and families cope with and recover from the effects of their loss to suicide. Services at this level may include information, emotional support, guidance; psychoeducation about suicide, grief, trauma, and effective self-care; and participation in peer help and other community-based services.
10. At the level of professional clinical services, provide an array of treatment, programs, and resources that help people affected by unrelenting or complicated grief, PTSD, depression, suicidality, and other acute or potentially debilitating conditions.

The goals in Strategic Direction 4 (Surveillance, Research & Evaluation) are strategies designed to increase the knowledge base related to the aftermath of suicide to guide the implementation of effective treatment and support:

11. Design studies of suicide loss survivors using appropriate scientific methods.
12. Establish valid and reliable estimates of the number of people exposed to suicide and the immediate and longer-term impact of exposure. This includes people (a) exposed to and (b) affected by a given suicide, as well as those who suffer (c) short-term and (d) long-term bereavement complications.
13. Identify common and unique impacts of suicide bereavement, as well as individual difference variables that function as risk factors for or buffers to such effects.
14. Study the utilization and efficacy of interventions and services designed to assist people bereaved by suicide.
15. Promote bridging of research and practice by soliciting engagement of relevant stakeholders in scientific studies of suicide loss and intervention.

Accomplishing these goals would result in accomplishing NSSP Objectives 10.1, on assisting people bereaved by suicide; 10.2, on responding to trauma and complications of grief; and 10.5, on caring for service providers, first responders, and others who are exposed to suicide. More generally, the goals and objectives provide guidance for those involved in suicide prevention efforts to incorporate more-effective care for the suicide bereaved and others affected by a suicide into all postvention policies and practices. They also pave the way for increased communication and collaboration between the field of suicide postvention and those working in fields such as grief counseling, trauma care, crisis response, mental health treatment, funeral services, and spiritual ministry.

The *National Guidelines* include three appendices:

- Appendix A delineates the overarching principles for postvention programs and services.
- Appendix B outlines key resources and contacts for survivors of suicide loss and for those who care for them.
- Appendix C identifies specific action steps that can be taken by officials at the local, tribal, state, and national levels to strengthen postvention.

Introduction

It has long been understood that the suicide of a family member, friend, or other emotionally close person can have a powerful and sometimes devastating impact on the people who are left behind (Cain, 1972; Jordan & McIntosh, 2011a). It is well established that exposure to death by suicide can be a significant risk factor for the development of many negative consequences in the bereaved, including an increased risk of suicide (Pittman, Osborn, King, & Erlangsen, 2014). These important connections between the suicide of an individual and the subsequent risk to people exposed to that suicide loom large in taking the full measure of the personal and societal damage suicide leaves in its wake. Despite this fact, the field of suicide prevention is only beginning to comprehensively include the most pervasive aftereffects of suicide in its planning, funding, and implementation of responses to a death by suicide. *Responding to Grief, Trauma, and Distress after a Suicide: National Guidelines (National Guidelines)* pave the way for decisive, effective advances in comprehensive care after a suicide occurs—and a strengthened partnership between the fields of suicide prevention and suicide grief support—by accomplishing three things.

First, they explain the compelling rationale for effective services and support being delivered after a suicide by addressing questions such as who is a suicide loss survivor and how many survivors might exist, and by reviewing the persuasive empirical evidence that suicide can have adverse effects on individuals exposed to a fatality. They also identify the range of needs of loss survivors as they recover from the impact of exposure to a suicide, and summarize the broad principles that should underlie all efforts to help those exposed to suicide. Overall, the document makes a solid case for increased efforts to provide systematic and effective outreach and care following a suicide in any cultural setting or community.

Second, the guidelines build upon the organizational structure of the current *National Strategy for Suicide Prevention* (NSSP) (U.S. Department of Health & Human Services, Office of the Surgeon General, & National Action Alliance for Suicide Prevention, 2012) and outline goals and objectives for the development of infrastructure, resources, and services at the community, state, tribal, and federal levels to deliver support to people affected by a suicide. The recommendations are organized around the four Strategic Directions of the NSSP (Healthy and Empowered Individuals, Families, and Communities; Clinical and Community Preventive Services; Treatment and Support Services; and Surveillance, Research, and Evaluation) and directly complement its overall goals.

Third, the *National Guidelines* include three appendices, which delineate overarching principles for postvention programs and services (Appendix A); identify action steps that can be taken by officials at the local, tribal, state, and national levels to develop postvention infrastructure for loss survivors (Appendix B); and outline key resources and contacts for survivors of suicide loss and for those who care for them (Appendix C).

Terminology: *Postvention* and *Loss Survivor*

It is necessary to address the potential confusion around two terms that are commonly used in the fields of suicide prevention and suicide grief support: *suicide postvention* and *suicide loss survivor*. Edwin Shneidman, the father of modern suicidology, famously declared that suicide postvention is a direct

form of prevention of future suicides (Shneidman, 1972). Shneidman himself coined the term *postvention* to refer to helping the grieving survivor-victims of suicidal deaths, by which he meant helping people who are bereaved by suicide. Over the years, *postvention* has come to mean not only assistance to the bereaved but also assistance to anyone whose risk of suicide might be increased in the aftermath of someone else's suicide. In addition, people who traditionally might not be categorized as *loss survivors* (such as first responders) can suffer negative effects from exposure to suicide, and outreach intended to help them is also properly called *postvention*. In summary, *postvention* as it is currently used in practice refers to an organized response in the aftermath of a suicide to accomplish any one or more of the following:

- To facilitate the healing of individuals from the grief and distress of suicide loss
- To mitigate other negative effects of exposure to suicide
- To prevent suicide among people who are at high risk after exposure to suicide

An overarching goal of these guidelines is to ensure that all postvention efforts accomplish all three of these objectives in an integrated, balanced, and effective way.

The other important term that is used in a somewhat confusing way in this arena is the phrase *suicide loss survivor*. The history of the term *suicide survivors* has been covered at length elsewhere (Andriessen, 2009; Dunne & Dunne-Maxim, 1987). In these guidelines, the terms *survivor*, *loss survivor*, and *survivor of suicide loss* are used to describe someone who is bereaved by suicide. This usage is common, longstanding, and widespread in North America, although *bereaved by suicide* is more widely used in other parts of the world. To avoid confusion in this document, the entire phrase *survivor of suicide attempt* is always used to describe someone who has made a nonfatal suicide attempt.

The matter is further complicated by the fact that some people who have lost a loved one to suicide object to being called a *survivor* because they feel that they are the *victims* of a calamity that has befallen them. In addition, some people may grieve the loss of someone who died by suicide, yet not identify with the term *survivor* because of the nature of the relationship they had with the deceased. For example, a co-worker may or may not identify with the statement, "I am a survivor of suicide loss," yet be sorely bereaved.

Finally, the *National Guidelines* bring fresh emphasis to the idea that postvention responses ought to be considered on behalf of *any* person who has been exposed to the death by suicide of another. While the bereaved carry a large burden in the aftermath of suicide, there are many people who may be affected by a suicide who are not bereaved, in the sense that they are not experiencing a grief response which is rooted in separation distress. For example, the driver of the subway train that a suicidal person jumped in front of may have no grief reaction whatsoever—but may be very traumatized by the suicide and would surely benefit from having access to systematic, comprehensive postvention resources and services.

The distinctions among the categories of people who may need support in the aftermath of suicide is further explored later (pp. 9–13) through a new conceptualization that uses the terms *exposed to suicide*, *affected by suicide*, and *short-term* bereaved by suicide, and *long-term* bereaved by suicide (Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014).

Development and Purpose of the Guidelines

The *National Guidelines* were created by the Survivors of Suicide Loss (SOSL) Task Force of the National Action Alliance for Suicide Prevention (Action Alliance) (bit.ly/actionalliance).² The Action Alliance is a public-private partnership created to advance the current NSSP in the United States. The Action Alliance created the SOSL Task Force to develop national guidelines that were called for more than a decade ago in the original NSSP (U.S. Department of Health & Human Services, U. S. Public Health Service, 2001). The guidelines include comprehensive goals and objectives to help communities support people affected by suicide in the United States, including recommendations for building infrastructure; creating policies and procedures; and developing programs and services to support people after a suicide, reduce the negative effects of suicide when it occurs, and help to prevent future suicides. More information about the SOSL Task Force can be accessed at bit.ly/sosl-taskforce.

The original NSSP made only brief mention of the impact of suicide on the bereaved and others who are affected by a fatality. However, the 2001 NSSP did state that one of its four aims was to “reduce the harmful aftereffects associated with suicidal behaviors and the traumatic impact of suicide on family and friends” (p. 28). Also, Objective 7.5 of the 2001 NSSP was to “increase the proportion of those who provide key services to suicide survivors (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors, faith leaders) who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors” (p. 93). Objective 8.7 also stated that the United States would “by 2005, define national guidelines for effective comprehensive support programs for suicide survivors [and] increase the proportion of counties (or comparable jurisdictions) in which the guidelines are implemented.” (p. 104). The authors of the 2001 NSSP were insightful in calling out these worthy objectives, but unfortunately, only minimal progress on achieving them had been made by the time the NSSP was revised in 2012.

Reflecting a growing awareness of the impact of suicide on the bereaved and others, Goal 10 of the most recent NSSP (U.S. Department of Health & Human Services et al., 2012, pp. 62–64) asks communities to “provide care and support to individuals affected by suicide,” and Objective 10.1 calls for the United States to “develop guidelines for effective comprehensive support programs for individuals bereaved by suicide.” *The current guidelines answer the call of both the 2001 and 2012 NSSPs to produce national guidelines for effective, comprehensive support programs for individuals bereaved by suicide and others affected by exposure to suicide.* Specifically, it outlines the overarching strategy for accomplishing NSSP Objectives 10.2 and 10.5, which respectively call for providing “appropriate clinical care to individuals affected by a suicide ... including trauma treatment and care for complicated grief,” as well as care and support for “health care providers, first responders, and others ... when a patient under their care dies by suicide.” Finally this document addresses Objective 10.4 of the NSSP, which calls for effective postvention to prevent suicide clusters and contagion, a topic covered extensively both by the NSSP and the Action Alliance Suicide Attempt Survivor (SAS) Task Force. The guidelines presented

² For brevity and ease of transcription, bitlinks (bit.ly/shortphrase) are used throughout this document. Bitlinks function the same way as a website’s original Internet address (to access a website, simply copy its bitlink into an Internet browser’s address bar).

here add to the work of the NSSP and SAS Task Force with an unprecedented and vital focus on the currently unmet needs of the bereaved and others affected by exposure to suicide.

In so much as survivors of suicide attempts may have been affected by someone else's completed suicide, their needs are addressed by the guidelines in the same ways that the needs of others exposed to suicide are addressed. However, these guidelines do not necessarily focus on the needs of people who have survived a nonfatal attempt, for the SOSL Task Force's charge is *to focus on the impact of suicide on people exposed to a fatality*. Even so, the SOSL Task Force's intention and the principles and values upon which its work is based strongly and unequivocally support the cause of survivors of nonfatal suicide attempts and the family, friends, and others affected by any suicidal behavior.

Two recently released resources are essential to advancing that cause (see NSSP Objective 10.3):

- A strategic document created by the SAS Task Force, *The Way Forward* (bit.ly/forwardway), outlines ambitious, groundbreaking goals, and objectives on behalf of this population.
- *A Journey Toward Help and Hope: Your Handbook for Recovery after a Suicide Attempt* will be available soon from SAMHSA at bit.ly/samhsastore.

Audience of the Guidelines

This document is intended for anyone in the United States who is in contact with, cares about, or wishes to help survivors of suicide loss and others affected by a suicide, including first responders (police, fire, and emergency rescue personnel), mental health clinicians, medical professionals, public health professionals, faith leaders, funeral professionals, and many others. Key audiences also include organizations such as hospitals, social service agencies, bereavement support organizations, faith communities, state and local offices of public health and/or suicide prevention, schools and colleges, military and veteran service providers, loss survivor support organizations, and others whose work is focused on trauma and traumatic loss—and of course, it includes survivors of suicide loss themselves. The goal is to provide a unified blueprint for the development of suicide postvention at all levels of U.S. society, so that the deleterious effects of exposure to suicide can be mitigated and the process of healing from a suicide loss can be augmented by an integrated and compassionate community response. This blueprint can also guide evaluation and research to ensure that programs implemented are safe and effective.

A secondary audience for these guidelines is the international community, as many nations are also responding to the risk of exposure to suicide by developing policies and programs aimed at suicide prevention and postvention. While serving the primary goal of addressing needs of loss survivors within the United States, the principles and practices outlined here also are intended as a contribution to this global effort.

Defining Survivor of Suicide Loss

The literature on suicide loss survivors has yet to clearly ascertain how many people in the United States are survivors, or even to define who a loss survivor is and what constitutes *survivorship*. A commonly cited figure for the number of loss survivors was offered by Shneidman when he suggested that for every suicide, there were at least six loss survivors (Shneidman & Leenaars, 1999). Unfortunately, this number has taken on the status of an empirically established fact, which it is not. The reality is that the

number of suicide loss survivors has not been established because the already difficult challenge of collecting such data is complicated by the lack of a clear definition of who a survivor of suicide loss is. Instead, the field is limited to estimates. With regard to exposure to suicide, Crosby and Sacks (2002) found that approximately 7 percent of the U.S. population reported that they had known someone who died by suicide within the last year. Berman found that there were an estimated 4.5–7.5 immediate family members and up to 15 to 20 extended family and other social network members, respectively, who meet the criterion of being “intimately and directly affected” by a suicide (Berman, 2011). Given the 41,149 suicides recorded in the United States in 2013, the most recent year for which statistics are available (Drapeau & McIntosh, 2015), and using the lower-end estimates of the number of survivors of each (4.5 immediate family plus 15 other survivors), Berman’s data suggest that over 800,000 Americans would enter the ranks of suicide loss survivors each year. Recent research has found that as much as 47 percent of the U.S. population has known someone who has died by suicide (Cerel, et al., in press), with approximately 20 percent of that group self-identifying that they were a survivor, that is, “personally affected” by the death (Cerel, Maple, Aldrich, & Van de Veene, 2013). These estimates should be refined through the use of converging epidemiological and surveillance methods, employing a clear definition of what constitutes *survivorship*. *Nonetheless, they indicate that exposure to suicide is widespread in the United States.*

In order to create an evidence-based number to show that Shneidman’s estimate of six people bereaved by each suicide is far too low, a random digit dial study was conducted by Cerel and colleagues (Cerel et al., in press). The study used the number of people exposed, the age of the people who reported exposure, and the population and the suicide rate in the respondents’ state of residence to calculate the average number of people exposed per suicide (Cerel et al., in press). These data-based calculations indicate that an average of 115 people are exposed when each suicide occurs. The study also asked respondents to rate on a 5-point scale the closeness of their relationship to the person who died by suicide whom they knew the best (with 1 representing “not close” and 5 representing “very close”). They found that of the 115 people exposed, 71 felt some degree of closeness, 42 of those 71 people felt a higher degree of closeness, and 21 of those 42 people felt a very high degree of closeness. A similar scale was used to assess the degree of impact respondents felt that the suicide had on their life, and of the 115 people exposed, 53 said their lives were disrupted for a short time, 25 of those 53 people said their lives were disrupted in a major way, and 11 of those 25 people said the suicide had a devastating effect on their lives.

In the research and clinical literature, perhaps the most common implied definition of a *loss survivor* has been the immediate kin of the deceased. Most research studies of survivors of suicide loss have confined themselves to investigation of biologically or conjugally related members of the deceased’s immediate social network (Bolton et al., 2013; De Groot & Kollen, 2013; Pittman et al., 2014; Rostila, Saarela, & Kawachi, 2013). It seems abundantly clear, however, that delivering an integrated response to suicide must reach a much wider circle than traditionally considered, a circle that includes all people who are exposed to and might be affected by any particular suicide.

Additionally, the response of a given individual to suicide can vary substantially based on a number of factors, including a person’s role and relationship with the circumstances of the death and the deceased. Different people with the same relationship to the deceased may have a relatively mild, moderate,

severe, or even debilitating reaction to the death. Some people will exhibit very brief reactions to the loss, while others will have long-term responses and even lifelong needs as a result of the suicide. Reactions may also vary based on different cultural norms and ethnic styles of coping with grief. In addition, people's needs related to the death will likely change over time as they move through the healing process—even years later. This may be particularly true for the offspring of parents who have died by suicide, who may be subject to a struggle with suicidality much later in their own adult life (Agerbo, Nordentoft, & Mortensen, 2002; De Groot & Killen, 2013; Kuramoto, Runeson, Stuart, Lichtenstein, & Wilcox 2013; Qin, Agerbo, & Mortensen, 2002; Qin, Agerbo, & Mortensen, 2005).

Historically, there have been a number of attempts to more precisely define who should be considered a loss survivor. In 1972, Albert Cain (1972) edited *Survivors of Suicide*, a groundbreaking book on grief after suicide, which established *survivor* as the de facto term in the United States for people bereaved by suicide. Dunne, McIntosh, and Dunne-Maxim (1987) defined the term *survivor* in McIntosh's introduction (1987, p. xvii) as "the family and friends who remain after a person" dies by suicide. Mishara (1995) later described the effects of suicide ideation, nonfatal attempts, and deaths on family and others—as well as on society as a whole.

Jordan and McIntosh clearly moved beyond the bounds of family relationships by recently defining a *survivor* as "...someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person" (Jordan & McIntosh, 2011a, p.7). Since kinship is a strong predictor of grief reactions (Cleiren, Diekstra, Kerkhof, & van der Wal, 1994), family are likely to be the largest group affected by a suicide, but this new definition uses a person's degree of distress over the loss, not exclusively kinship status, as the threshold for whether someone should be considered a loss survivor. Moreover, it includes the element of self-perceived impact as a necessary component of the definition. It also requires "a considerable length of time after exposure to the suicide of another person," which helps emphasize the duration of impact as a defining criterion for survivorship. However, this could also be problematic with regard to the early identification of survivors who have immediate needs after a suicide.

Suicide Exposure: The Continuum Model

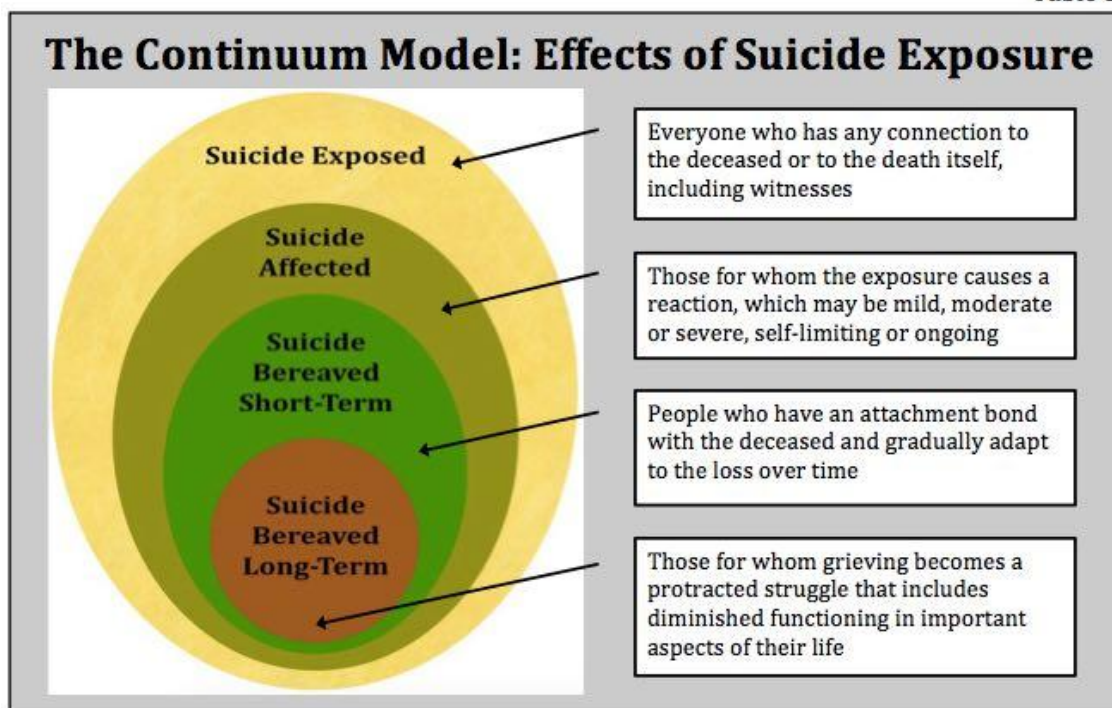
The question of defining *survivorship* is not yet settled, and dialogue around this important issue is ongoing, as is shown by the recent conceptualization offered by Cerel and colleagues (Cerel, McIntosh, Meimeyer, Maple, & Marshall, 2014). For the sake of clarity and currency, their schema will be used as a framework in these guidelines. The Cerel et al. (2014) conceptualization organizes people who are exposed to a suicide loss into four nested tiers: (1) exposed, (2) affected, (3) suicide bereaved short-term, and (4) suicide bereaved long-term. Determining how a particular person might be categorized is not linked to the person's title, role, or relationship in reference to the deceased. People will fit either in one category or another *depending on the person's reaction to the death*. The schema accounts for people who experience in any way an impact from being exposed to a suicide and categorizes them in a fashion designed to augment the delivery of effective assistance to everyone who might be affected. In other words, it describes people based on how research and interventions might best be designed to most effectively help the broadest range of people in the aftermath of suicide, as follows (see Table 1):

- The *exposed* category includes absolutely anyone whose life or activities in any way intersect with a particular suicide fatality.
- The *affected* category is a subset of those exposed and includes everyone who has a reaction to the suicide that might require some type of assistance, whether the reaction is due to grief or some other issue, such as posttraumatic stress disorder (PTSD).
- The *suicide bereaved short-term* category is a subset of those affected and includes everyone who has a reaction that is clearly related to grief, meaning that it stems from some type of personal or close relationship between the bereaved person and the deceased. The bereavement of people in this category would last for a duration that might be called “typical” in the wake of the death of a loved one by any cause.
- The *suicide bereaved long-term* category is a subset of those bereaved short-term and includes all bereaved people who encounter extraordinary difficulties in the course of their grief—with their intensive bereavement likely to endure for at least a year or longer.³ The individuals in this category are likely to require professional therapeutic assistance.

To illustrate these categories, consider the hypothetical example of a married man with children, who has taken his life while at his workplace.

The exposed in this instance would include everyone who experienced any connection whatsoever to

Table 1



³ The question of duration in diagnosing clinical conditions related to bereavement has always been problematic—and a subject of considerable debate. The proposed diagnosis Persistent Complex Bereavement Disorder is included in Section III of the recently released DSM 5 under the category “Conditions for Further Study” and sets its benchmark for duration at one year (American Psychiatric Association, 2013).

the deceased or to the suicide, from his family, friends, and colleagues at work to his neighbors and the members of his faith community. Also included would be the faith leader and funeral director who helped the family, as well as members of the public who learn about and react to the death through the media and other means. Many of the people in this category may have little or no problematic reaction after their exposure to the suicide. Others may experience immediate but very transitory shock, curiosity about the event, or even a short-term, low-level sadness over the death of the person or its effects on the deceased's loved ones—but without any significant or lasting disruption of their functioning or well-being. Their reactions would be self-limiting or require only informal assistance from those in their natural circles of support. Evidence shows that in any given year, about 7 percent of the U.S. population is exposed in this sense to the suicide of someone else (Crosby & Sacks, 2002). Cerel and colleagues (in press) have shown that almost half the U.S. population has lifetime exposure to suicide. According to this new study, as cited above, approximately 115 people may be exposed to each suicide the United States.

The affected category would include those who were exposed and also have a more palpable reaction to the suicide, even if they may not necessarily identify themselves as being bereaved by suicide. For instance, included here would be the custodian who found the deceased's body. This person is a Vietnam veteran and might be having flashbacks related to the death scene that are interfering with his ability to function. Another fellow employee, a young woman who did not work directly with the deceased but who suffers from depression, might be triggered by the man's death and experience a significant depressive episode accompanied by suicidal ideation. People who are in the affected category will likely benefit from some kind of assistance or support. Such support may be informal and come from their social and family networks or from community-based programs and services, or formal such as clinical treatment from a professional. The effects of the exposure may be mildly troublesome or more severe, short term or longer term—but the effects are not directly related to grief over the loss of the personal relationship with the deceased.

The suicide bereaved short-term category consists of people who have been exposed, are affected, and *in addition* are having grief reactions to the loss (i.e., separation distress and other problematic grief-related emotions, such as guilt, shame, or anger). This might involve a relatively high level of distress for a somewhat longer period of time (perhaps for a few months or a year). This group would very likely include members of the deceased's immediate family. Others who might be included would be a close colleague of the deceased who had worked regularly with him for many years and had noticed that he was having psychological difficulties before his suicide. In addition, members of the deceased's extended family, his longtime primary care physician, and a high school friend who grew up with the man and stayed in close touch with him might also experience grief because of the closeness of the relationships involved. One of the emergency medical personnel who responded to the scene and whose brother took his life only a few months previously might also experience a deepening of her grief in reference to her brother's suicide.

Those in the suicide bereaved short-term category, whose grief follows a course that is typical for a loss to suicide, at some point in time would be able to integrate their experience of this loss into their life. It is at this level of categorization where standards are needed to describe a *typical* course of grief after suicide and to establish the duration that separates short-term bereaved from long-term bereaved. As

noted previously, this issue has been problematic within the fields of suicidology and thanatology. These are ultimately empirical questions for which better and more extensive research can provide guidance (Prigerson et al., 2009). The short-term bereaved may need a great deal of assistance and support, including professional counseling, or they may go to great lengths to “work through” their grief on their own. Most individuals fitting into this category—even over the span of their lifetime—would feel occasional pangs of grief, periodically yearn for the company of the deceased, and at times “lose themselves” in memories or regrets about the deceased. But—however painful their journey might be—they would recover all of their functioning and heal from their grief in the way that the majority of people do after experiencing the death by any cause of someone to whom they are emotionally close.

But those who continue to suffer significant aftereffects from the exposure for an extended period of time and who are unable to experience a reasonable restitution of their normal functioning would likely fit in the suicide bereaved long-term category. Any close relationship might be involved—the deceased’s spouse, partner, child, sibling, parent, longtime best friend, etc. They would experience a high level of distress for a considerable period of time (at least a year and up to a lifetime). They might exhibit diagnostic levels of complicated grief, depression, or posttraumatic stress that would require professional treatment (American Psychiatric Association, 2013; Stroebe, Schut, & Van den Bout, 2013). They might try various kinds of assistance or repeatedly seek help without noting any improvement in the severity of their grief. Most would experience the loss as a seminal or transformational event in their own life narrative and report that they have been substantially changed by the suicide (Andriessen, 2009; Andriessen, Beautrais, Grad, Brockmann, & Simkin, 2007). Their experience of being transformed may revolve around the enduring sense of loss of a significant relationship and/or the feeling of being permanently depleted or damaged—and in contrast, the discovery of positive personal qualities or new purpose in their life. Both the short-term bereaved and the long-term bereaved may experience this paradoxical phenomenon of positive change, which is known as posttraumatic growth (PTG) (Calhoun & Tedeschi, 2006; Currier, Mallot, Martinez, Sandy, & Neimeyer, 2013; Tedeschi & Calhoun, 2008). They may gain resilience and coping skills, more complex and compassionate attitudes toward life, and/or meaningful aspirations or goals that did not exist before the death. While there are many anecdotal narratives of PTG after exposure to a suicide, there is little empirical research that is specific to suicide bereavement related to this important topic. One important exception is a new research by Moore and her colleagues (Moore, Cerel, & Jobes, in press). It is mentioned here to emphasize that exposure to suicide does not produce only damaging effects in loss survivors, for many of the bereaved experience a more complex mixture of psychological injury accompanied by psychological and spiritual growth.

It is also important to note that this schema is designed to describe the difficulties encountered by survivors of suicide loss with a focus on their experience of grief. Survivors may also face myriad other complicated challenges—such as absence of social support, financial struggles, estate disputes, family feuds, and all manner of secondary losses—that may have their own unhealthy short-term and long-term trajectories or that may hamper people’s ability to cope with their grief. In addition, the model is meant to highlight groups according to their risk of negative aftereffects at a point in time and is not intended to account for individual progression or digression in adaptation to suicide loss over time.

Table 2

The broad identification of people in these four categories and an assessment of the contributing risk and protective factors after exposure to a suicide would require sophisticated longitudinal studies, a type of research that has never been done with suicide loss. There is a growing number of studies from suicidology and thanatology that help to identify some of the mediating variables that influence which people exposed to a suicide are more likely to have difficult and complicated grief responses (L. A. Burke & Neimeyer, 2013; Lobb et al., 2010) (see Table 2 for a summary). These and other studies provide some of the foundation for further research (see Strategic Direction Four, pp. 34–36) and bolster the argument that the fields of suicidology and thanatology would benefit from stronger collaboration than what now exists between them.

The Nature of Suicide Bereavement

It is intuitively obvious—and clinically confirmed—that for at least some individuals, the suicide of someone they know has a significant and deleterious effect on their functioning. Nonetheless, while there has been and continues to be debate among academics and researchers about whether and in what ways bereavement after suicide is different from bereavement after other forms of loss (Jordan & McIntosh, 2011b), the personal narratives of countless loss survivors make it clear that, for them at least, suicide has had a transformative effect on their lives (Rappaport, 2009; Stimming & Stimming, 1999; Treadway, 1996). It appears that there are some aspects of bereavement after suicide that share elements with other forms of loss, particularly other traumatic deaths such as homicide (Currier, Holland, & Neimeyer, 2006; Murphy, Johnson, & Lohan, 2003; Murphy, Johnson, Wu, Fan, & Lohan, 2003; Vessier-Batchen, 2007). Nonetheless, it is reasonable to assert that there are aspects of suicide bereavement that are either characteristic of only suicide, or that are likely to be more prominent as a result of suicide than from other causes of death. Importantly, any formulation about the impact of suicide in the end generates empirical questions that, if answered, could lead to targeted responses that would greatly relieve the suffering of people exposed to suicide.

First, suicide bereavement is unique because *suicide itself is a singular manner of death*. This is a vital but overlooked perspective, which opens the door to asking not only, “What makes grief after suicide different?” but also, “How does the particular nature of suicide itself affect the bereavement experience

Effects of Exposure to Suicide: Potential Mediating Factors

- Kinship relationship to the deceased
- Perceived emotional closeness and/or attachment to the deceased
- Direct exposure to the suicide or to the death scene
- Perceived responsibility for causing or preventing the suicide
- Perceived degree of deceased’s willfulness, intent, and/or volition
- Inability to make meaning of the death
- Attachment style
- Preexisting psychiatric or substance abuse disorder
- Previous exposure to suicide and suicidal behavior
- Mourner’s own history of suicidality
- Demographics (age, sex, race, etc.)
- Quality of perceived social support and degree of perceived stigmatization
- Protective factors such as resources, connectivity, and coping skills

of survivors?” Following are several aspects of death by suicide that seem likely to influence the experience of suicide loss survivors.

Suicide creates ambiguity about the volition of the deceased. Depending on the circumstances leading to the death, suicidal volition can be understood as existing along a continuum from a “clear and free choice” (someone with a terminal illness who chooses physician-assisted suicide) to “not a choice at all” (someone with schizophrenia who hears command hallucinations telling them to “kill the demon in you”). Various people commonly take different viewpoints about the role of volition in any particular suicide. Some might believe that the thinking of the deceased has to have been severely impaired, and death could not have been a rational choice (Wroblewski, 1999). It has been said, for instance, that a person dying of suicide dies against his or her will, as does the victim of physical illness or accident. (Rolheiser, 1998). However, to even meet the definition of *suicide*, the deceased must have taken purposeful action to cause their own death (Andriessen, 2006). Ultimately, what is crucial to the experience of grief is the loss survivor’s *perception* of the degree of choice in the death, a matter that is often analyzed in excruciating detail by the bereaved. For suicide loss survivors, their belief about the deceased’s volition often becomes a central feature of their grief—and can have a profound impact on the meaning they attribute to the death (Sands, 2009; Sands, Jordan, & Neimeyer, 2011). On one hand, for example, when the behavior of the deceased is perceived as a choice by the survivor, it may lead to struggles with powerful feelings of rejection, abandonment, or anger. On the other hand, when a survivor believes that the deceased had no choice (for instance, because of severe depression), then she or he may be comforted by the idea that her or his loved one died of an illness.

Suicide is characterized as preventable in the population. Of course, broadly communicating the idea that suicide is preventable is essential to the public health approach to reducing suicide. However, this message can also contribute to the perception that if suicide in general is preventable, then every suicide is preventable, and therefore, “my loved one’s suicide could have—and should have—been prevented.” This perception (whether it is from the loss survivor’s or from another’s perspective) can add greatly to the suffering of the suicide bereaved. As with the issue of choice, the preventability of individual suicides exists along a continuum (from *not at all* to *unquestionably* preventable). A survivor’s view of whether the suicide was preventable or not—at any point during the deceased person’s life—can propel their grief experience in one direction or another. If a suicide is seen as being clearly preventable, then the bereaved may blame others or themselves; feel guilty or ashamed about their “role” in the death; or experience intense anger at others, at themselves, or at God. If, however, a suicide is seen as not at all preventable, survivors may have any number of reactions, ranging from relief (that the deceased’s pain has ended) to despair and helplessness (because nothing could have been done).

Suicide is stigmatized. The stigma historically associated with suicide in most Western societies comes from the belief that suicide is criminal or sinful, a sign of character weakness or the result of evil forces in possession of the individual (Colt, 2006). By extension, the family of someone who dies by suicide has also been viewed as tainted or culpable and, therefore, deserving of being shunned or punished. In contemporary times, there is probably less outright condemnation of suicide, but harsh, institutionalized judgments from the past have left a lingering discomfort in many people about how to respond in a supportive way to the suicide bereaved. Although societal views are changing, suicide stigma continues

to be a powerful and active force in interactions between loss survivors and their communities (Cvinar, 2005). Research suggests, in fact, that stigma negatively affects the tendency of people bereaved by suicide to seek help, the strength of their social connections, and their sense of isolation (Armour, 2006; Feigelman, Gorman, & Jordan, 2009; Feigelman, Jordan, McIntosh, & Feigelman, 2012; Sveen & Walby, 2008). When stigma contributes to a lack of support or sympathy—or to unkindness or even cruelty from other people—it can contribute to secondary wounds that may have a profound impact on loss survivors.

Suicide is traumatic. Death by traumatic means is not uncommon, including homicide, accidental injury, medical emergency, war, terrorism, and natural disaster. Suicide is arguably an inherently traumatizing way to die because its victims must develop and put into motion an immense psychological force in order to accomplish the task of destroying themselves. The magnitude and intensity of this self-destructive energy must overcome the biological drive for self-preservation (Joiner, Van Orden, Witte, & Rudd, 2009). Even if this occurs in small steps, incrementally over time; even if it appears to be a passive act of “giving up on life”; even if a disorder such as depression is “fueling” the person’s demise; even if the lethal action taken involves only “going to sleep”—the process of negating one’s life in this way can be construed as an act of violence against the self. When the death of a loved one involves trauma, there is a chance that whatever violence befell the deceased will traumatize the bereaved.

Survivors of suicide loss potentially are affected by three sources of trauma:

- *Psychological trauma:* The bereaved might reconstruct and brood over the psychological pain the deceased experienced and over the psychological force that was required for the deceased to kill himself or herself.
- *Direct exposure:* They might have witnessed the suicide, discovered the body, or been exposed to the death scene or to “artifacts” from the aftermath: personal belongings, an autopsy report, etc.
- *Imagined exposure:* Even when the survivor is not a direct eyewitness to the death, many survivors create—and some are “captured” by—a mental image of what the dying process was like and what the deceased suffered as they died.

All that has been described above as unique aspects of dying by suicide may come into play in other modes of death or trauma. It seems clear, however, that there are qualities related to the *volition*, *preventability*, *stigma*, and *trauma of suicide* that generate in the bereaved particular kinds of emotional reactions or certain patterns of reflection or mental struggle. Therefore, these forces at work in a death by suicide are likely going to color the bereavement experience that follows in its wake.

In addition to these more or less distinctive aspects of suicide, many other grief responses that are often more intense after suicide have been identified (Jordan, 2008, 2009; Jordan & McIntosh, 2011a). Noting that these themes can be present in grief after other kinds of death, Jordan and McIntosh (2011a) point out that suicide bereavement is *most different* from grief after a natural death; *somewhat different* from grief after a sudden, unexpected death; and *most similar* to grief after a traumatic or violent death, such as homicide (Jordan & McIntosh, 2011b, p. 36). In delineating the common themes after a suicide, Jordan and McIntosh (2011b) also strongly emphasize that “many (but not all) people bereaved by suicide will manifest many (but not all) of these themes, reactions, and features” (p. 30). Below is a discussion of each of the themes,

Suicide is shocking. Suicide is often (although not always) sudden and unexpected. Loss survivors often experience it as unfamiliar and unnatural—as being fundamentally wrong in one way (bad or punishing) or another (out of the natural order, unacceptable). As mentioned, the violence associated with suicide can be overwhelming, and its personal impact on survivors can be similar to that of any abrupt event, such as a natural disaster or an accidental death. Suicide is often the concluding event of an ongoing crisis for the deceased and, simultaneously, the initiation of an altogether new crisis for the bereaved.

Disbelief: A common reaction to any sudden death is “I can’t believe it,” for it is difficult to grasp and absorb such a profound and unplanned-for occurrence. With suicide, there is often strong disbelief. It seems impossible to some loss survivors that a person they knew intimately could have been thinking of ending their life without the survivor being aware of it. It violates the assumptive world or belief system that the bereaved had about their loved one, themselves, and the world as they knew it. In addition, there can be denial that the death was by means of suicide, which is often relatively short-lived but for some, may endure for a lifetime.

Asking “Why?” Death by any means often compels the bereaved to consider the deepest existential questions about life, death, and why certain things transpire. *With suicide, the search for the answer(s) as to why their loved one died is central to the experience of many loss survivors.* The complexity, troubling nature, and frequent absence of the answer(s) can be a heavy burden for the suicide bereaved. It is not unusual for loss survivors to feel compelled to conduct their own personal “inquest” or “psychological autopsy” into the death, focusing on learning as much as possible about what led to the death; the mental state of the deceased; and when, where, and how their loved one died. The bereaved might also be preoccupied with discovering who knew what, who saw what, who did what, etc. Finding answers, and/or accepting the elusiveness of those answers, is commonly a difficult but necessary part of the journey for the bereaved by suicide.

Shame. References to stigma elsewhere in this document help to explain the feelings of shame that befall many loss survivors. They may struggle with the moral standing of their deceased loved one, or of themselves (good vs. bad). This can include constructions about the deceased’s eligibility for redemption (heaven vs. hell, forgivable vs. unforgivable), character (strong vs. weak, selfish vs. generous, cowardly vs. courageous), normality (“crazy” vs. sane), and value (significant life vs. wasted life). Shame also can be exacerbated by other themes, especially feelings of self-blame, guilt, and perceived abandonment by the deceased. Police officers, fire fighters, military personnel, and others who place a high distinction on the way a person dies in service can be affected by real and/or perceived stigma related to suicide. A death by suicide may be seen as negating all other characteristics of the deceased, even noble or honorable ones.

Blame. It is common for the bereaved to assign responsibility for their loved one’s death to a particular person, event, or circumstance. They might ask, “Is my loved one responsible?” “Am I responsible?” “Is God responsible?” Assigning responsibility can also be driven by the loss survivor’s need to make sense of the incomprehensible. Blaming can be understood as a means of restoring a sense of order in the world—and of protecting the self from feelings of self-blame.

Guilt. People bereaved by any kind of death might feel guilty about what they believe they should, would, or could have done or not done to prevent the death. The answer many survivors of suicide loss arrive at when they ask “Am I responsible?” is “Yes.” People naturally believe in the power of their love

and caring to protect their loved ones. In the case of suicide, it is not unusual for people to believe that this power “should” have been able to save their loved one’s life. And in hindsight, they may be able to see actions that could have been taken (or avoided) that might have made a difference. This can contribute to a powerful kind of “magical” or counter-factual thinking about the preventability of the death that can haunt loss survivors for a very long time. There are also instances where a survivor points to a single—and even factual—event that preceded the suicide (“We had a fight”; “I left him alone”) and insists on a simple causal connection between that event and the suicide, even though suicide is multi-causal—involving numerous interrelated contributing factors—and in its essence is a very complex and enigmatic human behavior.

Abandonment and rejection. It is common for bereaved people to feel “left all alone” when someone dies of any cause. Suicide is sometimes seen as the most powerful form of abandonment or rejection possible, because from the point of view of the bereaved, the deceased “chose” death over continuing to live in relationship with the survivor (see the section on volition, above). The suicide bereaved may also feel that the deceased avoided the opportunity to reach out to them or rejected help that was offered. These feelings of abandonment can, in turn, lead to strong feelings of anger at the self (i.e., guilt) or anger at the deceased.

Anger. Anger is often caused by feelings of guilt, blame, abandonment, and preventability. The Latin root of the word *suicide* means “self-murder,” and in some ways, the reactions of suicide loss survivors can resemble the reactions of homicide survivors, who are often enraged with the perpetrator of the murder. The profound conundrum with suicide is that the “perpetrator” and the “victim” are one and the same person. This can make for a very conflicting and confusing set of emotions for the bereaved, which are not easily resolved. Another link between anger and suicide is that the survivor might feel angry about “secondary losses,” such as being left to raise children without a spouse, facing financial difficulties, or living unaccompanied through retirement.

Fear. Besides the fears that accompany all kinds of deaths—such as fear of being alone or of financial insecurity—the bereaved by suicide often fear that they or another family member or friend will also die by suicide. The conviction that suicide could happen to anyone, or that suicide “can come out of the blue,” can leave loss survivors wary and hypervigilant over the safety of other loved ones. Fear and hypervigilance can be particularly troublesome for clinicians who have lost a client to suicide.

Increased risk of suicide. In their seminal book on suicide bereavement and caring for loss survivors, Jordan and McIntosh (2011c, p.11) conclude:

Compelling evidence now shows that exposure to suicide carries with it the risk for a number of adverse sequelae. Perhaps the most disturbing of these risks is the elevated likelihood for suicide in a person exposed to the suicide of another individual.

This creates a challenge in supporting loss survivors, for it is surprisingly common for the suicide bereaved to express the wish to die in order to escape the pain of their loss or to join their loved one in an afterlife. It is vital, therefore, to determine whether anyone speaking of dying or of killing themselves is at risk for suicide, including ensuring the person’s safety and making a prompt and effective referral of the person to a competent mental health professional for a thorough clinical assessment if necessary.

Relief. Suicide sometimes marks the end of a long and grueling period in which a family is constantly in turmoil over a person's mental illness and/or substance abuse. They may have been on a prolonged "suicide watch" with the deceased. Or, as a result of the psychiatric disorder of the deceased, he or she may have been difficult, exhausting, or abusive to live with. Or it may simply have been very painful to watch the loved one struggle with his or her emotional and life problems. In such instances, it is natural to feel relief that the ordeal is over. However, this feeling can be troublesome, contradictory, and confusing to the survivor, because it is judged to be unacceptable to experience relief that someone has died. The bereaved also may feel reluctant or ashamed to share their feelings of relief with others, and they may feel misunderstood if they do disclose these emotions.

Finally, there are a several modes of suicide that likely affect those exposed to a fatality but about which there is little research on the effects. Among these are murder-suicide (a suicide follows a homicide), double suicide or suicide pacts (suicides that are directly related to each other), and ambiguous death (the manner of death cannot be definitively established).

Research on the Impact of Suicide

There is a significant and growing body of empirical evidence confirming the deleterious effects of being exposed to suicide. Data clearly show that exposure to suicidal behavior (ideation and attempts) or a fatality raises the risk of subsequent suicide in people who have been exposed. The 2012 NSSP declares that "helping those who have been bereaved by suicide is a direct form of suicide prevention with a population known to be at risk" (U.S. Department of Health & Human Services et al., 2012). For example, using a series of large population registers, researchers found that losing any first-degree relative to suicide increased the mourner's chance of suicide by about threefold (Agerbo, 2005). This study established that women who lose their husbands to any cause compared to suicide have, respectively, a 3-fold and 16-fold increase in their chances of dying by suicide. Men who have a spouse die of any cause have a 10-fold increase in their risk for suicide, while men who have a spouse die of suicide have a 46-fold increase in their chances of dying of suicide. A longitudinal study in Sweden (Hedström, Liu, & Nordvik, 2008) revealed that men exposed to a suicide in the workplace were 3.5 times more likely to die by suicide than men who were not exposed. The study also found that men exposed to the suicide of a family member were 8.3 times more likely to die by suicide than non-exposed men.

Mann and colleagues found that subjects with a mood disorder who attempted suicide were twice as likely to have a relative who had attempted or completed suicide than subjects with a mood disorder who did not. These authors also cite literature showing that the risk of a suicide attempt was up to six 6 times greater for subjects with a relative who had made a suicide attempt or completion (Mann et al., 2005). Roy and Janal (2005) found that, in addition to female gender and a childhood history of trauma, a family history of suicidal behavior was an independent risk factor for both an early onset of first-attempt suicide and for making additional attempts. Rostila et al. (2013) found higher rates of suicide in people who had lost a sibling to suicide. De Leo and Heller (2008) found that exposure to prior suicidal behavior and completions in both family and social acquaintance samples was associated with elevated rates of self-harm in study participants, particularly for adolescents. A number of studies have found elevated rates of suicide attempts and completions in children and adolescents who were bereaved by parental suicide (A. K. Burke et al., 2010; Kuramoto et al., 2013; Melhem et al., 2007). In fact, Spiwak et

al. (2011) found that risk for suicide attempt was elevated in offspring when their caregivers had either attempted or completed suicide—even after controlling for demographics, Axis I and II disorders, and childhood adversity. Finally, several studies have found that mental health effects can still be detected in loss survivors between 5 and 10 years after a suicide, demonstrating the long-term consequences of exposure to such a loss for some individuals (Feigelman et al., 2012; Kuramoto et al., 2013; Saarinen, Hintikka, Lehtonen, Lönnqvist, & Viinamäki, 2002; Saarinen, Hintikka, Viinamäki, Lehtonen, & Lönnqvist, 2000).

People in their teens and early 20s appear to be particularly vulnerable to adverse effects of exposure to the suicide of a peer, potentially leading to a phenomenon sometimes referred to as *suicide clusters* or *contagion* in a small percentage of people in this age group (Brent, Perper, Moritz, Allman, Friend, et al., 1992; Brent, Perper, Moritz, Allman, Liotus, et al., 1993; Brent, Perper, Moritz, Friend, et al., 1993; Brent, Perper, Moritz, Allman, Schweers, et al., 1993; Bridge et al., 2003; Gould, Wallenstein, & Davidson, 1989; Velting & Gould, 1997). Studies of suicide clusters indicate that between one and five percent of adolescent suicides may be related to other similar deaths (Insel & Gould, 2008). Another study showed that the relative risk of suicide was 2 to 4 times greater among 15–19 year olds if they knew a peer who had died by suicide (Gould, Wallerstein, Kleinman, O'Carroll, & Mercy, 1990). A recently published study of Canadian adolescents found that the suicide deaths of schoolmates predicted suicidal ideation and attempts two years and longer after the death of the peer, with the strongest effect being among younger adolescents (12–13 year olds)(Swanson & Colman, 2013). Similarly, using data from a large longitudinal study of adolescents in the United States, Feigelman and Gorman concluded that among teens, having a friend who died by suicide increased both suicidal ideation and attempts for at least a year following the loss (Feigelman & Gorman, 2008). In related research, De Leo and colleagues have found that exposure to nonfatal suicidal behavior in peers was a particularly strong predictor of similar behavior in peers exposed to that behavior (De Leo, Cerin, Spathonis, & Burgis, 2005; De Leo & Heller, 2008)

The elevated risk for suicidality is not the only adverse effect of exposure to suicide. Many studies have also found elevated rates of psychiatric disorder (particularly depression), social difficulties, and continuing grief reactions in the suicide bereaved when compared with other types of loss survivors or population-level norms. Among these studies are the following, which have found that survivors of suicide loss experience:

- Greater rates of bipolar disorder in persons exposed to the suicide of a parent (Tsuchiya, Agerbo, & Mortensen, 2005)
- Greater depression across all kinship losses (Kessing, Agerbo, & Mortensen, 2003)
- Greater depression in adolescent and young adult friends losing a peer (Brent, Moritz, Bridge, Perper, & Canobbio, 1996b))
- Greater depression in bereaved mothers (Brent, Moritz, Bridge, Perper, & Canobbio, 1996a)
- Greater depression and substance abuse in youth losing a parent (Brent, Melhem, Donohoe, & Walker, 2009)
- Greater psychiatric morbidity in elderly parents losing a child (Clarke & Wrigley, 2004)
- Greater rates of complicated grief disorder (Bailey, Kral, & Dunham, 1999; Holland & Neimeyer, 2011; Melhem et al., 2004b)

- Greater mental health symptoms and social isolation in surviving spouses 10 years after a loss (Saarinen et al., 2002)
- Poorer self-ratings of mental health and greater depression and suicidal ideation in bereaved mothers and fathers five or more years after the death of a child when compared to a non-bereaved national sample. The lowered ratings of mental health and depression persisted for more than 10 years for the bereaved mothers (Feigelman et al., 2012).
- Greater social strain and stigmatization within the social networks of loss survivors (Cvinar, 2005; Feigelman et al., 2009; Feigelman et al., 2012).

A recent literature review concludes that the effects of suicide bereavement on mental health and suicide risk include “an increased risk of suicide in partners bereaved by suicide, increased risk of required admission to psychiatric care for parents bereaved by the suicide of an offspring, increased risk of suicide in mothers bereaved by an adult child’s suicide, and increased risk of depression in offspring bereaved by the suicide of a parent” (Pittman et al., 2014, p. 86). The authors go on to say, “Policy recommendations for support services... [related to] suicide bereavement heavily rely on the voluntary sector with little input from psychiatric services to address described risks. *Policymakers should consider how to strengthen health and social care resources for people who have been bereaved by suicide to prevent avoidable mortality and distress*” (p. 86) [emphasis added]. These conclusions could not be more timely, for they directly support the vital purpose of these guidelines, which is to “pave the way for decisive, effective advances in comprehensive care after a suicide occurs.” *The evidence is clear and overwhelming—and, sadly, not definitively recognized in the suicide prevention field—that exposure to the suicide of another person, particularly of a close intimate, elevates the risk of suicidal behavior and completion in the person exposed. Additionally, exposure markedly increases the risk of numerous other deleterious mental health, relational, and social consequences.*

Research on the negative impact of suicide focuses primarily on its deleterious effects on individuals, and more study is needed to assess the societal costs of suicide. For instance, it has been shown that the StandBy Response Service (a comprehensive, community-oriented suicide postvention program in Australia) contributed measurable economic value to communities that responded effectively to suicide (Comans, Visser, & Scuffham, 2013). Certainly, economic costs are not the only aspect of suicide’s collective toll, and findings such as this ought to spur inquiry to discover the cumulative weight of the disease burden that suicide places on society.

The research delineated above represents the solid and growing body of evidence that, for a significant number of people exposed to the suicide completion or attempt of another person, there are long-term and harmful mental health consequences. A major challenge going forward is to empirically and clearly identify all distinguishable groups of loss survivors who are at elevated risk, and to develop effective supportive and clinical interventions that target those most likely to suffer complications over the long term. Shneidman’s declaration (1972) that postvention is prevention of the next generation of potential suicides has withstood the test of time, and now it should guide and inspire the current generation of suicidologists, as well as all stakeholders interested in suicide prevention. *The Survivors of Suicide Loss Task Force unequivocally believes that a comprehensive and systematic postvention response on behalf of the people exposed to a suicide fatality must be a core element of all suicide prevention planning and implementation efforts by communities, states, tribes, and the nation as a whole.*

Meeting the Needs of the Suicide Bereaved

This section delineates the needs that the bereaved commonly have after a suicide and the types of responses that may be helpful to them as they recover. Principles for helping individuals or families are covered first, followed by principles for supporting organizations where suicide has made an impact. A challenge that must be met in all responses after a suicide is the delivery of culturally competent services and support.

The formal research literature on interventions for the suicide bereaved is relatively sparse, with perhaps the most commonly studied intervention being face-to-face bereavement support groups. Three recent literature reviews on this subject have reached similar conclusions, suggesting that while the studies that have been published show some promise of effectiveness, most of the research has been plagued by small sample sizes, lack of comparison groups, and other methodological weaknesses that make evidence-based conclusions difficult to reach (Jordan & McMenemy, 2004; McDaid, Trowman, Golder, Hawton, & Sowden, 2008; McIntosh & Jordan, 2011a). Likewise, there have been only a small number of survey studies that have asked the bereaved directly about their perceived needs for help after the death (Dyregrov, 2002, 2003; Dyregrov & Dyregrov, 2008; Dyregrov, Plyhn, & Dieserud, 2012; Grad, Clark, Dyregrov, & Andriessen, 2004; McMenemy, Jordan, & Mitchell, 2008; Provini, Everett, & Pfeffer, 2000). In general, participants have indicated that they want good social support from family and friends, as well as contact with other loss survivors; guidance regarding how to best help children cope with a suicide loss; and assistance from professionals with their grief and trauma reactions. These studies also indicate that even when support services exist in communities, they are often difficult for people to locate and access. This includes the difficulties that the bereaved face in mobilizing the psychological energy needed to search for support in their communities (Jordan, Feigelman, McMenemy, & Mitchell, 2011).

By combining the findings of these studies with reports from clinical experience and the narratives of loss survivors, it is possible to articulate some of the essential needs of survivors that should guide postvention efforts. It is important, however, to recognize that the suicide bereaved are not a uniform population. Different people will need different resources at different times during their healing process. And, of course, the needs of bereaved people vary according to cultural and religious contexts. So while not all loss survivors will need or want all of these types of assistance, many will find that one or more of the following can be of significant help.

Coordinated, comprehensive community response. Typically, the caregivers with whom the bereaved interact have almost no contact with one another—from the police and medical personnel who respond immediately at the death scene to the clinicians who may work with them much later after the death. Thus, the burden of figuring out which services might be needed, where to find them, and how to access them falls on loss survivors themselves, including the newly bereaved. The stress experienced by those who have suffered a recent loss is often unnecessarily aggravated by this “hit-or-miss” response from the community. New models of highly coordinated response from caregivers that involve proactive outreach to loss survivors are being pioneered in this country and around the world (Bycroft, Fisher, & Beaton, 2011; Campbell, 2011; Campbell, Cataldie, McIntosh, & Millet, 2004; Dyregrov & Dyregrov, 2008; Dyregrov et al., 2012; United Synergies, 2011). In New Hampshire, for example, the Connect program trains caregivers across community systems to respond to suicide in a coordinated fashion,

based on best practices for prevention (Bean & Baber, 2011). Such models need to be researched, adapted to local communities—accounting for issues related to race, ethnicity, religion, gender, sexual orientation, age, disability, socioeconomic status, etc.—and disseminated throughout the United States.

Useful information. This includes information about the suicide (talking with the coroner, reading the suicide note); about factors that contribute to suicide in general (mental illness, substance abuse); about grief and trauma responses after suicide (PTSD, when and how to seek professional help); about coping skills (talking about the suicide with others, helping children deal with the death); and about how and where to access support resources (finding a local support group or an experienced therapist). Appendix C (pp. 42–50) provides numerous and readily accessible examples of information useful to survivors.

Compassionate assistance from first responders. Professionals who are likely to have early contact with the bereaved (police officers, coroners or medical examiners, emergency department personnel, faith leaders, funeral directors, etc.) can have a significant impact, for better or for worse, on the newly bereaved. They can be supportive and compassionate, providing comfort, needed information, and linkage to other resources. Or they can be detached, impersonal, or even hostile to loss survivors, focusing only on the technical requirements of their job rather than on helping the human beings they serve and ameliorating the shock and tragedy of suicide. The bereaved deserve a consistent response and first responders who are well trained, knowledgeable, and compassionate in their approach to new survivors. In addition, first responders themselves—and others exposed to suicide—may need assistance with their own grief and trauma reactions that result from their work experience.

Practical assistance. Whenever a suicide occurs, the bereaved face the tasks of handling the death itself, as well as tasks required to resume and sustain everyday life. Practical matters related to the death can include cleaning and restoration of the death scene, handling the deceased's personal effects, notification of family and friends, making funeral arrangements, helping with travel and logistics of immediate and extended family, making decisions about religious observances, dealing with details related to official investigations (law enforcement or other), settling insurance claims, taking care of financial costs of the death, etc. Helping survivors of suicide loss deal with these pragmatic issues can be extraordinarily valuable to the newly bereaved.

Support from social networks and communities. Observations of many people bereaved by suicide suggest that significant members of their social networks are often stunned into silence and inaction by the suicide, greatly reinforcing the survivors' sense of isolation. The long legacy of stigma and shame connected with psychiatric disorder and suicide is slowly changing, but far too many of the bereaved still encounter social awkwardness and, even worse, ignorance, prejudice, and outright condemnation from family and friends (Cvinar, 2005; Feigelman et al., 2009). Related research on homicide survivors suggests that larger networks containing more people who try to help are perceived as more supportive, and also are associated with less complicated grief outcomes for survivors. In contrast, the number of negative relationships identified by traumatic loss survivors is a significant predictor of both complicated grief and symptoms of posttraumatic stress (L. A. Burke, Neimeyer, & McDevitt-Murphy, 2010). Interventions should take into account the quality of the social support that the bereaved receive and help to improve the availability and resourcefulness of social networks on their behalf, including familiar settings such as school, workplace, and place of worship. As with first responders (see above) and service providers of clinical interventions (see below), proper training and preparations are sorely

needed for all kinds of professionals and caregivers who regularly come in contact with the suicide bereaved—beyond the first hours, days, and weeks of the death—including faith leaders, peer and volunteer grief support helpers, hospice staff, school personnel, social services workers, lawyers, military support personnel, and many others.

Help from skilled mental health professionals and other service providers. Research suggests that a significant percentage of the suicide bereaved will, at some point during their mourning process, seek the help of a mental health professional. Most of these people find counseling to be helpful in their journey (Feigelman et al., 2012; Jordan et al., 2011; McMenemy et al., 2008). Highly trained professionals can, of course, provide services such as psychopharmacology, psychotherapy, and family therapy. Research suggests that professional bereavement interventions may be most effective for at-risk mourners and that efficacy is greatest when clients are first screened for demonstrated need (Currier, Neimeyer, & Berman, 2008). Such a finding is compatible with the evidence that specialized therapy for complicated grief can be particularly helpful to those who are bereaved by violent causes (Shear, Boelen, & Neimeyer, 2011). Surprisingly, however, hardly any research has investigated treatments specifically tailored to suicide loss survivors (Jordan & McMenemy, 2004; McDaid et al., 2008; McIntosh & Jordan, 2011). Unfortunately, very little of the training of mental health professionals, faith leaders, or other service providers prepares them for dealing with the complex and sometimes long-term recovery needs of the suicide bereaved (Jordan, 2008, 2009, 2011). Many survivors of suicide loss need help finding skilled, knowledgeable, and compassionate caregivers who can provide effective assistance, support, and/or therapy for their grief (Jordan, McIntosh, et al., 2011).

Peer support. The literature suggests that contact with others who have experienced a suicide loss can be extremely helpful for many people (Dyregrov & Dyregrov, 2008; Feigelman et al., 2012; McMenemy et al., 2008). The most common form of peer support is mutual-help support groups, which have burgeoned in popularity throughout the developed world (Barlow et al., 2010; Cerel, Padgett, & Reed, 2009). Peer-led support groups are designed to empower the bereaved by encouraging them to help one another. Self-selected study participants who attend support groups report receiving a high level of acceptance and credible advice from those who have “been there,” arguably because they find a place to tell their story and seek meaning in it (Dyregrov et al., 2012; Feigelman et al., 2012). Peer support can take many forms in addition to face-to-face support groups, such as visits from outreach teams, loss survivor healing conferences, and telephone and online connections among people bereaved by suicide (Beal, 2011; Campbell, 2002, 2006, 2011; Campbell et al., 2004; Cerel & Campbell, 2008; Feigelman, Gorman, Beal, & Jordan, 2008; Jordan, McIntosh, et al., 2011). Delivering effective peer support also presents numerous challenges, such as proper training of facilitators, meeting the diverging needs of both newly bereaved and longtime loss survivors, and serving people who would like to interact specifically with others their own age or with a kinship loss (those who have experienced a loss similar to theirs).

Additional support for children and adolescents. Children and adolescents are generally more vulnerable to life’s traumas than adults. The needs of bereaved children and adolescents include grief support that is appropriate to the child’s age and developmental level, reassurance that someone will take care of their basic physical and emotional needs, support for exploring feelings of responsibility and affirmation that they did not cause the death, opportunities to tell the story of their loss in their own

words, help expressing negative thoughts and feelings, ongoing support as their cognitive and linguistic development unfolds and their life experience evolves, recognition that the experience and process of grief will be unique for each child, and effective professional assistance for grief complications (Webb, 2002, 2011). Some children witness the death, find the deceased's body, or have witnessed domestic violence prior to the death, and they may require specialized care for traumatic grief (Cohen & Mannarino, 2004, 2006; Cohen, Mannarino, & Deblinger, 2006). Expressive arts interventions may be especially relevant for bereaved children (Sands, 2014; Thompson & Neimeyer, 2014). (See Appendix C, which includes resources for helping bereaved children, pp. 45-46).

Family support. In addition to shame, blame, and guilt associated with suicide, family dysfunction and poor communications can contribute to the strain in relationships among immediate family members. Relationships between the nuclear and extended families also can be damaged or even ended after a suicide. In addition, different individuals in a family system commonly employ different methods of coping with loss and grief, and the resulting misunderstandings can create tension and strain for families. A family-oriented approach to suicide bereavement shows great promise in helping to mitigate these sometimes damaging and long-lasting effects of suicide (Kaslow & Gilman Aronson, 2004; Kaslow, Samples, Rhodes, & Gantt, 2011; Kissane & Bloch, 2002; Nadeau, 1998; Sandler et al., 2003).

Help for electronically connected communities. Postvention responses are necessary not only for communities such as the students in a school or the members of a religious congregation where a suicide occurs, but also for electronically and digitally connected communities. A real-life example that dramatically makes this point is the suicide of a transgender teen that received widespread media and social media coverage and had a stark impact on the transgender community nationwide. The number of contacts to crisis services at The Trevor Project increased threefold in the weeks that followed, and the average risk level of contacts significantly increased (D. Bond, personal communication, January 29, 2015). The Internet and the age of instant and ubiquitous interconnectivity provide conduits for communications among countless individuals in dispersed communities, making exposure to loss by suicide exponentially larger and more enduring. Research in this area is growing, and while benefits of practices such as online memorialization of the dead have been demonstrated, grieving in a digital world “presents a number of problems and issues which need addressing, particularly in the area of postvention” (Bailey, Bell, & Kennedy, 2014, p. 13).

Help with the common experience of grieving a death. It is important to remember that survivors of suicide loss are also people who are bereaved by the death of a loved one, irrespective of the fact that their loved one died by suicide. Supporting suicide loss survivors in the ways that all bereaved people need to be supported is an excellent guideline for building a foundation upon which their long-term healing can be built. (Appendix C includes resources on bereavement in general as well as books about grief support).

Organizational Support after a Suicide

The suicide of an individual may, in some cases, result in an organization or even a community becoming a “survivor”—with effects that are apparent in the system and its members for a considerable period of time. In addition to the effect of suicide on settings such as schools, workplaces, and first responder groups, the consequences for the functioning of whole families or other social networks also mandate a systemic focus that goes beyond individual bereavement (Jordan, 2001). This is especially important for organizations that are composed of groups of people who have established relationships and interact with one another on a regular basis. A suicide raises a number of concerns for an organization that are best dealt with directly by its leadership (American Foundation for Suicide Prevention & Suicide Prevention Resource Center, 2011; Berkowitz, McCauley, Schuurman, & Jordan, 2011). Following are some of the principles that organizations should consider when responding to a suicide within their setting.

Plan ahead. Establish a coordinating plan, response structure, and training before a suicide occurs. Far too often, organizations such as schools, hospitals, faith communities, and workplaces react to suicide only after a fatality has occurred. This produces a crisis for the leadership within the organization and adds to the chaos and distress caused by the death. The time to develop a coordinated response to an event such as suicide is before it happens, so that key leaders in the group will be trained and feel prepared to respond in a way that is helpful and reassuring to everyone affected by the death. The plans should include procedures for managing information about the death, coordinating internal and external resources, providing support for people affected by the death, commemorating the deceased, and following up with people who may be at elevated risk for bereavement or trauma complications (Berkowitz et al., 2011).

Communicate effectively. Coordinate sharing of information about the suicide. The suicide of a group member can immediately produce intense curiosity and anxiety about the nature of the death: Who died? When and how did the person die? Was the death a suicide? What were the motivations for the death? Who is to “blame”? Rumors are likely to circulate quickly through various communication channels, including face-to-face conversations, telephone, and social media. It is crucial that the leadership of the organization provide factual and accurate information about the circumstances of the death through designated persons and channels. At the same time—because suicide often transforms a very private matter into a public event—it is important to be sensitive to the needs of the deceased’s family members and others who are bereaved.

Aid mourning rituals, account for risk of contagion. Provide opportunities for healthy grieving, while working to minimize the risk of suicide contagion or other negative reactions to the death. In a well-meaning attempt to contain any negative consequences of the suicide (including additional suicidal behavior), authorities sometimes try to suppress information about the death and/or interfere with plans to memorialize the deceased. In fact, there is no empirical support that this form of “shut-down” response achieves its goals, and anecdotal evidence, at least, suggests that it may produce a number of other negative effects within the organization (Berkowitz et al., 2011). Human beings need to understand what has happened after a traumatic event occurs, and nowhere is this more important than after a suicide. Likewise, they need and have a right to grieve collectively over the loss of the community member, regardless of the cause of death. Organizational leadership should help channel

this process in healthy ways, rather than trying to block it. It is important to note, however, that there are serious and legitimate concerns about the contagion effects of suicide, especially regarding media coverage of a fatality and about public messages related to suicidal behavior (Gould, Jamieson, & Romer, 2003; Insel & Gould, 2008; Velting & Gould, 1997). (see Appendix C, pp. 47-48, for resources on memorials, media, and messaging).

Consider whether a teachable moment exists. Suicide is often a mysterious and frightening death for a community, and sadly, the suicide of a community member sometimes affords an opportunity to help educate people about what contributes to suicide; what people can do if they or others about whom they are concerned are suicidal; how to help the bereaved after suicide; and what community members can do to support anyone who has been affected by the death. In the immediate aftermath of a suicide, there are situations when sensitivity should be exercised in the distribution of suicide prevention information so as not to inadvertently communicate to the bereaved or others affected by the suicide that they should have prevented it and are at fault for not doing so (e.g., literature suggesting that all suicides are preventable). *A balance must be struck between the needs of the bereaved and the urgency of prevention efforts.* The importance of strategically designing appropriate messages for specific audiences is paramount.

Proactively help those at highest risk. Identify and reach out to people who are likely to be significantly affected. Leadership should provide support for all members of the community, but it is especially important to identify and offer assistance to people at high risk of complications or difficulties. Be prepared with self-care and referral information for people who are having problems with stress, relationships, health or mental health, substance abuse, loss (particularly other suicides), etc., and proactively approach them to express concern about their welfare and to encourage them to seek help if necessary.

Respond to the suicide over the long term. Many organizational responses to suicide are short term and crisis oriented. While helpful, focusing only on the immediate aftermath of a suicide can be insufficient for some community members who will have much longer-term reactions to the death. Postvention planning should include outreach to high-risk people over time, particularly around subsequent anniversaries of the death (Holland & Neimeyer, 2010), assessment of changing needs for assistance, and ensuring that adequate and appropriate resources are available (including access to services outside the organization). In addition, after organizations respond to a suicide, they should review and reflect on how they responded to the event, what can be learned from the experience, and what can be improved should such a crisis occur again.

Three High-Priority Challenges

These guidelines provide a lens through which leaders and stakeholders can view in a new light a community-based response to people's needs after a suicide. Suicide is not only the tragic culmination of a personal crisis for the deceased individual. It is also frequently the beginning of a momentous—and sometimes tragic—cascade of events that will unfold over a long expanse of time among diverse individuals and groups. The framework presented here is designed to guide the development of programs, services, resources, and systems to ensure that help is available for everyone affected by a suicide, and especially for those who are most profoundly and tragically touched by the loss of someone

close to them. A great deal of work lies ahead, and addressing the goals and objectives in these guidelines is only the beginning of a much larger process. Three of the most significant challenges that must be faced are discussed below.

Incorporating grief support fully into all postvention planning. Postvention has three goals: (1) to prevent further suicides, (2) to support the bereaved, and (3) to counteract the other negative effects of exposure to suicide. Currently available postvention programs—as is evidenced by the sum of the programs’ activities, resources, and support being focused mostly on suicide prevention—are strongest in their emphasis on the first goal. Preventing suicide, of course, is crucial, but there is also a vital—and often neglected—need to include in all postvention programs a focus on helping the bereaved and others who might be affected by the suicide. This should not be a zero-sum game (in which if more is given to one “side,” proportionately less is available to be given to the other “side”). Rather, it is a both-and issue (both are needed and possible, and they can powerfully complement one another—especially since the suicide bereaved themselves are a high-risk group).

Adapt crisis response principles and practices for initial postvention outreach. There are innovative approaches to responding to a suicide that are based on crisis response principles and practices, such as the Active Postvention Model (Campbell, 2011; Campbell et al., 2004) and Trauma Intervention Programs, a national organization that trains volunteer teams as first responders for all manners of sudden death, many of which are suicides (Chez & Fortin, 2010)). These promising response models, however, are operational in relatively few places. In most communities, the initial responses to suicide are guided by the disparate and uncoordinated policies and procedures adopted by various categories of first responders to suicide (law enforcement, emergency medical services, community mental health, etc.). This jumble of responses points to the challenge of creating a comprehensive and synchronized crisis response model that utilizes best practices in responding to suicide (American Foundation for Suicide Prevention & Suicide Prevention Resource Center, 2011; Bean & Baber, 2011; Bycroft et al., 2011; United Synergies, 2011). Importantly, empirically supported principles exist that, according to Hobfoll and colleagues, should guide and inform intervention and prevention efforts at the early to mid-term stages of crisis response. These principles—promoting a sense of safety, calm, self- and community efficacy, connectedness, and hope (Hobfoll et al., 2007)—are incorporated into models such as Psychological First Aid (Brymer et al., 2006) and Skills for Psychological Recovery (Berkowitz et al., 2010) and could provide a starting place for improving suicide postvention responses.

Strengthen suicide postvention with proven grief support principles and practices. Suicide grief support is an emerging field of practice poised to gain strength from newer understandings of bereavement adaptation in thanatology, for example, Dual Process Model, Two-Track, and meaning reconstruction models (Currier, Holland, Coleman, & Neimeyer, 2008; Currier & Neimeyer, 2006; Hansson & Stroebe, 2007; Neimeyer, 2002, 2006, 2015; Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010; Neimeyer, Harris, Winokuer, & Thornton, 2011; Neimeyer & Sands, 2011; Rubin, Malkinson, & Witzuin, 2011)) and from the growing evidence base that supports them (Neimeyer & Harris, 2011; Stroebe, Hansson, Schut, & Stroebe, 2008; Stroebe et al., 2013). The challenge of identifying, developing, and implementing professional interventions for people bereaved by suicide must go beyond talk therapy, support groups, and other generic approaches, valuable though those may be. To that end, it is essential to advance purposeful communication and collaboration among all disciplines

working to support the bereaved—especially those focused on addressing the effects of every manner of sudden or traumatic death.

Conclusion

Merely publishing and disseminating these guidelines cannot compel the strategic action necessary to systematically meet the challenges and realize the vision of delivering effective care to everyone touched by suicide.

Unfortunately, accomplishing such a goal is not currently an operational priority of the national suicide prevention movement. Almost no funding or fundraising is targeted towards the efforts that are required, and no representative community—not even the community of suicide loss survivors themselves—has decisively taken the lead in advancing this cause. Hopefully, however, the clear and comprehensive documentation of the knowledge base that has just been presented will support the development of action strategies called for by the goals and objectives that follow next. The overarching goal of these guidelines is to provide, for the first time, a foundation to help move the nation toward decisively addressing the needs of the bereaved and others exposed to suicide. The members of the Survivors of Suicide Loss Task Force see these guidelines as a summons to everyone with a stake in suicide prevention—individuals, organizations, communities, states and tribes, and the U.S. society as a whole—to ensure that every person suffering profound grief or struggling with distress after a suicide receives the compassionate outreach and healing support and services that they need to live healthy and fruitful lives.

Goals and Objectives

A Public Health Foundation for Effective Suicide Postvention

The goals and objectives for supporting the bereaved and others affected by a suicide are structured around the framework used by the National Strategy for Suicide Prevention (NSSP)(U.S. Department of Health & Human Services et al., 2012), which is based on the public health model:

- Strategic Direction 1 focuses on:
 - Healthy and empowered individuals, families, and communities
 - Universal strategies, which are interventions accomplished on behalf of the entire population (i.e., the public)
- Strategic Direction 2 focuses on:
 - Clinical and community preventive services
 - Selective strategies, which are interventions implemented on behalf of people who are at risk for negative mental health or other unhealthy outcomes in the aftermath of suicide (i.e., people who have been exposed to a suicide)
- Strategic Direction 3 focuses on:
 - Treatment and support services
 - Indicated strategies, which are interventions delivered on behalf of people who are currently experiencing negative outcomes because of a suicide
- Strategic Direction 4 focuses on:
 - Surveillance, research, and evaluation of the impact of suicide and of interventions designed to ameliorate its effects

These goals and objectives outline how the nation can accomplish NSSP Objectives 10.1, on assisting people bereaved by suicide; 10.2, on responding to trauma and complications of grief; and 10.5, on caring for service providers, first responders, and others who are exposed to suicide. Importantly, the goals and objectives constitute an essential addition to the work of the NSSP and the Suicide Attempt Survivor Task Force on NSSP Objective 10.4 on preventing suicide clusters and contagion. Combined with the overview of the issues in the section above, these goals and objectives provide guidance for those involved in suicide prevention to incorporate more effective care for the suicide bereaved and others affected by a suicide into all postvention policies and practices. They also pave the way for increased communications and collaboration between the field of suicide postvention and those working in fields such as grief counseling, trauma care, crisis response, mental health treatment, funeral services, and spiritual ministry. The goals and objectives—and all of the work of the SOSL Task Force—do not directly address but do adamantly affirm and support NSSP Objective 10.3 on assisting survivors of suicide attempts. These goals and objectives are presented, therefore, as an essential addendum to the NSSP, specifically focused on beginning to make the aspirations and intentions articulated in NSSP Goal 10 a reality.

Strategic Direction 1

Healthy and Empowered Individuals, Families, and Communities

Only recently have approaches to preventing suicide become part of the fabric of many communities and organizations in the United States. This strategic direction outlines goals and objectives that would lead to a similar, systemic response to bereavement and other effects of a death by suicide. In addition, they address the need for broad awareness about the nature of suicide bereavement and the need for all kinds of service providers trained in suicide grief support to be accessible to the entire population.

Goal 1: Integrate and coordinate effective suicide postvention activities across jurisdictions, organizations, and systems through increased communication, collaboration, and capacity building.

- Objective 1.1: Engage leadership and stakeholders in health and mental health care, grief support, trauma care, addiction recovery, emergency response, prevention, and related fields in integrating postvention values, expertise, and activities into their operations.
- Objective 1.2: Engage federal, state, tribal, and community leadership and stakeholders in integrating postvention into public operations and services and in coordinating activities among the various levels of government.
- Objective 1.3: Working through the Action Alliance and other avenues, develop and sustain public-private partnerships to advance suicide postvention at all levels and across all sectors (workplaces, faith communities, etc.).
- Objective 1.4: Ensure access to a wide array of effective preventative, supportive, and clinical services for all people affected by a suicide.
- Objective 1.5: Ensure that survivors of suicide loss are involved in meaningful ways in planning and implementing postvention programs and services.

Goal 2. Communicate accurate and useful information about the impact of suicide on individuals, organizations, and communities; the availability of services for people affected by suicide; and the nature and importance of suicide postvention.

- Objective 2.1: Ensure that the public receives information about postvention.
- Objective 2.2: Ensure that people working in health and mental health care, grief support, trauma-informed care, addiction recovery, emergency response, and similar fields receive information about postvention.
- Objective 2.3: Ensure that government, industry, and organization policymakers at every level receive information about postvention.

Goal 3. Work to ensure that media, entertainment, and online communications about suicide and its aftermath do not contribute to the distress of people bereaved by suicide or to the risk of suicidal behavior among people exposed to a fatality.

- Objective 3.1: Promote and support guidelines and initiatives designed to ensure that information about suicide includes positive, solution-oriented messages; highlights suicide warning signs and crisis resources; and does not contribute to suicide contagion.
- Objective 3.2: Incorporate information into all suicide prevention, entertainment, and other communication efforts about suicide loss and bereavement that meets the needs of survivors of suicide loss. The information should employ language that counters stigma by targeting negative

judgments and discrimination against people at risk of suicide, who die by suicide, and who are bereaved by suicide.

Goal 4: Create the infrastructure and delivery systems for training a wide array of service providers in suicide bereavement support and treatment and in minimizing the adverse effects of exposure to a suicide.

- Objective 4.1: Offer training and support for service providers that covers all levels of care and is based on best practices and evidence-based models for:
 - Delivery of a mental health crisis response (see Goal 5)
 - Support and treatment focused on coping with grief and healing from loss (see Goal 9)
 - Support and treatment focused on acute or chronic mental health issues, trauma, and other debilitating conditions related to exposure to suicide (see Goal 10)
- Objective 4.2: Provide customized training and support in responding to suicide loss survivors for:
 - Clinical service providers, such as grief counselors, mental health and social work practitioners, and physicians and nurses
 - Community-based service providers, such as coroners, medical examiners, and law enforcement personnel; emergency medical services staff and firefighters; crisis, disaster, and trauma response workers; funeral directors; faith leaders and chaplains; peer and volunteer grief support helpers; hospice staff; school personnel; social services workers; lawyers; life insurance claims representatives; and military support personnel⁴
- Objective 4.3: Include in all levels of education and training curricula for service providers—such as in licensing, certification, and job-related requirements—clear, quantifiable mandates for evidence- and skills-based instruction in suicide bereavement care and in minimizing other adverse effects of exposure to suicide.

Strategic Direction 2

Clinical and Community Preventive Services

A suicide tragically ends the deceased's life-or-death struggle and immediately begins the survivors' confrontation with the ramifications of death and loss. For those most closely associated with the deceased or the death scene, their situation can take on the extreme look and feel of an unfolding crisis, especially in the first moments, hours, and days after a suicide. This strategic direction advances goals and objectives that treat the immediate aftermath of a suicide as the most important period during which to initiate efforts focused on prevention and on meeting the most intense and alarming needs of all who were exposed to the loss and/or to the death scene. It also covers the types of information that might be helpful to the bereaved, both immediately after the loss and at any time during the course of their lives.

⁴ These lists of "clinical" and "community-based" service providers are not intended to be prescriptive or all-inclusive. Every community or service area is unique, so an assessment of local resources must be made to identify and categorize the pertinent service providers in each locale.

Goal 5: Develop and implement protocols in communities and across caregiving systems for effectively responding at the scene and in the immediate aftermath of all suicides.

- Objective 5.1: Ensure that services at the scene or in the immediate aftermath of a suicide are informed by the principles of mental health crisis response, with a focus on promoting safety, calm, hope, connectedness, and self-efficacy.
- Objective 5.2: Ensure that service providers responding to a suicide are able to assess and support the practical and emotional needs as well as the physical and mental health needs of people affected by the fatality. Providers should be able to deliver direct support and/or make effective referrals to address any acute grief or trauma reactions and/or other adverse effects of exposure to a suicide, including acute suicide risk.
- Objective 5.3: Ensure coordinated and effective follow-up across systems—beyond the period of crisis—that includes re-assessment as needed and continuity of care for those exposed to a suicide. (Also see Goal 1.)

Goal 6: Ensure that people exposed to a suicide receive essential and appropriate information.

- Objective 6.1: Enable all service providers who are likely to encounter people exposed to suicide to distribute accurate and helpful information to them.
- Objective 6.2: Make information about support and professional resources available through a centralized source that people exposed to suicide can readily access in local communities and nationally. (See Appendix B.)
- Objective 6.3: Provide the deceased's next of kin ready access to information regarding:
 - The fatality, such as the location, manner, and time of the death
 - Legal matters, such as police investigations, death notification, autopsy, suicide note, and the rights of people bereaved by suicide
 - Practical matters, such as regarding the deceased's personal effects, making funeral arrangements, and financial and estate issues
- Objective 6.4: Ensure that people exposed to a suicide have access to information that is applicable to their age and circumstances (including children and adolescents). This should include information regarding suicide bereavement, suicide risk, and mental illness; how to cope with grief, loss, and trauma; contacts for grief support and professional assistance; recommendations for reading materials and other resources; and guidance on handling interactions with the media. Systematically provide concise, essential information to the newly bereaved.
- Objective 6.5: Develop and/or disseminate guidelines for people bereaved by suicide to help them interact with the media and entertainment industry, on the Internet, and in other public settings in ways that promote healing and recovery from their grief and are in keeping with guidelines for safe and helpful messages about suicide prevention. (See Goal 3.)

Goal 7: Develop and implement effective postvention practices in organizational, workplace, and school settings.

- Objective 7.1: Organizations, workplaces, and schools should develop crisis plans that include protocols for responding to a sudden death, with specific guidelines for loss by suicide. Plans should emphasize collaboration among administrators, managers and supervisors, and staff;

distribution of information on common reactions to sudden loss and specifically to suicide; and referral to grief support resources and clinical intervention when necessary.

- Objective 7.2: Postvention plans should provide for skilled trauma response services as needed for those who may have witnessed a suicide death or been involved in rescue attempts or who show evidence of posttraumatic stress or other acute or potentially debilitating reactions to the fatality.
- Objective 7.3: Information and training in organizational settings should include psychoeducational materials for recognizing depression and suicide risk, self-screening tools, and guidance on how to obtain assistance for mental health and other problems.

Strategic Direction 3

Treatment and Support Services

Most people who experience the death of someone close to them, including people bereaved by suicide, more or less successfully navigate the course of their grief without specialized or professional assistance. But suicide loss commonly affects people in especially deleterious or long-lasting ways. The goals and objectives in this strategic direction address the roles of all kinds of service providers in assisting the bereaved, taking into account the impact of suicide and loss survivors' need for compassionate understanding and support from all quarters—as well as the possibility that they may require professional assistance in their healing.

Goal 8: Ensure that all support and treatment services delivered to the suicide bereaved are accessible, adequate, consistent, and coordinated across systems of care.

- Objective 8.1: Ensure that services for the suicide bereaved are implemented based on evidence of their effectiveness. Where evidence-based practices are lacking, ensure that services are congruent with widely accepted principles. (See Appendix A.)
- Objective 8.2: Provide services to people bereaved by suicide—in terms of timing, cultural appropriateness, ease of access, and affordability—that take into account the diverse needs and perspectives of various individuals, families, and communities.
- Objective 8.3: Ensure that providers who deliver assistance or services to people exposed to suicide are able to evaluate and identify possible acute or debilitating conditions that might stem from suicide loss—including suicide risk, depression, complicated grief, and posttraumatic stress disorder (PTSD)—and to make appropriate referrals to additional resources and/or a higher level of care.
- Objective 8.4: Strengthen communication and collaboration between support services (Goal 9) and clinical services (Goal 10) and among practitioners, agencies, communities, and systems that are focused on the importance of effectively responding to the needs of suicide loss survivors. (Also see Goal 1.)

Goal 9: At the level of support services, provide an array of assistance, programs, and resources that help bereaved individuals and families cope with and recover from the effects of their loss to suicide. Services at this level may include information, emotional support, and guidance; psychoeducation about suicide, grief, trauma, and effective self-care; and participation in peer help and other community-based services.

- Objective 9.1: Develop and maintain the infrastructure and capacity for professional caregivers—such as grief counselors, mental health and social work practitioners, physicians, and nurses—to provide guidance, support, and assistance that meet the characteristic needs of people bereaved by suicide.
- Objective 9.2: Develop and maintain the infrastructure and capacity for community caregivers—such as funeral directors, faith leaders, and chaplains, volunteer grief support helpers, hospice staff, school counselors, social services workers—to provide support and assistance that meets the characteristic needs of people bereaved by suicide.
- Objective 9.3: Develop and maintain the infrastructure and capacity for peer-to-peer support—in face-to-face mutual-help groups and one-on-one, through the telephone and Internet, and at activities such as healing conferences, retreats, and memorial services—to help meet the characteristic needs of people bereaved by suicide.

Goal 10: At the level of professional clinical services, provide an array of treatment, programs, and resources that help people affected by unremitting or complicated grief, PTSD, depression, suicidality, and other acute or potentially debilitating conditions.

- Objective 10.1: Ensure that professional assessment and treatment for loss survivors are provided by a clinician (licensed grief counselors, mental health and social work practitioners, physicians, nurses, etc.) with broad competencies in a relevant discipline (psychiatry, psychology, counseling, social work, etc.) and specialized knowledge of and experience with people exposed to suicide.
- Objective 10.2: Integrate medical intervention (e.g., pharmacotherapy) as part of the continuum of services offered to people exposed to suicide, while ensuring that such services are not routinely used as a substitute for therapy or other psychosocial treatments.
- Objective 10.3: Provide professional services at appropriate times across the lifespan of the suicide bereaved, using approaches relevant to the needs, strengths, and preferences of the client and including access to various modalities, such as individual, couple, family, and group therapy.

Strategic Direction 4

Surveillance, Research, and Evaluation

Although a great deal has been learned about the impact of suicide loss in the last two decades, the scientific yield of this research has been limited by both methodological problems and a restriction of topics receiving attention. This strategic direction offers goals and objectives intended to redress both of these constraints. The implementation of a targeted and high-quality research agenda on the impact of suicide and the amelioration of its negative effects is essential to further each and every one of the goals and objectives outlined above.

Goal 11: Design studies of suicide loss survivors using appropriate scientific methods.

- Objective 11.1: Improve the general methods used in suicide bereavement research, including using samples of sufficient size, valid and reliable instrumentation, and clear descriptions of relevant sample characteristics (e.g., kinship relationship or psychological closeness to the deceased, time since the death).
- Objective 11.2: Employ relevant control and/or comparison groups to justify descriptive and causal inferences regarding suicide loss and its treatment. Compare loss survivors to other relevant groups, such as people exposed to other forms of traumatic stress or bereaved by other modes of death, and include non-bereaved controls.
- Objective 11.3: Explore novel recruitment strategies for suicide loss research, such as peer nomination and “snowball” sampling. Also, establish a national registry of people bereaved by suicide who are willing to be contacted to participate in research.
- Objective 11.4: Pursue mixed methods research, using both quantitative and qualitative methods.

Goal 12: Establish valid and reliable estimates of the number of people exposed to suicide and the immediate and longer-term impact of exposure. This includes people (a) exposed to and (b) affected by a given suicide, as well as those who suffer (c) short-term and (d) long-term bereavement complications.

- Objective 12.1: Clearly explain the criteria used to define who is a survivor of suicide loss in a given study.
- Objective 12.2: Use epidemiological, prospective, and longitudinal methods to estimate the prevalence of suicide exposure and the subset of those exposed who suffer short-term and prolonged psychological distress. Trace the longer-term responses of loss survivors to identify the typical course(s) of adaptation to suicide loss, including longer-term negative and positive (posttraumatic growth) effects.
- Objective 12.3: Expand the assessment of relevant variables beyond those concerned with grief and psychiatric symptomatology to evaluate the broader impact of suicide on the personal, interpersonal, and spiritual functioning of survivors of suicide loss.

Goal 13: Identify common and unique impacts of suicide bereavement as well as individual difference variables that function as risk factors for or buffers to such effects.

- Objective 13.1: Using appropriate comparison groups, determine what features of response to suicide loss are shared with survivors of other types of losses, whether natural or violent, and what factors may be unique to bereavement after suicide.
- Objective 13.2: Investigate factors from general bereavement research that may mediate the response to suicide (e.g., kinship relationship, psychological closeness, attachment security, coping style, meaning making, social support).
- Objective 13.3: Consider the impact of developmental factors on adaptation to suicide loss, with special attention to such populations as children, adolescents, and older adults. Also included in this should be prior exposure to suicidal behavior and fatalities in the individual’s history.
- Objective 13.4: Examine the role of gender, culture and ethnicity, both within and beyond the U.S. context, in predicting the impact of suicide loss.

- Objective 13.5: Analyze the role of circumstantial factors concerning the death (e.g., expectedness of the death, duration of the period of prior psychiatric disorder in the deceased, direct witnessing of the death, discovering the body, level of violence of the death) in mediating the impact of exposure on survivors of suicide loss.
- Objective 13.6: Investigate the role of social response to suicide as a mediating factor in the healing process of survivors. This includes the response of family systems; social networks (friends, work colleagues, etc.); and institutions and organizations (schools, churches, workplaces, etc.). Particular attention should be paid to the impact of stigmatization of suicide on loss survivors.

Goal 14: Study the utilization and efficacy of interventions and services designed to assist people bereaved by suicide.

- Objective 14.1: Establish a national database of approved internal review board (IRB) protocols to provide guidance for future investigators and IRB bodies in balancing the delicate issues of protection of human subjects and adequate informed consent procedures in studies with suicide loss survivors.
- Objective 14.2: Describe utilization of and satisfaction with different forms of support and intervention (e.g., peer support groups, spiritual counseling, pharmacotherapy, grief therapy) sought out by survivors of suicide loss.
- Objective 14.3: Investigate effectiveness of peer support groups for suicide loss. Include variables such as training and experience level of group leadership, group format, frequency and duration of group meetings, participant attrition, and frequency of participation. Study group interventions both in the research laboratory and in naturalistic settings where most support groups operate.
- Objective 14.4: As opposed to generic studies of unspecified therapies, conduct randomized controlled trials of specific professional interventions that show promise of efficacy in the treatment of suicide bereavement (e.g., Eye Movement Desensitization and Reprocessing or EMDR, Active Postvention Model, complicated grief therapy, prolonged exposure interventions for PTSD, behavioral activation, narrative and meaning-oriented interventions).
- Objective 14.5: Investigate the role of clinician variables as a factor in outcomes. This includes level of training, level of experience in working with loss survivors, and clinician history of exposure to suicide in personal or professional contexts.

Goal 15: Promote bridging of research and practice by soliciting engagement of relevant stakeholders in scientific studies of suicide loss and intervention.

- Objective 15.1: Ensure representation of survivors of suicide loss in the design and interpretation of relevant studies.
- Objective 15.2: Involve clinical practitioners in the construction, implementation, and evaluation of support and treatment programs for loss survivors, including the naturalistic study of best practices currently implemented in the field.
- Objective 15.3: Secure the buy-in of relevant institutions (e.g., agencies, services, funders) in the design and evaluation of treatment programs in order to ensure their sustainability beyond the period of initial study.

Principles of Suicide Postvention Programs⁵

- Employ comprehensive strategies with multiple components to address a wide range of risk and protective factors and various individual, relationship, and community needs.
- Use evidence-based grief support practices, interventions supported by research, and approaches to care based on accepted theories and practices.
- Meet needs across the lifespan, using activities designed for people of all ages and appropriate to the age and developmental level of the individual.
- Provide culturally appropriate services congruent with people's race, religion, age, gender, sexual orientation, gender identity, occupation, health literacy, communication needs, etc.
- In order to *do no harm*, establish physical and psychological safety for the individual and employ measures to minimize the duration and possible negative impact of interventions.
- Intervene in person-centered ways that seek to understand the individual, his or her unique circumstances, and how that individual's personal preferences and goals can be maximally incorporated into the process—and ensure that people engage in services voluntarily.
- Share responsibility by assisting the individual in regaining control through considering the person as an active partner in—rather than a passive recipient of—services.
- Address trauma, taking into account that suicide itself can be intrinsically traumatic and that certain interventions or activities may impose further trauma—both physical and emotional. Services should be trauma informed, and access should be provided to additional resources and/or a higher level of care for trauma-related issues.
- Rely on strengths by sharing responsibility for problem solving and constructive action through affirming that an individual, even while in crisis, can marshal personal strengths and assist in the resolution of the emergency.
- Take a holistic approach by helping the person meet multiple, various, and individualistic needs—and by not limiting services according to caregiver or agency specialty or third-party priorities.
- Treat the person as a credible source by respecting the person's point of view as legitimate and treating the information—factual or emotional—that the person supplies as important to understanding the individual's needs and strengths.
- Include recovery, resilience, and natural supports by contributing to the individual's larger journey toward growth and fruition. Interventions should preserve dignity; foster a sense of hope; and promote engagement with formal systems and informal resources, including peer support.
- Focus on prevention by implementing measures that address the person's most crucial unmet needs, risk and protective factors, and especially any risk of suicide.

⁵ Adapted from: (California Department of Public Health, 2009; Center for Mental Health Services, 2009)

Examples of Concrete Action Steps

The way a community responds to people bereaved by suicide reflects—and has an impact on—that community’s general attitudes about suicide and about both people who are at risk of suicide and those who are affected in the aftermath of suicide. As Edwin Shneidman put it: “A benign community ought routinely to provide immediate postvention mental health care for the survivor-victims of suicidal deaths” (1969, p. 22). When considering the suggestions below, Dr. Shneidman’s admonition notwithstanding, please recognize that postvention must go beyond focusing on mental health services and include postvention practices integrated into every aspect of a community’s caregiving systems. Certainly, a top priority for postvention must be reaching out to immediate family members of the deceased, but it is also common for friends, classmates, colleagues, faith communities, neighbors, first responders, and a host of others to be affected by a suicide—and their needs must also be addressed. In addition, because attention to a crisis dissipates and support for people in grief often recedes after a few days or weeks, support for individuals and systems affected by suicide must be ongoing for as long as it is needed.

This appendix provides a list of suggestions for how governments, organizations, caregivers, first responders, and others might strategically assist individuals and groups who have been touched by suicide. With coordinated and comprehensive responses at the community, state, and national levels, it is possible to take a major step forward toward reducing the rate of suicide in the United States—and to support the healing journeys of everyone who is affected when the tragedy of suicide does occur.

Finally, please keep in mind that this is a “brainstorming” list, assembled by a group of volunteers (the members of the Survivors of Suicide Loss Task Force) at the conclusion of a very rewarding and also long and laborious project (the creation of the *National Guidelines*). The suggestions below are not intended to be all-inclusive or definitive in any way. They are offered here merely as a starting place for groups of volunteers, professionals, and stakeholders of every kind—throughout the country—to begin asking themselves, “What can we do?”

Federal Government and National Organizations

- Help develop infrastructure for bereavement support at the state and local levels that includes technical assistance
- Help develop and disseminate information about the availability of postvention services
- Fund research on the impact of exposure to suicide, suicide bereavement, and services for survivors, including needs assessments, efficacy studies of interventions, and studies of the needs of specific cultures and subgroups (see Strategic Direction Four, pp. 34–36)
- Directly fund postvention projects that have a national scope
- Increase awareness of how effective suicide postvention contributes to suicide prevention
- Fund the development of services, support programs, and resources for postvention
- Implement workplace postvention guidelines for suicide postvention in federal agencies
- Incorporate activities and resources focused on suicide bereavement into federally funded suicide prevention programs and grant-funding solicitations

- Integrate survivors of suicide loss into the membership and leadership of advisory and advocacy groups

State and Tribal Government

- Establish a statewide authority responsible for ensuring adequate capacity and effectiveness in postvention activities throughout the state
- Ensure that state suicide prevention plans include postvention strategies that address the needs of all individuals and organizations affected by suicide
- Fund statewide postvention programs that include evidence-based practices, such as proactive outreach to new survivors
- Encourage the designation of lead organizations in each county or region to coordinate suicide postvention efforts
- Integrate responses to and programs for suicide loss into all suicide prevention programs and services
- Ensure that 211 and other information and referral services provide up-to-date information on postvention resources, services, and support

Communities and Local Officials

- Work with lead agencies that are coordinating postvention efforts in each county or region in order to:
 - Make resource and referral information comprehensive, up-to-date, and widely available
 - Support systematic, coordinated, and sustained suicide postvention responses to all fatalities
- Help develop and implement training—for first responders, peer helpers, and others—on effective suicide grief support and on addressing other postvention needs
- Work through official channels and agencies, such as coroner’s offices, fire departments, emergency medical services, etc., to:
 - Provide support through outreach to survivors at the death scene and immediately after a suicide
 - Ensure that basic information and referral resources are available to survivors as soon as possible after a fatality
- Help suicide prevention coalitions and other umbrella groups develop policies, principles, and guidelines to strengthen suicide bereavement and other postvention practice among their stakeholders and constituents

Schools, Universities, Businesses, and Workplaces

- Create guidelines and policies for including suicide bereavement and other postvention programs as a component of institutional emergency preparedness plans
- Provide curriculum-based training on best practices in postvention for students studying to enter all fields of study that have a role in postvention

- Include information about suicide exposure and consequences and the value of effective postvention in any suicide prevention programming
- Promote general awareness of all aspects of the aftermath of suicide and the value of effective postvention for students, workers, and supervisors

Mental Health and Public Health Agencies

- Encourage specialized training among staff clinicians in working with trauma and suicide bereavement in individual, group, and family therapies
- Encourage and fund peer support and other interventions and therapies for loss survivors
- Provide training and support for peer survivor support group facilitators

Professional Organizations and Accrediting Bodies

- Include course work and continuing education in trauma, grief therapy, and suicide postvention care in education and licensing requirements
- Ensure that care providers understand the prevalence and scope of suicide exposure
- Ensure that services are universally sensitive to people who have had a loss to suicide of someone close to them (as in trauma-informed care)

Faith Communities, Religious Institutions, Clergy, and Faith Leaders

- Raise awareness about the needs of survivors of suicide loss and advocate for resources to meet those needs
- Honor loved ones lost to suicide in formal gatherings, and incorporate ideals of compassion and nonjudgment toward people who die by suicide and toward people bereaved by suicide
- Help develop training based on best practices for clergy, faith leaders, pastoral care providers, and youth group leaders on suicide loss and basic coping skills for the bereaved

Funeral Professionals

- Raise awareness about the needs of survivors of suicide loss and advocate for resources to meet those needs
- Provide professional services for families who have lost a loved one to suicide that meet the special needs of loss survivors
- Provide information about and facilitate referral to mental health, peer support, and other resources for loss survivors in their communities
- Routinely provide follow-up and aftercare to survivors

Law Enforcement and Fire and Emergency Medical Services

- Train first responders to be knowledgeable, sensitive, and compassionate about the needs of traumatized and/or bereaved people in the aftermath of suicide
- Partner with victim-advocates and peer helpers to assist in providing emotional support at the scene of fatalities or death notifications

- Offer routine organizational identification, support, and referrals for first responders who may be traumatized or bereaved by their professional contact with new survivors

Social Media and Online Communities

- Help develop guidelines and policies regarding communications and user interactions in the aftermath of suicide and suicidal behavior

Media

- Partner with local suicide prevention and postvention organizations to share information about postvention in the aftermath of suicide deaths
- Participate in education and training on how to cover newsworthy suicide-related stories safely and compassionately
- Follow media recommendations from the field of suicide prevention in the coverage of suicide and its aftermath

Loss and Attempt Survivors and Others Affected by Suicide

- Utilize and share resources such as those in Appendix B, including referral information for support and therapy
- After sufficient time and recovery from the distress and grief related to the loss:
 - Speak publicly about the experience of loss in keeping with safe messaging guidelines and in ways that contribute to the empowerment and growth of the survivor who is speaking
 - Help with peer support services for people who are newly bereaved by suicide.
 - Advocate for suicide postvention and prevention efforts
 - Participate in research studies on the needs of survivors and interventions designed to help survivors
 - Collaborate with suicide attempt survivors to amplify the voices of people affected by suicide and its aftermath
- Take part in online communities for suicide survivors, both to seek and offer support and to experience a sense of community among survivors of suicide loss

Researchers

- Utilize the developing uniform definitions of *survivor* and related groups to improve the specificity of the findings and implications of their work
- Encourage improvement in research methodologies so that research in postvention can contribute to the efficacy of interventions and assist in the development of evidence-based services and program delivery
- Work with institutional review boards (IRBs) to promote a better understanding of issues associated with suicide and suicide-bereavement research
- Support and validate research in postvention interests, efforts, and involvement by graduate and undergraduate students

Resources: Supporting the Suicide Bereaved

This appendix organizes resources and information for people bereaved by suicide as well as for caregivers who work with survivors. It has three sections: The first is an outline of the types of information, in general, that survivors are likely to find useful. It can guide the work of individuals and organizations developing programs or services. The second is a directory of resources from After a Suicide: Coping with Grief, Trauma, and Distress, a free online clearinghouse, available at bit.ly/afterasuicide.^① The third is a list of books about grief after suicide. These lists are not exhaustive, for there are many other resources available, and the choice of items listed is not prescriptive, for their appropriateness must be judged ultimately by those who use them. Feedback about the contents of this appendix may be submitted at the After a Suicide contact page, bit.ly/contactafter.

Types of Information

People bereaved by suicide are likely to find the following types of information helpful:

- Information about caring for themselves:
 - How to cope with grief, loss, and trauma and how other loss survivors have coped
 - Conditions or developments related to the loss that might require additional or more intensive assistance
 - How and what to tell children about the suicide death of someone with whom they have a close relationship
 - Impact of suicide on families and strategies for enhancing family communication and functioning after suicide
- Information about the nature of suicide bereavement:
 - Grief in general and what the experience and evolution of mourning is like
 - Common reactions to suicide loss, such as intense grief, trauma symptoms, guilt, and preoccupation with why the suicide occurred
 - Physiological responses, such as sleep disruption, appetite loss, and difficulty concentrating or making decisions
 - Severe or long-term reactions, such as depression, increased anxiety or hypervigilance, a changed view of the world, strain in interpersonal relationships, and the possibility of posttraumatic growth
- Contact information for programs, services, and treatment:
 - Medical, mental health, and other specialized professional assistance
 - Local, state, tribal, and national organizations focused on grief support, trauma and crisis response, or suicide prevention
 - Peer-led and community-based programs, spiritual assistance, and natural helpers (everyday individuals who have a knack for helping others)

^① For brevity and ease of transcription, bitlinks (bit.ly/shortphrase) are used in the directory. Bitlinks function the same way as a website's original Internet address (to access a website, simply copy its bitlink into an Internet browser's address bar).

- Information about suicide risk and mental illnesses associated with exposure to suicide:
 - Depression, posttraumatic stress disorder (PTSD) or other anxiety disorders, and complicated or prolonged grief
 - Warning signs of suicide and how to respond safely and effectively to suicide risk in oneself or others

Crisis Line

- National Suicide Prevention Lifeline — bit.ly/suicidelifeline — 1-800-273-TALK (8255)
- SAMHSA (Substance Abuse and Mental Health Services Administration) National Helpline — 1-800-662-HELP (4357)

Grief in General

- Coping with Grief and Loss: Understanding the Grieving Process — bit.ly/grievingprocess — Concise and comprehensive webpage from HelpGuide
- The Grief Toolbox — bit.ly/toolsgrief — Online grief community, articles, and products
- LifeCare Guide to Grief and Bereavement — bit.ly/lifecaregrief — Booklet with complete summary of the topic
- Open to Hope — bit.ly/hopeopen — Website offering grief articles and interviews
- Understanding Grief — bit.ly/undergrief — 25-minute video, from the Hospice Foundation

Suicide Grief Websites

- Alliance of Hope for Suicide Loss Survivors — bit.ly/hopeall — Internet community focused on 24/7 peer assistance for the suicide bereaved
- American Association of Suicidology (AAS) — bit.ly/survivors-aas — Section of AAS website for survivors of suicide loss
- American Foundation for Suicide Prevention (AFSP) — bit.ly/afsp-sosl — Section of AFSP website for survivors of suicide loss
- Friends for Survival — bit.ly/friendsurvive — Publisher of national newsletter for suicide bereaved, “Comforting Friends”
- Suicide Awareness Voices of Education (SAVE) — bit.ly/savecope — Section of SAVE website for survivors of suicide loss
- Suicide: Finding Hope — bit.ly/hopefind — Features a coping with loss section
- Suicide Prevention Resource Center (SPRC) Library — bit.ly/survivorlibrary — Resource listings for the suicide bereaved, from SPRC

Suicide Grief Materials

Booklets

- Coping with the Loss of a Friend or Loved One — bit.ly/copeloss — Booklet for the suicide bereaved, from SAVE
- Hope and Healing after Suicide — bit.ly/hopeandheal — Comprehensive overview of suicide bereavement, from the Ontario Centre for Addiction and Mental Health

- SOS: A Handbook for Survivors of Suicide — bit.ly/sosaas — Booklet for the suicide bereaved, from AAS
- Surviving a Suicide Loss: Resource & Healing Guide — bit.ly/surviveloss — Booklet for the suicide bereaved, from AFSP
- Surviving a Suicide Loss: A Financial Guide — bit.ly/lossfinance — Comprehensive, authoritative financial information, from AFSP

Handouts

- After a Suicide: Coping with Grief — bit.ly/griefcard — Wallet card, from SAVE
- Beyond Surviving — bit.ly/beyondsurviving — Tips for the suicide bereaved, by Iris Bolton
- Surviving Your Child's Suicide — bit.ly/childsuicide — Brochure for suicide-bereaved parents, from The Compassionate Friends
- Trauma Intervention Programs (TIP) — bit.ly/tiptrauma — Four handouts for suicide loss survivors plus more for trauma care, from the resource page of TIP International

Online Assistance

Discussion Forums

- Alliance of Hope - Community Forum — bit.ly/forumaoh — Forum for the suicide bereaved, moderated by trained peer helpers
- Parents of Suicides/Friends & Families of Suicides — bit.ly/forumposffos — Two forums, one for parents bereaved by suicide and one for bereaved family and friends
- PTSD Forum — bit.ly/forumptsd — Discussion forum on coping with posttraumatic stress

Listservs

- GriefNet - Grief/Suicide — bit.ly/griefnet-suicide — Listserv for the suicide bereaved
- Parents of Suicides/Friends & Families of Suicides — bit.ly/listposffos — One listserv for parents and one for others bereaved by suicide

Chat Rooms

- The Compassionate Friends - Survivors of Suicide — bit.ly/tcf-chat — Chat room for parents bereaved by suicide
- Parents of Suicides/Friends & Families of Suicides — bit.ly/posffos-chat — One chat room for parents and one for others bereaved by suicide
- Tragedy Assistance Program for Survivors (TAPS) — bit.ly/tapsevents — Chat room for military, veterans, and family members bereaved by suicide
- Veterans Crisis Line Chat — bit.ly/vetcrisischat — Chat room for active duty military, veterans, and family members on all topics, including grief

Blogs

- Alliance of Hope Blog — bit.ly/hope-blog — Topics include coping with suicide bereavement, guidance from peer helpers, and sharing from the Community Forum (bit.ly/forumaoh)

- Grief after Suicide Blog — bit.ly/suicidegriefblog — Covers topics of interest to the suicide bereaved and caregivers, by a survivor of suicide loss, from Personal Grief Coaching
- Promoting Hope, Preventing Suicide — bit.ly/promoteprevent — Suicide prevention and grief blog, by a survivor of suicide loss, from Psychology Today

Suicide Bereavement Support Groups

Handbooks/Guidelines

- Guiding Principles for Suicide Bereavement Support Groups — bit.ly/sbsgaas — Concise outline of principles for peer-led support groups, from an AAS work group
- Heartbeat — bit.ly/heartsurvive — Website of Heartbeat suicide grief support groups
- How to Start a Survivors' Group — bit.ly/handbooksbsg — Basic handbook on all aspects of suicide bereavement support groups, from the World Health Organization
- Pathways to Purpose and Hope — bit.ly/pathhope — Comprehensive manual for community-based support for the suicide bereaved, from Friends for Survival
- Practice Handbook: Suicide Bereavement Support Group Facilitation — bit.ly/sbsg-handbook — Thorough handbook for conducting peer-led suicide bereavement support groups, from Lifeline Australia; applies principles from Towards Good Practice: Standards and Guidelines for Suicide Bereavement Support Groups (bit.ly/sbsg-guidelines)
- Recommended Guiding Principles for Effective Suicide Bereavement Support Groups — bit.ly/sbsgaas — Checklist-style outline of essential characteristics for peer-led mutual-help support groups for loss survivors, from an AAS work group
- Support Group Facilitation Self-Study Guide — bit.ly/selfguide — Manual based on the AFSP Support Group Facilitator Training

Training

- Support Group Facilitator Training — bit.ly/afsp-facilitators — Two-day training, one version for adult groups and one for child or teen groups, from AFSP

Group Directories

- Suicide Bereavement Support Group Directories — Maintained by AAS (bit.ly/aasdirect), AFSP (bit.ly/afspdirect), and SAVE (bit.ly/savedirect)

Bereaved Children

The next set of resources is about children and grief in general. (See later, Books on Grief after Suicide, for examples of books for children and their caregivers about suicide bereavement.)

- A Child in Grief — bit.ly/achildgrief — Comprehensive website, from New York Life Foundation
- Dougy Center — bit.ly/dougygrief — Resource page of the Dougy Center website
- When a Brother or Sister Dies — bit.ly/siblingdies — Brochure for those who have experienced the death of a sibling by any means, from The Compassionate Friends
- When Families Grieve — bit.ly/familiesgrief — Lots of resources in various formats for bereaved families and children, from Sesame Street (access downloads at bit.ly/kidsgriefresources)

Children's Caregivers

Grief after Suicide

- After a Suicide Death: Ten Tips for Helping Children & Teens — bit.ly/tipshelping — Brochure, from the Dougy Center
- Child Survivors of Suicide: A Guidebook — bit.ly/childsurvive — Comprehensive guidance on helping children bereaved by suicide, by Rebecca Parkin and Karen Dunne-Maxim (Spanish version: bit.ly/childsurvive-sp)
- Helping Children Cope — bit.ly/helpcope — Concise overview of helping suicide bereaved children, including activities, from a presentation at a VA medical center
- "Talking to Your Child about Suicide" — bit.ly/childabout — Brief article, from the NAMI New Hampshire loss survivor packet
- Understanding Suicide, Supporting Children — bit.ly/kidsupport — In-depth video on the point of view and needs of children bereaved by suicide, from the Dougy Center
- When a Child's Friend Dies by Suicide — bit.ly/childfrienddies — Tips for parents and caregivers, from Society for the Prevention of Teen Suicide

Trauma and Grief in General

- National Alliance for Grieving Children — bit.ly/childalliance — Resource page of the website
- National Child Traumatic Stress Network — bit.ly/childgrieftrauma — Links and information about children affected by trauma
- NCTSN Caregiver Quick Tips — bit.ly/nctsnstips — Brief, authoritative handouts for helping young children, school-age children, and teens
- NCTSN Advice for Educators — bit.ly/adviceeducators — Handout to help educators in the aftermath of trauma affecting school populations

Specific Groups or Perspectives

Relationships

- The Compassionate Friends — bit.ly/compassionfriends — Links to local chapters nationwide that help people cope with the death by any means of a child, sibling, or grandchild
- Sibling Survivors of Suicide Loss — bit.ly/sibsurvive — Website focused on the needs of siblings bereaved by suicide

LGBT Youth

- The Trevor Project — bit.ly/trevproject — Crisis services by phone, text, or chat

Clinicians and Peer Helpers

- Clinicians as Survivors: After a Suicide Loss — bit.ly/cliniciansurvivors — Comprehensive website for caregivers who have lost a client to suicide
- Connect SurvivorVoices Training: Sharing the Story of Suicide Loss — bit.ly/survivorvoices — Training for loss survivors who want to do public speaking, from NAMI New Hampshire

Military & Families

- Make the Connection: Death of Family or Friends — bit.ly/vetgriefconnection — Resources and peer videos for bereaved active duty military and veterans, from the Department of Defense
- Make the Connection: Family Resources — bit.ly/vetfamilyfriends — Resources and peer videos for family members, from the Department of Defense
- Military One Source, Casualty Assistance Program — bit.ly/dodcasualty — Department of Defense program responsible for aiding the bereaved
- Tragedy Assistance Program for Survivors (TAPS) — bit.ly/tragedyassist — Website of private organization assisting the bereaved from military and veteran deaths, including suicide
- Veterans Crisis Line — bit.ly/vetscrisis — Crisis line (800-273-8255, press 1), chat (bit.ly/vetcrisischat), and text (838255) services for active duty military, veterans, family, and friends

Communities and Workplaces

Community/School Postvention

- After a Suicide: A Toolkit for Schools — bit.ly/schooltoolkit — Handbook designed to help prepare for and respond to school suicide, from AFSP and SPRC
- Connect Postvention Training — bit.ly/connect-postvention — Community-based training for comprehensive, systemic response to suicide, from NAMI New Hampshire
- Lifelines Postvention: Responding to Suicide — bit.ly/lifelinepost — Comprehensive approach for schools to respond to any traumatic death, from Hazelden Publishing
- Maine Youth Suicide Prevention, Intervention, Postvention — bit.ly/maine-postvention — In-depth handbook on all aspects of suicide, developed for statewide implementation in schools
- Riverside Trauma Center Postvention Protocols — bit.ly/riverside-postvention — Guidelines applicable to schools, workplaces, and communities

Workplaces

- Breaking the Silence in the Workplace — bit.ly/silencework — Thorough guide for employers in the event of an employee or work site suicide, from Console and the Irish Hospice Foundation
- Manager's Guide to Suicide Postvention in the Workplace — bit.ly/manageguide — Handbook organized around 10 action steps to take after a suicide, from the Carson J Spencer Foundation

Helping Others

Immediate Aftermath

- After a Suicide: Religious Services, Memorial Observances — bit.ly/suicideservices — Overview of considerations in memorializing a person who has died by suicide, from SPRC
- Casualty and Death Notification — bit.ly/notedeath — Protocols for death notification, from the National Center for PTSD
- Help at Hand: A Guide for Funeral Directors — bit.ly/guidefuneral — Booklet on suicide bereavement issues for funeral professionals, from the Substance Abuse and Mental Health Services Administration (SAMHSA)

Media and Messaging

- Recommendations for Reporting on Suicide — bit.ly/suicidereport — Information about the link between media coverage of suicide and suggestions for covering the topic safely
- Safe and Effective Messaging for Suicide Prevention — bit.ly/safemessage — Guidelines for creating public messages about suicide, and a list of do's and don'ts, from SPRC

Principles, Theory, Guidance

- Grief After Suicide: Understanding the Consequences and Caring for the Survivors — bit.ly/griefjordan — Seminal book on suicide bereavement care and counseling, edited by John Jordan and John McIntosh
- Psychological First Aid Field Operations Guide — bit.ly/psychfirstaid — Practical handbook on an evidence-based approach for responding to tragedy, from National Child Traumatic Stress Network and National Center for PTSD
- Tripartite Model of Suicide Bereavement — bit.ly/tripartitemodel — Article on an overarching theory of suicide bereavement, by Diana Sands
- After a Suicide: A Postvention Primer for Providers — bit.ly/primerprovider — Article covering all aspects of the immediate needs of people bereaved by suicide, from Montgomery County (PA) Emergency Service

First Responders

- Guide for Early Responders Supporting Survivors Bereaved by Suicide — bit.ly/earlyrespond — Overview of issues and helpful approaches, from Winnipeg Suicide Prevention Network
- LOSS Teams (Active Postvention Model) — bit.ly/lossteams — Website covering LOSS background and training information, from Frank Campbell & Associates
- Supporting People Bereaved by Suicide: A Good Practice Guide — bit.ly/practicegood — Comprehensive handbook on responding to the scene of a suicide, from NHS Health Scotland

Books on Grief after Suicide

Helping: Individual Self-Help

- *After Suicide*. Hewett, J. (1980). Westminster Press.
- *After Suicide Loss: Coping with Your Grief*. Baugher, R., & Jordan, J. R. (2002). Self-published (contact b_kbaugher@yahoo.com).
- *Finding Peace Without All the Pieces: After A Loved One's Suicide*. Archibald, L. (2012). Larch Publishing.
- *Healing the Hurt Spirit: Daily Affirmations for People Who Have Lost a Loved One to Suicide*. Greenleaf, C. (2006). St. Dymphna Press.
- *Life After Suicide: A Ray of Hope for Those Left Behind*. Ross, E. B. (1997). Insight Books.
- *Mourning After Suicide*. Bloom, L. A. (1986). Pilgrim Press.
- *My Son, My Son: A Guide to Healing After a Suicide in the Family*. Bolton, I. with Mitchell, C. (1984). Bolton Press.
- *No Time to Say Goodbye*. Fine, C. (1999). Main Street Books.

- *Touched by Suicide: Hope and Healing After Suicide*. Myers, M. F. & Fine, C. (2006). Gotham.

Helping: Principles, Theory, Guidance

- *Devastating Losses: How Parents Cope With the Death of a Child to Suicide or Drugs*. Feigelman, W., Jordan, J. R., McIntosh, J. L., & Feigelman, B. (2011). Springer.
- *Grief After Suicide: Understanding the Consequences and Caring for the Survivors*. Jordan, J. R., & McIntosh, J. L. (2010). Routledge.
- *The Impact of Suicide*. Mishara, B. L. (1995). Springer.
- *Left Alive: After a Suicide Death in the Family*. Rosenfeld, L., & Prupas, M. (1984). Charles C. Thomas.
- *Living with Grief after Sudden Loss*. Doka, K. (1996). Taylor & Francis.
- *Retelling Violent Death*. Rynearson E. K. (2001). Brunner/Routledge.
- *Rocky Roads: The Journeys of Families through Suicide Grief*. Linn-Gust, M. (2010). Chellehead Works.
- *Silent Grief: Living in the Wake of Suicide* (revised edition). Lucas, C., & Seiden, H. M. (2007). Jessica Kingsley Publishers.
- *Suicide and Its Aftermath: Understanding and Counseling the Survivors*. Dunne, E. J., McIntosh, J. L., & Dunne-Maxim, K. (1987). Norton.
- *Survivors of Suicide*. Cain, A. C. (1972). Charles C. Thomas.
- *Why Suicide?: Questions and Answers About Suicide, Suicide Prevention, and Coping with the Suicide of Someone You Know* (revised edition). Marcus, E. (2010). HarperOne.
- *A Winding Road: A Handbook for Those Supporting the Suicide Bereaved*. Linn-Gust, M., & Peters, J. (2010). Chellehead Works.

Personal Accounts: Lived Experiences with Suicide Grief

- *Artful Grief: A Diary of Healing*. Strouse, S. (2013). Balboa Press.
- *Before Their Time: Adult Children's Experiences of Parental Suicide*. Stimming, Mary, & Stimming, Maureen. (1999). Temple University Press.
- *Blue Genes: A Memoir of Loss and Survival*. Lukas, C. (2008). Doubleday.
- *Do They Have Bad Days in Heaven? Surviving the Suicide Loss of a Sibling*. Linn-Gust, M. (2001). Bolton Press.
- *His Bright Light: The Story of Nick Traina*. Steel, D. (1998). Delacorte Press.
- *In Her Wake: A Child Psychiatrist Explores the Mystery of Her Mother's Suicide*. Rappaport, N. (2009). Basic Books.
- *Real Men Do Cry*. Hipple, E. (2008). Quality of Life Publishing Co.
- *Seeking Hope: Stories of the Suicide Bereaved*. Linn-Gust, M., & Cerel, J. (2011). Chellehead Works.
- *Stronger Than Death: When Suicide Touches Your Life*. Chance, S. (1992). Norton.
- *The Suicide Index: Putting My Father's Death in Order*. Wickersham, J. (2008). Mariner Books.
- *Words I Never Thought to Speak: Stories of Life in the Wake of Suicide*. Alexander, V. (1991). Lexington Books.

For Children and Their Caregivers

- *After a Parent's Suicide: Helping Children Heal*. Requarth, M. (2008). Healing Hearts Press.
- *After a Suicide Death: An Activity Book for Grieving Kids*. (2001). The Dougy Center.
- *But I Didn't Say Goodbye: Helping Children and Families after a Suicide*. Rubel, B. (2000). Griefwork Center.
- *Red Chocolate Elephants: For Children Bereaved by Suicide* (includes DVD). Sands, D. (2010). Karridale Pty Ltd.
- *Someone I Love Died by Suicide: A Story for Child Survivors and Those Who Care for Them*. Cammarata, D.T. (2009). Limitless Press.

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