ELLIPSE
E-Lifelong Learning in Prevention of Suicide in Europe
POSTVENTION

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ELLIPSE POSTVENTION

HANDBOOK

spes BLEKINGE

UNIWERSYTET JAGIELLOŃSKI W KRAKOWIE

pts Stowarzyszenie Polskie Towarzystwo Suicydologiczne

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INTRODUCTION

Welcome to the manual for ELLIPSE Postvention Course (e-learning). The unexpected loss of a loved one often causes radical changes in our lives, leading to an identity crisis during which we question our choices regarding a partner, studies, work, behaviour, life roles and more. This manual introduces us to the world of people who have experienced suicide loss and shows us what can help us in difficult moments of life after a traumatic loss. We will also try to answer the question: How can a postvention course improve the ability to cope with losses in other areas of life?

Experiencing various losses is an inevitable part of life's journey, interspersed with periods of joy and well-being. A famous statement from the movie "Forrest Gump": "Life is like a box of chocolates. You never know what you're going to get" draws attention to the unpredictability of the situations we face in life.

The news of loss shifts us from well-being to anxiety as we lose so many elements of our own lives at the same time. When we lose a person, we also lose everyday activities, our position in that person's life, the values associated with this relationship and some of the roles that are particularly close to us, e.g. the role of parent, child, friend, supporter, healer, teacher and many others.

As a result, the loss of a significant other often triggers a range of grief responses – feelings, thoughts, and behaviours – that profoundly impact our lives. We will focus mainly on how we react to information about the suicide of someone close to us. Our reactions to such a huge loss often mirror our responses to previous losses. Suppose our coping strategies prioritised life and health. In that case, we may find it easier to turn to these orientations when faced with an unexpected, unwanted, and tragic situation, such as the loss of suicide.

Conversely, suppose our previous responses were loss-oriented and unhealthy coping habits. In that case, the feelings we experience while grieving after suicide will deepen our distress by reminding us of other difficult times related to losses in our past. This is where the concept of postvention comes into play, emphasising the importance of building a support system that allows you to survive the difficult period after loss. Postvention includes both complicated mourning and post-traumatic growth. It is worth remembering that even the most tremendous trauma is also a chance for a new beginning, which, although unwanted, can make our lives more satisfying.

Losses can be shocking, and we often don't know how to react. Therefore, the purpose of this handbook and course is to guide how others have dealt with similar experiences, how scientists describe this period, and what recommendations they offer. The guide provides many practical skills, procedures and principles that will help us grieve and thrive despite adversity, finding paths in life that are good enough and sometimes even profoundly satisfying despite the trauma.

Each of the six modules (A-F) contains a lesson/chapter that begins with an introductory question for use in the discussion, a bullet-point description of the chapter content, what you will learn, chapter content, conclusions, and multiple-choice questions with answers and references.

We advise you to study this complex topic in the company of another person(s). It will increase your learning efficiency, make the course more interesting, and provide natural support.

We wish you a supportive journey,
"ELLIPSE Postvention" project team

Helplines for personal crises: **findahelpline.com**
12-Steps Safety Plan: **12stepsplan.com**

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A.01
DEBUNKING MYTHS AND UNVEILING FACTS ABOUT GRIEF

Introductory Question:
How can dispelling common myths about grief transform our understanding and support of those navigating the complex journey of loss?

What You Will Learn:
1. The Emotional Complexity of Grief
2. Understanding Disenfranchised Grief
3. Recognising Silent Mourners
4. Exploring Diverse Coping Mechanisms
5. Identifying Varied Support Needs
6. Challenging Mental Health Misconceptions
7. The Timeless Nature of Grief
8. Unpacking the Multifaceted Causes of Grief

Introduction:
Grieving is something everyone goes through, yet it's often clouded in misconceptions and myths that can make it harder to provide the proper support and understanding. By debunking these myths and acknowledging the multifaceted nature of grief, we can better support those grieving and foster a more compassionate and informed society. This exploration sheds light on the emotional complexity of grief, the wide-reaching impact on various individuals, and the diverse coping mechanisms and support needs that accompany the grieving process.

10 MYTHS AND FACTS

1. Myth: Grief is only the feeling of sadness and sorrow.

Fact: In grief, we may experience various emotions: anger, anxiety, guilt, shame, and pain.

2. Myth: Grief affects only people close to the deceased (family, friends).

Fact: Grief extends to many others, often overlooked, termed "forgotten mourners": healthcare professionals, social care workers, schoolteachers, witnesses to the death by suicide, and individuals with psychiatric issues. It is also called disenfranchised grief.

3. Myth: You can identify all those who may need help by their expression of grief.

Fact: Many affected by grief, known as "silent mourners," may not display outward emotions, making it challenging to gauge their need for support.

4. Myth: People cope with grief by talking about it.

Fact: Coping mechanisms vary, and while some seek solace in conversation, others may not feel inclined to discuss their grief.

5. Myth: Those not talking about grief do not experience its emotions.

Fact: People avoiding discussion may still undergo intense grief, hindered by shame and fear of judgment, particularly concerning suicide.

6. Myth: People in grief share identical support expectations and needs.

Fact: Support needs significantly differ; some seek assistance, while others prefer supporting fellow

mourners. Some seek immediate aid, while others may need assistance weeks, months, or even years post-loss.

7. Myth: Grief is a mental health disorder. That is why we need to contact healthcare professionals about medication.

Fact: Grief is an emotional reaction to the loss of a person, place, or idea. We can grieve the death of a person, we grieve the loss of the future we thought we would have, and we grieve the emotional connections we had before they died.

8. Myth: Bereaved individuals inevitably develop post-traumatic stress disorder (PTSD) after suicide.

Fact: With a lot of work and support to process the grief and trauma a person faces following the loss by suicide, some people may experience Post-Traumatic Growth. Some may not. One thing we know for sure is we are never the same person we were after the death. For some this will be measured as PTG - for others it will be measured by other means.

The latest research refers to "Post-Traumatic Stress (PTS)" and not PTSD. PTS is a natural reaction to a very traumatic experience and therefore it is not a disorder.

9. Myth: We shouldn't feel pain after a few months.

Fact: There is no set timetable for the emotions that occur.

10. Myth: Grief stems solely from psychological causes.

Fact: Grief is influenced by various factors, including biological, psychological, social, and cultural elements. We grieve because we experience love and connection.

Conclusion:

Dispelling myths about grief is crucial for fostering a deeper understanding and more effective support for those who are grieving. Recognising the emotional complexity, the broad impact of grief, and the diverse ways individuals cope and seek support can lead to more compassionate and informed approaches. By embracing these truths, we can better support those navigating the challenging grief journey and promote healing and resilience in our communities.

Takeaways:

1. **Emotional Complexity:** Grief encompasses a range of emotions beyond sadness, including anger, anxiety, guilt, and shame.
2. **Disenfranchised Grief:** Grief affects not only close family and friends but also healthcare professionals, social care workers, and others who may be overlooked.
3. **Silent Mourners:** Many people experience grief without outwardly showing their emotions, making it difficult to identify their need for support.
4. **Diverse Coping Mechanisms:** Individuals cope with grief in various ways, and not everyone finds comfort in talking openly about their loss.
5. **Varied Support Needs:** Individuals' needs for support vary, with different expectations and timelines for seeking help.

Appendix 1.A.01 provides ten basic facts about grief after suicide.

Multiple-Choice Questions:

1. **Which statement about grief is accurate?**
   A. Grief is solely characterised by sadness.
   B. Grief affects only close family and friends of the deceased.
   C. People cope with grief by discussing it openly.
   D. Grief reactions are uniform and consistent across individuals.

2. **According to the passage, who might be considered "forgotten mourners" affected by grief?**
   A. Family members of the deceased.
   B. Healthcare professionals.
   C. Close friends of the deceased.
   D. All the above.

3. **What misconception about grief does the passage debunk?**
   A. People who avoid discussing grief may experience emotional distress.
   B. Grieving individuals always expect immediate support.
   C. Psychological factors solely influence grief reactions.
   D. The bereaved always develop PTSD following a suicide.

4. **What does the expression of grief suggest about the influence of culture on grief reactions?**
   A. Cultural norms have no impact on how people experience grief.
   B. Neurobiological factors entirely determine grief reactions.
   C. Different cultures may shape how individuals experience and express grief.
   D. All grief reactions are uniform across cultural backgrounds.

Answers:

1. C. People cope with grief by discussing it openly.
2. B. Healthcare professionals.
3. A. People who avoid discussing grief may experience emotional distress,
4. C. Diverse cultures may shape how individuals experience and express grief.

A.02
FINDING STRENGTH: HOW TO COPE WITH SUICIDE LOSS

Introductory Question:
How can you navigate the overwhelming grief of losing someone to suicide and find a path toward healing?

What You Will Learn:
1. **Recognising Grief Reactions:** Understand the wide range of emotions and physical symptoms associated with grief.
2. **Caring for Your Physical Health**: Learn self-care practices to combat the physical toll of grief.
3. **Honouring Your Loved One's Memory:** Explore meaningful ways to keep their memory alive.
4. **Positive Emotional Channels:** Discover how to channel your emotions into positive actions and find solace.
5. **Avoiding Harmful Behaviours:** Identify common pitfalls to avoid during the grieving process to support your healing.

Introduction:
If you have lost someone in suicide, you are in grief. Grieving a suicide loss is a deeply personal and often isolating experience. The emotions you encounter—ranging from intense sorrow and anger to guilt and numbness—can be overwhelming. Understanding that these reactions are normal can provide some comfort. This Chapter aims to provide you with practical strategies to manage your grief, honour your loved one's memory, and ultimately find a way to heal. You can navigate this difficult journey with resilience and hope by recognising the importance of self-care, embracing support systems, and avoiding detrimental behaviours.

This Chapter aims to help you deal with feelings that "accompany" a severe loss. Knowing what to do and what to avoid can help make grief reactions more manageable. You may practice these tips alone, with your family, a friend, or a "grief facilitator."

10 THINGS TO DO IN GRIEF

1. Recognise your grief reactions. Sorrow and crying, difficulties in everyday functioning, searching for answers to what and why this happened, blaming, and accusing help us cope with trauma. We may feel that it is impossible to think that we will feel less pain from the loss, and the fog of distress blurs our vision. It is normal! However, it is also expected that some of us will automatically focus on helping others concerned about losing even more, i.e., a mother who focuses all her energy on other children or friends.

Tips: Take the time you need to identify coping skills that work best for you.

2. Take care of your physical health. We may feel a range of physical stress symptoms, such as pain, loss of appetite, dizziness, insomnia, and tiredness. We may think that even a small action is a considerable and impossible effort. Sometimes, it will be precisely the opposite - we will run away to work and not feel any bodily disturbances.

Tips: Help counteract stress and fatigue by getting enough sleep, eating well, and practising awareness and training. In distress, practice, i.e., box breathing (https://12stepsapp.com).

3. Remember a person you have lost. Allow a person you have lost to have a positive influence on your life despite this tragic death.

Tips: Find ways to remember a person you have lost, as it can help you tackle the pain of loss. Maybe a memory page, an album with photos of a person›s life, commitment to work in the NGO organisation, helping others, or making donations to suicide research, crisis lines and education in suicide prevention?

4. Do something good. Death often awakens adverse reactions. It can be an act of revenge or punishment on those you suspect contributed to your loss, i.e., a

concrete person or, more general, i.e., doctors who did not save our beloved, and a desire to punish the guilty.

Tips: Allow yourself for a positive action that can help you and other people experiencing grief. It may be a turning point in your life.

5. Accept your feelings and thoughts. It is expected to feel guilt, anxiety, anger, pain, shame, sadness, but even shock, relief or a lack of feelings, a kind of apathy and numbness. We experience grief feelings with a different intensity. We may be "immobilised" or «freeze» in one to two opposing emotions, often sorrow and pain, thinking that we will never be able to laugh again and enjoy life. Some of us may "freeze" in helping others to recover and feel that is the meaning of life. Not being able to help others can cause severe distress.

Tips: Allow yourself gradually to feel better and return to "new normal" level of functioning

6. Forgive yourself and others. Anger comes from the experience of being hurt and feeling injustice. A grieving person may think that forgiveness is impossible. Nurturing the negativity leads to conflicts and other negative consequences for you and your close relatives.

Tips: Forgiveness is a conscious decision or action over which we have control and which helps our close relatives and us to recover after trauma and gradually feel better and adjust to the new reality.

7. If you are religious, seek consolation in your faith. Strong faith and a religious community can help you regain peace and control your negative emotions.

Tips: You can pray for a lost person and talk to the priest about your grief.

8. Take farewell. Unexpected death may leave us with many unexpressed feelings and unspoken words. You may also think of them after a funeral.

Tips: Write a letter expressing feelings you would like to communicate to a deceased.

9. Find a strategy for tough times. There will be times when painful feelings emerge with a greater force, i.e., during holidays, anniversaries, and other special occasions that «trigger» your sadness. Sometimes, sadness, despair, and pain may come back for no reason.
Tips: On the anniversary of your loss, you may want to be alone or go to a cemetery or church. You can plan to spend it with your friends or family. In the case of suicidal thoughts, you may also e.g., call the crisis line.

10. Allow yourself to grow through your grief. Grief can give you the energy to build a successful life against all odds. What separates those who have succeeded in their lives and those who have failed is not the number or severity of traumatic experiences. It is a way in which they have learned to handle those experiences. They have learned to live with their grief in a constructive and enriching way, to learn lessons, and to use them in situations that involve even more grief. Sharing your loss lightens the weight of grief, making it more bearable. Wherever the support comes from, accept it. You do not have to mourn alone. Connect with others to heal.

Tips: Localize resources and allies: Family. What is the name of a family member you can contact in need? People with similar experiences. Professionals.

10 THINGS NOT TO DO IN GRIEF

1. Don't block your feelings. Learn how to transform them! If you stop your emotions and avoid thinking about your loss, it usually prolongs the mourning process. It is not unusual that those grief reactions show up eventually, sometimes after many months or even years when you do not even expect that.

2. Don´t numb your pain with alcohol and drugs. They artificially and temporarily can block complicated feelings, but eventually, they can result in losing control and avoidable, unnecessary losses, health problems and life-threatening situations.

3. Don't nurture negativity. Negative feelings and memories will show off, and it is natural as you suffer a huge loss. The negative emotions can lead you to despair, fear, revenge, and hate. You may even think that you need the punishment. The grief emotions may lead to avoidable depressive distortions and more losses, blocking your true potential. Choosing a more positive attitude is possible.

4. Don't isolate yourself. You may avoid others feeling like no one can understand your pain. You may feel shame seeing what you could do the other way. You may be afraid of others blaming you. Some people pull themselves more blame than others. So, isolating may feel like the most natural way of dealing with the

situation. A severe loss constricts our vision, resulting in tunnel vision and a fog of negativity. We do not see anything positive and feel we›re alone. You don›t have to mourn alone. Others are often more understanding than you think. The experience of discovering it can be a turning point in your life.

5. Don't hurt others. You suffer a severe loss, and it hurts you. You were not able to help. And the others were not able to help. You may think they should know better than you what to do. Hurting them may feel like the most natural thing to do. And it might even make you feel a bit better. However, accusing, blaming, scapegoating, and stigmatising others only temporarily reduces suffering and guilt. The negativity makes things worse. Sometimes, people make mistakes, often in good faith, convinced that they did right without being able to foresee the consequences. Join others in the fight to reduce the risk of human mistakes and better suicide prevention.

6. Don't stigmatise other ways of coping and mourning. Sometimes, we put all our negativity on things that potentially result in the death of our beloved. Let´s remember that the thing causing death in one person can be hope and lifesaving for another one. A classic example is medicines, which are often lifesaving but can also be dangerous to life and health if some precautions are not in place.

7. Don't make critical decisions under the influence of negative feelings. Feelings are like waves: they come and go away. Wait always with critical decisions for strong waves to pass in a "safe harbour" without making any drastic movements.

8. Don't let loss decide your path in life. You have the right to your own life even if you suffered a severe loss. Learn skills that strengthen your resilience and coping. Learn to cope with recurring waves of sorrow, pain, guilt, and other difficult emotions.

9. Don't forget the power of your interests and daily routines. You have the right to continue your interests. You have the right to feel well. Your daily routines and interests were helping you to feel well before, and if you allow, they can help you now and in the future. They are your best allies!

10. Don't give up! There is hope, even if you cannot see it right now! To be able to have better contact with positive memories, you can use, i.e., 12 Steps Safety Plan describing the things that have value for you in life, illustrating them with photos, audio, and videos. Such a Safety Plan can keep you safe during periods of life that are challenging and tough. Life is not all in roses, but it is still the most precious and the only one we have. Taking care of ourselves, others, nature around us, and our planet makes the world a better place and a more friendly place to live in.

SHORT LIST 10 THINGS TO DO IN GRIEF

1. Recognise Your Grief Reactions: Acknowledge and understand your emotional and physical responses to loss. Give yourself time to return to daily functioning gradually.

2. Take Care of Your Physical Health. Prioritise self-care with rest, a balanced diet, and mindfulness practices.

3. Cherish and honour your loved one's memory. Create a memory page or photo album or engage in charitable work.

4. Engage in Acts of Kindness: Channel your emotions into positive actions. Perform acts of kindness to aid your healing.

5. Accept Your Feelings and Thoughts: Embrace the wide range of emotions during grief. Allow yourself time to navigate your feelings and work towards healing.

6. Forgive Yourself and Others: Let go of anger and embrace forgiveness. Choose forgiveness as a step towards healing.

7. Seek Consolation in Faith: Draw strength from faith and religious communities. Engage in prayer and seek guidance from spiritual leaders.

8. Take Farewell: Address unresolved emotions and unspoken words. Compose a letter expressing your feelings to the departed.

9. Find Strategies for Difficult Times: Prepare for challenging moments like holidays and anniversaries. Plan and reach out to crisis hotlines if needed.

10. Allow Yourself to Grow: Embrace personal growth through grief. Learn from your experiences and seek support to aid in healing.

SHORT LIST
10 Things To Avoid in Grief

1. **Avoid Suppressing Your Feelings:** Don't ignore your emotions; it can prolong grief.

2. **Don't Use Alcohol or Drugs:** Avoid substances as they can lead to health issues.

3. **Avoid Dwelling on Negativity:** Focus on positive aspects and seek support.

4. **Don't Withdraw or Isolate Yourself:** Contact friends, family, or professionals.

5. **Avoid Harming Others:** Don't lash out; instead, work towards reducing human error in suicide prevention.

6. **Avoid Stigmatizing Alternative Coping Methods:** Respect diverse coping strategies.

7. **Refrain from Making Major Decisions in Distress:** Wait until emotions are more stable.

8. **Don't Let Helplessness Take Over:** Focus on retaining control and building resilience.

9. **Don't Relinquish Your Routines and Interests:** Maintain your interests and daily routines.

10. **Never Lose Hope:** Hold onto hope and use tools like the 12 Steps Safety Plan for support.

Conclusion:

Coping with the loss of a loved one to suicide is an arduous journey, but you are not alone. By incorporating the strategies detailed in this manual, you can adeptly navigate your grief journey and foster a process of healing. Give yourself permission to experience and work through your emotions, lean on the support of those close to you and professionals, and prioritise self-care above all else. Avoid behaviours that can hinder your recovery and focus on positive actions that honour your loved one's memory. You can find strength and resilience even in the face of profound loss through patience, compassion, and determination.

Takeaways:

1. **Recognise and Accept Your Emotions:** Acknowledge the diverse emotions you may feel during grief.
2. **Prioritise Physical Health:** Ensure you get enough rest, maintain a balanced diet, and incorporate mindfulness practices.
3. **Honour Your Loved One's Memory:** Find meaningful ways to remember and celebrate their life.
4. **Seek Support and Self-Forgiveness:** Lean on your support network and practice self-forgiveness to aid your healing journey.
5. **Avoid Harmful Coping Mechanisms:** Avoid behaviours that can exacerbate your grief and focus on positive, constructive actions.

Postvention activity

Multiple-Choice Questions:

1. What is an essential first step in managing grief reactions?
A. Suppressing your feelings
B. Recognizing your grief reactions
C. Isolating yourself
D. Ignoring your emotions

2. Which self-care practice is recommended to help with physical health during grief?
A. Ignoring physical symptoms
B. Using alcohol to cope
C. Prioritizing rest and a balanced diet
D. Avoiding exercise

3. What is a suggested way to keep the memory of a loved one alive?
A. Forgetting the past
B. Creating a dedicated memory page
C. Isolating from family
D. Ignoring memories

4. What should you avoid doing during grief?
A. Seeking support from friends
B. Performing acts of kindness
C. Suppressing your feelings
D. Practicing self-care

5. Why is it essential to avoid making significant decisions during intense grief?
A. Emotions are stable during grief
B. Major decisions are easy to make
C. Emotions can cloud judgment
D. Grief has no impact on decision-making

Answers:
1: B. Recognizing your grief reactions
2: C. Prioritizing rest and a balanced diet
3: B. Creating a dedicated memory page
4: C. Suppressing your feelings
5: C. Emotions can cloud judgment

A.03
FAMILY RESILIENCE: EMBRACING A HEALING NARRATIVE

Introductory Question:
How can we transform the overwhelming pain of losing someone to suicide into a narrative of healing and resilience?

What You Will Learn:
1. Recognise the importance of creating a family-focused healing narrative to navigate the grief journey.
2. Train coping together with grief and processing intense feelings.
3. Express safely the complex emotions involved in grieving a suicide loss.
4. Learn how to foster open dialogue and support within the family unit.
5. Explore methods for self-care and managing emotional triggers.

Introduction:
Suicide is a difficult experience for the whole family. Losing a loved one to suicide is a deep trauma, leaving individuals and families grappling with intense emotions and unanswered questions. It can feel overwhelming, leaving us paralysed and inundated with complex emotions. We're all affected by what we can call GAPS feelings (Guilt, Anxiety, Anger, Pain, Shame and Sadness), which have a profound impact on our thoughts, actions, and future.

It's natural to repeatedly ask ourselves, "Why did it happen?" as we try to comprehend the tragedy and shield ourselves from further pain. If we are not equipped to manage these highly intensive feelings and complex questions, they can become dangerous and destructive, triggering self-harming and suicidal behaviours.

In some cases, individuals may harm themselves as a way to feel "connected" to the person they lost, as this person died because of harming themself. Unfortunately, this only exacerbates GAPS' feelings of guilt, anxiety, anger, pain, shock, sadness and shame. These intense emotions are a warning sign, indicating that we're veering off course from our core values. It signals that we need to shift our focus towards caring for ourselves and others to improve the situation. In the aftermath of such a loss, it's crucial to find ways to navigate the grief journey and cultivate resilience. This Chapter aims to provide insights and practical strategies for processing grief, fostering support, and finding healing after a suicide loss. While we can't erase the trauma of suicide, we can take steps to protect ourselves and others from its devastating effects. We can do it by creating a healing narrative, a story, an explanation that protects us from suicide and its unwanted consequences in the future.

FINDING STRENGTH IN GRIEF: A STORY OF RESILIENCE

Several years back, I had a conversation with a 16-year-old young man who had experienced profound pain in his early years, prompting him to resort to self-harm as a means of coping. When his brother died by suicide, it was a devastating shock. Despite their strained relationship, he was profoundly saddened by his brother's death, realising that family bonds are more potent than differences and conflicts.

Grappling with feelings of anger, guilt, sorrow, and anxiety, he made a conscious decision to stop harming himself. He recognised that suicide only perpetuates pain and decided to focus on kindness and self-care instead. He did not want to inflict the same unbearable suffering on his family that they experienced after his brother's death.

Amid his grief, he learned the importance of shifting focus towards self-care, considering the well-being of family members, and healing from trauma. Simply being present and supporting one another provided solace and helped them cope with their loss.

Remember, you are never alone, even if it feels that way in the depths of sorrow and pain.
We are in this together, sharing your pain and suffering and making it easier for us to overcome it eventually. We will never give up!

TEN WAYS TO COPE WITH GRIEF AFTER SUICIDE AS A FAMILY

1. Acknowledge: *Loss is a part of our life's journey. It teaches us that adversities are inevitable.*

2. Normalise discussions about mental health and suicide, treating them with the same openness as cancer or traffic accidents: *Some families lose their loved one in cancer, while other families lose someone they loved in suicide. We would like to protect them, but it is not always possible. We know that looking for help in time saves lives*. This can reduce stigma and encourage seeking help to prevent fu r t h e r tragedies.

3. Recognise that we cannot always control life's events or the actions of our loved ones. *"Feeling helpless and hopeless is a natural response, but it's essential not to let* it define *us"*. Sometimes, this sense of loss can grow into self-loathing or resentment towards others perceived as responsible.

4. Foster open conversations about emotions, ensuring everyone knows it's normal to experience a wide range of feelings. This teaches children that emotional expression is healthy, even when it involves profound pain.

5. Learn to manage and channel your emotions constructively. While feelings can be overwhelming, they don't have to dictate our lives or relationships.

6. Accept that you will not get answers to many of your questions.

7. Reach out to those around you for help with daily tasks when grieving feels particularly exhausting. This is especially important when you are more immersed in your grief. Family members and friends often want to support you after a suicide loss but may not know precisely how to help.

8. Practice self-care while grieving a suicide loss. Make sure to drink enough water, get a daily exercise routine, get out for a walk in nature, or prepare some nutritious food and try to get enough sleep.

9. Remind yourself and your family that these painful feelings are temporary and may resurface in certain situations. Preparation is vital; plan coping strategies such as lighting a candle, saying a prayer, or looking at photos of the loved one when triggered.

10. Despite adversity, reaffirm that you and your family can maintain your essence and continue caring for yourselves and each other. Let your child know that they are deeply loved.

GRIEF PROCESSING - TALKING TO OTHERS

Navigating conversations with others after a suicide loss can be challenging as we grapple with how to address their inquiries or describe the circumstances. These sentence prompts can be a valuable tool for initiating dialogue, whether it is with your child, teenager, friend, or even yourself. By offering a structured framework, these prompts can alleviate the unease associated with discussing the event, articulating your emotions, and sharing insights into how you are navigating the trauma.

ANSWERING QUESTIONS ABOUT SUICIDE:

→ *The person who died in my life is*

_____

→ *The cause of death was*

_____

→ *I found out about the death when*

_____

→ *My first feeling was*

_____

because

_____

→ *Now I feel:*

_____

because

_____

→ *What makes me most angry is*

_____

→ *I worry most about*

_____

because

_____

→ *The hardest thing about school/work is*

_____

because

_____

→ *My trusted friends are*

_____

→ *They told me*

_____

→ *What helps me the most is*

_____

→ *What does not help me is*

_____

→ *I can talk about it with*

_____

→ *I feel I cannot talk about it with*

_____

because

_____

GRIEF PROCESSING - SELF-TALK (GPS)

The sudden loss of a loved one, including through suicide, often leaves us grappling with unspoken feelings and thoughts towards the deceased. These lingering emotions can become persistent ruminations, replaying in our minds without resolution. One effective method to confront these thoughts is to articulate them in writing, whether in a note, card, or letter. This act can offer a sense of closure, relieving the burden of unfinished business. Below is a template every family member can use to express their sentiments and fill communication gaps.

Dear Dad/Mom/Child/Sister/Brother/Friend/ [insert your relationship to the person you lost]:

_____

As you died so unexpectedly/As we are not sure what was precisely the cause of your death, but we know that you are no longer here with us, I want to bid you farewell as I could not do before your passing. I will share with you some of my feelings and thoughts:

1. *As you were my Dad/Mom/Child/Sister/ Brother/ Friend/ [insert your relationship to the person you lost]*:

_____

2. *(Sadness) … it saddens me greatly that you are no longer with me/us.*

3. *(Moments of Joy and Happiness) … we shared many experiences. I remember, for example, [insert memory]*

_____

_____

I want you to know that I will cherish those moments dearly.

_____

4. *(Love)… I recall feeling loved/happy when you [describe a loving moment]. I will always cherish those moments of joy.*

_____

_____

5. *(Anger)… we had our conflicts. I couldn't stand it when you [describe a situation]. I responded in anger by [describe your reaction]. And now, I am angry that you are not here/that we cannot do things together.*

6. *Fear (anxiety)… I remember feeling fearful when [describe a situation]. And now, I fear how I will cope without your support/presence.*

7. *Guilt… I often felt guilty when [describe a situation]. I feel guilty now that I [describe your feelings/actions]. They say I should not feel guilty, but it's precisely what I think. I know that guilt is a natural part of grief, like sadness, anger, or fear.*

8. *Pain… I felt almost physical pain when [describe a painful moment]. And now, I feel pain knowing we won't be able to [describe activities you'll miss doing together].*

9. *Feeling Bad (unrecognised/mixed feelings) … I feel so bad when I think about everything you could have done in your life and that you are no longer with me/us.*

10. *I forgive myself for not being good, wise, and strong enough to [describe a situation].*

11. *Thanks to you, I feel gratitude for all the good things that happened in my life.*

12. *I accept that I will not have physical contact with you again (I will never again feel your touch, hear your voice, see you, [describe other senses]).*

13. *For now, I will focus on… surviving the grief that I feel and supporting all who are grieving with me.*

14. *Future… While looking to the future, I will continue to be the person you wanted me to be, the person you could be proud of. But I want you to know that your death has changed me, my life, and our family's life forever. I will miss you, especially all the beautiful moments we shared.*

15. *People, places, activities, anniversaries, and holidays will remind me of you. I will light a candle, look at your photo, say a prayer, visit [your grave/place where we used to be together] (or engage in other meaningful activities when reminded of your loss).*

16. *I will do everything to recover from the emotional wounds due to my losses, including losing you. I will strive to be as good/kind as I can be to myself and others I encounter in life, as life is too precious not to focus on the good things and forgive the bad.*

Rest in peace, [your relationship].
PS [optional additional thoughts]

Conclusion:

Grief after suicide is a complex journey filled with difficulties, but it's crucial to remember that growth is possible. We can gradually find solace and resilience in tragedy by acknowledging our emotions, fostering open communication, practising self-care, and creating a healing narrative. Together, we can support each other with the pain and emerge stronger.

Takeaways:

1. **Embrace Emotions**: Accept and validate the full spectrum of emotions that come with a suicide loss, recognising that each feeling is a natural part of the grieving process.
2. **Foster Open Dialogue**: Encourage and maintain open communication within the family to build understanding, share experiences, and offer mutual support during this challenging time.
3. **Prioritise Self-Care**: Engage in self-care activities together to maintain your physical health and emotional well-being. This includes getting adequate rest, eating nutritious meals together, and finding moments for mindfulness and relaxation.
4. **Create a Healing Narrative**: Write down your family members' thoughts and feelings to help process the grief and find closure. This practice can provide clarity and a sense of resolution.
5. **Allow Time for Healing**: Understand that healing is a journey requiring patience. With the support of loved ones and a focus on resilience, finding peace and strength amidst the pain is possible.

Restoring family routines and discussing together how to express GAPS emotions: Guilt, Anxiety, Anger, Pain, Sadness, and Shame

Multiple-Choice Questions:

1. How can families normalise discussions about mental health and suicide?
A. By avoiding the topic altogether
B. Treating mental health discussions differently than other health issues
C. By discussing mental health openly and seeking help when needed
D. Ignoring signs of distress in loved ones

2. What is a recommended strategy for managing emotions constructively during grief?
A. Suppressing emotions to avoid feeling overwhelmed
B. Ignoring emotions altogether
C. Allowing emotions to dictate actions and behaviours
D. Learning to manage and channel emotions effectively

3. How can individuals encourage open dialogue within the family about their feelings?
A. By avoiding discussions about emotions
B. By dismissing others' feelings as unimportant
C. By reassuring each other that it's okay to experience a wide range of emotions
D. By bottling up emotions and avoiding confrontation

4. What is the importance of creating a healing narrative after a suicide loss?
A. It serves as a distraction from the pain of grief
B. It helps individuals avoid confronting their emotions
C. It provides closure and resolution to unresolved feelings and thoughts
D. It perpetuates feelings of guilt and shame

Answers:
1: C. By discussing mental health openly and seeking help when needed
2: D. Learning to manage and channel emotions effectively
3: C. By reassuring each other that it's okay to experience a wide range of emotions
4: C. It provides closure and resolution to unresolved feelings and thoughts

A.04 UNDERSTANDING AND MANAGING GRIEF: IDENTIFYING "RED FLAGS"

Introductory Question:
How can we effectively recognise warning signs of distress and provide support to those experiencing grief, especially children and teenagers?

What You Will Learn:
1. Identifying "red flags" signalling distress in grieving individuals, especially children and teenagers.
2. Recognising behavioural changes like social withdrawal and loss of interest in daily activities.
3. Understanding expressions of preoccupation with death and suicidal ideation.
4. Addressing school-related issues and social isolation in teenagers.
5. Distinguishing between healthy and unhealthy coping strategies.
6. Encouraging open communication and support in discussing grief.
7. Stressing the importance of reaching out for professional help whenever it is needed.

Introduction:
Dealing with grief, particularly after a loss as profound as suicide, can be an overwhelming experience, especially for children and teenagers. Recognising warning signs and understanding when to seek help are crucial in effectively supporting individuals navigating through grief. This Chapter aims to provide you with the knowledge and tools to recognise distress signals and offer appropriate support to those in need. The so-called "red flags" can be subtle in children. While a young adult might say, *"You'll be better off when I'm gone,"* a child might say something like, "*No one cares if I'm here.*"

SHORT LIST OF "RED FLAGS":

1. Suicidality:
- ➔ Previous suicide attempt (regardless of how serious)
- ➔ Family history of suicide threats, suicide attempts or suicide

2. Access to lethal means: weapons, medication, sharp objects

3. Experiencing loss:
- ➔ Dealing with loss can encompass mourning following the end of a relationship due to divorce or familial strife.
- ➔ Acute rejection as this person is no longer with us
- ➔ Loss of routines, self-esteem or hope about the future

4. Experiencing chronic problems with relationships:
- ➔ Chronic bullying
- ➔ Violence or witnessing violence
- ➔ Impulsivity

5. Symptoms of depression:
- ➔ Hopelessness, helplessness, loneliness and burden: "Nothing can be done"

LONG LIST OF "RED FLAGS" IN CHILDREN:

1. Changes in everyday behaviour:
Trust your instincts. While suicidal behaviour is often linked to symptoms of depression, you may also observe the following changes in your child:

- ➔ Altered sleeping patterns (excessive sleep, insomnia, or frequent night wakings)
- ➔ Changes in eating habits (overeating or undereating)
- ➔ Withdrawal from family and friends (social isolation)
- ➔ Psychosomatic symptoms, such as unexplained headaches, stomach aches, and other pains

2. Changes at school:
   It is entirely normal for kids to have ups and downs during the learning process. However, a consistent pattern of negative changes can be a "red flag" indicating that a child needs help. Take note of the following signs:

- Decline in academic performance
- Reduced interaction with teachers and peers
- Lack of interest in school and friendships
- School refusal or truancy
- Lack of interest in daily activities such as sports, playing, and extracurricular activities

3. Preoccupation with death:
   Watch for the following warning signs:
- Repeatedly asking about or researching topics related to death or self-harm methods.
- Statements expressing thoughts about death or discussing what might happen if they were no longer around. (e.g., "*You won't miss me when I die," "I wish I were dead," "I won't bother you anymore when I'm gone."*)

It's crucial to acknowledge that kids can grapple with thoughts of death, especially in difficult circumstances like loss or exposure to tragic events in the media. Any mention of suicide should always be taken seriously, and seeking professional help is imperative. Signs such as an intense preoccupation with death, researching methods of self-harm, or talking about their own death should never be overlooked. Offering support and helping them access the right resources is vital for ensuring their safety and overall well-being.

4. Child-sized will:
   Some children might give away their favourite possessions or tell parents, siblings, or friends who should have them. While this may seem like fantasy play to parents, it can indicate thoughts of suicide when combined with other concerning behaviours.

5. Artwork about death or suicide:
   Young children often struggle to express intense emotions verbally but may do so through writing or drawing. Encourage your child to share their poems, stories, or artwork that depict suicide or frequently portray themes of death with you, as these could be signs that they need professional help.

6. Significant mood changes:
   Notable shifts in mood can indicate a problem. If your child suddenly changes from calm and relatively happy to aggressive, withdrawn, or highly anxious, it is crucial to seek help.

"RED FLAGS" INDICATING A TEENAGER MAY NEED PSYCHIATRIC HELP

Recognising when a teenager requires psychiatric assistance is critical for their well-being. Here are some signals to watch out for:

1. **Dramatic Changes in Behaviour:** Pay attention to noticeable changes in behaviour at home, school, and social settings. Keep track of any concerning comments or questions the teenager may express.
2. **School Problems:** Inquire about any difficulties the teenager may face academically or emotionally. Address issues related to school performance, emotional distress, and social interactions.
3. **School Absences or Declining Grades:** Recognize that grief can result in a lack of motivation. Encourage the teenager to recognise that intense sadness is temporary and that avoiding schoolwork can make the situation even worse.
4. **Social Isolation:** Monitor whether the teenager withdraws from social activities and spends excessive time alone. Encourage social engagement and participation in activities with friends.
5. **Depression:** Differentiate between grief and depression and encourage the teenager to seek additional support if needed. Help them access counselling services through their school or other resources.
6. **Anger Issues:** Address any anger-related problems at home, school, or social settings. Teach healthy ways to express and manage anger.
7. **Feelings of Guilt:** Offer support to help the teenager cope with guilt and shame. Encourage open communication and self-forgiveness.

Additional Signals to Look Out For:

1. **Longing for Death**: Take seriously any indications of a desire for death, especially if accompanied by a history of depression or suicidal behaviour. Seek immediate professional assistance if necessary.
2. **Increased Suicide Risk:** Be vigilant for warning signs and consider joining survivor support groups for those who have lost a family member to suicide.
3. **Substance Abuse:** Educate the teenager about the risks of substance abuse and provide support if you suspect drug or alcohol use.

4. **Sexual Behaviour:** Be aware that grief may lead to risky sexual behaviours as a means of coping. Offer guidance and emphasise the importance of healthy coping strategies.

If you're concerned, ask direct questions about suicidal ideation and seek professional help promptly.

Openly discuss depression with your child to convey empathy and support.

Collaborate on creating a safety plan and ensure that potentially harmful items are secured safely.

DEALING WITH ANGER

Sometimes, "red flag" behaviours result in anger that is expressed in an unhealthy way, leading to even more losses.

Here is a story that gives an example from real life of how important it is to be able to cope with angry feelings and confront statements of other people, both youth and adults, who are loaded with anger.

A young woman in an abusive relationship that almost resulted in her death decided to protect her life and separate from the abuser. She also had contact with the Police. She stopped answering the calls from a person who behaved in a highly abusive way, both emotionally and physically.

Soon after, she got a message that this man had taken his life. She started to feel guilty and blamed herself; what could have been worse was when someone from her work became irritated with her and said to her that she was the reason for suicide.

Such stories when a person from school, work, family or other who is supposed to support the bereaved instead expresses their anger and frustration associated with their grief and powerlessness, blames, and stigmatises the bereaved, adding even more anger and guilt that they feel, to themselves. When stressed, they have a problem defending themselves and finding appropriate words. So, it is crucial to be prepared for such abusive situations that can happen after suicide.

Example of an Anti-Stigmatizing Talk (AST) (what a bereaved can think/answer):

"When a suicide happens, we feel so bad that we often unwillingly place guilt on someone else. When you tell me that it is my fault, it makes me feel bad, but I understand that you do not know how to express your anger without hurting me. Suicide has many causes, and we can never predict how a person will react. We cannot read someone's mind. But, if you want to talk to find out what we can do with our frustration, we can meet for lunch together and try to sort things out."

Example of an Anti-Self-Stigmatizing Talk (ASST) (what a bereaved can think in response to their automatic self-blaming and self-accusing thoughts):

"I loved him and miss these moments when our relationship made me happy. But my life and health were in danger, and I had to protect myself. I had to separate to stop his abusive behaviour. And, I had to stop answering his calls. (It was advice I got from the Police). I am sad that our relationship ended with his suicide, but in the other way, it could have ended with my death. Every person has the right to defence. I could not predict that he would take his own life a day after I did not answer his phone. I don't think I could do anything else in this situation. So, I do not think I should blame myself anymore for that, as I will only feel worse about that. It taught me to take better care of myself."

TEST ACRONYM CEASE FOR DEALING WITH CONFLICTS AND UNWANTED BEHAVIOURS

In navigating conflicts, particularly within the realm of suicide bereavement and addressing unwanted behaviours from others, employing the CEASE acronym can offer valuable guidance. This is especially crucial as expressions of anger and disruptive actions, including self-harm, may serve as indicators that a child or teenager requires support. The CEASE acronym provides a structured approach for engaging in conversations with individuals who evoke feelings of anger, whether in professional or personal settings. Moreover, it proves beneficial in assisting adolescents dealing with a spectrum of challenging behaviours, which adults may find daunting to address both at home and in educational environments.

CEASE acronym:

C - CALM DOWN
Maintain a calm demeanour throughout the conversation, using an even, polite, and friendly tone. Remember, your child's anger is directed not at you but at the situation. Put yourself in their shoes and practice patience. If you feel yourself becoming angry or offended, take a moment to count to 10 or take a deep breath to calm down.

E - EMPATHIZE
Sometimes, we need to express our frustration. Listen to them without judgment, showing that you're on their side and that you understand their feelings. Use phrases like "*I understand"* or *"I can see why you're angry/sad/frustrated."* While your child is speaking/screaming/yelling/accusing you, try to understand the problem/situation.

A - APOLOGIZE
Even if you are not to blame for the situation, you can still apologise for the stress/inconvenience your child/teenager has experienced.

Say something like:
"I'm sorry you are unhappy with the situation. Let's work together to turn things around and make it work for us as well as possible."

S - SEARCH A SOLUTION
Tell your child how you will try to fix the problem: *"I will talk to …., and we will see what we can do that all of us feel better" or "We need to find out how we can show more respect to each other".* Don't make any promises you won't be able to keep, as it will make things worse!

E - ENSURE SAFETY AND LOVE
Assure your child that you love them, even if you do not accept the acting-out behaviour, and that you do all you can to make the situation better/more acceptable for them. *"I love you even if I do not accept when you yell at me. It makes me sad and angry. It is important to respect other people even if we do not agree with them and feel angry!."*

Conclusion:

Navigating the aftermath of a loss, particularly suicide, requires vigilance and empathy. By recognising "red flags" signalling distress and understanding when to seek professional help, we can effectively support individuals coping with grief, ensuring their well-being and resilience in the face of adversity.

Takeaways:

1. **Recognise Signs of Distress:** Be alert to behavioural changes like social withdrawal, disrupted eating and sleeping patterns, and loss of interest in daily activities as potential indicators of emotional distress.
2. **Take Seriously Warning Signs**: Pay attention to expressions of preoccupation with death, suicidal thoughts, and giving away possessions, and promptly seek professional help when these signs arise.
3. **Address School and Social Issues**: Understand the significance of addressing school-related problems and social isolation in teenagers, as they may signify underlying emotional struggles that require support and intervention.
4. **Differentiate Coping Mechanisms**: Learn to differentiate between healthy and unhealthy coping mechanisms, encourage healthy distractions, and seek professional psychiatric assistance when needed.
5. **Encourage Open Communication**: Create an environment that fosters open dialogue, empathy, and support when discussing grief with children and teenagers, emphasising the importance of seeking help and professional guidance when necessary.

Multiple-Choice Questions:

1. **Why is recognising behavioural changes in individuals coping with grief crucial?**
   - A. A. To label them as "red flags"
   - B. To intervene early and provide appropriate support
   - C. To ignore them as a natural part of the grieving process
   - D. To avoid seeking professional help

2. **What are some examples of changes in behaviour that may indicate distress in children and teenagers?**
   - A. Increased academic performance and social engagement
   - B. Decreased interaction with teachers and peers
   - C. Improved eating and sleeping habits
   - D. Enhanced interest in daily activities

3. **Why should expressions of preoccupation with death and suicidal ideation be taken seriously?**
   - A. They are common in individuals coping with grief
   - B. They indicate a lack of understanding of death
   - C. They may signal underlying emotional distress and a need for professional help.
   - D. They are harmless ways of seeking attention.

4. **What should be encouraged when discussing grief with children and teenagers?**
   - A. Avoiding open communication to prevent emotional discomfort
   - B. Minimising the significance of their feelings
   - C. Fostering empathy, support, and seeking help when needed
   - D. Ignoring their expressions of distress

5. **What should be encouraged when discussing grief with children and teenagers?**
   - A. They are typical developmental phases.
   - B. They indicate high academic achievement.
   - C. They may indicate underlying emotional distress.
   - D. They signify healthy adjustment to grief.

Answers:

1: B. To intervene early and provide appropriate support
2: B. Decreased interaction with teachers and peers
3: C. They may signal underlying emotional distress and a need for professional help
4: D. Fostering empathy, support, and seeking help when needed
5: C. They may indicate underlying emotional distress

A.05
TALKING WITH A CHILD IN GRIEF

Introductory Question:
How can we support and guide our children through the complicated process of grief?

What You Will Learn:

1. **Preparing for Difficult Conversations**
→ Learn strategies to prepare yourself for challenging discussions about grief mentally.
2. **Timing and Approach**
→ Discover the best times and methods for broaching sensitive topics with children.
3. **Creating a Safe Environment**
→ Understand how to choose a private and comfortable setting for these important conversations.
4. **Effective Listening Techniques**
→ Master the art of active listening to support your child's needs better.
5. **Encouraging Emotional Expression**
→ Explore ways to help your child freely express all their emotions without judgment.
6. **Normalising Feelings**
→ Learn how to validate and discuss a wide range of emotions, helping children understand that their feelings are normal.
7. **Age-Appropriate Communication**
→ Get guidelines on tailoring your communication to be suitable for your child's age and understanding.
8. **Managing Your Own Emotions**
→ Develop techniques to be mindful of and appropriately express your own feelings during these conversations.
9. **What to Avoid When Talking About Grief**
→ Identify common pitfalls to avoid ensuring effective and compassionate communication.
10. **When and How to Discuss Suicide**
→ Gain insights on determining when it's necessary to discuss suicide and how to approach the topic with sensitivity and care.

Introduction:
Talking with a child about grief, especially following a sudden death or suicide, can be one of the most challenging conversations a parent or guardian can have. Children process grief differently from adults and may struggle to understand the complex emotions that come with loss. This chapter provides strategies and tips to help navigate these sensitive discussions, ensuring your child feels supported and understood.

TIPS ON HOW TO TALK WITH A CHILD IN GRIEF

- **Grief Preparation:** Mentally prepare yourself for a challenging conversation.
- **Timing and Approach**: Decide when and how to broach the topic and what narrative to share.
- **Choose a Private Setting:** Select a private location where your child feels comfortable talking.
- **Awareness of Overhearing:** Monitor what your child may overhear from other conversations.
- **Focus on Listening:** Prioritize listening to your child's needs without judgment.
- **Encourage Expression:** Allow your child to express all emotions without judgment freely.
- **Normalise Feelings:** Expect and openly discuss all emotions.
- **Age-Appropriate Questions:** Pose questions about trauma suitable for your child's age.
- **Invite Questions:** Invite your child to ask questions and answer them calmly and nonjudgmentally. *What are you thinking happened to X?*
- **Simplicity:** Use age-appropriate language and keep explanations simple.
- **Manage Your Feelings:** Be mindful of your emotions and how you communicate them.

TIPS ON WHAT TO AVOID WHEN TALKING TO A CHILD IN GRIEF

→ **Do Not Hide Your Tears:** It's essential not to conceal your tears. Crying in front of your child sends the message that it's okay to express feelings.
→ **Do Not Force Public Grief:** Avoid pressuring your child to display grief in public if they are not comfortable doing so.

➔ **Do Not Discourage Crying:** Do not tell your child to stop crying, as this may suppress their emotions and make them feel invalidated.
➔ **Avoid Overprotection:** Resist the temptation to overprotect your child from loss. Children understand more than we often realise, and going through the grieving process helps them adjust.
➔ **Do Not Confide in Your Child:** Avoid treating your child as your confidant. Instead, seek support from another trusted adult or a support group.
➔ **Avoid Misinterpreted Expressions:** Be cautious with expressions that your child could misunderstand. Young children interpret language literally, so avoid phrases that might instil fear or confusion.

Mom "fell asleep". Dad "sleeps" now.
God came and took Dad to heaven.
The sibling "was called home".
The brother "passed away".
"He is happy now."
The family "lost" their mother.
The cousin died because he "felt bad".
The father "could not take it anymore", and therefore, he died.

➔ **Avoid Linking Suicide to Common Life Events**: Refrain from associating suicide with situations like separation, break-ups, bullying, or feeling tired, as these are not singular causes of suicide.
➔ **Avoid Idealizing the Deceased:** Resist the urge to idealise the deceased child, as it may make siblings feel inadequate compared to the love shown to the deceased.
➔ **Avoid Comparisons:** Refrain from comparing the deceased child to surviving siblings, which can lead to feelings of unworthiness in the survivors.
➔ **Avoid Punishment:** Do not resort to punishment; avoid shouting, criticising, or judging your child's expressions, even if you find them inappropriate. This may be the only opportunity to build trust with your child.

TO TELL OR NOT TO TELL A CHILD ABOUT SUICIDE

Knowing when and what to say, as well as how to help children come to terms with loss and grief, is essential for their grieving process and overall health. However, discussing suicide can be particularly challenging, especially when dealing with the loss and accompanying emotions.
Intense or prolonged grief can significantly impact both adults and children, potentially leading to mental health issues such as anxiety, depression, or even suicidal behaviour, even long after the loss has occurred. Therefore, it's crucial to assess whether it's necessary to discuss suicide with children:

➔ If the suicide does not directly affect the children, there may not be a need to address it with them.
➔ If there is a possibility that they will hear about it, even among the youngest children, it's crucial to have the conversation. Even if the suicide didn't occur within the family, discussing it provides an opportunity for parents to initiate a caring dialogue about suicide, its consequences, and prevention measures. This approach helps instil the understanding that suicide is preventable right from the start, empowering children with valuable information.
➔ Children often sense when something significant is happening within their family or social circle. If they are not informed about a suicide, they may experience confusion or worry, wondering why no one is discussing the situation with them. This absence of communication may result in feelings of solitude or self-reproach.
➔ Grief can manifest differently in children, sometimes appearing to come and go. Even if children seem unaffected sometimes, it doesn't mean they aren't experiencing the loss. They may exhibit behaviours such as withdrawal, somatic problems, or sleep disturbances, indicating underlying grief that needs acknowledgement and support.

Who should tell a child about suicide?
You might assume that a professional is the ideal person to discuss suicide with your child. However, it is more effective for a parent, guardian, or trusted individual to have this conversation. Before broaching the topic, it is helpful to gauge your child's understanding by asking questions like, *"Have you heard anything about suicide? What do you think it is?*" This approach fosters open communication and allows for tailored discussions based on the child's level of comprehension.

When should you tell a child about suicide?
It is vital that a caregiver, a trusted person, informs a child about the suicide of a family member as soon as possible. This ensures that a child safely receives this information rather than gets it unexpectedly from social media or other sources.

If a parent or caregiver does not tell the child, they can also think that one should not talk about suicide in a family. It can result in stigmatisation of not only suicide but even help-seeking.

TALKING ABOUT SUICIDE WITH A CHILD

A child's comprehension of death varies depending on their age, that is why when faced with the task of discussing death with children, mainly if the deceased was a parent or someone close to them, it's essential to address their needs in an age-dependent manner. For a significant adult figure in their lives, ignoring their understanding of death is not an option.

Children's understanding of death in different ages:

- 0-6 months: At this age, infants have no concept of death but may respond to the reactions of their parents to the loss.
- 6-18 months: They may perceive death as temporary.
- Eighteen months to 5 years: Children in this age range continue to view grief as temporary and require concrete explanations about the meaning of death.
- 6-8 years: They understand that the deceased person will not return and grasp that death is something that can happen to anyone.
- 9-12 years: Curiosity about the biological aspects of death and burial emerges. They may engage in magical thinking, believing, for example, that someone died because of certain behaviours or wishing the person were dead. Additionally, they might personify death, imagining the deceased as a ghost or skeleton.
- 18 years or older (adolescents) fully understand the concept of death. To avoid instilling fear in a younger sibling that they may also die, it's important to explain that people die for two main reasons: severe illness or old age.

Here are some ways to explain suicide to a child:

→ *"Suicide is when someone dies because their brain is very, very sick. It's rare, but it happens and makes people very sad."*

→ *"The person had an illness in their brain that caused them to die. Their brain became very sick, and that's why they died."*

→ *"The brain is an organ in the body, like the heart, liver, and kidneys. Sometimes, the brain can get sick, just like other organs."*

It's possible that someone the child knows, or even the child themselves, has a brain illness. In such cases, it's crucial to emphasise that deaths from such diseases are sporadic.

Children often struggle to grasp the concept of death and may repeatedly ask where the loved one is or when they'll return, even after being told. It's important to calmly reiterate that the person has died and won't come back.

When explaining death, use simple, honest, and concrete sentences.

Young children may blame themselves for what happened, so it's essential to reassure them that it's not their fault.

Additionally, when explaining suicide, avoid associating it with situations your child may encounter in their life, such as separations or bullying, as these are never sole causes of suicide.
If an older child or teenager asks why someone died by suicide, you can respond with empathy and encouragement:

→ *"I don't know why they didn't seek help. Help is available! Many people receive support to overcome suicidal thoughts. The first step is always to talk to a trusted adult. If you or anyone you know is struggling with suicidal thoughts, I hope you'll feel comfortable discussing it with me."*

Be prepared for questions kids may ask you:

→ *"Why did she die?"*
→ *"She died because she was very, very sick."*

→ *"Did I do something to make this happen?"*
→ *"No. You didn't do."*

→ *"Is it my fault?"*
→ *"No, it's not your fault. Sometimes we think something is our fault, even if it is not."*

→ *"What could I have done differently?"*
→ *"You couldn't have done things differently, as you didn't know they would die in suicide."*

→ *"Will I die by suicide, too?"*
→ *"No, because one does not die in suicide if one has a safety plan and seeks help."*

→ *"Are you going to die too? Will I be left alone?"*
→ *"No, because I have a safety plan, and I know I would seek help if I had such a problem."*

→ *"If I die by suicide too, will I see my parent again?"*
→ *"We don't know what is after someone dies."*

- *What do I tell kids at school?"*
- *You can tell: My Dad died by suicide.*

- *"Will they think bad things about my family?"*
- *"It can happen. Some kids get angry and Say, mean things."*

- *"They make mean jokes at me. They say: "Ha ha, your Dad killed himself."*
- *"Some kids say so because they feel angry and don't know what to do with it. It is much better to say, "I am angry," than to say mean things that make others sad."*

- *"Why am I so sad? Will I be this miserable forever?"*
- *"No! Sadness and other feelings go over."*

- *"What can I do to feel better?"*
- *"You can, for example, talk to me."*

- *"How can I remember my Mom better?"*
- *"We can make an album and write a letter to her."*

- *"How can I make sure I never forget my dad?"*
- *"We can write about your dad."*

Source: https://www.camh.ca/en/health-info/guides-and-publications/when-a-parent-dies-by-suicide

TALKING ABOUT GRIEF EMOTIONS

G: Guilt *"Sometimes, after someone important to us dies, we might feel guilty. We might believe that something we did caused them to become ill or die. You might blame yourself, thinking that if you had done better at school, the person wouldn't have died. You might even blame someone else in the family. Feeling guilty can make us want to stop talking to people because we're afraid they'll blame us, too. Have you ever felt guilty like this?"*

A: Anxiety *"It's normal to feel afraid of losing someone else we love in the same way. We might worry, 'Will I lose my sister, my mum, or my pet too?' or 'Will I get sick like that too?' Have you ever had thoughts like these? It's okay if you have."*

A: Anger *"Have you ever felt angry? Sometimes, after someone we love dies, we might feel very lonely and even angry at our mum, dad, sister, brother, or friend for leaving us. It's hard to be angry at someone who's not here anymore, so sometimes we might turn that anger toward ourselves or other people around us. We might neglect our schoolwork or other responsibilities or find it hard to get up in the morning or care for ourselves. The anger can feel strong initially but gets weaker and goes away with time."*

P: Pain *"After someone dies, we might feel a lot of pain, making it hard to feel anything else. It's like a heavy pressure or tension that makes it difficult to move, think, or do things. With time, though, the pain feels a little easier to bear. When you're feeling this pain, it's okay to rest and take it easy. You'll slowly start to feel better as time goes on."*

S: Sadness *"Feeling very sad is one of the most common emotions after someone dies. Sometimes, we might feel like crying all the time, while other times, we might feel numb and not feel anything. The sadness can be so overwhelming that it's hard to describe."*

S: Shame *"When we feel guilty, we might also feel ashamed, making it hard to talk about our feelings. We might feel ashamed that we lost someone we loved or that they died by suicide. Sometimes, we might even tell others that they died from something else to avoid their reactions. It's okay to use different words to describe what happened if you're not ready to say 'suicide' yet."*

Conclusion:

Helping a child through grief involves patience, honesty, and sensitivity. By creating a safe environment, listening actively, and encouraging open expression of emotions, you can support your child through their grief journey. Remember, managing your feelings and seeking support when needed is essential. Grief is a complex and ongoing process, but with the right tools and understanding, you can help your child navigate through it.

Takeaways:

1. Grief Preparation is Key: Mentally prepare for the conversation, ensuring you are ready to support your child.
2. Create a Safe Space: Choose a private and comfortable setting for discussions about grief.
3. Listen and Encourage Expression of Feelings: Prioritize listening and encourage your child to express their emotions without judgment.
4. Use Age-Appropriate Language: Tailor your communication to your child's age and understanding.
5. Manage Your Own Emotions: Be mindful of your feelings and how they may affect your child.

Multiple-Choice Questions:

1. What is the first step in preparing to talk to a child about grief?
A. Tell them to stop crying.
B. Mentally prepare yourself for the conversation.
C. Give them a book about grief.
D. Avoid the topic altogether.

2. Why is it important to choose a private setting for discussions about grief?
A. To avoid distractions
B. To ensure the child feels comfortable
C. To prevent others from overhearing
D. All the above

3. How should you respond to a child's questions about grief?
A. Ignore them
B. Answer calmly and non-judgementally
C. Tell them to stop asking questions
D. Change the subject

4. What should you avoid when discussing grief with a child?
A. Using simple language
B. Showing your own emotions
C. Forcing them to display grief in public
D. Encouraging them to express their feelings

5. Why is it important to discuss suicide with a child if there is a possibility, they will hear about it?
A. To ensure they get the correct information from you
B. To avoid discussing it altogether
C. To scare them
D. To blame someone

Answers:
1: B. Mentally prepare yourself for the conversation
2: D. All the above
3: B. Answer calmly and non-judgmentally
4: C. Forcing them to display grief in public
5: A. To ensure they get the correct information from you

A.06 SUPPORTING OTHERS AFTER A SUICIDE LOSS: ESSENTIAL GUIDANCE

Introductory Question:
How can we offer genuine support to friends and family navigating the complexities of grief after losing a loved one to suicide?

What You Will Learn:

1. **Effective Communication Strategies**:
   - How to approach sensitive conversations about grief and loss.
   - Words and phrases that offer comfort and avoid causing additional pain.
2. **Creating a Supportive Environment**:
   - Techniques for fostering a safe and nurturing space for grieving individuals.
   - Ways to respect and accommodate different grieving styles.
3. **Emotional and Practical Support**:
   - Offering practical help and companionship to those in grief.
   - Recognising signs that someone may need professional help.
4. **Understanding Grief Dynamics**:
   - Insight into the varied emotional responses to grief.
   - Strategies to support children and adults differently through their unique grieving processes.
5. **Avoiding Common Pitfalls**:
   - Phrases and actions to avoid that may unintentionally harm or invalidate a grieving person's feelings.
   - How to provide meaningful support without imposing your own beliefs or expectations.

Introduction:
Navigating the intricate terrain of grief, mainly when supporting a child, other family members, friends or others in need, can present significant challenges for parents and caregivers. However, with the right strategies and support systems in place, it's possible to offer practical assistance to children as they process their emotions and navigate through their grief. This chapter provides actionable advice on how to best support others going through the grieving process.

WHAT TO SAY TO A PARENT WONDERING HOW TO HELP THEIR CHILD IN GRIEF?

Your child may feel better if you, as a parent, focus on supportive activities, showing your willingness to build a healthy relationship with your child. Choose which supportive activities you would use:

- **Respect Individual Grieving Styles:** Children may grieve privately or show emotions unexpectedly. Be supportive during these moments.
- **Acknowledge Varied Relationships:** Recognize that your surviving child shared moments of both love and anger with their deceased family member.
- **Address Guilt:** Children may feel guilty about past conflicts and may erroneously blame themselves for their sibling's death.
- **Provide Reassurance:** Assure your child that they were loved and that their actions did not cause the death, even if they may feel so. After a loss, feeling guilt and shame is common.
- **Encourage Positive Outlets:** Help your child express grief through constructive activities like drawing, journaling, or reading.
- **Show Patience and Affection:** Share comforting stories and engage in activities that help your child cope with grief.
- **Notice Positive Actions:** Pay attention to and acknowledge the positive things your child does, offering praise and encouragement.
- **Share With Your Child Values and Faith:** Communicate your beliefs about life and death with your child. If you are religious, you may pray together to provide spiritual comfort.
- **Express Emotions:** Don't avoid displaying emotions in front of your child. Showing an appropriate level of grief reassures them that it's okay to express their feelings.
- **Family Support:** Regularly check in with family members to assess how everyone copes with grief and offer mutual support.

- **Allow Participation in Rituals:** If desired, let your child, even young ones, attend the funeral or other mourning ceremonies.
- **Remember the Deceased:** Help your child find meaningful ways to honour and remember the deceased, such as creating memorial moments or sharing memories.
- **Share Belongings:** Offer your child keepsakes or belongings of the deceased as tangible reminders of their loved ones.
- **Maintain Normalcy:** Keep your child's everyday routine as consistent as possible and spend quality time together to provide stability and comfort.
- **Observe Play:** Observe how your child plays, as it can serve as a means of communication and expression during their grieving process.
- **Inform Others**: Do not assume teachers or coaches know your child's situation. Inform significant adults about what happened and how you've discussed it with your child so they can provide appropriate support.
- **Seek Professional Help:** If your child struggles to adjust to their new life, encourage them to talk to a qualified counsellor, psychologist, or psychiatrist.
- **Remember that You Are a Role Model for Your Child**: Model healthy grieving behaviours for your child by acknowledging the death, expressing emotions, and permitting them to do the same.

HOW TO SUPPORT A FRIEND OR A FAMILY MEMBER AFTER SUICIDE LOSS

It can be challenging to know how to provide support when someone you care about is grieving after a suicide loss. Here are some tips to help you navigate this tricky situation:

- **Be Present:** Survivors often feel isolated and alone in their grief. Simply being there for them can make a significant difference in their healing process. Offer your presence and support, even if you need help with what to say.
- **Listen with Compassion:** Helpers may feel helpless and unsure of how to offer support. Focus on listening to their feelings and experiences without judgment or trying to fix things. At times, simply having someone to listen can provide profound solace.
- **Offer Genuine Acknowledgment:** Start by acknowledging the situation and using precise language. For example, you could say, *"I heard about the loss of ____."* Using the word "died" shows you are open to discussing their feelings.
- **Express Sympathy:** Let them know you care and empathise with their pain. You can say, *"I'm sorry to hear about what you're going through."*

Supporting a friend (CC)

- **Ask How They're Feeling:** Check in with the bereaved person regularly and ask how they're doing. Avoid assuming that you know their feelings on any given day. A simple question like, *"How are you feeling?"* can open space for them to share their emotions.
- **Be Authentic:** Be honest about your feelings and reactions to the situation. It's okay to admit if you're unsure of what to say. You can say, "*I'm not sure how to express this, but I want you to know I care."*
- **Offer Practical Support:** Let them know you're available to help in any way they need. You can say, "*Tell me what I can do for you,"* or offer specific support based on their needs.
- **Validate Their Experience:** Encourage them by reminding them that there's no correct or incorrect method of grieving. Grief is a profoundly personal journey, and each person navigates it uniquely. Avoid imposing expectations or judgments on their emotions or actions.
- **Recognise the Rollercoaster of Grief:** Understand that grief doesn't follow a linear path and can involve unexpected ups and downs. Be patient and supportive through the emotional highs and lows and avoid pressuring them to "move on" or "get over it."
- **Accept the intensity of feelings**. Be prepared for extreme emotions and behaviours as part of the grieving process.
- **Understand your grief.** Emotions like guilt, anger, despair, and fear are typical responses to grief. The mourner may express these emotions in numerous ways, such as shouting, lashing out, or crying for extended periods. It's important to reassure them that their feelings are normal and not to judge or take their reactions personally.
- **Assure the mourner that there's no set timeline for grief.** While recovery for many people may take 18 to 24 months, the grieving process can vary in duration for different individuals. Avoid pressuring mourners to move on or making them feel like they're mourning for too long, as this can hinder the healing process.
- **Encourage open discussion about the loss**. Acknowledge the importance of addressing the deceased and their memory, as avoiding the topic can make mourners feel that their loss is being ignored or forgotten. While it's essential not to force someone to talk, let them know they have the space to express their feelings.
- **Validate all emotions.** Let the grieving person know that expressing their feelings is acceptable, whether through tears, anger, or breakdowns. Avoid trying to rationalise or dictate how they should feel.
- **Allow storytelling.** Understand that the bereaved may need to recount the details of their loved one's death multiple times as part of their grieving process. Offer patience, ask follow-up questions, and normalise their need to share their story to process and accept the loss.
- **Provide silent support.** If the grieving person doesn't feel like talking, offer comfort and companionship through your presence. Simple gestures like eye contact, a handshake, or a comforting hug can convey your support.

HOW TO OFFER PRACTICAL ASSISTANCE

- Offer practical assistance without waiting for them to ask. Many grieving individuals may struggle to reach out for help due to feelings of guilt, fear of being a burden, or depression.
- Make it easier for them by providing specific suggestions, such as offering to run errands or asking what groceries they need. You can extend an open invitation by saying, *"Let me know what I can do for you"* or *"Where can we meet?"*
- Be patient and stay as long as needed. Your consistent presence and support can comfort them without forcing them to ask for help repeatedly.
- Help with everyday chores like grocery shopping or meal preparation.
- Offer to help with funeral arrangements or administrative tasks like insurance or bills.
- Assist with household chores such as cleaning or laundry.
- Offer to babysit or provide transportation for their children.
- Drive them to appointments or wherever else they need to go.
- Take care of their pets if needed.
- Invite them to join you for lunch, a movie, or other enjoyable activities as a brief respite from their grief.
- Organise fun activities like games, puzzles, or art projects to distract and lift their spirits.

WHAT TO AVOID WHEN YOU TALK WITH A FRIEND OR FAMILY MEMBER AFTER SUICIDE

- Avoid saying, *"This is behind you now; it's time to move on with your life,"* as it may imply forgetting their loved one.
- Refrain from using statements beginning with *"You should" or "You will."* Instead, you can start your comment with*, "Have you thought …" or "You can …"*
- Avoid saying, *"You should not have to feel this bad,"* as it may invalidate their emotions.
- Refrain from saying, *"He's in a better place now,"* as the mourner may or may not share this belief.
- Avoid saying, *"I know how you feel,"* as you can never fully understand another person's emotions. Instead, ask the persons to share how they feel.
- If you have experienced a similar loss, share your experiences only if you believe they may help. However, avoid giving unwanted advice or comparing your grief to theirs.
- Avoid saying, *"It's part of God's plan,"* as this may upset some individuals.
- Refrain from saying, *"Look at what you have to be grateful for,"* as the grieving person may not feel those things are important.
- Avoid statements like, *"You look so good,"* as it may pressure the person to hide their true feelings.

Conclusion:

By offering genuine companionship, attentive listening, and practical assistance, we can provide invaluable support to our loved ones. It's essential to approach conversations with empathy, avoid judgment or platitudes, and prioritise the individual's emotional well-being throughout the grieving process.

Takeaways:

1. Recognise the importance of being present and offering genuine support to grieving friends and family members.

2. Listen compassionately and avoid judgment or attempts to "fix" the situation.

3. Offer practical assistance and emotional comfort without waiting for them to ask.

4. Avoid common pitfalls in communication, such as invalidating their emotions or imposing expectations.

5. Foster open discussion and understanding surrounding the loss, allowing space to express grief in all forms.

Multiple-Choice Questions:

1. What is a crucial aspect of supporting loved ones after a suicide loss?
A. Offering unsolicited advice
B. Avoiding all conversations about the loss
C. Providing genuine presence and support
D. Ignoring their emotional needs

2. How can you offer practical assistance to grieving individuals?
A. Wait for them to ask for help
B. Avoid offering any assistance to respect their privacy
C. Provide specific suggestions and extend open invitations
D. Assume they don't need any help

3. What should you avoid when communicating with bereaved individuals?
A. Listening attentively and validating their emotions
B. Using statements beginning with "You should" or "You will"
C. Sharing your own experiences of grief
D. Offering empathy and understanding

4. Why is it important to foster open discussion about the loss?
A. To minimise the significance of the loss
B. To forget faster about the deceased
C. To rush the grieving process
D. To recognise the deceased and their memory

Answers:
1: C. Providing genuine presence and support
2: C. Provide specific suggestions and extend open invitations
3: B. Using statements starting with "You should" or "You will"
4: D. To recognise the deceased and their memory

A.07
MIND YOUR BRAIN: HEALTHY AND UNHEALTHY COPING LOOPS, SCARS AND 12 STEPS SAFETY PLAN

Introductory Question:
How can we transform our grief into proactive steps to prevent unnecessary tragedies?

What You Will Learn:

1. Understanding Coping Loops:
- The difference between unhealthy and healthy coping strategies after a loss.
- The impact of self-harming behaviors and why they are detrimental.
- How healthy coping mechanisms can lead to growth and healing.

2. The SCARS Interventions:
- Starting a Secure transition through grief.
- Caring Communication with yourself and others.
- Aligning with Allies and embracing supportive skills and environments.
- Reset and Refocus on positive behaviours and meaningful connections.
- Sticking to a structured safety plan for stability and well-being.

3. 12 Steps Safety Plan:
- Steps to understanding the impact of a loss and managing grief.
- Techniques for immediate distraction and long-term self-care.
- Strategies for preventing self-harm and fostering personal growth.
- How to engage with support systems and professionals.
- Establishing safe spaces and emergency response measures for crisis situations.

4. Practical Techniques:
- Breathing exercises, muscle relaxation, and other simple methods to manage intense emotions.
- Building and maintaining positive routines and habits.
- How to restrict access to harmful influences and environments.

5. Emotional and Mental Resilience:
- The role of oxytocin, dopamine, and endorphins in coping with loss.
- Understanding the psychological and hormonal responses to grief.
- Developing resilience and the potential for Posttraumatic Growth (PTG).

Introduction:
Grief is an inevitable part of life, touching each of us in unique ways. While the anguish of loss may seem impossible, structured support and compassionate interventions can guide us through the most challenging moments. By learning strategies, you will gain the tools and knowledge to navigate the complexities of grief, fostering a path towards healing and resilience.

The Unhealthy and Healthy Coping Loops help understand the importance of positive coping strategies over unhealthy, self-harm and harmful activities for dealing with losses, including suicide.

The SCARS interventions offer a comprehensive approach to coping with grief. They emphasize secure transitions, caring communication, alignment with allies, refocusing on positive behaviours, and sticking to a safety plan. The 12 Steps Safety Plan helps us manage grief and promote growth and healing.

UNHEALTHY AND HEALTHY COPING LOOPS AFTER A LOSS HYPOTHESIS

Why is it hazardous to turn to "self-treatment" with different self-harming activities (alcohol, drugs,

unhealthy eating, self-cutting, abusive behaviours, etc.) when you're overwhelmed by grief emotions after a loss? Let's discuss this!

Explanation of Unhealthy and Healthy Coping Loops after a Loss (suicide, separation):

The increase in NA/A (Noradrenaline/ Adrenaline) and activation of the HPA-axis with a rise in ACTH and cortisol are natural hormonal responses to a stressful situation, such as the loss of someone to suicide, which is an extreme stressor. This loss results in pain, as it leads to a decrease in endorphins, our natural painkillers, giving us very unpleasant feelings that we seek to avoid or escape from as quickly as possible.

To cope with the pain and other emotions present in grief, we can start to engage in certain activities: unhealthy (self-harming) or healthy.

These unhealthy and healthy activities may trigger an increase in oxytocin (OXT), a well-being hormone that helps us cope with trauma, protect our family and friends and feel attached to them. It also influences our tendency to identify with those who share similar experiences while distancing ourselves from those who do not. This means that after a suicide loss, we may naturally seek out others who have experienced similar losses, as we feel they understand us better than those without such experiences.

Then, Oxytocin triggers an increase in Dopamine (DA), one of the crucial hormones of the reward system in our brain and our natural painkillers called endorphins (EN). The OXT, DA and EN contribute to the formation of a habit or "addiction" or a Loop that automatically activates this system in similar situations of loss or in case of specific activities that we use to cope with pain and grief in the aftermath of a loss. The OXT, DA and EN combinations are highly potent. That is why it is challenging to change from one activity to another. We get addicted to the activities we have chosen to cope with trauma. We will repeat them to get our OXT, DA and EN "kick," We must increase the intensity of the activity to get the same rewarding effects because of increased tolerance.

In an **Unhealthy Coping Loop**, engaging in self-harm or harmful behaviour (e.g. drinking alcohol, drugs, self-cutting) triggers the described reward system. This makes it highly challenging to introduce change, especially when attempting to recover from addiction to self-harm, substance abuse, or other harmful behaviours. Due to the development of tolerance, a person caught in an Unhealthy Coping Loop can feel the urgent and extreme drive to increase levels of self-harm or harm, at all costs, only to get the same or higher level of OXT, DA and EN reward, which can ultimately lead to self-destruction. This system is so powerful that it is tough to change it with the Logical Brain understanding that self-harming and harmful activities increase damage. The more a person wants/tries to end the self-harming activity, the more guilt, anxiety, anger, pain, shame, and sadness, as OXT, DA and EN activity decrease. A person continues and often increases the use of self-harming behaviours only to keep the OXT, DA and EN activity on a sufficient level. It can result in death/self-destruction.

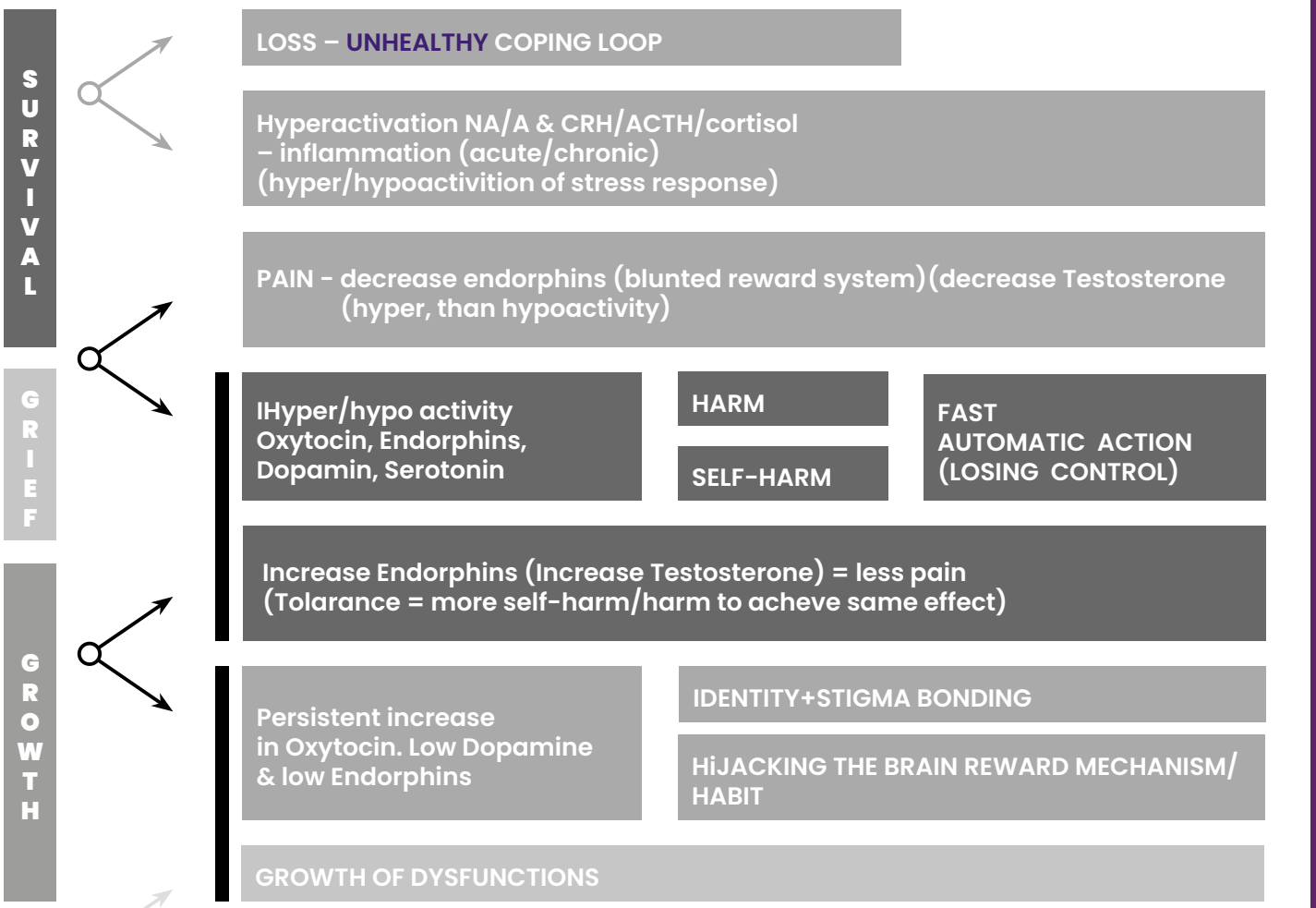
Now, let's consider a **Healthy Coping Loop (HCL).** After experiencing a loss, a person starts with distractors to immediately reduce the intensity of unpleasant feelings by activating the parasympathetic system and vagal response. Here are three examples of such distractors:

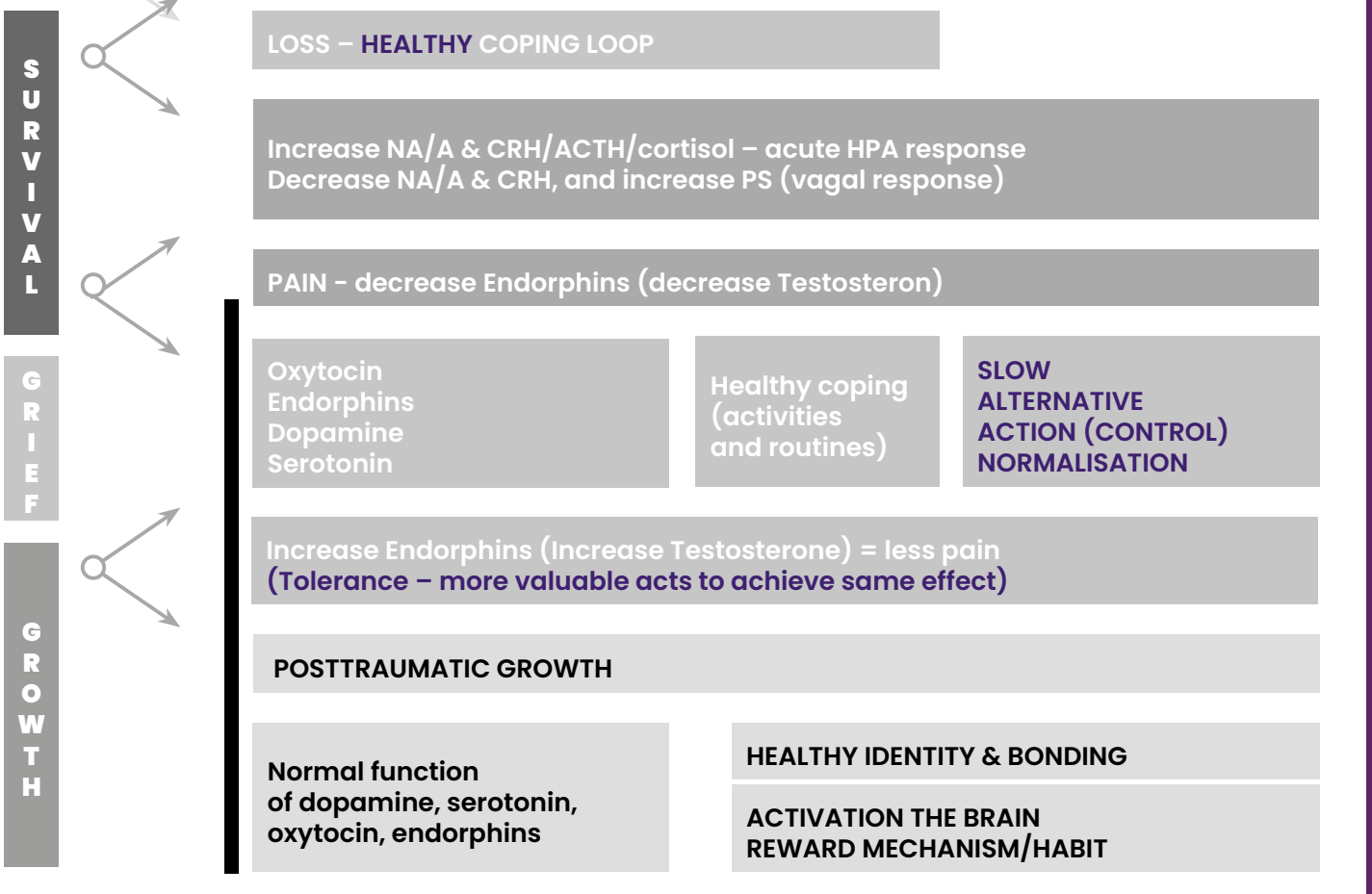
- Breathing exercises (Inhale – count 1,2,3,4 and Exhale – count 1,2,3,4,5,6,7)
- Muscle relaxation techniques
- Briefly immerse your face in cold water and count to four, then lift it out and count again.

These three simple and healthy distractors have significant power as they help to keep some control over the intensity of feelings. They decrease the intensity of complicated GAPS feelings, which can also increase well-being hormones like oxytocin, dopamine, endorphins, and serotonin.

In Healthy Coping Loop, tolerance (need to increase activity to get the same kick of reward (OXT, DA and EN activity) helps a person to achieve growth, excellence, and success as a person increases the number and intensity of positive activities. It increases healing and rewarding effect of OXT, DA and EN. A person who had chosen at an early age healthy activity, probably due to interactions between genes and environment, in a situation of a loss, will focus on growth and will have more chances to reach PTG (Posttraumatic Growth), which will ultimately help coping not only with the current loss but also with potential future losses and separations.

UNHEALTHY AND HEALTHY COPING LOOPS AFTER A LOSS





SCARS INTERVENTIONS

S - Start Secure Transition: Allow yourself to experience grief securely and supportedly.

- Before (anticipating something unpleasant)
- During (feeling immobilised amid something unpleasant)
- After (dealing with something unpleasant that has already happened)
- Later in life (experiencing unexpected grief reactions)

C - Communicate with Care with yourself and others: Be gentle and compassionate!

- Keep breathing (inhale - count 1-2-3-4, exhale - count 1-2-3-4-5-6-7)
- Muscle relaxation (tighten muscles - count 1-2-3-4, then relax - count 1-2-3-4-5-6-7)
- Cool your face with ice water - count 1-2-3-4, then relax - count 1-2-3-4-5-6-7)
- Engage in a relaxing and healthy activity of your choice!

A - Align with your allies: Embrace new skills and role models in uncharted territory!

- Techniques to support your well-being (require constant practice)
- Knowledge to understand what truly helps you
- Access to safe places such as gyms, support groups, outpatient and inpatient clinics.
- Connection with a professional team, where you lead your "Feel Well" project team.
- Peer-group support, including people with lived experience (brochures, helplines)

R – Reset. Re-focus: Rediscover the skill of shifting from harmful to healing behaviour.

- Re-attach to family: Seek support from family members, who may benefit from psychoeducation to assist you better.
- Re-attach to friends: Lean on friends for support, ensuring they have the necessary knowledge to offer practical assistance.
- Re-attach to places: Find comfort and stability by re-establishing connections with familiar environments such as home, school, or work.
- Re-attach to values and positive emotions: Rediscover and reinforce positive values like love, caring and positive emotions like joy.
- Re-establish basic routines and rhythms (SEED): Prioritize sleep, engage in everyday activities, and maintain regular eating and drinking habits.
- Restrict temporary access to destructive and potentially lethal means: Take measures to limit access to harmful substances or objects during vulnerable periods.
- Restrict temporary access to potentially dangerous places: Avoid environments that may pose risks.
- Restrict temporary access to negative emotions, actions, and thoughts (acronym GAPS): Implement strategies to manage and mitigate difficult emotions, actions, and thoughts.
- Restrict temporary access to people/role models that focus on accusing, attacking, blaming and stigmatising people around you: Surround yourself with supportive individuals & positive attitudes.

S – Stick to your Postvention 12 Steps Safety Plan (to do if you feel "shaky")

- Acknowledge the Situation & your Warning Signs (Emotions, Actions & Thoughts (SEAT))
- Focus on YOURSELF (Mental Fitness Skills Training with MFA (Mental Fitness Acronyms) and 12 Steps Safety Plan)
- Focus on reaching OTHERS (Family – Friend – Peer – Professional – 112)
- Monitor. Analyse. Acquire new knowledge and skills and Document the process.

12 STEPS SAFETY PLAN

Grieving involves considering ways to prevent similar tragedies in the future. This transition from the world with a beloved person to the world without this person can be associated not only with suffering but even with self-harm in the hope of decreasing intense emotions. Preventing self-harm and increasing chances for Posttraumatic Growth, 12 Steps Safety Plan can help in managing challenging emotions, unsettling thoughts, and unwanted behaviours.

Write answers to the questions below (1-12):

A. Understanding Suicide and Its Effects (Grief/ Trauma)

- Step 1. Understanding the Event: How do I discuss or describe the suicide with others? (My narrative about the loss)

- Step 2. Exploring Emotions: What emotions do suicide loss survivors experience? What have I been feeling?
- Step 3. Examining Thoughts: What thoughts do suicide survivors have? What have I been thinking?
- Step 4. Coping Strategies: How do suicide loss survivors cope? What have I and my family members been doing to manage this trauma?

B. Personal Growth and Self-Care

- Step 5. Immediate Distractions and Long-term Coping: How do I distract myself in the moment? How do I practice self-care in the long run to neutralise excessive grief feelings, thoughts, or urges?
- Step 6. Long-term Improvement: How can I work towards improving the situation in the future?
- Step 7. Avoidance Strategies: What behaviours or actions do I need to avoid to prevent disconnection from my protective factors (my family, values, dreams)?
- Step 8. Meaningful Connections: What aspects of my life give me purpose? What is important to me, and how can I improve the world?

C. Engaging with Others

- Step 9. Communication with Support Systems: How do I interact with family, friends, or NGO organisations? What support do I expect from them?
- Step 10. Seeking Professional Help: How do I engage with professionals or visit friends and family for support? What assistance do I anticipate from them?
- Step 11. Establishing Safe Spaces: Where can I find safe environments or places of comfort during challenging times?
- Step 12. Emergency Response: What steps do I take if all else fails and my safety is at risk? (e.g., calling emergency services)

You will find more information about the 12-Steps Safety Plan in ***Appendix 3.A.07.***

Conclusion:

Grieving is a multifaceted process that requires an understanding of the importance of healthy and unhealthy coping in childhood and adolescence.

By following the SCARS interventions, we can navigate our grief journey more effectively, finding solace and strength in the support of others and ourselves. Embracing these strategies can transform our pain into a pathway for growth and healing, helping us rebuild our lives with resilience and compassion.

By engaging with these 12 steps, individuals can take proactive measures to address their emotional needs, foster meaningful connections, and establish strategies for maintaining safety and well-being in the aftermath of suicide loss. By encouraging self-awareness, open communication, and seeking support, survivors can navigate the complexities of grief and strive towards a future imbued with hope and resilience.

Takeaways:

1. Grief should be experienced in a secure and supportive environment to facilitate healing.
2. Self-compassion and effective communication are crucial during the grieving process.
3. Establishing a network of allies and support systems can offer vital guidance and comfort.
4. Refocusing on positive behaviours and values can help shift from harmful to healing actions.
5. A personalised safety plan is vital for managing grief and maintaining mental fitness.

Multiple-Choice Questions:

1. What is the first step in the SCARS interventions?
A. Communicate with Care
B. Align with Allies
C. Start Secure Transition
D. Refocus

2. Which of the following is a technique recommended for self-compassion during grief?
A. Ignoring your feelings
B. Keeping emotions bottled up
C. Muscle relaxation
D. Avoiding support groups

3. What is emphasised in the 'Align with Allies' step?
A. Isolating yourself from others
B. Embracing new skills and role models
C. Avoiding professional help
D. Focusing solely on past traumas

4. What is one of the recommended actions in the Re-focus step?
A. Restrict access to positive emotions.
B. Re-attach to family and friends.
C. Avoid routine activities
D. Isolate yourself from familiar environments.

5. What is the '12 Steps Safety Plan' purpose in the SCARS interventions?
A. To suppress emotions
B. To provide a structured approach to managing grief
C. To focus on blaming others for the loss
D. To avoid documenting the grief

6. What is the purpose of Step 1 in the safety planning process?
A. Exploring emotions
B. Understanding the event of suicide loss
C. Establishing safe spaces
D. Seeking professional help

7. What is the focus of Step 5 in the safety planning process?
A. Long-term improvement
B. Avoidance strategies
C. Immediate distractions and long-term coping
D. Meaningful connections

8. 8. Which step involves examining thoughts and coping strategies employed by survivors?
A. Step 2
B. Step 4
C. Step 7
D. Step 9

9. What is the emphasis of Step 10 in the safety planning process?
A. Establishing safe spaces
B. Seeking professional help
C. Avoidance strategies
D. Communication with support systems

10. Why is Step 12 crucial in the safety planning process?
A. To intensify emotions
B. To understand suicide
C. To implement avoidance strategies
D. To address emergency response protocols

Answers:
1: C. Start Secure Transition
2: C. Muscle relaxation
3: B. Embracing new skills and role models
4: B. Re-attach to family and friends
5: B. To provide a structured approach to managing grief
6: B. Understanding the event of suicide loss
7: C. Immediate distractions and long-term coping
8: B. Step 4
9. B. Seeking professional help
10. D. To address emergency response protocols

MODULE B

B.01 The Ripple Effect of Suicide: Understanding the Impact on Suicide Loss Survivors

B.02 The Wide-Reaching Impact of Suicide on Individuals, Families, Groups, Education, Employment, and Communities

B.03 Differences in Grief Following Suicide and Grief Following Other Causes of Death

B.04 Understanding Complicated Grief and Prolonged Grief Disorder

B.05 Navigating Grief After Suicide: Understanding Modes and Phases of Grief

B.06 From Trauma to Transformation: Exploring the Power of Posttraumatic Growth

B.07 Understanding Suicide Postvention: Support and Healing After Tragedy

B.08 Global Perspectives on Suicide Postvention: Postvention Services Around the World

B.01
THE RIPPLE EFECT OF SUICIDE: UNDERSTANDING THE IMPACT ON SUICIDE LOSS SURVIVORS

Introductory Question:
How does the impact of one suicide extend beyond the individual to affect an entire community, shaping the experiences of countless others?

What You Will Learn:
1. The evolving understanding of the number of individuals affected by a single suicide over the years, from Shneidman's initial assertion to recent empirical research.
2. Insights into the diverse experiences of suicide loss survivors, categorised into four distinct groups: Exposed to suicide, Affected by suicide, Bereaved by suicide (short-term and long-term), and Suicide loss survivors.
3. The psychological and emotional impact experienced by each group ranged from minimal disruption to profound and enduring grief.
4. The significance of recognising and addressing the needs of suicide loss survivors, from immediate crisis intervention to ongoing support and counselling services.

Introduction:
The aftermath of a suicide reverberates far beyond the individual, touching the lives of countless others in profound and varied ways. Over the years, empirical research has shed light on the extent of this impact, challenging earlier assumptions and highlighting the complex experiences of suicide loss survivors. From those who are indirectly exposed to suicide to those directly bereaved by the loss of a loved one, each navigates a unique journey of grief and healing. Understanding the diverse experiences of suicide loss survivors is essential for providing adequate support and intervention, guiding communities toward healing and resilience.

FOUR GROUPS:

Cerel et al. (2014) described the duration and impact of suicide as a continuum measured by the answer to a question:

"Thinking about the effect of the person's suicide on your life, what response is closest to your experience:

(1) the death had little effect on my life,
(2) the death had somewhat of an effect on me but did not disrupt my life,
(3) the death disrupted my life for a short time,
(4) the death disrupted my life in a significant or devastating way, but I no longer feel that way,
(5) the death had a significant or devastating effect on me that I still feel."

Exposed to suicide: This category refers to individuals who have been made aware of or have knowledge about suicide, but they may not have experienced the direct impact of losing someone to suicide themselves. Examples include fans of celebrities who died by suicide or individuals who knew an acquaintance within their social circle, workplace, or school. Surveys conducted within communities have shown that over 40% of the population reports knowing at least one person who died by suicide during their lifetime (Cerel et al., 2013). Community-level postvention efforts, such as educational programs and public health initiatives, are aimed at providing support to anyone exposed to suicide.

Affected by suicide: This category encompasses a broad range of individuals who experience emotional distress or psychological impact due to various aspects of suicide, including witnessing a suicide, knowing someone who died by suicide, or struggling with mental health challenges related to suicide. While some individuals who are "affected by suicide" may be "suicide loss survivors," not all affected individuals have experienced the direct loss of a loved one to suicide.

Bereaved by suicide (short-term, below 12 months): This category includes individuals with close connections to the deceased, which profoundly impacts their emotional security. It encompasses family members, partners, close friends, associates, and therapists.
Bereaved by suicide (bereaved long-term, over 12 months): This category includes individuals with close connections to the deceased, which profoundly impacts their emotional security. It encompasses family members, partners, close friends, associates, and therapists.

SUICIDE LOSS SURVIVOR

"Suicide loss survivors" and "Bereaved by suicide" refer to the same group of individuals who have experienced the death of a loved one or someone close to them because of suicide. They grapple with the profound grief, emotional anguish, and life-altering consequences that accompany the loss of a loved one to suicide.
Suggested support: Immediate crisis intervention and support services, such as offering grief and bereavement counsellors in school settings following a suicide or identifying community grief and counselling services, are essential for this group.

HOW MANY INDIVIDUALS ARE AFFECTED BY ONE SUICIDE?

1973: While Shneidman's assertion that there were six survivors for every suicide lacked systematic research support, it persisted in the literature on suicide prevention for over 40 years (Andress & Corey, 1978).

1994: Crosby & Sacks (1994) conducted the first empirical survey of survivorship in the United States. Through a nationally representative telephone survey with 5,238 participants, they found that 7% of the population had been exposed to suicide in the past year, and 20% had lost a close relative. This study suggested that there were more than six suicide loss survivors for every suicide.

1997: Campbell (1997) discovered that among individuals with 28 different relationships with the deceased, those who sought treatment from a support group overwhelmingly represented some form of family kinship.

2005: Shear & Shair (2005) highlighted that for around 10–20% of the bereaved, the experience of intense grief extends beyond the typical adaptive period of around six months and significantly impacts daily functioning. This is conceptualised as 'complicated grief.'

2009: Chen et al (2009) reported approximately five bereaved family members per suicide in Japan. In 2006, around 90,000 children had lost a parent to suicide, and about three million living family members had lost a loved one to suicide.

2013: Cerel et al. (2013) found that 40% of 302 individuals had been exposed to suicide over their lifetime, and 50% were significantly affected by these deaths.

2016: Cerel et al (2016) examined 1,736 surveys matching the entire Kentucky population and found that 48% had one or more lifetime exposures to suicide.

2017: Feigelman et al (2017) analysed 1,500 surveys based on 11 questions added to the 2016 General Social Survey (GSS study) in a nationally representative American adult population household sample. They found that half of the sample had been exposed to one or more suicides of someone they knew during their lifetime, and one-third of the sample was emotionally distressed by these deaths. This study suggested that there could be up to 40 million suicide-bereaved adults in the United States. About 10% were first-degree relatives (parents, children, spouses, and siblings), 40% identified themselves as friends of the deceased, and the remaining 50% identified themselves as remote relatives, co-workers, patients, and clients. 40% had lost their loved ones during the last six years.

2019: Cerel (2019) published a study suggesting approximately 135 bereaved individuals for every suicide.

2023: The suicide of one person impacts 60 people, known as suicide loss survivors (Zimmerman et al., 2023).

Conclusion:

The impact of suicide extends far beyond the individual, shaping the experiences of entire communities and leaving a lasting imprint on those left behind. As empirical research continues to deepen our understanding of suicide loss, it is crucial to recognise and address the diverse needs of suicide loss survivors. We can foster healing and resilience in the face of profound loss by providing comprehensive support and intervention, from immediate crisis response to ongoing counselling services.

Takeaways:

1. Suicide loss affects a wide range of individuals, from those directly bereaved to those indirectly exposed to suicide.

2. Each group of suicide loss survivors experiences a unique journey of grief and healing, characterised by varying degrees of emotional impact.

3. Recognising and addressing the needs of suicide loss survivors is essential for fostering healing and resilience in communities.

4. Comprehensive support and intervention, including immediate crisis response and ongoing counselling services, are vital for assisting suicide loss survivors on their journey toward healing and recovery.

References:

Andress, V. R., & Corey, D. M. (1978). Survivor-victims: who discovers or witnesses suicide?. *Psychological reports*, *42*(3 PT 1), 759–764. https://doi.org/10.2466/pr0.1978.42.3.759

Campbell, F. R. (1997). Changing the legacy of suicide. Suicide and Life-Threatening Behavior, 27(4), 329-338. https://psycnet.apa.org/record/1997-38589-001

Cerel, J., Jordan, J. R., & Duberstein, P. R. (2008). The impact of suicide on the family. *Crisis*, *29*(1), 38–44. https://doi.org/10.1027/0227-5910.29.1.38

Cerel, J., Brown, M. M., Maple, M., Singleton, M., van de Venne, J., Moore, M., & Flaherty, C. (2019). How Many People Are Exposed to Suicide? Not Six. *Suicide & life-threatening behavior*, *49*(2), 529–534. https://doi.org/10.1111/sltb.12450

Cerel, J., Maple, M., van de Venne, J., Brown, M., Moore, M., & Flaherty, C. (2017). Suicide Exposure in the Population: Perceptions of Impact and Closeness. *Suicide & life-threatening behavior*, *47*(6), 696–708. https://doi.org/10.1111/sltb.12333

Cerel, J., McIntosh, J. L., Neimeyer, R. A., Maple, M., & Marshall, D. (2014). The continuum of "survivorship": Definitional issues in the aftermath of suicide. Suicide and Life-Threatening Behavior, 44(6), 591-600. https://onlinelibrary.wiley.com/doi/abs/10.1111/sltb.12093

Cerel, J., McIntosh, J. L., Neimeyer, R. A., Maple, M., & Marshall, D. (2014). The continuum of "survivorship": Definitional issues in the aftermath of suicide. Suicide and Life-Threatening Behavior, 44(6), 591-600. https://onlinelibrary.wiley.com/doi/abs/10.1111/sltb.12093

Chen, J., Choi, Y.J., Mori, K. *et al.* Those Who are Left Behind: An Estimate of the Number of Family Members of Suicide Victims in Japan. *Soc Indic Res 94*, 535–544 (2009). https://doi.org/10.1007/s11205-009-9448-3

Crosby, A. E., & Sacks, J. J. (2002). Exposure to suicide: incidence and association with suicidal ideation and behavior: United States, 1994. *Suicide & life-threatening behavior*, *32*(3), 321–328. https://doi.org/10.1521/suli.32.3.321.22170

Feigelman, W., Gorman, B. S., & Jordan, J. R. (2009). Stigmatization and suicide bereavement. *Death studies*, *33*(7), 591–608. https://doi.org/10.1080/07481180902979973

Shear, K., & Shair, H. (2005). Attachment, loss, and complicated grief. Developmental Psychobiology, 47(3), 253-267. https://doi/abs/10.1002/dev.20091

Zimmerman, M. S. (2023). The information seeking behaviors and needs of suicide survivors during bereavement. *Libri*, *73*(1), 25-35. https://doi.org/10.1515/libri-2021-0119

Multiple-Choice Questions:

1. According to Crosby & Sacks (1994), what percentage of the population had been exposed to suicide in the past year?

A. 7%
B. 10%
C. 15%
D. 20%

2. What did Cerel et al. (2013) find regarding individuals exposed to suicide within communities?

A. Over 20% of the population reports knowing at least one person who died by suicide.
B. Less than 10% of the population reports knowing someone who died by suicide.
C. Approximately 30% of the population reports knowing someone who died by suicide.
D. Over 40% of the population reports knowing at least one person who died by suicide.

3. What do Cerel et al. (2014) categorise as "Bereaved by suicide"?

A. Individuals who have been made aware of or have knowledge about suicide.
B. Individuals who experience emotional distress or psychological impact due to various aspects of suicide.
C. Individuals who experienced the direct impact of losing someone to suicide.
D. Individuals who have close connections to the deceased profoundly impact their emotional security.

4. How do Cerel et al. (2014) categorise individuals "Affected by suicide"?

A. Cultural Individuals who have close connections to the deceased profoundly impact their emotional security.
B. Individuals who have been made aware of or have knowledge about suicide.
C. Individuals who experience emotional distress or psychological impact due to various aspects of suicide.
D. Individuals who experienced the direct impact of losing someone to suicide.

5. What is the primary aim of community-level postvention efforts?

A. Offering grief and bereavement counsellors in school settings following a suicide.
B. Providing support to individuals exposed to suicide through educational programs and public health initiatives.
C. Identifying individuals who experience emotional distress due to suicide.
D. Offering immediate crisis intervention and support services to individuals bereaved by suicide.

6. How is the duration and impact of the continuum measured according to the text?

A. By assessing the severity of emotional distress experienced by individuals bereaved by suicide.
B. By analysing the number of individuals affected by suicide within communities.
C. By categorising individuals into groups based on their connection to the deceased.
D. By asking individuals about the effect of the person's suicide on their life and providing response options.

Answers:

1: A. 7%
2: D. Over 40% of the population reports knowing at least one person who died by suicide.
3: D. Individuals who have close connections to the deceased, profoundly impacting their emotional security.
4: C. Individuals who experience emotional distress or psychological impact due to various aspects of suicide.
5: B. Providing support to individuals exposed to suicide through educational programs and public health initiatives.
6: D. By asking individuals about the effect of the person's suicide on their life and providing response options.

B.02
THE WIDE-REACHING IMPACT OF SUICIDE ON INDIVIDUALS, FAMILIES, GROUPS, EDUCATION, EMPLOYMENT, AND COMMUNITIES

Introductory Question:
How can understanding the multifaceted impact of suicide on individuals, families, social networks, and communities inspire comprehensive prevention and intervention strategies?

What You Will Learn:
1. **Identifying Individual Impact:** Explore the psychological and emotional repercussions of suicide on individuals, including heightened risk factors and the challenges of navigating grief and guilt.
2. **Family Dynamics:** Understand how suicide bereavement reshapes family dynamics, communication patterns, and coping mechanisms, impacting relationships and fostering feelings of shame and isolation.
3. **Social Networks:** Discover the ripple effects of suicide on social networks, including changes in relationships, social withdrawal, and the complex interplay of fear, discomfort, and shared experiences among peers.
4. **Community Economic Burdens:** Examine the substantial economic costs associated with suicide and suicide attempts, spanning healthcare expenses, lost productivity, and the financial toll on families and societies.

Introduction:
Globally, suicides constitute 1.4% of premature deaths worldwide (Bachman et al., 2018). Each year, approximately 164,000 self-inflicted deaths occur worldwide in individuals under 25 years of age (Andriessen et al., 2017). Suicide reverberates far beyond the individual act, leaving indelible marks on families, social networks, and entire communities. From the profound emotional toll on survivors to the economic burdens borne by societies, understanding the comprehensive impact of suicide is essential for effective prevention and intervention efforts. In this exploration, we delve into the intricate web of consequences. Suicide exerts detrimental effects on individuals, families, and communities due to several factors, including mental health issues), social challenges (including unemployment, poverty, and social isolation), familial and interpersonal disruptions, and broader societal ramifications, necessitating community engagement in prevention and intervention efforts. Genetic vulnerability, psychiatric, psychological, familial, social, and cultural factors, as well as media influence and contagion, contribute to the harmful impact of suicide (Hawton et al., 2012).

I. IMPACT ON INDIVIDUALS:

Those exposed to suicide face heightened risks of adverse outcomes, including mental illness, impaired social functioning, and both fatal and non-fatal suicidal behaviour (Andriessen et al., 2017). Compared to the general population, individuals bereaved by suicide are at a greater risk of suicidal behaviour and mental health challenges such as depression, anxiety, posttraumatic stress disorder (PTSD), and substance abuse (Erlangsen et al., 2017). Suicide bereavement also serves as a risk factor for complicated grief (Bellini et al., 2018).

The risk of suicide and suicide attempts extends beyond genetically related individuals to include non-relatives such as spouses and friends, indicating that the psychological (environmental) effects may permeate widely within the social circles of the deceased (Azorina et al., 2019).

Feelings of blameworthiness can serve as a good indicator of grief since it correlates well with other grief difficulties and mental health problem measures. Peer support plays a vital role in averting the detrimental

effects of guilt, which can manifest at any stage of the grieving journey, helping individuals navigate away from potential downward spirals (Feigelman & Cerel, 2020).

II. IMPACT ON FAMILIES:

The transmission of suicidal behaviour within families appears to be independent of the presence of mental illness, with aggression transmission being a significant contributor. This is consistent with findings linking changes in serotonergic function to both impulsive aggression and suicidal behaviour. Notably, the risk of suicidal behaviour in one monozygotic twin is four times greater if the other twin has died by suicide, and the risk of suicide in first-degree relatives of suicide victims increases up to fourfold.

Research by McMenamy, Jordan, and Mitchell (2008) revealed that 64 percent of suicide survivors experienced difficulty sharing their grief with family members, while 61 per cent struggled to share it with anyone, fostering secrecy, blame, conflict, and role strain that may lead the family's support system to collapse.

Suicide bereavement alters family dynamics and communication, often leading to feelings of shame, guilt, and blame, as well as crises of faith and the management of internalised messages (Hunt et al., 2015). Family discord frequently serves as a precipitant of suicide, which increases the risk of blaming family members (Hawton et al., 2012).

Survivors of suicide loss sometimes feel judged by others or find it challenging to express their grief openly. This dynamic can manifest as social pressure to "move on" swiftly or discomfort with emotional expression, contributing to isolation and frustration among survivors (Azorina et al., 2019). For instance, one survivor shared,

"I think that my friends expected me to cry and wail… but I just did not feel like that…there is this culture of talking and talking, but I did not feel there was anything to talk about." (Azorina et al., 2019).

Another survivor reflected,

"After my partner passed, I was treated differently, as my family did not want me to talk about it… I realise now I could not and will not be able to talk to family about my issues again." (Azorina et al., 2019).

Families needing to come together may paradoxically experience decreased support and increased distance due to dysfunctional communication. Attachment injuries between the deceased and individual family members, as well as among surviving family members, can exacerbate conflicts and strain familial bonds (Hunt et al., 2015). Differing coping strategies within families may lead to judgment and conflict, further complicating the grieving process. As one survivor noted,

"We all seemed to deal with the death differently… this may be the reason why we are not close, we did not deal with it together as a family." (Hunt et al., 2015)

Feelings of worthlessness and isolation among the bereaved family members may manifest as suicidal ideation, driven by a desire to reunite with the deceased and escape suffering. Bereaved parents often grapple with feelings of blameworthiness, believing they could have prevented their child's death. Such feelings strongly correlate with grief difficulties and mental health problems, including complicated grief, PTSD, and depression (Feigelman & Cerel, 2020).

Survivors may wrestle with "should-have" and "what-if" questions, fostering intense shame and self-blame. Shame emerges within relationships and requires relational interventions. Postvention interventions offer an opportunity for survivors to confront these feelings and share their experiences, fostering acceptance and healing through shared understanding and compassion. Safe spaces for open expression facilitated by individuals with lived experience can significantly aid this healing process (Hunt et al., 2015).

III. IMPACT ON GROUPS AND SOCIAL NETWORKS

People bereaved by suicide are more likely to report poor social functioning than people bereaved by other unnatural deaths. They describe receiving less support from family and friends than people bereaved by any other causes of sudden death, as well as delays in receiving support.

The impact of suicide on relationships, whether within families, workplaces, or other social circles, is profound. Those bereaved by suicide often grapple with feelings of guilt, shame, and fear of being blamed, which can lead them to avoid social interactions, places where they might encounter blame, and activities associated with painful memories or trauma, such as discussing their emotions openly. There is also a fear of encountering others who may harbour anger and seek to assign blame, leading to a reluctance to engage in conversations about suicide as a means of self-protection.

Furthermore, bereaved individuals may experience their anger and, in an effort not to hurt others, avoid conversations altogether. Conversely, fostering forgiveness and cultivating practical communication skills can mitigate the risk of trauma, facilitate open dialogue, and strengthen interpersonal relationships.
Questions such as "*How has your relationship with your partner, or potential partners, changed since the bereavement?"* and *"How have your relationships within your immediate family (parents, siblings, children) evolved since the loss?"* probe the depth of these relational shifts. Similarly, inquiries about relationships with extended family members, close friends, classmates, colleagues, and supervisors shed light on the broader impact of suicide on social connections and support networks (Azorina et al, 2019).

Four main changes in relationships
According to Azorina and colleagues (2019), suicide bereavement leads to four main changes in relationships:

1. Fear of further losses and overprotectiveness,
2. Social discomfort,
3. Social withdrawal and
4. Shared bereavement experience

1. Fear of further losses and overprotectiveness.

Fear of further losses can result in conscious awareness of becoming more attentive and protective of others (primarily close family and partners). Others may try to maintain a distance to protect themselves against abandonment by close friends.

"I am much more scared of those I love (partners or potential partners) dying or abandoning me." A young female who lost her partner in suicide.

2. Social discomfort over the death

Relationships had become strained due to others' discomfort with the suicide. The awkwardness of these encounters appeared to reduce respondents' sense of belonging within their social networks. Discomfort in talking about suicide also arises because it can feel too painful and upsetting to discuss, either for the person or for others.

There can be social pressure to "get over it" quickly, embarrassment over outpourings, or disapproval over not displaying "enough" emotion.

"We (my immediate family) just never talked about it. It is like the elephant in the room." A young female whose uncle had died by suicide.

3. Social withdrawal and the need for contact

A temporary social withdrawal can be an adaptive coping mechanism. Some can see a temporary withdrawal resulting in a loss of self-esteem, disappointment in others' reactions, or a sense of being a burden to others.

→ *"I often feel like I am a burden to my friends if I vent my grief."*
→ *"I cannot discuss (it) with (my immediate family) as it upsets them, and I do not want to make them upset."*
→ *"I need to be close to my friends, but they push me away."*
→ *"I tend to withdraw myself from others (people in general) most of the time whilst at the same time feeling a need to be close to them."*

4. Shared bereavement experience, the need for closeness or avoidance

→ *"I find I am drawn to (people) who have lost someone to suicide. It is like I can pick them out in a crowd. I can talk to them about everything in my life, and they are instant friends and confidants."*
→ *"(…) Those who were directly involved (in bereavement), I found it harder to speak to them and tried to avoid them."*

IV. COMMUNITY IMPACT:

Studies indicate that the economic repercussions of suicide and suicide attempts are significant, spanning direct medical expenses, decreased productivity, and other financial burdens, with estimates varying widely across different nations.

In the United States, research by Shepard et al. (2015) revealed that the cost associated with suicides and suicide attempts in 2013 amounted to $58.4 billion, predominantly attributed to lost productivity. Adjusting for under-reporting increased this total to $93.5 billion, or $298 per capita. Investing in enhanced continuity of care for individuals with a history of nonfatal attempts could yield substantial benefits, with a favourable benefit-to-cost ratio of 6 to 1.

Similarly, in Australia, Kinchin et al. (2017) found that the economic impact of suicide and related behaviours

in the workplace amounted to $6.73 billion in 2014. Implementing a universal workplace strategy was projected to yield a positive financial return, with benefits outweighing costs by a considerable margin.

Youth suicide poses a significant economic burden in Australia as well, with estimated annual losses totalling $22 billion, encompassing various direct and indirect costs (Kinchin et al., 2018).

In Finland, Sollin et al. (2022) identified costs related to suicides ranging from EUR 309,020 to EUR 456,279, encompassing factors such as labour input loss, costs directly following a suicide, and expenses associated with bereaved family members. Understanding these costs aids in allocating resources for effective intervention strategies.
In Ireland, Kennedy et al. (2007) estimated the total cost of suicide to exceed Euro 906 million in 2001 and Euro 835 million in 2002, representing nearly 1% of the gross national product.

Slovenia considers suicide prevention a national priority. Sedlak et al. (2022) reported annual indirect costs of EUR 8.2 million, highlighting the importance of targeted interventions despite being a relatively small fraction of healthcare expenditures and GDP.

Finally, in Japan, Chen et al. (2009) highlighted the significant direct production loss incurred by bereaved family members at approximately 197 million USD, emphasising the need to evaluate the cost-effectiveness of suicide prevention programs in addressing these financial burdens.

Conclusion:

The impact of suicide extends beyond the loss of life, permeating the fabric of families, social networks, and communities. Understanding these impacts is crucial for providing comprehensive support and fostering resilience after such tragedies.

By recognising the interconnectedness of these impacts—from the "psychological scars" of survivors to the economic strains on society—we can galvanise comprehensive strategies to prevent future tragedies and support those affected by suicide.

Takeaways:

1. **Impact on Individuals:**
   1. **Emotional Distress**: Survivors often experience intense grief, guilt, anger, and confusion.
   2. **Mental Health**: Increased risk of depression, anxiety, and Post-Traumatic Stress..
   3. **Physical Health**: Stress-related physical health problems, such as insomnia, headaches, and weakened immune systems.
   4. **Holistic Understanding:** Suicide's impact spans psychological, emotional, and economic domains, necessitating holistic approaches to prevention and intervention.

2. **Impact on Families:**
   1. **Grief and Mourning**: Families face prolonged periods of mourning and adjustment.
   2. **Relationships**: Strain on family relationships and dynamics due to differing grieving processes.
   3. **Financial Burden**: Potential financial strain from funeral costs and loss of income.
   4. **Family Resilience:** Suicide bereavement reshapes family dynamics and communication, underscoring the importance of fostering open dialogue and support networks.

3. **Impact on Groups:**
   1. **Peer Support**: Friends and social groups struggle with their grief while supporting each other.
   2. **Stigma and Isolation**: Groups may feel stigmatised or isolated due to societal perceptions of suicide.
   3. **Collective Trauma**: A shared sense of loss can affect group cohesion and attitudes.
   4. **Contagion Risk**: Increased risk for following suicidal behaviours.

4. **Impact on Education:**
   1. **School Environment**: Disruption in the school community, affecting students, teachers, and staff.
   2. **Academic Performance**: Decline in academic performance among grieving students.
   3. **Support Services**: Increased demand for school counselling and mental health services.

5. **Impact on Employment:**
   1. **Workplace Atmosphere**: Altered workplace dynamics and morale following a colleague's suicide.
   2. **Productivity**: Decreased productivity and increased absenteeism among grieving employees.
   3. **Employer Responsibilities**: Employers need to provide support and mental health resources.
   4. **Social Support Networks:** Recognize the pivotal

role of social networks in mitigating the stigma and isolation associated with suicide, fostering empathy and resilience among peers.

6. Impact on Communities:

1. **Community Cohesion**: A suicide can disrupt the sense of community and collective well-being.

2. **Public Health**: Increased focus on mental health resources and suicide prevention strategies.

3. **Social Services**: Greater demand for social services to support affected individuals and families.

4. **Economic Considerations:** Acknowledge the significant financial burdens of suicide on societies, advocating for targeted interventions and resource allocation.

References:

Andriessen, K., Rahman, B., Draper, B., Dudley, M., & Mitchell, P. B. (2017). Prevalence of exposure to suicide: A meta-analysis of population-based studies. *Journal of psychiatric research*, *88*, 113–120. https://doi.org/10.1016/j.jpsychires.2017.01.017

Azorina, V., Morant, N., Nesse, H., Stevenson, F., Osborn, D., King, M., & Pitman, A. (2019). The Perceived Impact of Suicide Bereavement on Specific Interpersonal Relationships: A Qualitative Study of Survey Data. *International journal of environmental research and public health*, *16*(10), 1801. https://doi.org/10.3390/ijerph16101801

Bachman, R., & Schutt, R. K. (2018). The practice of research in criminology and criminal justice (6th ed.). Sage Publications.

Bellini, S., Erbuto, D., Andriessen, K., Milelli, M., Innamorati, M., Lester, D., Sampogna, G., Fiorillo, A., & Pompili, M. (2018). Depression, Hopelessness, and Complicated Grief in Survivors of Suicide. Frontiers in psychology, 9, 198. https://doi.org/10.3389/fpsyg.2018.00198

Doran, C. M., & Kinchin, I. (2020). Economic and epidemiological impact of youth suicide in countries with the highest human development index. PloS one, 15(5), e0232940. https://doi.org/10.1371/journal.pone.0232940

Erlangsen, A., Runeson, B., Bolton, J. M., Wilcox, H. C., Forman, J. L., Krogh, J., ... & Conwell, Y. (2017). Association between spousal suicide and mental, physical, and social health outcomes: A longitudinal and nationwide register-based study. JAMA Psychiatry, 74(5), 456-464. https://doi.org/10.1001/jamapsychiatry.2017.0226

Feigelman, W., & Cerel, J. (2020). Feelings of Blameworthiness and Their Associations With the Grieving Process in Suicide Mourning. *Frontiers in psychology*, *11*, 610. https://doi.org/10.3389/fpsyg.2020.00610

Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., Hegerl, U., Lonnqvist, J., Malone, K., Marusic, A., Mehlum, L., Patton, G., Phillips, M., Rutz, W., Rihmer, Z., Schmidtke, A., Shaffer, D., Silverman, M., Takahashi, Y., Varnik, A., ... Hendin, H. (2005). Suicide prevention strategies: a systematic review. JAMA, 294(16), 2064–2074. https://doi.org/10.1001/jama.294.16.2064

Hunt, Q. A., & Hertlein, K. M. (2015). Conceptualizing suicide bereavement from an attachment lens. American Journal of Family Therapy, 43(1), 16–27. https://doi.org/10.1080/01926187.2014.975651

Kinchin, I., & Doran, C. M. (2017). The Economic Cost of Suicide and Non-Fatal Suicide Behavior in the Australian Workforce and the Potential Impact of a Workplace Suicide Prevention Strategy. *International journal of environmental research and public health*, *14*(4), 347. https://doi.org/10.3390/ijerph14040347

Kinchin, I., Doran, C. M., & Meurk, C. (2018). The cost of youth suicide in Australia. International Journal of Environmental Research and Public Health, 15(4), 672. https://doi.org/10.3390/ijerph15040672

McMenamy, J. M., Jordan, J. R., & Mitchell, A. M. (2008). What do suicide survivors tell us they need? Results of a pilot study. Suicide and Life-Threatening Behavior, 38(4), 375-389. https://doi.org/10.1521/suli.2008.38.4.375

Sedlak, S., Jelenc, M., & Sambt, J. (2023). Alarming issue of suicides and their indirect costs in Slovenia. *European Journal of Public Health*, *33*(Supplement_2), ckad160-1681. https://doi.org/10.1093/eurpub/ckad160.1681

Shepard, D. S., Gurewich, D., Lwin, A. K., Reed, G. A., Jr., & Silverman, M. M. (2015). Suicide and suicidal attempts in the United States: Costs and policy implications. Suicide and Life-Threatening Behavior, 46(3), 352-362. https://doi.org/10.1111/sltb.12225

Solin, P., Tamminen, N., Seppänen, A., & Partonen, T. (2022). Calculation of costs related to death by suicide in Finland. Social Sciences, 11(10), 468. https://doi.org/10.3390/socsci11100468

Multiple-Choice Questions:

1. How does suicide bereavement impact individuals compared to the general population, as indicated by Erlangsen et al. (2017)?

A. It decreases the risk of mental health challenges
B. It increases the risk of physical health issues
C. It decreases the likelihood of suicidal behavior
D. It increases the risk of PTSD, depression and suicidal behaviours

2. How does Azorina et al. (2019) suggest the psychological effects of suicide may extend beyond genetically related individuals?

A. Through social networks including friends and colleagues
B. Through physical health complications
C. Through government policies and regulations
D. Through religious institutions and practices

3. According to research findings, what is the relationship between the familial transmission of suicidal behaviour and mental illness?

A. It is closely associated with mental illness being the primary determinant.
B. It is independent, with aggression transmission playing a significant role.
C. It is negligible, with mental illness having no impact on transmission.
D. It is uncertain, with conflicting evidence from different studies.

4. How does suicide bereavement impact family dynamics and communication?

A. It fosters open communication and strengthens familial bonds.
B. It leads to increased trust and understanding among family members.
C. It often results in shame, guilt, and blame, causing communication breakdown.
D. It has no discernible effect on family relationships.

5. What percentage of suicide survivors, according to McMenamy, Jordan, and Mitchell (2008), reported difficulty sharing their grief with family members?

A. 50%
B. 61%
C. 75%
D. 90%

6. Which emotion is commonly experienced by survivors of suicide loss, often leading to suicidal ideation as described in the text?

A. Happiness
B. Gratitude
C. Shame
D. Contentment

7. How do individuals bereaved by suicide respond to feelings of guilt, shame, and fear of blame?
A. They seek out social interactions to confront these emotions head-on.
B. They avoid situations where they might encounter blame or discuss their emotions openly.
C. They engage in conversations about suicide to alleviate their feelings of guilt.
D. They confront others who express anger or assign blame to resolve conflicts.

8. According to the text, what is one potential consequence of avoiding conversations about suicide?
A. It increased openness and understanding among family members.
B. Reduced risk of trauma and strengthened relationships.
C. Continued feelings of guilt and shame among bereaved individuals.
D. Protection from confrontations with others who may harbour anger.

9. Which approach is suggested in the text to mitigate the impact of suicide on relationships?
A. Avoiding discussions about the traumatic event to prevent further emotional distress.
B. Cultivating forgiveness and training practical communication skills.
C. Assigning blame to others as a means of coping with personal feelings of guilt.
D. Seeking isolation to shield oneself from potential confrontations.

10. What is the primary factor contributing to the economic cost of suicide in the United States, according to Shepard et al. (2015)?
A. Direct medical expenses
B. Lost productivity
C. Under-reported cases
D. Continuity of care services

11. Which country's study estimates the economic impact of suicide and non-fatal behaviours in the workplace, suggesting a positive return on investment for implementing a workplace strategy?
A. Australia
B. Finland
C. Ireland
D. Slovenia

12. According to Kinchin et al. (2018), what is the estimated annual economic loss attributed to youth suicide in Australia?
A. USD 55.4 billion
B. USD 22 billion
C. USD 2 billion
D. USD 309,020

Answers:
1: D. It increases the risk of PTSD, depression and suicidal behaviours
2: A. Through social networks including friends and colleagues
3: B. It is independent, with aggression transmission playing a significant role.
4: C. It often results in shame, guilt, and blame, causing communication breakdown.
5: B. 61%
6: C. Shame
7: B. They avoid situations where they might encounter blame or discuss their emotions openly.
8: C. Continued feelings of guilt and shame among bereaved individuals.
9: B. Cultivating forgiveness and honing practical communication skills.
10: C. Lost productivity
11: A. Australia
12: B. USD 22 billion

B.03
DIFFERENCES IN GRIEF FOLLOWING SUICIDE AND GRIEF FOLLOWING OTHER CAUSES OF DEATH

Introductory Question:
Does Grief Following Suicide Differ from Grief Following Other Causes of Death?

What You Will Learn:
1. **Heightened Emotions:** Understand the increased levels of shame, stigma, guilt, anger, and feelings of abandonment that survivors of suicide loss experience.
2. **Search for Answers:** Learn about the persistent quest for explanations and understanding that survivors undertake to make sense of the suicide.
3. **Unique Grief Reactions:** Explore the distinct grief reactions among survivors of suicide, including heightened experiences of rejection and responsibility.
4. **Parental Grief Patterns:** Discover the specific grief patterns of parents who have lost a child to suicide, marked by intense shame and frequent post-death life events.
5. **Long-Term Impact:** Recognize the long-term psychological effects on suicide survivors, such as increased rates of lifelong depression, suicidal ideation, and social adjustment difficulties.
6. **Stigma and Shame:** Identify the pervasive feelings of stigma and shame in post-suicide grief, necessitating specialised counselling approaches.
7. **Impact on Relationships:** Examine how survivors of suicide loss often report lower levels of positive relationships with the deceased, affecting their ability to experience post-traumatic growth.

Introduction:
Grieving after a suicide presents distinct challenges compared to mourning after other causes of death, as highlighted by Sveen et al. (2008) in their pioneering study comparing the reactions of suicide survivors with survivors of various types of deaths. Although no substantial variations emerged regarding overall mental health, depressive symptoms, post-traumatic stress disorder (PTSD) manifestations, anxiety levels, or suicidal tendencies when comparing suicide survivors to other bereaved groups, an examination of specific grief-related factors revealed pronounced discrepancies. The intricate landscape of grief reactions exhibited distinct patterns among those bereaved by suicide, setting them apart from other forms of grief.

NINE KEY DIFFERENCES

Key contrasts between grieving after a suicide and grieving after other causes of death include:

1. Survivors of suicide loss often contend with heightened feelings of shame, stigma, guilt, and inadequacy. They may also experience increased anger and a sense of abandonment due to the perceived inability to prevent the suicide or provide help (Sveen et al., 2008).

2. The search for answers regarding the circumstances and reasons behind the suicide is a common theme among survivors, serving to keep the memories of the deceased alive (Sveen et al., 2008).

3. Compared to other bereaved groups, survivors of suicide loss report more frequent experiences of rejection, responsibility, and unique grief reactions. They also exhibit higher levels of overall grief reactions and may face increased levels of shame and perceived stigma (Bailey et al., 1999).

4. Parents who have lost a child to suicide often experience distinct grief patterns characterised by heightened feelings of shame and increased post-death life events compared to parents who have lost a child to accidents. Additionally, parental grief following suicide occurs more frequently in vulnerable families (Séguin et al., 1995).

5. Survivors of suicide tend to exhibit higher rates of lifelong depression, passive suicidal ideation before the loss, self-blame, and impaired occupational and social adjustment compared to survivors of accidents, homicides, or natural causes (Tal et al., 2017).

6. The type of bereavement (suicide vs. sudden death) significantly influences feelings of rejection, somatic reactions, stigmatisation, responsibility, and shame (Kõlves et al., 2019).

7. Stigma, shame, and feelings of rejection are prevalent themes in post-suicide grief, suggesting the need for specialised counselling approaches for individuals experiencing this type of loss (Harwood et al., 2002).

8. Survivors of suicide loss often report lower levels of positive relationships with the deceased compared to other groups, which can impact their ability to experience post-traumatic growth. Intense grief and preoccupation with the deceased may impede positive personal transformation, particularly among those struggling with the suicide of a loved one (Levi-Belz, 2017).

9. Higher levels of expectation and understanding are associated with reduced tendencies to seek explanations and preoccupation with the suicide. However, these factors do not directly correlate with other grief experiences (Wojtkowiak et al., 2012).

Conclusion:

Grief after suicide differs significantly from grief after other causes of death, marked by heightened feelings of shame, guilt, and a persistent search for answers.

Tailored support services are essential, particularly for parents coping with the suicide of a child, as they experience distinct grief patterns.

Takeaways:

1. **Heightened Emotions**: Survivors of suicide loss often experience intense shame, stigma, guilt, anger, and abandonment.
2. **Search for Answers**: Survivors frequently seek explanations for the suicide, maintaining a connection with the deceased.
3. **Unique Grief Reactions**: Compared to other types of bereavement, survivors of suicide report more rejection, responsibility, and intense grief reactions.
4. **Parental Grief**: Parents who lose a child to suicide face unique grief patterns, including heightened shame and post-death life events.
5. **Long-Term Effects**: Survivors of suicide exhibit higher rates of lifelong depression, suicidal ideation, self-blame, and social adjustment issues.
6. **Stigma and Shame**: Stigma, shame, and rejection are common in post-suicide grief, requiring specialised counselling.
7. **Relationship Impact**: Survivors often have lower levels of positive relationships with the deceased, hindering post-traumatic growth.

References:

Bailley, S. E., Kral, M. J., & Dunham, K. (1999). Survivors of suicide do grieve differently: empirical support for a common sense proposition. Suicide & life-threatening behavior, 29(3), 256–271.

Harwood, D., Hawton, K., Hope, T., & Jacoby, R. (2002). The grief experiences and needs of bereaved relatives and friends of older people dying through suicide: a descriptive and case-control study. Journal of affective disorders, 72(2), 185–194. https://doi.org/10.1016/s0165-0327(01)00462-1

Kõlves, K., Zhao, Q., Ross, V., Hawgood, J., Spence, S. H., & de Leo, D. (2019). Suicide and other sudden death bereavement of immediate family members: An analysis of grief reactions six-months after death. *Journal of affective disorders*, *243*, 96–102. https://doi.org/10.1016/j.jad.2018.09.018

Kõlves, K., Ross, V., Hawgood, J., Spence, S. H., & De Leo, D. (2017). The impact of a student's suicide: Teachers' perspectives. *Journal of affective disorders*, *207*, 276–281. https://doi.org/10.1016/j.jad.2016.09.058

Levi-Belz Y. (2015). Stress-Related Growth among Suicide Survivors: The Role of Interpersonal and Cognitive Factors. *Archives of suicide research : official journal of the International Academy for Suicide Research*, *19*(3), 305–320. https://doi.org/10.1080/13811118.2014.957452

Séguin, M., Lesage, A., & Kiely, M. C. (1995). Parental bereavement after suicide and accident: a comparative study. *Suicide & life-threatening behavior*, *25*(4), 489–492.

Sveen, C. A., & Walby, F. A. (2008). Suicide survivors' mental health and grief reactions: a systematic review of controlled studies. *Suicide & life-threatening behavior*, *38*(1), 13–29. https://doi.org/10.1521/suli.2008.38.1.13

Tal, I., Mauro, C., Reynolds, C. F., 3rd, Shear, M. K., Simon, N., Lebowitz, B., Skritskaya, N., Wang, Y., Qiu, X., Iglewicz, A., Glorioso, D., Avanzino, J., Wetherell, J. L., Karp, J. F., Robinaugh, D., & Zisook, S. (2017). Complicated grief after suicide bereavement and other causes of death. Death studies, 41(5), 267–275. https://doi.org/10.1080/07481187.2016.1265028

Wojtkowiak, J., Wild, V., & Egger, J. (2012). Grief experiences and expectance of suicide. *Suicide & life-threatening behavior*, *42*(1), 56–66. https://doi.org/10.1111/j.1943-278X.2011.00070.x

Multiple-Choice Questions:

1. According to research cited in the text, what distinguishes grief following a suicide from grief after other causes of death?

A. No significant differences in grief reactions were found between suicide survivors and other bereaved groups.
B. Survivors of suicide loss often experience heightened feelings of shame, stigma, guilt, and inadequacy.
C. Survivors of suicide report fewer experiences of rejection and responsibility compared to other bereaved groups.
D. The search for answers regarding the circumstances of the death is less common among survivors of suicide loss.

2. How do parents who have lost a child to suicide differ from parents who have lost a child to accidents, according to the text?

A. Parents of suicide victims experience fewer post-death life events compared to parents of accident victims.
B. Increased feelings of shame and post-death life events characterise grief patterns among parents of suicide victims.
C. Parental grief following suicide is less frequent in vulnerable families compared to grief following accidents.
D. There are no significant differences in grief patterns between parents who have lost a child to suicide and those who have lost a child to accidents.

3. What is a common theme among survivors of suicide loss, as mentioned in the text?

A. A lack of interest in understanding the reasons behind the suicide
B. Heightened levels of positive relationships with the deceased
C. Increased feelings of rejection and responsibility
D. The search for answers regarding the circumstances and reasons behind the suicide

4. Which statement accurately reflects the impact of bereavement type on grief experiences?

A. Somatic reactions are more prevalent in survivors of accidents compared to survivors of suicide.
B. Feelings of rejection are higher in survivors of homicide compared to survivors of suicide.
C. The type of grief, whether suicide or sudden death, does not influence feelings of responsibility.
D. Stigma, shame, and feelings of rejection are prevalent themes in post-suicide grief.

5. What influences survivors' tendencies to seek explanations and preoccupation with suicide?

A. Higher level of understanding of suicide
B. Weaker Bonds with the deceased
C. Intense grief and preoccupation with the deceased
D. Increased levels of overall grief reactions

6. What is one of the significant challenges faced by survivors of suicide loss compared to other bereaved groups?

A. Lower levels of overall grief reactions
B. Reduced tendencies to seek explanations for the death
C. Increased feelings of shame, stigma, and guilt
D. Higher rates of post-traumatic growth

Answers:

1: B. Survivors of suicide loss often experience heightened feelings of shame, stigma, guilt, and inadequacy.
2: B. Grief patterns among parents of suicide victims are characterised by increased feelings of shame and post-death life events.
3: D. The search for answers regarding the circumstances and reasons behind the suicide
4: D. Stigma, shame, and feelings of rejection are prevalent themes in post-suicide grief.
5: A. Higher level of understanding of suicide
6: C Increased feelings of shame, stigma, and guilt

B.04
UNDERSTANDING COMPLICATED GRIEF AND PROLONGED GRIEF DISORDER

Introductory Question:
How can understanding of complicated grief and prolonged grief disorder offer pathways to healing for those experiencing profound loss?

What You Will Learn:
1. **The Spectrum of Prolonged Grief:** Explore the nuances of complicated grief, Prolonged Grief Disorder (PGD), and their key differences.
2. **Risk Factors and Diagnostic Criteria:** Understand the factors contributing to prolonged grief, including risk factors, diagnostic criteria, and how it is recognised in clinical settings.
3. **Neurobiological Underpinnings:** Delve into the neurobiology of prolonged grief disorder, uncovering how physiological systems and brain structures contribute to the experience of grief.
4. **Therapeutic Approaches:** Discover effective therapeutic interventions, from exposure therapy to integrative cognitive behavioural treatment, that offer hope and healing for those navigating prolonged grief.

Introduction:
Grief following the loss of a loved one can take on many forms, with complicated grief and prolonged grief disorder representing significant challenges for individuals seeking to navigate their loss. In this exploration, we delve into the complexities of grief, from the emotional and psychological to the neurobiological, offering insights into understanding and addressing prolonged grief disorder.

COMPLICATED GRIEF

Persistent, traumatic, pathological, prolonged, and complicated grief (CG) are terminologies used to describe a condition where bereaved individuals struggle to adapt to or accept their loss, leading to a problematic, slowed, or halted grieving process.
For 7–10% of bereaved individuals, grief resulting from the loss of a loved one evolves into a severe, persistent, and disabling condition (Prigerson et al., 2009; Eisma et al., 2018).

A meta-analysis focusing on PGD following unnatural losses, including suicide, revealed that nearly 50% of bereaved adults experienced PGD (Djelantik et al., 2020). Certain factors heighten an individual's susceptibility to developing Prolonged Grief Disorder (PGD). These risk factors encompass gender, with females exhibiting a higher propensity and a paradoxical combination of profound religious convictions coupled with dissatisfaction with one's religious beliefs. Moreover, a profound emotional bond with the deceased, the unanticipated nature of the loss, a personal history of psychiatric conditions, a family legacy of mental health disorders, exposure to death, an intimate relationship with the victim, and the presence of stressful life events all contribute to an elevated risk of experiencing PGD. (Schaal et al., 2014; Melhem et al., 2004).

Individuals experiencing complicated grief (CG) after a suicide exhibit the highest rates of lifetime depression, pre-loss passive suicidal ideation, self-blame, and impaired work and social adjustment (Tal et al., 2017).

CG is significantly associated with a 9.68 times greater likelihood of suicidal ideation, even after adjusting for depression. This underscores the heightened vulnerability to suicidal thoughts in individuals with complicated grief, necessitating clinicians to conduct thorough assessments (Mitchell et al., 2005). Moreover, individuals with
CG have a 6.58 times higher likelihood of experiencing "high suicidality" initially, and an 11.30 times greater risk at follow-up, controlling for factors such as gender, race, major depressive disorder (MDD), posttraumatic stress disorder (PTSD), and social support (Latham et al., 2004).

"Complicated grief" is recognised as a distinct mental disorder with established diagnostic criteria. It is currently integrated into the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, as a Persistent Complex Bereavement Disorder. It is also included in the eleventh revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11) as Prolonged Grief Disorder.

COMPARISON OF ICD-11 AND DSM-5-TR FOR PROLONGED GRIEF DISORDER CRITERIA

"6B42 Prolonged grief disorder (ICD-11)

A. History of grief after the death of a partner, parent, child, or other loved one.
B. At least one of the following symptoms: A persistent and pervasive longing for the deceased; a persistent and pervasive preoccupation with the deceased
C. At least one symptom of intense emotional pain: sadness, guilt, anger, denial, blame; difficulty accepting the death; feeling one has lost a part of oneself; an inability to experience positive mood; emotional numbness; difficulty in engaging with social or other activities
D. The disturbance causes significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.
E. Time and impairment: persisted for an abnormally long period (more than six months at a minimum); following the loss, clearly exceeding expected social, cultural, or religious norms for the individual's culture and context." (Linde et al, 2017)

"Criteria for Prolonged Grief Disorder (DSM-5-TR)

A. The death, at least 12 months ago, of a person who was close to the suffering individual (for children and adolescents, at least six months ago).
B. Since the death, the development of a persistent grief response is characterised by one or both of the following symptoms, which have been present most days to a clinically significant degree. In addition, the symptom(s) have occurred nearly every day for at least the last month: Intense yearning/longing for the deceased person Preoccupation with thoughts or memories of the deceased person (in children and adolescents, preoccupation may focus on the circumstances of the death)
C. Since the death, at least 3 of the following symptoms have been present most days to a clinically significant degree. In addition, the symptoms have occurred nearly every day for at least the last month:

1. Identity disruption (e.g., feeling as though part of oneself has died) since the death
2. Marked sense of disbelief about the death
3. Avoidance of reminders that the person is dead (in children and adolescents, may be characterised by efforts to avoid reminders)
4. Intense emotional pain (e.g., anger, bitterness, sorrow) related to the death
5. Difficulty reintegrating into one's relationships and activities after the death (e.g., problems engaging with friends, pursuing interests, or planning for the future)
6. Emotional numbness (absence or marked reduction of emotional experience) because of the death
7. Feeling that life is meaningless because of death
8. Intense loneliness because of death.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The duration and severity of the bereavement reaction clearly exceed the expected social, cultural, or religious norms for the individual's culture and context.
F. The symptoms are not better explained by major depressive disorder, posttraumatic stress disorder, or another mental disorder, or attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition" (DSM-5-TR).

The clinical efficacy of prolonged grief disorder (PGD) symptoms is bolstered by evidence indicating that these symptoms respond more effectively to grief-specific interventions rather than other approaches, such as those focused on depression (Shear et al., 2014). Individuals meeting the criteria for prolonged grief disorder have elevated risk for both current and future major depressive disorder, post-traumatic stress disorder (PTSD), and generalised anxiety disorder (GAD) (Prigerson et al., 2008; Stroebe et al., 2007).

The severity of PGD symptoms significantly correlates with suicidal ideation, with PGD commonly co-occurring with severe depression and PTSD symptoms (Rings et al., 2014).

The symptoms of prolonged grief have been established as distinct from those of depression, anxiety, and post-traumatic stress disorder (PTSD) (Prigerson et al., 2008).

Differential diagnosis with acute grief, depression, and PTSD.

Acute grief following a loss, particularly the death of a loved one with a strong attachment, is considered a normal process and should not be pathologised. Initial post-loss reactions commonly involve intense emotions. Some typical signs of normal grief overlap with prolonged grief disorder, including feelings of shock or disbelief, yearning, waves of sadness or other intense emotions, feeling disconnected from others, and a desire to disengage from roles or responsibilities.

Differences between PGD and depression: What distinguishes prolonged grief disorder from depression?

Distinguishing prolonged grief disorder from depression involves several critical assessments (Szuhany et al., 2021):

1. Assessment focuses on whether thoughts and emotions continue to revolve around the deceased (prolonged grief) or are more generalised and less associated with the loss itself (depression). In prolonged grief, low mood (dysphoria) is linked to separation from the deceased, while depression involves persistent and pervasive dysphoria, often combined with pessimistic rumination and a sense of hopelessness.

2. Depression typically involves reduced interest in or ability to enjoy everyday activities. In contrast, prolonged grief entails persistent preoccupation with the deceased, often accompanied by intense longing and seeking sensory experiences that connect them with the deceased.

3. While depression often manifests as a global feeling of guilt and worthlessness, prolonged grief may involve guilt for specific actions or inactions related to the deceased, characterised by counterfactual thinking such as "*If only I had done something differently.*"

4. Individuals with depression tend to engage in general avoidance behaviour and social withdrawal, whereas those with prolonged grief often avoid specific places, things, and activities, reminding them of the loss.

5. Suicidal ideation in depression can be associated with ending an intolerable situation or relieving perceived burdensomeness. In contrast, prolonged grief is often associated with a desire to be reunited with the deceased.

6. Prominent symptoms such as pronounced weight loss, psychomotor retardation, and difficulty in decision-making are common in depression but absent in prolonged grief.

Differences between PGD and PTSD: What sets prolonged grief disorder apart from PTSD?

Here are four distinctions between PGD and PTSD (Szuhany et al., 2021):

1. While fear predominates in PTSD, yearning and sadness are more prevalent in prolonged grief disorder.
2. In PTSD, intrusive thoughts centre around the traumatic event, whereas in prolonged grief disorder, they focus on the circumstances of the death. However, there may be overlap in cases of violent or accidental deaths.
3. Avoidance behaviours in PTSD primarily revolve around safety concerns or reducing potential threats, whereas in prolonged grief disorder, avoidance pertains to evading painful reminders of the loss and its permanence.
4. Hyperarousal and hypervigilance are typically associated with PTSD. In contrast, challenges in re-engaging in life without the deceased (such as feelings of meaninglessness, a desire to join the deceased, or loneliness) are linked to prolonged grief disorder.

There are also shared features between PTSD and prolonged grief disorder, including intrusive thoughts or images of the death, avoidance related to the death, and emotional numbness. Both conditions may also lead to sleep disturbances.

EXPLORING THE NEUROBIOLOGY OF PROLONGED GRIEF DISORDER

Complicated Grief may stem from pre-existing individual differences present at the time of the death of the attachment figure, which play a crucial role in emotion regulation. The loss of the attachment figure can result in CG being characterised by a relative inability to disengage from intense grief triggered by the suicide.

Bereavement triggers a generalised physiological response known as the "fight-or-flight" stress response, involving the cardiovascular system (e.g., heart rate, catecholamines) and the hypothalamic–pituitary–adrenal (HPA) axis (e.g., corticotrophin-releasing hormone (CRH), cortisol). Studies on bereavement have shown increases in catecholamines and cortisol during the preliminary stages of grief. This stress response to bereavement is like reactions to other stressful life events (O'Connor et al., 2008). Circulating catecholamines are a measure of stress (O'Neill, 2019), which the amygdala integrates into memory consolidation and recall through its connections with the hippocampal complex and prefrontal cortex (Roozendaal et al., 2009). Higher levels of peripheral adrenaline predicted higher PGD symptomatology after therapy, regardless of intervention.

Physiological grief involves subcortical and cortical structures such as the nucleus accumbens, amygdala, cerebellum, orbitofrontal cortex, temporoparietal

junction, medial, and posterior cingulate cortex. During physiological grief, activation of the nucleus accumbens (NAc) is initially high in response to cues recalling the deceased but decreases over time. Prolonged grief disorder (PGD) exhibits a distinct pattern of activity in the amygdala and orbitofrontal cortex, different activity in the posterior cingulate cortex (PCC), rostral or subgenual anterior cingulate cortex (rACC, sgACC), and basal ganglia, including the nucleus accumbens, and possible differential activity in the insula (Kakarala et al., 2020).

Individuals experiencing complicated grief (CG) with intrusive thoughts and avoidance behaviours exhibit reduced connectivity between the amygdala and emotion regulatory regions, such as the rACC/DLPFC, during exposure to grief-related words in an emotional Stroop task (Freed et al., 2009). They demonstrate an inhibited ability to disengage from emotionally relevant stimuli and an attentional bias toward psychopathology-related cues, as evidenced by delayed reaction times in trials with loss-related words compared to non-complicated grief and non-bereaved controls (O'Connor & Arizmendi, 2014).

Human survival depends on our capacity to form connections and bonds with others. Physiological systems involved in the attachment-specific stress response include the dopamine system, the opioid system, and the oxytocin system. Losing an attachment figure can lead to changes in all these systems. Activation of the reward system is associated with alleviating pain sensations by releasing endorphins (Younger et al., 2010). Dopamine, oxytocin, and opioid receptors converge in the nucleus accumbens (NAc), a primary node of the reward system. Oxytocin is associated with trust and bond formation; opioids create a positive experience of social contact; and dopamine motivates one to pursue social contact (O'Connor 2012).
Complicated grief is associated with dysfunctional cerebral oxytocinergic signalling and persistent hyperactivation of the nucleus accumbens. This mechanism limits the reduction of interpersonal attachment to the deceased during acute phases and drives the search for new interpersonal relationships during the recovery phase (Bottemanne et al., 2024). Changes in the oxytocin system during grief may contribute to anxiety suppression during psychosocial stress, enhanced trust toward in-group members, increased aggression toward out-group members, heightened suffering and loneliness, and an elevated risk of blaming and attacking others. Peer support early after a suicide loss may help normalise changes in the oxytocin system and decrease the risk of complicated grief.

According to the brain opioid theory of social attachment, opioids, specifically the mu-opioid receptor system, form the neurochemical foundation for the rewarding and pleasurable sensations derived from social connections (Inagaki et al., 2016). This neurobiological mechanism is particularly pronounced in relationships with strong emotional bonds and attachment. The theory suggests that the opioid system plays a pivotal role in the profoundly gratifying experiences associated with meaningful social interactions and the maintenance of close interpersonal ties. (Panksepp et al., 1978). Social loss or separation results in reduced opioid activity and heightened reactivity to social stressors, leading to increased pain when confronted with factors associated with the loss of the attachment figure. The co-activation of the nucleus accumbens (NAc) with areas linked to pain-related regions (dorsal anterior cingulate cortex (dACC), insula, and periaqueductal grey (PAG)) suggests that the "craving" for the deceased may be experienced similarly to addiction. Bereaved individuals may refrain from engaging in activities previously enjoyed with the deceased to avoid intense sadness and longing, which can contribute to increased isolation and withdrawal.

In the dopamine reward system, an increase in dopamine in the nucleus accumbens triggered by stimuli such as a photo of the deceased can evoke both pleasant feelings and the pain of loss and longing associated with activation in pain-related regions (dACC, insula, and periaqueductal grey) (O'Connor et al., 2008).

Therapeutic Approaches for Prolonged Grief Disorder

Currently, there is no documented psychopharmacological treatment specifically targeting prolonged grief disorder (PGD). However, certain medications, such as citalopram, have demonstrated efficacy in reducing comorbid symptoms of depression (Bryant et al., 2017).

Exposure therapy, integrated with cognitive behavioural therapy (CBT), has resulted in decreasing symptoms of PGD. Studies indicate that exposure therapy within the context of CBT leads to a more significant reduction in PGD symptoms than CBT alone, with the beneficial effects persisting for up to two years post-treatment completion (Rosner et al., 2015). Therapists are encouraged to incorporate some form of exposure therapy to memories of the death to optimise treatment outcomes for PGD patients.

Integrative Cognitive Behavioural Therapy for PGD (PG-CBT) has demonstrated short- and long-term

effectiveness (Treml et al., 2021). This comprehensive approach combines cognitive-behavioural techniques tailored specifically to address PGD symptoms, offering promising results for patients seeking relief from their grief-related distress.

Internet-based cognitive-behavioural grief therapy (ICBGT) provides a convenient and effective alternative to traditional face-to-face interventions. This five-week program, designed for individuals bereaved by suicide, involves ten writing assignments structured across three phases: self-confrontation, cognitive restructuring, and social sharing. Research indicates that ICBGT significantly reduces symptoms of PGD, typical grief reactions following suicide, and depressive symptoms (Berardelli et al., 2020, Italy).

Weekly group programs, facilitated by trained psychologists and tailored for individuals bereaved by suicide, have been well-received by participants. Employing a psychoeducational approach, these programs aim to provide support, normalise grief reactions, and help integrate the loss into participants' lives. By fostering interaction among participants, these programs assist individuals in resuming their daily routines and offer a broader perspective on the suicide of a loved one (Hagström et al., 2020, Sweden).

Finally, research-based theatre plays have emerged as a promising means to counteract the stigmatisation associated with suicide bereavement. A play depicting constrained family communication, often referred to as "a pact of silence," combined with the quest for answers, such as a child's exposure to and attempt to comprehend a parent's psychological struggles, substance abuse, or suicide, which have adversely impacted the family, can serve several purposes. These include expressing emotions, seeking validation, and symbolically bidding farewell to the deceased or the past, directing attention toward one's present life and future endeavours. Such a theatrical production holds the potential to facilitate psychological processing among those bereaved by suicide, foster a changed perspective on suicide, and contribute to overall mental health and well-being. They resonate with the experiences of the bereaved, offering a cost-effective avenue for creating new narratives and meanings surrounding suicide loss (Hagström et al., 2020, Sweden).

Conclusion:

The journey through grief is not uniform, and for some, it becomes a prolonged struggle that impacts every aspect of life. By recognising the unique challenges of complicated grief and prolonged grief disorder, we open avenues for support, healing, and resilience. From therapeutic interventions grounded in evidence-based practices to innovative approaches like research-based theatre, there is hope for those grappling with profound loss to find solace and meaning in their journey.

Takeaways:

1. **Recognising Complexity:** Complicated grief and prolonged grief disorder present distinct challenges, requiring tailored interventions and support systems.
2. **Holistic Healing:** Understanding the neurobiological underpinnings of grief expands our toolkit for therapeutic approaches, offering holistic pathways to healing.
3. **Community and Connection:** Fostering community and connection, whether through group programs or creative expressions like theatre, can provide invaluable support for individuals navigating prolonged grief.

References:

Berardelli, I., Erbuto, D., Rogante, E., Sarubbi, S., Lester, D., & Pompili, M. (2020). Making Sense of the Unique Pain of Survivors: A Psychoeducational Approach for Suicide Bereavement. *Frontiers in psychology*, *11*, 1244. https://doi.org/10.3389/fpsyg.2020.01244

Bottemanne, H., English, I., Bottemanne, L., Torres, P., Beauquier, B., & Joly, L. (2024). From love to pain: is oxytocin the key to grief complications?. *L'Encephale*, *50*(1), 85–90. https://doi.org/10.1016/j.encep.2023.08.006

Bryant, R. A., Kenny, L., Joscelyne, A., Rawson, N., Maccallum, F., Cahill, C., Hopwood, S., & Nickerson, A. (2017). Treating Prolonged Grief Disorder: A 2-Year Follow-Up of a Randomized Controlled Trial. *The Journal of clinical psychiatry*, *78*(9), 1363–1368. https://doi.org/10.4088/JCP.16m10729

Djelantik, A. A. A. M. J., Smid, G. E., Mroz, A., Kleber, R. J., & Boelen, P. A. (2020). The prevalence of prolonged grief disorder in bereaved individuals following unnatural losses: Systematic review and meta regression analysis. Journal of affective disorders, 265, 146–156. https://doi.org/10.1016/j.jad.2020.01.034

Eisma, M. C., & Stroebe, M. S. (2018). The efficacy of grief interventions: A systematic review and meta-analysis. Clinical Psychology Review, 63, 17-29. https://doi.org/10.1016/j.cpr.2018.05.001

Eisma, M. C., Bernemann, K., Aehlig, L., Janshen, A., & Doering, B. K. (2023). Adult attachment and prolonged grief: A systematic review and meta-analysis. Personality and Individual Differences, 214, 112315. https://doi.org/10.1016/j.paid.2023.112315

Eisma, M. C., Boelen, P. A., van den Bout, J., Stroebe, W., Schut, H. A., Lancee, J., & Stroebe, M. S. (2015). Internet-Based Exposure and Behavioral Activation for Complicated Grief and Rumination: A Randomized Controlled Trial. Behavior therapy, 46(6), 729–748. https://doi.org/10.1016/j.beth.2015.05.007

Eisma M. C. (2023). Prolonged grief disorder in ICD-11 and *DSM*-5-TR: Challenges and controversies. *The Australian and New Zealand journal of psychiatry*, *57*(7), 944–951. https://doi.org/10.1177/00048674231154206

Freed, P. J., Yanagihara, T. K., Hirsch, J., & Mann, J. J. (2009). Neural mechanisms of grief regulation. Biological psychiatry, 66(1), 33–40. https://doi.org/10.1016/j.biopsych.2009.01.019

Silvén Hagström A. (2020). Research-Based Theater and "Stigmatized Trauma": The Case of Suicide Bereavement. *Frontiers in psychology*, *11*, 1129. https://doi.org/10.3389/fpsyg.2020.01129

Inagaki, T. K., & Eisenberger, N. I. (2016). Giving support to others reduces sympathetic nervous system-related responses to stress. Psychophysiology, 53(4), 427–435. https://doi.org/10.1111/psyp.12578

Kakarala, S. E., Roberts, K. E., Rogers, M., Coats, T., Falzarano, F., Gang, J., Chilov, M., Avery, J., Maciejewski, P. K., Lichtenthal, W. G., & Prigerson, H. G. (2020). The neurobiological reward system in Prolonged Grief Disorder (PGD): A systematic review. Psychiatry research. Neuroimaging, 303, 111135. https://doi.org/10.1016/j.pscychresns.2020.111135

Linde, K., Treml, J., Steinig, J., & Wagner, B. (2017). Prolonged grief disorder in the ICD-11 and DSM-5: Differences and similarities. Psychopathology, 50(4), 211-220. https://doi.org/10.1159/000477670

Melhem, N. M., Day, N., Shear, M. K., Day, R., Reynolds, C. F., 3rd, & Brent, D. (2004). Traumatic grief among adolescents exposed to a peer's suicide. The American journal of psychiatry, 161(8), 1411–1416. https://doi.org/10.1176/appi.ajp.161.8.1411

Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer, M. K. (2005). Complicated grief and suicidal ideation in adult survivors of suicide. Suicide & life-threatening behavior, 35(5), 498–506. https://doi.org/10.1521/suli.2005.35.5.498

O'Connor, M. F., & Arizmendi, B. J. (2014). Neuropsychological correlates of complicated grief in older spousally bereaved adults. The journals of gerontology. Series B, Psychological sciences and social sciences, 69(1), 12–18. https://doi.org/10.1093/geronb/gbt025

O'Neill, A. (2019). A review on the involvement of catecholamines in animal behaviour, South African Journal of Animal Science 2019, 49 (No. 1) https://www.ajol.info/index.php/sajas/article/view/185172

Panksepp, J. (1986). The anatomy of emotions. In Biological foundations of emotion (pp. 91-124). Academic Press. https://www.sciencedirect.com/science/article/pii/B9780125587037500103

Prigerson, H. G., Horowitz, M. J., Jacobs, S. C., Parkes, C. M., Aslan, M., Goodkin, K., Raphael, B., Marwit, S. J., Wortman, C., Neimeyer, R. A., Bonanno, G. A., Block, S. D., Kissane, D., Boelen, P., Maercker, A., Litz, B. T., Johnson, J. G., First, M. B., & Maciejewski, P. K. (2009). Prolonged grief disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11. PLoS medicine, 6(8), e1000121. https://doi.org/10.1371/journal.pmed.1000121

Rings, J. A., Gutierrez, P. M., & Forster, J. E. (2014). Exploring Prolonged Grief Disorder and Its Relationship to Suicidal Ideation Among Veterans. *Military Behavioral Health*, *2*(3), 283–292. https://doi.org/10.1080/21635781.2014.963758

Rosner, R., Bartl, H., Pfoh, G., Kotoučová, M., & Hagl, M. (2015). Efficacy of an integrative CBT for prolonged grief disorder: A long-term follow-up. Journal of affective disorders, 183, 106–112. https://doi.org/10.1016/j.jad.2015.04.051

Roozendaal, B., McEwen, B. S., & Chattarji, S. (2009). Stress, memory and the amygdala. *Nature reviews. Neuroscience*, *10*(6), 423–433. https://doi.org/10.1038/nrn2651

Schaal, S., Richter, A., & Elbert, T. (2014). Prolonged grief disorder and depression in a German community sample. *Death studies*, *38*(6-10), 476–481. https://doi.org/10.1080/07481187.2013.809032

Séguin, M., Lesage, A., & Kiely, M. C. (1995). Parental bereavement after suicide and accident: a comparative study. *Suicide & life-threatening behavior*, *25*(4), 489–492.

Shear, K., Frank, E., Houck, P. R., & Reynolds, C. F., 3rd (2005). Treatment of complicated grief: a randomized controlled trial. *JAMA*, *293*(21), 2601–2608. https://doi.org/10.1001/jama.293.21.2601

Stroebe, M., Schut, H., & Stroebe, W. (2007). Health outcomes of bereavement. *Lancet (London, England)*, *370*(9603), 1960–1973. https://doi.org/10.1016/S0140-6736(07)61816-9

Szuhany, K. L., Malgaroli, M., Miron, C. D., & Simon, N. M. (2021). Prolonged Grief Disorder: Course, Diagnosis, Assessment, and Treatment. *Focus (American Psychiatric Publishing)*, *19*(2), 161–172. https://doi.org/10.1176/appi.focus.20200052

Tal, I., Mauro, C., Reynolds, C. F., 3rd, Shear, M. K., Simon, N., Lebowitz, B., Skritskaya, N., Wang, Y., Qiu, X., Iglewicz, A., Glorioso, D., Avanzino, J., Wetherell, J. L., Karp, J. F., Robinaugh, D., & Zisook, S. (2017). Complicated grief after suicide bereavement and other causes of death. *Death studies*, *41*(5), 267–275. https://doi.org/10.1080/07481187.2016.1265028

Treml, J., Nagl, M., Linde, K., Kündiger, C., Peterhänsel, C., & Kersting, A. (2021). Efficacy of an Internet-based cognitive-behavioural grief therapy for people bereaved by suicide: a randomized controlled trial. *European journal of psychotraumatology*, *12*(1), 1926650. https://doi.org/10.1080/20008198.2021.1926650

Younger, J., Aron, A., Parke, S., Chatterjee, N., & Mackey, S. (2010). Viewing pictures of a romantic partner reduces experimental pain: involvement of neural reward systems. *PloS one*, *5*(10), e13309. https://doi.org/10.1371/journal.pone.0013309

Multiple-Choice Questions:

1. Which of the following is a shared criterion between ICD-11 and DSM-5-TR for prolonged grief disorder?
A. Intense yearning for the deceased
B. Difficulty reintegrating into relationships
C. Emotional numbness
D. A marked sense of disbelief about the death

2. In the ICD-11 criteria, how long should symptoms persist to qualify for prolonged grief disorder?
A. At least six months
B. At least three months
C. At least twelve months
D. At least nine months

3. According to the DSM-5-TR criteria, how many of the listed symptoms must be present for at least the last month to qualify for prolonged grief disorder?
A. 3
B. 4
C. 5
D. 6

4. Which criterion is unique to the DSM-5-TR criteria for prolonged grief disorder?
A. Feeling that life is meaningless because of the death
B. Persistent longing for the deceased
C. Intense loneliness because of the death
D. Avoidance of reminders that the person is dead

5. Which symptom is included in the DSM-5-TR criteria but not in the ICD-11 criteria for prolonged grief disorder?
A. Emotional numbness
Feeling that life is meaningless because of the death
A marked sense of disbelief about the death
Intense emotional pain related to the death

6. Which emotion is more predominant in PTSD compared to prolonged grief disorder?
A. Sadness
B. Yearning
C. Fear
D. Loneliness

7. What distinguishes intrusive thoughts in PTSD from those in prolonged grief disorder?
A. In PTSD, intrusive thoughts are related to the circumstances of the death.
B. In prolonged grief disorder, intrusive thoughts focus on safety concerns.
C. In PTSD, intrusive thoughts revolve around the traumatic event.
D. In prolonged grief disorder, intrusive thoughts are associated with hyperarousal.

8. What is the primary focus of avoidance behaviours in prolonged grief disorder?
A. Safety concerns
B. Reducing potential threats
C. Painful reminders of the permanence of loss

D. Coping with loneliness

9. Which physiological response is commonly triggered by grief, according to the text?
A. "Rest-and-digest" response
B. "Fight-or-flight" stress response
C. "Freeze" response
D. "Tend-and-befriend" response

10. Which brain structure is primarily associated with the reward system mentioned in the text?
A. Hippocampus
B. Cerebellum
C. Nucleus accumbens
D. Medial prefrontal cortex

11. According to the text, what is a characteristic feature of individuals experiencing complicated grief (CG) in an emotional Stroop task?
A. Enhanced ability to disengage from emotionally relevant stimuli
B. Reduced connectivity between the amygdala and emotion regulatory regions
C. Faster reaction times in trials with loss-related words compared to non-bereaved controls
D. Lack of attentional bias toward psychopathology-related cues

12. What is the current status of psychopharmacological treatment for prolonged grief disorder (PGD), according to the text?
A. Several medications have been developed specifically for PGD.
B. Citalopram has been proven to treat PGD symptoms effectively.
C. There is no documented psychopharmacological treatment for PGD.
D. All antidepressants are effective in treating PGD.

13. Which therapeutic approach has shown a more significant reduction in PGD symptoms compared to cognitive behavioural therapy (CBT) alone?
A. Exposure therapy
B. Psychodynamic therapy
C. Mindfulness-based therapy
D. Dialectical behaviour therapy

14. What is a crucial component of integrative cognitive behavioural therapy for PGD (PG-CBT)?
A. Medication management
B. Exposure therapy
C. Art therapy
D. Music therapy

15. Which population is internet-based cognitive-behavioural grief therapy (ICBGT) specifically designed for?
A. Individuals experiencing acute grief
B. People with generalised anxiety disorder
C. Individuals bereaved by suicide
D. Those with posttraumatic stress disorder (PTSD)

Answers:

1: A. Intense yearning for the deceased
2: D. At least six months
3: A. 3
4: D. Avoidance of reminders that the person is dead
5: C. Marked sense of disbelief about the death
6: C. Fear
7: C. In PTSD, intrusive thoughts revolve around the traumatic event.
8: C. Painful reminders of the loss and its permanence
9: B. "Fight-or-flight" stress response
10: C. Nucleus accumbens (NAc)
11: B Reduced connectivity between the amygdala and emotion regulatory regions
12: C. There is no documented psychopharmacological treatment for PGD
13: A. Exposure therapy
14: B. Exposure therapy
15: C. Individuals bereaved by suicide

B.05
NAVIGATING GRIEF AFTER SUICIDE: UNDERSTANDING MODES AND PHASES OF GRIEF

Introductory Question:
How can we navigate the intricate journey of grief after a loved one's suicide, finding meaning and growth amidst the pain?

What You Will Learn:
1. Explore different models in the grief process after suicide
2. Understand the distinct themes and emotions associated with each mode, guiding survivors through the complexities of grief.
3. Gain insights into the Stages of Grief, and their application in understanding and navigating the grieving process.
4. Recognise that these stages and modes offer a framework for understanding and processing the diverse emotions experienced after loss, providing avenues for healing and growth.

Introduction:
In the aftermath of a suicide, individuals and communities are thrust into a whirlwind of emotions, grappling with shock, disbelief, and overwhelming grief.

Understanding the intricate nuances of grief is crucial for navigating this tumultuous journey and finding pathways to healing and resilience. Fielden's four modes in the grief process after suicide and Kübler-Ross's Five Stages of Grief offer invaluable insights into the diverse emotional landscapes experienced by survivors, providing a framework for understanding and processing the complexities of grief.

FOUR MODES IN THE GRIEF PROCESS AFTER SUICIDE

The significance of various stages of grief lies in recognising and acknowledging the varied emotional responses that individuals and cultures undergo. Fielden (2003) delineates four modes in the grief process after suicide: Thrown-ness, Survival Mode, Searching Mode, and Moving on Mode. Each mode is characterised by distinct themes, guiding survivors through the complexities of grief.

I. THROWN-NESS:

1. **Experiencing chaos:** The initial shock of discovering a loved one's suicide throws survivors into emotional turmoil, marked by feelings of shock, disbelief, numbness, and paralysis, hindering daily functioning and emotional engagement with the world.

2. **Dreaming as a way of saying goodbye**: Bereaved individuals often dream of reuniting with the deceased to bid them farewell and address unfinished business.

II. SURVIVAL MODE:

3. **Fear of not coming through**: Survivors grapple with intense emotional chaos and overwhelming feelings, struggling to accept their loved one's death.

4. **Living in the world of stigma and shame**: Stigmatization and shame surrounding suicide leads to feelings of avoidance and hiding, compounded by societal attitudes and lack of understanding.

5. **Moving through the lifeworld of blame**: The quest to assign blame serves as a coping mechanism to alleviate the tension of uncertainty surrounding the causes of suicide.

III. SEARCHING MODE:

6. **The why questions:** Survivors engage in a relentless pursuit of answers, seeking to comprehend why their loved one took their life.

7. **Suicide notes and written passages**: Actively searching for clues, survivors uncover insights into their loved one's emotional pain and turmoil, grappling with the complexities of suicide.

8. **Reflecting on the relationship with the deceased:** Reflections on the dynamics of the relationship and personal responsibility for the death prompt survivors to confront unresolved issues and emotions.

IV. MOVING ON MODE:

9. **Living in the lifeworld of guilt**: Guilt over perceived failures and missed opportunities weighs heavily on survivors, hindering their ability to reconcile with the loss.

10. **Living in the lifeworld of anger:** Feelings of anger and frustration surface, often directed towards health professionals, services, or societal norms that contribute to stigma and inadequate support.

11. **Searching for reminders of the loved one**: Familiar places and activities evoke memories, aiding survivors in processing their grief and accepting the reality of the loss.

12. **Creating a different lifeworld:** Over time, survivors transition to a new phase of acceptance, embracing the permanence of their loved one's death and forging a path forward in their own lives.

THE FIVE STAGES OF GRIEF

The Five Stages of Grief, as described by Kübler-Ross, originated from her observations of patients with terminal illnesses as they grappled with their mortality. These stages were first introduced by Elisabeth Kübler-Ross in her 1969 book "On Death and Dying." While not everyone experiences all stages, and the order can vary, these stages provide a framework for understanding the emotional responses to grief. This model, often represented by the **acronym DABDA**, has since been widely applied to the grieving process experienced by individuals coping with various losses. It was also used in the context of suicide bereavement.

Denial
Description: Denial is the initial stage where individuals refuse to accept the reality of the loss. It acts as a defence mechanism to numb the immediate shock.
Common Thoughts: "This can't be happening," "They can't really be gone," "There must be some mistake."

Anger
Description: As denial fades, the reality and pain of the situation emerge, leading to anger. This anger can be directed at oneself, others, or even the deceased.
Common Thoughts: *"How could they do this to us?" "Why didn't they reach out for help?" "This is so unfair."*

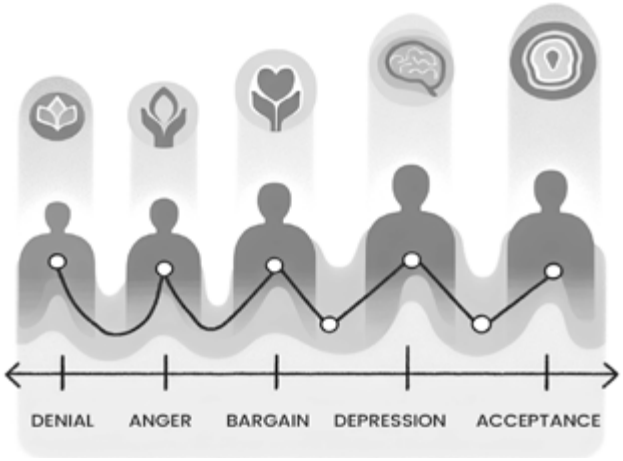
Bargaining
Description: In this stage, individuals attempt to regain control by making deals or promises, often to a higher power, in hopes of reversing or minimising the loss.
Common Thoughts: *"If only I had noticed the signs earlier," "I promise to be more attentive if they could just come back," "What if I had done something differently?"*

Depression
Description: Depression sets in as the individual confronts the reality of the loss and its implications. This stage is marked by deep sadness, regret, and hopelessness.
Common Thoughts: *"I can't believe they're really gone," "I miss them so much it hurts," "I don't know how to go on without them."*

Acceptance
Description: Acceptance is the stage where individuals come to terms with the loss. It doesn't imply happiness but rather a resigned acknowledgement of reality.
Common Thoughts: *"I understand that they're gone," "It's time to find a way to move forward," "I need to find a way to live with this loss."*

Understanding these stages can help individuals and those around them navigate the complex emotions associated with grief, providing insight and empathy during tough times, especially when dealing with the unique challenges of suicide bereavement.

It's important to note that Kübler-Ross emphasised that these stages are not meant to be rigid or prescriptive but rather to provide a framework for understanding and navigating the complex emotions of grief. They serve as a tool for individuals to recognise and process their reactions to loss and for healthcare providers to support grieving patients.



Five Stages of Grief (Kübler-Ross)

THE SIX-STAGE MODEL OF GRIEF

David Kessler has expanded upon the classic five stages of grief introduced by Elisabeth Kübler-Ross by adding a sixth stage: finding meaning.

Finding Meaning

Description: Finding meaning is the stage where individuals seek to understand the significance of the loss and how it can be integrated into their lives. This stage involves finding a way to remember the deceased with more love than pain and moving forward in a manner that honours their memory.
Common Thoughts: *"How can I honour their life?" "What can I learn from this experience?" "How can I use this loss to help others?"*

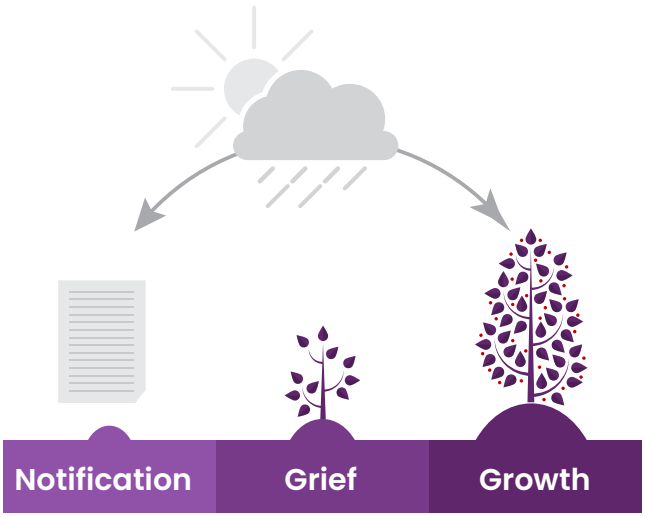
Kessler emphasises that finding meaning does not imply that the loss itself has meaning, but rather that individuals can find meaning in their own lives and in the lives of those they have lost. This stage is about transforming grief into a more peaceful and hopeful experience, allowing individuals to move forward while still honouring their loved ones.

THE THREE-STAGE MODEL OF GRIEF

In the wake of suicide, individuals and communities are thrust into a whirlwind of emotions, uncertainties, and questions. How do we effectively communicate such heartbreaking news? How can we navigate the treacherous terrain of grief while constructing a supportive narrative? And perhaps most importantly, how do we find the potential for growth amidst such profound loss?

The Three-Stage Modell of Grief presented for the first time in this manual, delineates three critical phases and associated tasks following a suicide:
I. Notification & Surviving the Initial Shock,
II. Grief, Debriefing & Constructing a Supportive Narrative, and
III. Growth, Retrospective Analysis & Improvements.

Each stage is meticulously designed to provide understanding, guidance, support, and a pathway toward healing for those impacted by suicide.



The Three-Stage Model of Grief

Phase I: Notification & Surviving the Initial Shock, sets the foundation by emphasising the importance of empathetic communication and immediate support. It outlines a step-by-step process for sensitive notifying relevant parties, from interactions with bereaved families to educational settings and workplaces, while offering strategies for coping with the initial shock.

Phase II: **Grief, Debriefing & Constructing a Supportive Narrative**, focuses on the complex emotions that accompany grief after a suicide. It acknowledges the profound sense of loss, guilt, anger, anxiety, shame and sorrow that may arise, emphasising the necessity of open communication and the construction of a safe narrative about the devastating loss to facilitate healing.

Phase III: Growth, Retrospective Analysis & Improvements, illuminates the potential for personal growth in the aftermath of trauma. It encourages reflection, connection with the departed individual, time management strategies, engagement in meaningful activities, and self-development as avenues for navigating grief and fostering positive change.

By traversing successfully and safely these three critical phases after every critical loss that we encounter in our life, with compassion, introspection, and resilience, individuals and communities can not only survive the aftermath of suicide and other personal and group catastrophes but also emerge more robust, more empathetic, and better equipped to support one another through life's most challenging moments.

I.NOTIFICATION AND SURVIVING THE INITIAL SHOCK

Objective: To provide information about suicide sensitively to reduce the intensity of emotions.

Question: How can we effectively and safely notify others?

In a workplace setting, the individual who first receives information about a suicide begins by sharing it with a manager. The news should be disseminated to other employees only after informing the manager and individuals who may be most affected.

→ Employee: *Hello, Boss. I've received information regarding the suicide of one of our patients/clients. According to our policies, I should inform you first, and then you can share the news with the staff members who may be most affected.*
→ Boss: *Hi. That's very sad. Can you provide more details? Who do you think will be most impacted by this news? I'll try to reach them today, so please inform the others at the workplace tomorrow only. In the meantime, you can speak with someone from the Crisis Team who will assist in this matter. I'll send you the contact information shortly via email.*
The next step involves the manager informing the employee responsible for the patient or client and the crisis team leader, who will organise a debriefing meeting for all staff members who had contact as soon as possible, but no later than one week after the notification.

→ Boss (to potentially affected employee): *I've received information that X has died by suicide. As you were the last person to have contact with X/ X, who was your patient, I'm sharing this news with you first through our Postvention Notification Policy. It's always challenging to address questions from other staff members when one receives unexpected and distressing news. I suggest we meet in the afternoon or tomorrow and review this patient's records together. Feel free to call or come to my office to talk to me.*

If other patients inquire, a professional can respond: *We've also received this sad news. We're currently investigating the circumstances following hospital procedures. Have you had any interactions with X?*

The boss contacts the bereaved family:
→ *I've been informed by one of our nurses/doctors that X has died by suicide—my sincerest condolences. We would like to offer our assistance in any way possible. As we seek to understand the situation, you're welcome to meet with a doctor/psychologist who had contact with your (insert relation), or you may submit your comments in writing. If you're not ready to decide about it right now, that's understandable. I'll follow up with you in 2-3 weeks. If there's anything we can do to support you, please don't hesitate to reach out. I have the contact information for an organisation that assists the bereaved. Have you heard of them? If not, I'd be happy to share their details with you.*

To enhance our chances of avoiding prolonged grief disorder and other disturbances, we could:

1. Educate ourselves on coping mechanisms for dealing with shock after receiving distressing news or experiencing traumatic events.
2. Employ distraction techniques (such as deep breathing, muscle relaxation, or cold-water exposure) to reduce immediate stress responses and facilitate vagal responses.
3. Begin the process of building recovery blocks from the outset to aid in healing.
4. Establish a connection with a peer with lived experience who can act as a supportive companion, akin to a doula for a pregnant woman preparing for delivery, offering a source of guidance.

II. GRIEF, DEBRIEFING & CONSTRUCTING A SUPPORTIVE NARRATIVE

Objective: To navigate grief after a suicide and initiate the construction of a supportive narrative.

Question: How can we effectively address grief after a suicide in a safe manner?

We can initiate a conversation by expressing empathy:

"I'm deeply sorry for your loss of [insert the relationship to the deceased]. Losing someone to suicide is an incredibly challenging experience for every individual and those close to the deceased. Suicide triggers a multitude of complex emotions that can persist for

prolonged periods if left unexpressed. Therefore, I appreciate your willingness to talk with me."

Primarily, every suicide confronts us with our inadequacies and feelings of powerlessness. It underscores the reality that we are not always in control and that preventing suicide is not as simple as often portrayed. Each instance of suicide serves as a stark reminder of our limitations in safeguarding or aiding someone who held significant importance to us. The theme of lack of control and personal inadequacies may resurface repeatedly in the immediate aftermath of the loss, during anniversaries, and in situations where we grapple with helplessness.

This is precisely why open communication is essential; it enables us to articulate our emotions, thoughts, and behaviours, fostering a better understanding of ourselves. Without this reflective dialogue, our ability to prevent future suicides remains stagnant. By vocalising our feelings and thoughts, we gain clarity and establish a healthy distance from them. This distance empowers us to recognise that while certain situations may have been beyond our control, we can approach similar circumstances differently by cultivating hope, enhancing interpersonal connections, empathising with others, and assisting them in recognising their inherent worth.

We can learn to cope with the overwhelming emotions of powerlessness and helplessness and prevent them from permeating every aspect of our lives. Suppose feelings of powerlessness and helplessness begin to define our identity post-suicide or any other loss. In that case, they are often accompanied by a myriad of challenging emotions bundled in what can be described as the "GAPS" framework:

- **Guilt** (attributed to actions taken or not taken),
- **Anger** (directed towards oneself or others due to perceived inadequacy),
- **Anxiety** (stemming from feelings of vulnerability and fear),
- **Pain** of loss (resulting from the decrease in endorphins and subsequent vulnerability to emotional distress), and
- **Shame** (following a loss arises from the perception that we fell short of expectations or could have been more effective).

"GAPS" is an acronym encompassing these fundamental challenging emotions. Addressing and expressing all these feelings is crucial, as well as constructing a safe narrative around them to enhance our self-esteem and interpersonal connections. These feelings are likely to resurface in various contexts and occasions in the future.

III. GROWTH, RETROSPECTIVE ANALYSIS & IMPROVEMENTS

Objective: To explore the potential for personal growth following a trauma and to transform grief and sorrow into positive outcomes.

Question: What actions can we take to enhance our likelihood of experiencing Posttraumatic Growth?

Understanding the Loss: Understanding the true impact of the loss is crucial. It's not just about losing a person; it's about losing an entire world intertwined with that individual. We lose the time spent together, the myriad of positive and negative interactions, the moments of love and joy, shared activities, and our roles concerning that person—whether as a parent, child, sibling, or professional. We also lose the support and sense of togetherness they provided.

Maintaining Connection: To embark on a pathway of posttraumatic growth, we must find ways to keep our connection with the departed individual, even though they are no longer with us physically.

Time Management: Regarding time, it's essential to decide how much time we will dedicate to memories of the person and when we will set aside time to process our grief. This includes expected occasions like holidays and anniversaries and unexpected triggers that evoke strong memories of the person.

Engaging in Activities: In terms of activities, we need to determine how we will spend time with the person we've lost. This could involve talking to them, reflecting on our shared experiences, looking at items associated with them, or engaging in rituals like lighting a candle or saying a special prayer. These activities can be deeply personal and meaningful.

Initiating the Conversation: We can begin a dialogue by acknowledging that losing someone significant in our lives often triggers profound and unexpected changes. It's a tumultuous period, especially when we lose a cherished relationship or someone closely associated with our values, such as professional competence. This upheaval thrusts us into unfamiliar territory, requiring us to adapt to our new circumstances.

Navigating Solitude vs. Social Interaction: Deciding whether to grieve alone or with others presents challenges. It's natural to fear that seeking solace elsewhere may feel like a betrayal, but communication is critical as keeping emotional wounds open hinders the recovery, so it's essential to address these concerns openly and find a solution that supports our healing journey.

Preserving Memories: When reflecting on the person we've lost, it's essential to determine the aspects we want to focus on and to construct our memories around them in a manner that aids in our healing process. There are numerous ways to achieve this. For instance, one might consider composing a song, poem, or story that encapsulates our relationship with the departed individual. By associating the loss with an activity we can control, such as creative expression, we can gradually regain a sense of agency in our lives. Those who find solace in the company of others who share similar experiences may benefit from joining an organisation that supports individuals dealing with loss. Alternatively, if such an organisation doesn't exist, creating one—perhaps in the form of a social media group—can provide ongoing support and alleviate feelings of loneliness and worthlessness.

Self-development: Following a loss, it's essential to allocate time for self-reflection and identify ways to evolve into better versions of ourselves. This process extends to us and others affected by the loss, as well as to institutions such as hospitals and workplaces. By introspecting and seeking areas for improvement, we can foster personal growth and contribute positively to our communities.

THE DUAL PROCESS MODEL OF COPING WITH BEREAVEMENT

The Dual Process Model of Coping with Bereavement, developed by Margaret Stroebe and Henk Schut, provides a comprehensive framework for understanding how individuals navigate grief. This model suggests that people oscillate between two types of coping processes: loss-oriented and restoration-oriented.

Loss-Oriented Coping

Loss-oriented coping involves activities and thoughts that focus directly on the deceased and the pain of the loss. This includes:

- Grieving and crying
- Thinking about the loved one
- Yearning for the deceased
- Reminiscing and looking at old photos
- Expressing emotions related to the loss

These activities help individuals confront and process their grief, allowing them to acknowledge the reality of the loss and the associated emotional pain (Stroebe & Schut, 1999).

Restoration-Oriented Coping

Restoration-oriented coping involves activities that help individuals adjust to life without the deceased and manage the secondary stressors that arise from the loss. This includes:

- Learning new skills (e.g., managing finances)
- Taking on new roles and responsibilities
- Engaging in new activities and hobbies
- Forming new relationships
- Focusing on day-to-day tasks and routines

These activities provide a temporary respite from the emotional intensity of grief and help individuals rebuild their lives and find a new sense of normalcy (Stroebe & Schut, 1999).

A key feature of the Dual Process Model is the concept of oscillation, which refers to the dynamic process of moving back and forth between loss-oriented and restoration-oriented coping. This oscillation allows individuals to balance the need to confront their grief with the need to take breaks from it and engage in restorative activities. It acknowledges that grief is a fluctuating experience where individuals may feel intense grief at times and more focused on practical tasks at other times.

The Dual Process Model normalizes the experience of moving between different types of coping, helping individuals understand that it is natural to have periods of intense grief followed by periods of relative calm. It provides a flexible approach to grieving, allowing individuals to cope in ways that feel most appropriate for them at different times. It acknowledges that different people may have different coping styles and that both emotional expression and practical problem-solving are valid ways to cope with loss.

The intense emotions and complex grief reactions associated with suicide loss may require frequent oscillation between confronting the pain of the loss and engaging in rebuilding their lives.

Conclusion:

Grief after suicide is a multifaceted journey marked by intense emotions and profound challenges. By exploring the four modes and five stages of grief, survivors can gain a deeper understanding of their own experiences and emotions, finding solace in the knowledge that their feelings are part of a more extensive process of healing and growth. While grief may feel overwhelming at times, it also offers opportunities for reflection, connection, and personal transformation.

Takeaways:

1. The grief process after suicide is characterised by distinct stages and modes, each with its themes and emotions.

2. Understanding these stages and modes can provide survivors a framework for navigating their grief journey, fostering healing and resilience.

3. While grief may feel overwhelming, it offers growth and personal transformation opportunities.

4. By recognising and processing their emotions, survivors can find meaning and hope amidst the pain of loss, forging pathways to healing and resilience.

References:

Azorina, V., Morant, N., Nesse, H., Stevenson, F., Osborn, D., King, M., & Pitman, A. (2019). The Perceived Impact of Suicide Bereavement on Specific Interpersonal Relationships: A Qualitative Study of Survey Data. International Journal of Environmental Research and Public Health, 16. https://doi.org/10.3390/ijerph16101801

Fielden, J. (2003). Grief as a transformative experience: weaving through different lifeworlds after a loved one has completed suicide.. International journal of mental health nursing, 12 1, 74-85. https://doi.org/10.1046/J.1440-0979.2003.00271.X

Hunt, Q., & Hertlein, K. (2015). Conceptualising Suicide Bereavement From an Attachment Lens. The American Journal of Family Therapy, 43, 16 - 27. https://doi.org/10.1080/01926187.2014.975651

Kubler-Ross, E., & Kessler, D. (2005). On grief and grieving: Finding the meaning of grief through the five stages of loss. Simon and Schuster.

Kessler, D. (2021, May). How to find meaning after loss [Video]. TED. Retrieved May 27, 2024, from https://www.ted.com/talks/david_kessler_how_to_find_meaning_after_loss/transcript

Kessler, D. (n.d.). Free Suicide Loss Support Series. Retrieved May 27, 2024, from https://www.davidkesslertraining.com/live-suicide-loss-support-web

Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies, 23*(3), 197–224. https://doi.org/10.1080/074811899201046

Stroebe, M., & Schut, H. (2010). The dual process model of coping with bereavement: a decade on. *Omega, 61*(4), 273–289. https://doi.org/10.2190/OM.61.4.b

Multiple-Choice Questions:

1. What characterises the "Thrown-ness" mode in the grief process after suicide?
A. Fear of not coming through
B. Reflection on the relationship with the deceased
C. Experiencing chaos and emotional turmoil
D. Actively searching for clues in suicide notes

2. In the "Survival mode" of grief after suicide, what do survivors struggle to accept?
A. The reality of their loved one's death
B. The need to move on and forget
C. The societal stigma surrounding suicide
D. The emotional closure provided by dreams

3. What characterises the "Searching mode" of grief after suicide?
A. Fear of not coming through
B. Living in a world of stigma and shame
C. Engaging in a relentless pursuit of answers
D. Creating a different lifeworld

4. Which emotion is predominant in the "Moving on mode" of grief after suicide?
A. Guilt
B. Anger
C. Sadness
D. Acceptance

5. Which stage of grief involves refusing to accept the loss?
A. Anger
B. Bargaining
C. Denial
D. Depression

6. What emotion is commonly experienced during the anger stage of grief?
A. Happiness
B. Frustration
C. Serenity
D. Acceptance

7. What characterises the bargaining stage of grief?
A. Withdrawal from social interactions
B. Attempting to negotiate with fate
C. Feeling a sense of calm and emotional stability
D. Questioning the purpose of life

8. According to Kübler-Ross, what is the purpose of the stages of grief?
A. To prescribe a rigid framework for grief
B. To provide a tool for healthcare providers only
C. To help individuals understand and navigate complex emotions
D. To avoid experiencing grief altogether

9. How should information about suicide be initially shared in a workplace setting?
A. Inform all staff members immediately.
B. Please share it with the manager first, then with potentially affected individuals.
C. Keep the information confidential
D. Notify only the crisis team leader

10. What is the recommended response when other patients inquire about suicide?
A. Avoid discussing the topic with them.
B. Share the news openly with all patients.
C. Provide a brief acknowledgement and reassure them that the situation is being addressed according to hospital procedures.
D. Direct them to the bereaved family for further information.

11. What strategies are suggested to mitigate the impact of receiving distressing news?
A. React impulsively without considering the consequences.
B. Seek immediate closure by contacting the bereaved family
C. Employ distraction techniques like deep breathing or muscle relaxation
D. Refrain from discussing the news with anyone and internalise emotions.

12. How can individuals initiate a conversation to address grief after a suicide in a safe manner?
A. Express empathy and acknowledge the loss, encouraging open dialogue.
B. Avoid discussing the suicide to prevent further emotional distress.
C. Immediately offer advice on coping mechanisms without acknowledging the loss.
D. Minimise the significance of the loss to avoid discomfort.

13. What is emphasised as a primary theme regarding grief after suicide in the text?
A. The certainty of preventing suicide with adequate support.
B. The complexity of emotions triggered by suicide and feelings of powerlessness.
C. There is a need to overlook personal inadequacies and focus on external factors.
D. The simplicity of navigating grief without addressing underlying emotions.

14. Which acronym is used to describe the fundamental complicated feelings associated with grief after suicide in the text?
A. CRISIS
B. GRIEF
C. GAPS
D. LOSS

15. What is recommended regarding time management in the context of grief?
A. Spending all available time reminiscing about the lost person
B. Avoiding holidays and anniversaries to prevent triggering memories
C. Setting aside specific times to process grief, including unexpected triggers
D. Focusing solely on future plans to avoid dwelling on the past

16. How is the importance of self-reflection and improvement emphasised in the text?
A. By recommending avoidance of any changes post-loss
B. Through allocating time for self-development and growth
C. By discouraging introspection to prevent further emotional distress
D. Advising against seeking support from others for personal improvement

Answers:

1: C. Experiencing chaos and emotional turmoil
2: C. The societal stigma surrounding suicide
3: C. Engaging in a relentless pursuit of answers
4: D. Acceptance
5: C. Denial
6: B. Frustration
7: B. Attempting to negotiate with fate
8: C. To help individuals understand and navigate complex emotions
9: B. Share it with the manager first, then with potentially affected individuals
10: C. Provide a brief acknowledgement and reassure them that the situation is being addressed according to hospital procedures
11: C. Employ distraction techniques like deep breathing or muscle relaxation
12: A. Express empathy and acknowledge the loss, encouraging open dialogue.
13: B. The complexity of emotions triggered by suicide and feelings of powerlessness.
14: C. GAPS
15: B. Setting aside specific times to process grief, including unexpected triggers
16: B. Through allocating time for self-development and growth

B.06
FROM TRAUMA TO TRANSFORMATION: EXPLORING THE POWER OF POSTTRAUMATIC GROWTH

Introductory Question:
How can individuals and communities harness the power of resilience to transform the pain of trauma into meaningful personal growth and compassionate action?

What You Will Learn:
1. **Definition and Importance of Posttraumatic Growth (PTG)**: Understand what PTG is and why it is a crucial concept in trauma and recovery.
2. **Mechanisms and Dimensions of PTG**: Learn about the psychological and social mechanisms that facilitate PTG and the critical dimensions through which PTG manifests.
3. **PTG in the Context of Suicide Loss**: Explore how PTG affects those after suicide loss.
4. **Strategies for Promoting PTG in Postvention**: Discover practical strategies and interventions that can help promote PTG among survivors of suicide loss.
5. **Neurobiology of PTG**: Gain insights into the brain's role in PTG and how cognitive and emotional processes are involved in growth after trauma.
6. **Inspirational Stories of Resilience and Compassion**: Read about examples of individuals who have transformed their grief into positive action, demonstrating the power of PTG in fostering resilience and community support.

Introduction:
Grief In the face of profound trauma and loss, it is often assumed that individuals will be left with enduring scars that impede their ability to lead fulfilling lives. However, research and real-life stories reveal a more nuanced narrative where adversity can catalyse significant positive change. This phenomenon, known as Posttraumatic Growth (PTG), describes the positive psychological shifts that can occur when individuals grapple with severe stressors. Coined by Tedeschi and Calhoun in 2004, PTG encompasses the profound transformations in self-perception, relationships, and life philosophy that arise from enduring and overcoming traumatic experiences.

This Chapter delves into the multifaceted nature of PTG, examining how individuals, particularly those bereaved by suicide, can find paths to personal growth amidst their pain. It explores the mechanisms that foster PTG, including adaptive coping strategies and the crucial role of social support.

POSTTRAUMATIC GROWTH DEFINITION

Tedeschi & Calhoun (2004) introduced the concept of Posttraumatic Growth (PTG), which refers to the positive changes that can emerge from grappling with significant traumatic stressors.

Posttraumatic Growth (PTG) refers to positive psychological changes that individuals experience in the aftermath of significant life challenges or traumatic events. Instead of being overwhelmed by the trauma, some individuals find ways to cope and adapt, leading to personal growth and development. This growth can manifest as increased resilience and a greater appreciation for life, enhanced personal relationships, a sense of purpose or meaning, and a deepened spiritual or existential outlook. PTG does not negate the adverse effects of trauma but acknowledges that growth and positive change can emerge from adversity.

PTG is observable following suicide loss and is positively linked to factors such as the passage of time since the loss, effective coping mechanisms, and seeking assistance, with social support and self-disclosure playing essential roles in these associations (Levi-Belz et al., 2020). Individuals with secure attachments tend to experience more often PTG than those with insecure

attachments. Interventions grounded in attachment theory can benefit the latter (Levi-Belz et al., 2020; Bonnemort, 2020)).

Strategies in postvention that are adaptive can foster psychological growth among survivors of suicide loss (Levi-Belz, 2015).

Sharing personal thoughts and emotions is integral to the grieving process and adjusting to the new circumstances. This sharing fosters intimacy, solidarity, and support among individuals. Through disclosure, survivors can feel a sense of belonging and discover renewed purpose in life. Additionally, sharing emotional narratives can aid survivors in constructing new interpretations of their experiences (Levi-Belz et al., 2014).

Key interpersonal factors such as feelings of belongingness, self-disclosure, and perceived social support play significant roles in facilitating PTG among those bereaved by suicide (Levi-Belz, 2019). Coping mechanisms have been strongly associated with promoting PTG in the aftermath of suicide loss (Levi-Belz, 2015; Bonnemort, 2020)).

Self-forgiveness is a process wherein individuals acknowledge their shortcomings and mistakes, letting go of self-anger and resentment, which fosters positive emotions, thoughts, and behaviours towards oneself (Enright et al., 2000). Studies have shown that self-forgiveness correlates with improved emotion regulation and higher positive relationships and social support (Webb & Boye, 2024). This forgiveness also plays a crucial role in mitigating negative emotions associated with addictive and suicidal behaviours, such as shame, guilt, and self-stigma (Webb & Boye, 2024). Adaptive coping strategies, like positive reappraisal and refocusing, are inversely related to symptoms of depression, anxiety, anger, and other indicators of mental health problems (Garnefski et al., 2001).

KEY DIMENSIONS OF PTG

The concept of PTG, as outlined by Tedeschi & Calhoun in 2004, is measured through a scale focusing on self-perception, relationships, and spiritual outlook changes.

I. Changes in the Self: This dimension includes shifts in attitudes, character traits, behaviour, and a growing sense of self-reliance and acceptance of life's challenges.

Example statements: *"I discovered I am stronger than I thought I was," "I developed new interests," and "I'm more likely to try to change things which need changing."* (Novora, 2010).

II. Changes in Relationships: This category encompasses improvements in social interactions, such as overcoming shyness or anxiety, forming meaningful connections with others, and experiencing greater empathy and compassion.
Example statements: *"I was shy or anxious – now I developed relationships with others," "I am more open, I met great people, I have learned I can count on people in times of trouble," "I am having more compassion for others. I am putting more effort into my relationships."*

III. Spiritual Change: Spiritual growth involves shifts in one's philosophy of life and finding meaning amid adversity, leading to a deeper appreciation for life and a stronger sense of purpose.

Example statements: *"I am taking life easier and enjoying it more," "I am no longer taking life for granted; I am living each day to the fullest, as it was the last day of my life," "I am finding meaning amid trauma and its aftermath."* (Novora, 2010).

NEUROBIOLOGY OF PTG

The initial study on the neurobiology of PTG revealed a correlation between PTG and specific brain structures (Ochsner et al., 2002): cognitive reappraisal of highly negative photographs led to a reduction in the subjective experience of negative affect, an increase in brain activity in the lateral and medial prefrontal cortex (PFC), and a decrease in activation in the amygdala and medial orbitofrontal cortex. Cognitive reappraisal is a cognitive strategy used to manage emotions by reframing the meaning of a situation. Instead of reacting automatically to a potentially stressful or adverse event, individuals employing cognitive reappraisal reinterpret the situation in a more positive or neutral light. This technique involves changing one's perspective or understanding of the event, which can reduce the intensity of difficult emotions. Cognitive reappraisal is often used in emotion regulation to cope with challenging circumstances and promote psychological well-being.

Scores on the Posttraumatic Growth Inventory (PTGI) were positively associated with brain activation in the rostral PFC (rPFC) and the superior parietal lobule (SPL) within the left central executive network (CEN). The CEN maintains information in working memory and plays a role in decision-making and problem-solving for goal-directed behaviour (Menon, 2011). Activation of the rPFC within the CEN suggested that individuals with higher

PTG experienced more positive functional changes in prospective memory. In contrast, activation of the SPL suggested a positive correlation with working memory, which involves the flexible allocation of attention (Koenigs et al., 2009).

PTGI scores were also positively correlated with increased connectivity between the SPL seed and the supramarginal gyrus (SMG), a brain region associated with the ability to reflect on the mental states of others, activated during language and verbal working memory tasks. The right SMG enables individuals to distinguish their perceptions from those of others. Participants who project their feelings onto others often show disruption of neurons in these brain regions.

Enhanced connectivity between memory functions and social functioning may be associated with increased memory use to reflect on other mental states during social interactions (Fujisawa et al., 2015).

INSPIRATIONAL STORIES OF RESILIENCE AND COMPASSION

In the annals of human resilience and compassion, some stories stand as beacons of hope, illuminating the path for others amidst the darkest of times. These stories are tales of survival and narratives of transformation, where the lived experience of trauma becomes the catalyst for profound change and altruism.

One such story begins with the family of suicidologist professor Diego de Leo, who, in the wake of the tragedy of losing their two children in a traffic accident, found solace in the warmth and empathy of their community. On April 5, 2005, Nicola and Vittorio, their beloved children, were suddenly taken from them, leaving behind a void that seemed impossible. However, amidst the abyss of grief, the De Leo family discovered a glimmer of light born from the kindness of those who rallied around them, offering support and guidance in their darkest hour. They founded the De Leo Fund Onlus, a hope for those grappling with traumatic grief. Their vision was simple yet profound: to transform their tragic experience into a lifeline for others, sharing stories, memories, and experiences to alleviate the burden of sorrow. Over time, the De Leo Fund has launched complimentary services tailored to those affected by abrupt loss, including individual, couple, and family counselling, self-help groups, a national helpline, live chat support, an online forum, and specialised creative workshops designed for suicide survivors.

Across oceans and continents, others like Fiona Tuomey, Maryan Fasth, Alice Harding, Denise Meine-Graham, and Bonnie Carroll embarked on similar journeys of resilience and compassion. Fiona, Maryan, Alice, Denise, and Bonnie, each touched by the loss of a loved one in suicide, found the seeds of empathy and understanding within their grief.

Fiona Tuomey, spurred by the memory of her daughter, founded HUGG, a sanctuary for those bereaved by suicide, offering solace and support in times of despair. Maryan Fasth, whose daughter's life was claimed by suicide, pioneered SPES, a platform for survivors to find solidarity and healing in shared experiences in Sweden. Alice Harding, grappling with the aftermath of her husband's suicide, established SOBS, a peer-led support network for survivors navigating the complex terrain of grief. Denise Meine-Graham, haunted by the loss of her son, founded LOSS, extending a compassionate hand to those thrust into the tumultuous journey of grief. Bonnie Carroll, a military spouse bereaved by loss, founded TAPS, offering support for families mourning the loss of loved ones in the military.

These inspirational individuals, driven by the transformative power of empathy and compassion, have turned their pain into purpose and their grief into guidance. In addition to founding these organisations, each embarked on a journey of personal growth and transformation following their devastating losses. Their experiences exemplify the concept of posttraumatic growth, wherein individuals find meaning, resilience, and positive change in the aftermath of trauma.

Their dedication to helping others and creating supportive communities inspired countless others to find hope and healing in the face of adversity. They have illuminated the path for others, offering solace, support, and hope to those navigating the labyrinth of loss. In their stories, we find the resilience of the human spirit and the enduring power of compassion to heal and unite us all. Their stories stand as a testament to the power of human resilience, demonstrating that even in the darkest times, there is always the potential for growth and renewal.

Conclusion:

In conclusion, this chapter has comprehensively explored PTG, from the pioneering work of Tedeschi and Calhoun to the inspiring stories of individuals who have turned their pain into purpose.

We have learned that PTG is not merely about bouncing back from trauma but about thriving in its aftermath, finding meaning, resilience, and positive change. Through personal narratives and scientific research, we have seen how PTG can manifest in various domains of life, from enhanced relationships to spiritual growth.

We have gained insights into the neurobiological underpinnings of PTG, understanding how cognitive reappraisal and brain connectivity contribute to psychological flourishing in the aftermath of trauma.

Ultimately, the stories of resilience and compassion shared in this chapter serve as beacons of hope, illuminating the path for others grappling with trauma and loss. They remind us that even in the darkest of times, there is potential for growth. By embracing the concept of PTG and fostering supportive communities, we can cultivate a culture of resilience and compassion where individuals can find solace, support, and hope on their journey toward healing and growth.

Takeaways:

1. **Posttraumatic Growth (PTG) as a Path to Positive Change**: PTG highlights the potential for individuals to experience significant positive psychological changes after facing traumatic events. This growth includes enhanced self-perception, deeper relationships, and a more profound sense of purpose and spirituality.

2. **Critical Role of Social Support**: Effective coping mechanisms and the support of friends, family, and community play vital roles in fostering PTG. Social support and self-disclosure are essential for individuals to process their experiences and find meaning in their trauma.

3. **Adaptive Coping Strategies:** Utilizing adaptive coping strategies, such as positive reappraisal and self-forgiveness, can significantly mitigate the adverse effects of trauma and promote PTG. These strategies help individuals reframe their experiences and develop resilience.

4. **Neurobiological Foundations of PTG:** Research indicates that PTG is associated with specific brain structure and function changes. Understanding the neurobiology of PTG, including cognitive reappraisal and enhanced connectivity in particular brain regions, sheds light on the biological processes that support posttraumatic growth.

5. **Inspirational Examples of Resilience:** Real-life stories of individuals who have transformed their grief into purposeful action are potent examples of PTG. These narratives demonstrate how personal tragedy can lead to the creation of supportive communities and inspire others to find hope and healing in the face of adversity.

References:

Alderholm J., Arvidsson L. (2007). Growing through suffering: posttraumatic growth and positive changes after the suicide of a close relative, https://www.diva-portal.org/smash/get/diva2:135145/FULLTEXT01.pdf

Levi-Belz, Y., & Lev-Ari, L. (2019). Attachment Styles and Posttraumatic Growth Among Suicide-Loss Survivors. *Crisis*, *40*(3), 186–195. https://doi.org/10.1027/0227-5910/a000550

Bonnemort, L. (2020). Exploring the Impact of Insecure Attachment Styles in Couple Adjustment Through the Lens of Cluster B Pathology. https://digitalcommons.nl.edu/diss/460/

Enright, R. D. (**2019**). *Forgiveness is a choice: A step-by-step process for resolving anger and restoring hope*. American Psychological Association.

Fujisawa, T. X., Jung, M., Kojima, M., Saito, D. N., Kosaka, H., & Tomoda, A. (2015). Neural basis of psychological growth following adverse experiences: A resting-state functional MRI study. PLOS ONE, 10(8), e0136427. https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0136427

Garnefski, N., Kraaij, V., & Spinhoven, P. (2001). Negative life events, cognitive emotion regulation and emotional problems. Personality and Individual Differences, 30(8), 1311-1327. https://doi.org/10.1016/S0191-8869(00)00113-6

Koenigs, M., Barbey, A. K., Postle, B. R., & Grafman, J. (2009). Superior parietal cortex is critical for the manipulation of information in working memory. Journal of Neuroscience, 29(47), 14980-14986. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2799248/

Levi-Belz, Y. (2015). Stress-related growth among suicide survivors: The role of interpersonal and cognitive factors. Archives of Suicide Research, 19(3), 305-320. https://doi.org/10.1080/13811118.2014.957452

Levi-Belz, Y. (2019). With a little help from my friends: A follow-up study on the contribution of interpersonal characteristics to posttraumatic growth among suicide-loss survivors. Psychological Trauma: Theory, Research, Practice, and Policy, 11(8), 895-904. https://doi.org/10.1037/tra0000456

Levi-Belz, Y., Krysinska, K., & Andriessen, K. (2021). "Turning personal tragedy into triumph": A systematic review and meta-analysis of studies on posttraumatic growth among suicide-loss survivors. *Psychological trauma : theory, research, practice and policy*, *13*(3), 322–332. https://doi.org/10.1037/tra0000977

Menon V. (2011). Large-scale brain networks and psychopathology: a unifying triple network model. *Trends in cognitive sciences*, *15*(10), 483–506. https://doi.org/10.1016/j.tics.2011.08.003

Morgan, J. K., Desmarais, S. L., Mitchell, R. E., & Simons-Rudolph, J. M. (2017). Posttraumatic Stress, Posttraumatic Growth, and Satisfaction With Life in Military Veterans. *Military Psychology*, *29*(5), 434–447. https://doi.org/10.1037/mil0000182

Ochsner, K. N., Bunge, S. A., Gross, J. J., & Gabrieli, J. D. (2002). Rethinking feelings: an FMRI study of the cognitive regulation of emotion. *Journal of cognitive neuroscience*, *14*(8), 1215–1229. https://doi.org/10.1162/089892902760807212

Tedeschi, R. G., & Calhoun, L. G. (2004). TARGET ARTICLE: "Posttraumatic Growth: Conceptual Foundations and Empirical Evidence." *Psychological Inquiry*, *15*(1), 1–18. https://doi.org/10.1207/s15327965pli1501_01

Webb, J. R., & Boye, C. M. (2024). Self-Forgiveness and Self-Condemnation in the Context of Addictive Behavior and Suicidal Behavior. *Substance abuse and rehabilitation*, *15*, 21–30. https://doi.org/10.2147/SAR.S396964

Multiple-Choice Questions:

1. What is Posttraumatic Growth (PTG), according to Tedeschi & Calhoun, 2004?
A. The process of accepting one's mistakes and seeking self-anger or self-resentment.
B. Positive changes experienced after struggling with major dramatic stressors.
C. A scale designed to measure anxiety.
D. A therapeutic intervention focused on a cognitive reappraisal of negative emotions.

2. How are adaptive coping strategies related to Posttraumatic Growth (PTG), according to Garnefski et al., 2001?
A. Adaptive coping strategies have no significant impact on PTG.
B. They are positively related to depressive symptoms and anxiety.
C. They are negatively related to depressive symptoms, anxiety, anger, and other measures of mental ill-health.
D. They are positively correlated with the severity of mental health problems.

3. According to the text, what is a critical factor in facilitating Posttraumatic Growth (PTG) among suicide-loss survivors?
A. Avoiding social interactions to prevent further emotional distress.
B. Taking cannabis.
C. Having a solid attachment style characterised by insecurity.
D. A sense of belongingness, self-disclosure, and perceived social support.

4. According to the study by Ochsner et al., 2002, what brain structures were correlated with Posttraumatic Growth Inventory (PTGI) scores?
A. Activation in the amygdala and medial orbitofrontal cortex.
B. Decreased activation in the lateral and medial prefrontal cortex (PFC).
C. Activation in the supramarginal gyrus (SMG) and superior parietal lobule (SPL).
D. Increased activation in the rostral PFC (rPFC) and SPL within the left central executive network (CEN).

5. How does self-forgiveness contribute to emotional regulation and social support?
A. Self-forgiveness fosters negative emotions and maladaptive behaviours.
B. It has no significant impact on emotional regulation or social support.
C. Self-forgiveness promotes positive emotions, thoughts, and behaviours toward oneself.
D. It leads to increased self-condemnation and self-stigma, worsening mental health outcomes.

Answers:
1: B. Positive changes experienced after struggling with major dramatic stressors.
2: C. They are negatively related to depressive symptoms, anxiety, anger, and other measures of mental ill-health.
3: D. A sense of belongingness, self-disclosure, and perceived social support.
4: D. Increased activation in the rostral PFC (rPFC) and SPL within the left central executive network (CEN).
5: C Self-forgiveness promotes positive emotions, thoughts, and behaviours toward oneself.

B.07 UNDERSTANDING SUICIDE POSTVENTION: SUPPORT AND HEALING AFTER TRAGEDY

Introductory Question:
How can communities effectively support individuals grieving after a suicide and prevent further tragedies?

What You Will Learn:
1. **Definition and Importance of Postvention:** Learn about suicide postvention, its purpose in helping survivors cope, and preventing further suicides.
2. **Objectives of Postvention:** Understand key goals: healing, counteracting complicated grief, mitigating adverse effects, preventing additional suicides, and promoting posttraumatic growth.
3. **Types of Interventions:** Explore primary, secondary, and tertiary interventions based on the risk and complexity of grief.
4. **Active vs. Passive Postvention:** Differentiate between proactive, immediate support (active postvention) and waiting for survivors to seek help (passive postvention).
5. **Challenges in Postvention:** Identify common challenges, including stigma, communication barriers, emotional impact, and the risk of suicide ideation among the bereaved.

Introduction:
Suicide postvention refers to the organised response and support provided to individuals and communities affected by a suicide or traumatic event. Coined by Shneidman in 1981, the concept aims to help survivors cope with their loss, prevent further suicides, and promote healing. This approach involves various interventions to address the emotional impact and facilitate the grieving process.

WHAT IS POSTVENTION?

Postvention was defined as "the provision of crisis intervention, support, and assistance for those affected by a suicide." By the American Association of Suicidology (1998)). Individuals "affected" by suicide are classmates, friends, teachers, and family members, often referred to as "survivors" of suicide (Knieper, 1999).

"Suicide postvention is a response or reaction to a community or individual following a suicide attempt or suicide by someone known to that community to facilitate healthy psychological adjustment" (Brock, 1990).

Postvention entails support for families and communities after a suicide (Andriessen et al., 2011). It involves concerted suicide bereavement support, utilising trained volunteers/peers and focusing on grief (Andriessen et al., 2019).

ACTIVE VS PASSIVE POSTVENTION

Active postvention, defined as intervention after a suicide, aims to limit the impact after a suicide by educating those first on the scene of a suicide and assisting survivors in finding professional and peer support. Active postvention involves intervention after a suicide, while passive postvention involves waiting for individuals to seek support. (Cerel et al., 2009; Peace, 2016)).

OBJECTIVES OF POSTVENTION

The goal of postvention is to support and debrief in an organised way to:

1. Facilitate healing of sorrow and distress after a suicide loss,
2. Counteract complicated grief reactions,
3. Mitigate other adverse effects one is exposed to after a suicide,
4. Prevent suicide among the suicide victim's family and friends, as they can have an increased risk for suicide, and e) promote posttraumatic growth.

Schut and Stroebe (2005) distinguished three types of bereavement interventions:

1. Primary preventive interventions offer professional help to all bereaved people, irrespective of intervention. (Linde et al., 2017)

2. Secondary preventive interventions are for bereaved people at high risk of
a complicated form of grief, such as people bereaved due to suicide or homicide.

3. Tertiary preventive interventions target suffering people who are experiencing complications in their grieving process.

All suicide prevention programs should include postvention after suicide to the bereaved, a population at heightened risk for suicide (Jordan, 2017).

CHALLENGES IN POSTVENTION

Challenges in postvention can vary but often include:

1. **Stigma and Social Taboos:** Societal stigma surrounding suicide may hinder open discussion and support for those affected by suicide. It can lead to shame and isolation.

2. **Communication Barriers:** Effective communication about suicide loss can be challenging due to the fear of saying the wrong thing. Breaking down communication barriers and fostering open, supportive dialogue among family members, friends, and communities is essential for healing.

3. **Impact on Relationships and Social Support:** Suicide loss can strain close relationships with family, friends, and peers, as individuals may struggle to understand or relate to the survivor's experience. This strain on social support networks can further exacerbate feelings of isolation and loneliness, making it challenging for survivors to find the support they need.

4. **Emotional Impact:** Dealing with the intense emotions of grief, guilt, anger, and confusion can be overwhelming for those affected by suicide loss. Finding healthy coping mechanisms and processing these emotions can be challenging.

5. **Complex Grief Reactions:** Bereavement by suicide can trigger complicated grief reactions, which may include feelings of abandonment, rejection, or unresolved questions about the death. Navigating these complex emotions and finding closure can be particularly challenging.

6. **Risk of Suicide Ideation:** Individuals bereaved by suicide may be at an increased risk of experiencing suicidal thoughts or behaviours themselves. Addressing and managing this risk while supporting the grieving process is crucial in postvention efforts.

7. **Long-Term Mental Health Impacts:** The mental health impacts of suicide loss can extend far beyond the immediate aftermath, leading to long-term psychological challenges such as e.g. depression, anxiety, and PTSD. Addressing these ongoing mental health needs and providing sustained support is crucial for survivors' well-being.

8. **Lack of Support Services:** Access to appropriate support services, such as counselling or support groups tailored for suicide survivors, may be limited or unavailable in some areas. This lack of support exacerbates feelings of isolation and hinders the healing process.

9. **Supporting Vulnerable Populations:** Some populations, such as children, adolescents, or individuals with mental health issues, may be especially vulnerable to the impact of suicide loss. Tailoring support services to meet the needs is essential.

10. **Cultural and Religious Differences:** Cultural and religious beliefs surrounding death and mourning vary widely, which can influence how individuals and communities respond to suicide loss. Understanding and respecting these differences while providing support is essential in postvention efforts.

11. **Effectiveness of Postvention: Identifying the Most Effective Components.** Defining the scope of interventions in postvention is crucial. Are we referring to interventions like easy access to various types of support tailored to the specific needs of each person bereaved by suicide, or are we considering interventions evaluated in postvention research? The effectiveness of postvention can vary based on these factors. Research suggests that models like the TAPS Suicide Postvention Model TM and postvention protocols can promote posttraumatic growth after suicide by offering pathways to recovery, strengthening suicide prevention, reducing stigma, and supporting caregivers.

12. **Contrasting Outcomes: Active vs. Passive Approaches to Suicide Postvention Support.** Active postvention refers to proactive measures and interventions implemented to support individuals who have experienced a suicide loss. Unlike passive approaches, where support is made available but not actively promoted or initiated, active postvention involves actively reaching out to those affected by suicide, providing resources, counselling, and support groups, and facilitating their access to these services. This approach aims to reduce the stigma and promote healing and recovery among survivors. Active postvention models tend to be more effective for suicide survivors than passive ones. They increase the likelihood of attending support group meetings and result in more consistent group attendance. Active postvention programs significantly reduce the time between death and seeking help for suicide survivors, offering hope and support in the grief process. This approach is essential for those who have experienced violent suicide.

13. **Assessing the Fulfilment of Informational Needs Among Suicide Loss Survivors.**
Suicide loss survivors often feel that their informational needs are not adequately met. Initially, they seek information related to the suffering of the deceased, but over time, they also seek guidance on coping with their loss and preventing suicide in others. Many survivors are motivated to engage in advocacy work. Zimmerman et al. (2023) suggest that information policies should be developed to support survivors and potentially prevent suicide contagion.

14. **Evaluating the Efficacy of Suicide Loss Survivors in Supporting Others Bereaved by Suicide: The Role of Training and Education in Postvention.**
Suicide survivors can offer hope and support in the grief process to newly bereaved individuals, as well as refer them to healthcare resources if necessary. Peer suicide bereavement support groups have been shown to improve well-being and reduce grief reactions by providing a sense of belonging and hope. These groups normalise grief experiences and share coping strategies. Peer-led support groups hold promise for those bereaved by suicide, addressing motivation, impact, and intervention aspects.

15. **Assessing the Impact of Postvention Policies on Mitigating the Consequences of Suicide: Identifying Essential Elements for Inclusion across Different Settings.** Postvention protocols are helpful to residents and potentially effective at mitigating the psychological and professional consequences of patient suicide. However, research indicates that psychiatrists rarely utilise postvention procedures. Enhanced suicide postvention efforts are necessary to address survivor care better and strengthen suicide prevention among psychiatrists. Postvention protocols are also needed in other settings.

16. **Development of postvention routines**. Postvention routines are needed in various environments.

Conclusion:

Postvention is an essential part of suicide prevention strategies, focusing on aiding survivors through organised support and education. By addressing the needs of those left behind, postvention not only helps in healing but also mitigates the risk of subsequent suicides. Understanding the types of interventions and their applications can significantly enhance the effectiveness of postvention programs.

Takeaways

1. **Postvention Definition**: It is the organised support provided after a suicide to help survivors cope and prevent further suicides.
2. **Key Objectives**: Facilitate healing, counteract complicated grief, mitigate adverse effects, prevent further suicides, and promote posttraumatic growth.
3. **Types of Interventions**: Primary, secondary, and tertiary interventions target different needs based on risk and complications in grief.
4. **Active vs. Passive Postvention**: Active postvention involves immediate intervention and education, while passive postvention waits for survivors to seek help.
5. **Importance in Prevention**: Postvention is crucial for suicide prevention programs as it addresses the heightened risk among suicide loss survivors.

References:

Andriessen, K., Krysinska, K., & Grad, O. (Eds.). (2019). *Postvention in action: The international handbook of suicide bereavement support*. Hogrefe Publishing GmbH.

Mauk, G. W., & Sharpnack, J. D. (2013). A light unto the darkness: The psychoeducational imperative of school-based suicide postvention. In *Adolescent Psychiatry, V. 23* (pp. 179-205). Routledge.

Cerel, J., Padgett, J. H., Conwell, Y., & Reed Jr, G. A. (2009). A call for research: The need to better understand the impact of support groups for suicide survivors. *Suicide and Life-Threatening Behavior*, *39*(3), 269-281.

Jordan, J. R. (2017). Postvention is prevention—The case for suicide postvention. Death Studies, 41(10), 614-621. https://doi.org/10.1080/07481187.2017.1335544

Knieper, A. J. (1999). The suicide survivor's grief and recovery. Suicide and Life-Threatening Behavior, 29(4), 353-364. https://doi.org/10.1111/j.1943-278X.1999.tb00530.x

Linde, K., Treml, J., Steinig, J., Nagl, M., & Kersting, A. (2017). Grief interventions for people bereaved by suicide: A systematic review. PLOS ONE, 12(6), e0179496. https://doi.org/10.1371/journal.pone.0179496

Higher Education Mental Health Alliance (HEMHA) (2014). Postvention: A guide for response to suicide on college campuses. https://sprc.org/wp-content/uploads/2023/01/Hemha-postvention-guide.pdf

Schut, H., & Stroebe, M. S. (2005). Interventions to enhance adaptation to bereavement. Journal of Palliative Medicine, 8(sup1), S140-S147. https://doi.org/10.1089/jpm.2005.8.s-140

Shneidman, E. S. (1981). Postvention: The care of the bereaved. *Suicide and Life-Threatening Behavior, 11*(4), 349–359. https://doi.org/10.1111/j.1943-278X.1981.tb01011.x

Zimmerman, M. S. (2023). The information seeking behaviors and needs of suicide survivors during bereavement. *Libri, 73*(1), 25-35. https://doi.org/10.1515/libri-2021-0119

Multiple-Choice Questions:

1. What is the primary goal of suicide postvention?
A. Providing educational resources for suicide prevention
B. Facilitating psychological adjustment and healing after a suicide loss
C. Identifying individuals at risk for suicide attempts
D. Promoting awareness about the prevalence of suicide in communities

2. How does active postvention differ from passive postvention?
A. Active postvention focuses on providing educational resources, while passive postvention offers direct support.
B. Active postvention involves intervention after a suicide, while passive postvention involves waiting for individuals to seek support.
C. Active postvention relies solely on professional support, while passive postvention involves peer support.
D. Active postvention is aimed at preventing suicide attempts, while passive postvention focuses on supporting survivors.

3. According to Schut and Stroebe (2005), what
A. distinguishes secondary preventive interventions in suicide postvention?
B. They offer professional help to all bereaved persons, irrespective of whether intervention is indicated.
C. They target suffering people who are experiencing complications in their grieving process.
D. They are designed for bereaved people at high risk of experiencing complicated grief, such as those bereaved due to suicide or homicide. They focus on providing support and assistance for those affected by suicide.

4. What is a crucial aspect of the goal of postvention?
A. Promoting awareness about suicide prevention strategies
B. Encouraging people to seek professional help
C. Facilitating healing of sorrow and distress after a suicide loss
D. Educating communities about the warning signs of suicidal behaviour

5. Why is postvention considered a direct form of suicide prevention?
A. It aims to promote awareness about suicide prevention strategies
B. It provides crisis intervention and support for those affected by suicide.
C. It focuses on identifying individuals at risk for suicide attempts.
D. It involves offering educational resources for suicide prevention.

6. How does postvention contribute to preventing suicide among the suicide victim's family and friends?
A. By providing educational resources on suicide prevention techniques
B. By facilitating healing and debriefing to counteract adverse effects after a suicide
C. By identifying individuals at high risk for experiencing complicated grief
D. By promoting awareness about the prevalence of suicide in communities

7. What challenge in postvention is exacerbated by societal attitudes and perceptions surrounding suicide?
A. Emotional Impact
B. Lack of Support Services
C. Stigma and Social Taboos
D. Risk of Suicide Ideation

8. Why is effective communication about suicide loss difficult?

A. Due to the lack of emotional impact
B. Because there are no complex grief reactions
C. Fear of saying the wrong thing
D. Cultural and religious differences

9. What may individuals bereaved by suicide experience as a result of strained relationships and social support?

A. Increased emotional resilience
B. Greater sense of community
C. Feelings of isolation and loneliness
D. Improved coping mechanisms

10. Which long-term mental health impacts can arise from suicide loss?

A. Reduced risk of depression and anxiety
B. Improved overall well-being
C. Development of PTSD
D. Enhanced access to support service

Answers:

1: B. Facilitating psychological adjustment and healing after a suicide loss
2: B. Active postvention involves intervention after a suicide, while passive postvention involves waiting for individuals to seek support.
3: C. They are designed for bereaved people at high risk of experiencing complicated grief, such as those bereaved due to suicide or homicide.
4: C. Facilitating healing of sorrow and distress after a suicide loss
5: B. It provides crisis intervention and support for those affected by suicide.
6: B. By facilitating healing and debriefing to counteract adverse effects after a suicide
7: C. Stigma and Social Taboos
8: C. Fear of saying the wrong thing
9: C. Feelings of isolation and loneliness
10: C. Development of PTSD

B.08
GLOBAL PERSPECTIVES ON SUICIDE POSTVENTION: POSTVENTION SERVICES AROUND THE WORLD

Introductory Question:
Have you ever wondered about the support easily accessible to individuals and families grappling with the aftermath of a suicide?

What You Will Learn:
1. Explore the global landscape of suicide postvention services.
2. Discover the diverse range of support services offered by ten exemplary organisations.
3. Learn about tailored support, community engagement, and evidence-informed practices.
4. Understand the role of compassion in fostering healing and resilience among suicide survivors.
5. Gain insights into digital accessibility, specialised support for specific groups, and collective efforts for healing worldwide.

Introduction:
After suicide, individuals and families often find themselves grappling with overwhelming grief. Recognising the profound impact of suicide loss, organisations around the world have emerged to provide crucial postvention services aimed at supporting survivors through their healing journey.

This text explores ten organisations dedicated to suicide postvention services in different countries. Each offers an array of support tailored to the needs of survivors. From providing compassionate counselling and peer support groups to advocating for policy changes and funding research, these organisations play a vital role in strengthening resilience, promoting understanding, and offering hope amidst the darkness of loss.

Through their commitment to care, information dissemination, and research, these organisations stand as beacons of support, guiding survivors through the intricate labyrinth of grief and providing pathways towards healing and renewal.

PRESENTING TEN POSTVENTION ORGANISATIONS

Let us delve into the stories and initiatives of these organisations, united in their mission to support and uplift those affected by suicide loss worldwide.

Australia: StandBy – Support After Suicide
Website: https://standbysupport.com.au/

Australia's leading suicide postvention program, Standby, is dedicated to supporting individuals, families, friends, witnesses, first responders, service providers, and communities affected by suicide. Standby offers free face-to-face or telephone support provided by local staff committed to the well-being of those impacted. The program is a central coordination point, connecting individuals to tailored support through referrals to local services, groups, and organisations. Accessible seven days a week, Standby provides ongoing support for up to two years, ensuring individuals are not alone in their journey. Employing a settings-based approach, Standby offers group support sessions for schools, workplaces, and community groups, fostering community preparedness and resilience through comprehensive training initiatives. Informed by advisory groups and backed by research, Standby has demonstrated significant improvements in well-being, reduced suicidality, and lower healthcare usage, making it a cost-effective intervention for suicide postvention.

Ireland: HUGG (Healing Untold Grief Groups)
Website: www.hugg.ie

HUGG (Healing Untold Grief Groups) is a peer support organisation offering community-based groups to adults bereaved by suicide. Founded by Fiona Tuomey, who lost her daughter, HUGG provides hope and healing through information, telephone support, and local peer groups led by experienced volunteers. Their mission includes engaging with research, collaborating with professionals, and advocating for improved

bereavement services. HUGG's evidence-informed groups, led by trained facilitators, emphasise respect, non-judgment, and confidentiality. Each session closes with a grounding exercise and reminders of self-care. HUGG recruits individuals with over three years of bereavement experience for facilitator training, ensuring comprehensive support. The guidance of the UK and Australia influences the meeting structure, with traditional face-to-face fortnightly sessions accommodating up to 12 participants.

Ireland: Pieta – Suicide Bereavement Liaison Service
Website: https://www.pieta.ie/about/

Pieta's journey commenced in Lucan, County Dublin, in 2006, with a steadfast commitment to fostering hope, self-care, and acceptance, envisioning a world liberated from the shackles of suicide, self-harm, and stigma. Their core mission revolves around extending accessible, professional services to individuals and communities in crisis.

Through their Suicide Bereavement Liaison (SBL) Service, Pieta serves as a beacon of support, offering guidance, practical information, and emotional solace to those grappling with the immediate aftermath of a suicide loss. The SBL Officer (SBLO) extends a compassionate hand to anyone impacted by suicide, offering up to 10 sessions tailored to individual needs. Whether meeting in the comfort of one's home or a chosen neutral space, the SBLO provides invaluable practical and emotional support, aiding in accessing additional therapeutic services and navigating the complexities surrounding such losses.

Moreover, Pieta's dedication extends to supporting parents in assisting their children through this challenging period, providing crucial information and support during inquests or coroner's court proceedings. Through their unwavering commitment, Pieta strives to alleviate the burdens of grief and provide a pathway towards healing and resilience.

Italy: De Leo Fund Onlus
Website: https://www.deleofund.org/

De Leo Fund Onlus is a non-profit organisation co-founded by a suicidologist, Professor Diego De Leo in 2005. The De Leo Fund provides support for people traumatised by sudden or traumatic deaths (road or work accidents, suicide, murder, natural disasters) through a national telephone helpline, live chat, forums, and online or in-person interviews.

Norway: LEVE –The Norwegian Organisation for Suicide Survivors
Website: https://leve.no/

LEVE – Landsforeningen for etterlatte ved selvmord (The Norwegian Organisation for Suicide Survivors) is dedicated to supporting individuals and families after suicide loss. Derived from the Norwegian word for "live," LEVE embodies the spirit of resilience and hope in the face of tragedy.

With a focus on care, information, and research, LEVE aims to ensure survivors receive active help and support while advocating for public follow-up schemes. Through informative activities, they seek to raise awareness about suicide and the challenges faced by survivors among both the population and healthcare professionals. LEVE is committed to funding research initiatives aimed at preventing suicides and improving care for survivors. Adopting a multifaceted approach, LEVE's objectives include providing adequate assistance and support for survivors, contributing to suicide prevention efforts, and promoting understanding and visibility for suicide survivors. By harnessing the experiences of survivors as a valuable resource for grief support and suicide prevention, LEVE strives to create a more compassionate and supportive society for those affected by suicide loss.

Sweden: SPES (National Association for Suicide Prevention and Survivors Support)
Website: https://spes.se

SPES (Riksförbundet för SuicidPrevention och EfterlevandeStöd) is association is for anyone who has lost a family member, relative, partner or good friend through suicide. In 1986, a mother named Maryan Fasth found herself grappling with an unimaginable loss: her daughter's life had been claimed by suicide. Struggling to navigate the unfathomable depths of grief, Maryan reached out to Hemmets Journal, a beacon of hope amidst her despair. Her heartfelt plea for connection resonated with others who had also lost loved ones to suicide.
In 1987, seventeen individuals united to form REST, the National Association for Survivors' Support in Stockholm. Maryan Fasth emerged as the interim chairman, a role she embraced with unwavering determination. Together, they forged a healing path, laying the foundation for a community bound by shared experiences of loss and resilience. Among their first initiatives was the creation of a membership sheet, lovingly named "The Forget-Me-Not Sheet," symbolising their commitment to honouring the memories of those they had lost.

As the fledgling organisation gained momentum, 1988 marked a pivotal moment with the inaugural annual meeting in Stockholm. With the adoption of statutes and the election of Maryan Fasth as chairman, SPES took its first steps toward formalisation. Local departments began to take shape, extending the reach of support to survivors nationwide. Professor Hans Åkerberg lent his expertise as the organisation's first advisor, solidifying SPES's commitment to excellence in its mission.

By 1989, SPES had evolved, embracing a new name reflective of its expanded vision: the Swedish Organization for Prevention and Survivors' Support, SPES, as translated from Latin, means hope. SPES has monthly meetings in different regions, digital meetings, a helpline, and chat. It engages nationally in survivor loss survivors' support.

SPES Blekinge was a partner in the international project ELLIPSE, co-funded by the European Union Erasmus+ programme (2019-2022) and ELLIPSE Postvention (2023-2024). It is a co-creator of the ELLIPSE Gatekeeper+ Course in Suicide Prevention and the online Ellipse Postvention Course in 2023-2024.

Sweden: HOPE-To live on
Website: hopeattlevavidare.se

Hope is a non-profit organisation for suicide loss survivors that intends to help its members to find hope. Life will never be the same, but it's about returning to a meaningful everyday life. The goal of the support activities is to give survivors tools to move forward in grief, to see the future, to live and not just survive. It was founded in 2023 by four mothers who lost their children to suicide. They organise conversation meetings, coffee evenings, and Walk & Talk in various places in the country, as well as digital conversation meetings and inspiration days. The association has received a 90-account as a quality assurance so that donors and donors know that a government authority is reviewing the business.

From the depths of personal tragedy emerged a beacon of hope named SPES, a testament to the resilience of the human spirit and the power of community in the face of loss. In the decades that followed, SPES would continue to shine brightly, offering support and assistance to those who had lost loved ones to suicide, embodying the very essence of its name: hope.

UK: Survivors of Bereavement by Suicide (SOBS)
Website: https://uksobs.com/

Survivors of Bereavement by Suicide (SOBS) have been steadfast support for those grieving the loss of a loved one to suicide, offering peer-led local and virtual online support groups, a national telephone helpline, email support, and an online community forum.

SOBS facilitates a safe, confidential space where individuals can share their experiences and give and receive support from others, both in the immediate aftermath of their loss and in the months and years that follow. Recognising the unique challenges faced by survivors, SOBS provides invaluable information for professionals who engage with and support individuals bereaved by suicide.

Members of SOBS support groups often encounter difficulties in adjusting to their loss, which motivates them to seek solace and solidarity in peer support. By connecting with others who have experienced similar losses, individuals can normalise their grief experiences and discover coping strategies, fostering a sense of community and understanding in their healing journey.

USA: Local Outreach to Survivors of Suicide (LOSS)
Website: https://losscs.org/about-us/

Denise Meine-Graham, founder of Local Outreach to Survivors of Suicide (LOSS), experienced the devastating loss of her son to suicide in 2012. Finding solace in the support of a fellow survivor, she recognised the invaluable role such support plays in the healing process. In 2014, LOSS emerged to extend this vital lifeline to others, driven by a mission to instil hope and empower survivors to thrive amidst grief. Activated by the Coroner's office, LOSS's trained volunteers swiftly offer resources, understanding, and support to newly bereaved individuals. At least one volunteer, a survivor of suicide loss, lends an empathetic ear, forging strong connections with those in need. Witnessing the resilience of fellow survivors inspires hope, planting seeds of healing in the hearts of the newly bereaved.

LOSS offers support groups, remembrance events, companioning, suicide postvention and prevention education, and training for communities interested in bolstering their postvention and prevention efforts. Their teams, comprising mental health professionals, crisis centre staff, and survivor volunteers, extend outreach to suicide survivors immediately following a loss, providing crucial support and resources.

Implemented across communities in America, Australia, and Singapore, LOSS-type programs exemplify active postvention for survivors. Research is ongoing to determine whether active postvention correlates with fewer symptoms of depression and complicated grief and whether it leads to improved long-term outcomes, offering hope for enhanced support for survivors in the future.

USA: Tragedy Assistance Program for Survivors (TAPS)
Website: https://www.taps.org/

TAPS, the Tragedy Assistance Program for Survivors is the national nonprofit organization providing compassionate care and comprehensive resources to all those grieving a death in the military or veteran community. Founded in 1994 by Bonnie Carroll, a bereaved military spouse, TAPS emerged from personal tragedy to provide comfort, support, and healing to thousands of grieving families.

At its core, TAPS is dedicated to being a lifeline for those navigating the complexities of grief after the loss of loved one in the military and veteran community.. Through many programs and services, TAPS offers compassionate support tailored to the unique needs of each survivor. From peer support groups and individual counselling to retreats and online communities, TAPS provides a safe space for survivors to share their stories, find solidarity, and discover hope amidst their pain.

One of the hallmarks of TAPS is its commitment to empowering survivors to thrive in the face of adversity. Through educational resources, advocacy initiatives, and outreach programs, TAPS equips survivors with the tools and resources they need to honour their loved one's legacy while building resilience for the future.

TAPS also serves as a leading voice in military and veteran bereavement support and suicide prevention efforts. By partnering with government agencies, military organisations, and community stakeholders, TAPS works tirelessly to raise awareness, promote healing, and advocate for policies that support the needs of grieving families.

Poland: Nagle Sami
Website: https://naglesami.org.pl/

Recognising the need for support in times of grief, the Nagle Sami Foundation was born. Established as a beacon of solace for those navigating the turbulent waters of loss, the Nagle Sami Foundation offers a sanctuary of understanding and empathy. At its core lies the unwavering belief that while loss is an inevitable part of life, the journey through grief is profoundly personal and unique to each individual. With this understanding, the foundation extends a compassionate hand to all who seek comfort and support. The Nagle Sami Foundation endeavours to provide a lifeline to those in need through various initiatives. Support groups offer a safe space for the bereaved to share their experiences and find solace in the company of others who understand their pain. Individual therapies provide personalised support tailored to the needs of each person, guiding them through the intricate labyrinth of grief with compassion and care.

The Nagle Sami Foundation offers in-person and online support meetings, ensuring accessibility for all. Additionally, the foundation is committed to education and empowerment, offering training sessions and webinars to help individuals navigate their grief journey with resilience and strength. The foundation's therapeutic centre stands as a symbol of hope and healing. And for those who may feel isolated in their grief, the foundation's free, anonymous nationwide support phone line stands as a beacon of light, offering a listening ear and a comforting voice in times of need.

At the heart of the Nagle Sami Foundation lies a simple yet profound mission: to listen, support, and be there for those navigating the often-tumultuous terrain of grief. With compassion as their compass and empathy as their guiding light, the foundation stands as a steadfast companion on the journey toward healing and renewal.

Conclusions:

The narrative features ten organisations dedicated to providing support for individuals, families and groups affected by suicide globally. From Australia's StandBy, offering free face-to-face and telephone support, to Ireland's HUGG, providing peer support groups, each organisation is committed to addressing the unique needs of suicide loss survivors.

Pieta in Ireland extends emotional and practical support through its Suicide Bereavement Liaison Service, while SOPROXI in Italy offers specialised assistance and information to suicide loss survivors. LEVE in Norway focuses on care, information, and research, advocating for survivors and funding research initiatives to prevent suicides. SPES in Sweden emerged from personal tragedy to form a national association supporting survivors, emphasising community and resilience. Survivors of Bereavement by Suicide (SOBS) in the UK provides peer-

led support groups and resources, aiming to normalise grief experiences and foster understanding.
In the USA, Local Outreach to Survivors of Suicide (LOSS) offers comprehensive postvention and prevention efforts. At the same time, the Tragedy Assistance Program for Survivors (TAPS) supports military families through grief with tailored programs and advocacy. Finally, Nagle Sami in Poland provides a sanctuary of understanding and empathy, offering support groups, individual therapies, and nationwide support services for those navigating grief.

These organisations exemplify diverse approaches to postvention, aiming to alleviate the burdens of grief and provide pathways towards healing and resilience for suicide survivors worldwide.

Takeaways:

1. **Global Reach:** Suicide postvention services are provided worldwide by diverse organisations.
2. **Tailored Support:** Each organisation offers unique support tailored to survivors' needs, including counselling, peer groups, and practical assistance.
3. **Community Engagement:** Many organisations prioritise community resilience through group sessions and awareness initiatives.
4. **Evidence-Informed:** Services are often based on research, showing effectiveness in improving well-being and reducing suicidality.
5. **Peer Support:** Peer-led groups provide a safe space for sharing experiences
6. **Advocacy and Awareness:** Organizations advocate for improved services and raise awareness about suicide prevention.
7. **Digital Access:** Some offer online support for increased accessibility.
8. **Specialised Support:** Some organisations cater to specific groups, such as military families.
9. **Compassionate Approach:** All emphasise compassion and empathy when supporting survivors.
10. **Pathways to Healing:** Services aim to provide healing, resilience, and renewal pathways for survivors worldwide.

References

Australia: StandBy – Support After Suicide StandBy – Support After Suicide. (n.d.). Retrieved July 19, 2024, from https://standbysupport.com.au/

Ireland: HUGG (Healing Untold Grief Groups) HUGG (Healing Untold Grief Groups). (n.d.). Retrieved July 19, 2024, from https://www.hugg.ie

Ireland: Pieta – Suicide Bereavement Liaison Service Pieta. (n.d.). About us. Retrieved July 19, 2024, from https://www.pieta.ie/about/

Italy: SOPROXI SOPROXI. (n.d.). Retrieved July 19, 2024, from https://www.soproxi.it/en/soproxi-project/

Norway: LEVE – The Norwegian Organisation for Suicide Survivors LEVE – Landsforeningen for etterlatte ved selvmord. (n.d.). Retrieved July 19, 2024, from https://leve.no/

Sweden: SPES (Riksförbundet för SuicidPrevention och EfterlevandeStöd) Retrieved July 19, 2024, from https://spes.se

UK: Survivors of Bereavement by Suicide (SOBS) Survivors of Bereavement by Suicide (SOBS). (n.d.). Retrieved July 19, 2024, from https://uksobs.com/

USA: Local Outreach to Survivors of Suicide (LOSS) Local Outreach to Survivors of Suicide (LOSS). (n.d.). About us. Retrieved July 19, 2024, from https://losscs.org/about-us/

USA: Tragedy Assistance Program for Survivors (TAPS) Tragedy Assistance Program for Survivors (TAPS). (n.d.). Retrieved July 19, 2024, from https://www.taps.org/

Poland: Nagle Sami Nagle Sami. (n.d.). Retrieved July 19, 2024, from https://naglesami.org.pl/

Multiple-Choice Questions:

1. What is the primary focus of StandBy – Support After Suicide in Australia?
A. Providing free face-to-face or telephone support to individuals affected by suicide
B. Organising group support sessions for schools, workplaces, and community groups
C. Conducting research on suicide prevention strategies
D. Offering training initiatives for mental health professionals

2. What is the core mission of Pieta – Suicide Bereavement Liaison Service in Ireland?
A. To provide support for individuals and communities in crisis
B. To offer free face-to-face or telephone support to those impacted by suicide
C. To raise awareness about mental health issues
D. To research suicide bereavement

3. What is SOPROXI's mission in Italy?
A. To promote psychological well-being and provide specialised support to suicide survivors
B. To advocate for improved mental health services
C. To conduct residential seminars on mindfulness
D. To offer individual psychotherapy to mental health professionals

4. What is the primary goal of SPES in Sweden?
A. To provide face-to-face support to individuals bereaved by suicide
B. To offer online support meetings for suicide attempt survivors
C. To train mental health professionals in suicide prevention strategies
D. To promote psychological well-being and provide support to survivors

5. What distinguishes the Tragedy Assistance Program for Survivors (TAPS) in the USA?
A. It offers support to military and veteran families grieving the loss of a service member.
B. It focuses on providing grief support to individuals after natural disasters.
C. It primarily provides online counselling services to bereaved individuals.
D. It organises retreats for survivors of various types of loss.

6. What distinguishes the Local Outreach to Survivors of Suicide (LOSS) in the USA?
A. It provides grief support to individuals who have lost a military loved one.
It does not offer support groups for survivors of suicide loss.
It focuses on providing support to individuals bereaved by natural disasters.
It primarily offers online counselling services to bereaved individuals.

Answers:
1: A. Providing free face-to-face or telephone support to individuals affected by suicide
2: A. To provide support for individuals and communities in crisis
3: A. To promote psychological well-being and provide specialised support to suicide survivors
4: A. To provide face-to-face support to individuals bereaved by suicide
5: A. It offers support to military and veteran familiesgrieving the loss of a service member.
6: A. It provides grief support to individuals who have lost a military loved one.

MODULE C

C.01 Postvention Supoort Program in Kalmar County

C.02 Essential Considerations for Healthcare and Social Care Workers Supporting Individuals Affected by Suicide Loss

C.03 Empathetic Conversations: A Guide to Supporting the Bereaved

C.04 Family postvention: Early and Frequent Bereavement Support for Families

C.05 Empowering Together: Group Postvention Intervention

C.06 TAPS Suicide Postvention Model™

C.01 POSTVENTION SUPPORT PROGRAM IN KALMAR COUNTY

Introductory Question:
How can we provide outreach to individuals bereaved by suicide, ensuring they receive the care and guidance needed during their most vulnerable time?

What You Will Learn:
1. **Purpose and Scope of Bereavement Support**: Understanding the aims and boundaries of post-suicide support.
2. **Roles and Responsibilities**: Identifying the key players and their duties in providing support to the bereaved.
3. **Effective Communication Strategies**: Learning how to communicate empathetically and effectively with those who have lost a loved one to suicide.
4. **Practical Steps for Immediate Support**: Gain insight into the immediate actions and follow-up procedures necessary to support the bereaved.
5. **Evaluating and Adapting Support Services**: Understanding how to evaluate the effectiveness of support services and make necessary adjustments..

Introduction:
Historically, there has been no systematic support for those bereaved by suicide in Kalmar County. Swedish research, however, shows that 96% of suicide survivors would like healthcare personnel to actively reach out and offer support and information following a suicide. First responders (police, paramedics and firefighters) have assumed significant responsibility for support during the acute phase but often have to leave to respond to new alarms. The support received has depended mainly on dedicated individuals, resulting in inconsistent support across the county. Moreover, there has been no specific function with clearly defined responsibility.

In Sweden, legislation regulating support to those bereaved by suicide is lacking. Therefore, it is legally unclear who is responsible for providing the support. At the same time, the healthcare system has an obligation to prevent ill-health (Chapter 3, Section 2 HSL), and municipalities have the ultimate responsibility under the Social Services Act to ensure that people receive the help and support they need (Chapter 2, Section 1 SoL).

PURPOSE OF THE PROGRAM

The purpose of the county-wide program is to quickly identify the needs of the bereaved and offer continuous, proactive support. . Support for the bereaved should be offered regardless of whether the deceased had ongoing contact with healthcare services or the municipality. The program applies county-wide, and support should be provided to bereaved residents of Kalmar County regardless of where the death occurred.

DEFINITION OF THE BEREAVED

Suicide survivors are typically defined by the police as next of kin; usually one or two people. Research, however, shows that there are significantly more people close to the deceased who are affected by suicide deaths. A more relevant definition of suicide survivor therefore, in addition to biological kinship, also considers the nature of the relationship and the degree to which the death affects a person. This more comprehensive definition also considers the time aspect, i.e. how long the death may affect a person in a significant way.

Therefore, the program has adopted a broader definition of suicide survivors, largely based on their need for support. Other suicide survivors are typically identified later, when postvention support is underway with the next of kin.

BEREAVED OUTSIDE THE COUNTY

Bereaved individuals residing outside Kalmar County are not currently covered by this program, even if the death, geographically, occurred in Kalmar County.

CONFIRMED AND SUSPECTED SUICIDES

In some cases, it is beyond all doubt that the death in question is a suicide, while in other cases, it takes time to investigate and determine the intent. Therefore, support is given to survivors of both confirmed and suspected suicides.

BEREAVEMENT SUPPORT

ince July 2022, Kalmar County has been offering proactive and coordinated support to county residents affected by a relative's suicide. Support is provided to adults and children (from preschool age to 17 years). Bereavement support for minors is provided by the school or preschool they attend where a School Postvention Support Navigator (SPSN) is assigned by the principal.

Responsibilities

- **Police or Doctor:** Upon confirming the death, they contact the primary care clinic where the bereaved is listed to initiate bereavement support.
- **Reporting details:** The bereaved's name, personal identity number, current contact information, any vital information for the person contacting them, and the police/doctor's name and contact details are passed to the care clinic manager (or their representative).
- **Manager of health care clinic (private or public):** Assigns suitable employee to act as Postvention Support Navigator (PSN) who contacts the survivor the following weekday.
- **Postvention Support Navigator (PSN):** Responsible for coordinating and providing long-term postvention support for surviving adults. Specific guidelines/checklist are available to support the assignment.

Coordination of Bereavement Support

- **Immediate Phone Contact:** The PSN contacts the bereaved immediately (the next working day).
- **First Meeting:** Typically occurs after one week, preferably in person. .
- **Follow-Up Contacts:** Continued follow-up phone contacts at 1, 3, 6, and 12 months (more frequently if needed). Support can last beyond one year if needed.
- **Evaluation and Survey:** During the final contact, the support should be evaluated, and a survey completed by those who accepted and received support. The survey should always be given at the concluding contact, even if the support lasted less than 12 months.

If Support is Declined

- **First Contact:** Leave contact information and inform them you will contact them again within a month.
- **Second Contact:** If support is still declined after the second contact attempt, this should be respected, and no further attempts should be made at this time.
- **Ensure Information:** The PSN confirms that they have current contact details for the bereaved and provide their own contact information, encouraging them to reach out if needed. .

Key Considerations

- **Role of the PSN:** Primarily to take inventory of the survivor's need for support, mediate psychoeducation and normalization, and refer the survivor to existing healthcare and support services; not medically and therapeutically treat.
- **Encouragement and Empathy:** Encourage and strengthen the individual's ability to seek help using empathetic listening.
- **Respecting Emotions:** All emotions are valid during grief.
- **Maintaining Regular Activities:** Encourage the bereaved to continue with regular activities (work, exercise, choir, etc.), as taking sick leave may not always be helpful.
- **Family Support:** If other family members need support, it should be offered at the clinic where they are listed.
- **Practical Advice:** Encourage the bereaved to keep paper and pen handy to note important information.

First Phone Contact (Next Working Day)

- **Acknowledge the Incident and Offer Condolences:** Confirm the incident and express condolences.
- **Explain the program:** Briefly explain the pillars of the postvention support program in Kalmar County.
- **Describe Your Role:** Explain the role of the PSN, including what you can and cannot do.
- **Allow Space for Conversation:** Leave room for the bereaved to talk if they wish.
- **Normalize Emotions:** Reassure that all feelings are normal.
- **Assessing Minors' Needs:** Gather information about minors' ages, schools, and whether the principal has been informed. If the guardian cannot notify the school, the PSN may take on this task with the guardian's consent.
- **Offer Support:** Provide the opportunity for the bereaved to accept or decline support. If accepted, schedule a meeting. If declined, inform that another contact attempt will be made in a month.
- **Ensure Contact Information:** The PSN confirms that they have current contact details for the bereaved and provide their own contact information, encouraging them to reach out if needed

After the First Phone Contact

- **Send SMS with Support Information:** Send a text message with links to support and information pages on 1177.se, inclincluding PSN contact details and PSN work schedule/availability.

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Documentation

Document the conversation in the medical records system (Cosmic). Plan follow-up according to program intervals or as agreed with the bereaved.

Follow-Up Visits/Contacts

- **Review Previous Conversation:** Follow up on the previous conversation.
- **Allow Space for Conversation:** Allow for the bereaved to talk if they wish. .
- **Normalize Emotions:** Reassure that all feelings are normal.
- **Topics to cover**: Cover areas such as current care needs, needs of minors, support networks, other bereaved individuals, support groups, workplace needs, social services, practical questions, and information sources.

OTHER CONSIDERATIONS

- **Information on 1177.se and provider web:** Details on grief and bereavement reactions are available on 1177.se. The county's bereavement support page includes brochures, book tips, and information on BRIS support weekends for children and families affected by a parent's suicide.
- **Social media:** Encourage caution with respect to social media updates in order to prevent rumors and misinformation. This is especially important for children and young people.
- **Suicidal Risk:** Bereaved individuals often report more suicidal thoughts than those bereaved by other causes. If the bereaved shows signs of suicidal thoughts, they should be prioritized for a doctor's visit with suicide risk assessment the same day.

Conclusion:

Providing support to individuals bereaved by suicide is a critical and sensitive task that requires a clear understanding of roles, responsibilities, and effective communication strategies. The Postvention Support Navigator (PSN) outlines a structured approach to ensuring consistent and compassionate care, highlighting the importance of proactive support and continuous evaluation. Adhering to these guidelines can help those in need, fostering healing and resilience in the aftermath of a tragic loss.

The text in this chapter is an extract from the program created in Kalmar County, which was presented at an ELLIPSE Postvention webinar on 11.04.2024 by Cecilia Gamme, Region Kalmar län, and Daniel Abrahamsson, Association of Municipalities Kalmar län, in a presentation entitled "Postvention in Kalmar County." A description of the entire program (in Swedish) can be found on the Region Kalmar website: https://vardgivare.regionkalmar.se/vard- -behandling/psykisk-halsa/efterlevandestod-vid-suicid/

Takeaways:

1. **Clear Purpose**: The importance of a well-defined program for providing consistent support to the bereaved.
2. **Designated Roles**: The necessity of assigning specific responsibilities to various actors involved in bereavement support.
3. **Effective Communication**: The role of empathetic and informative communication in supporting the bereaved.
4. **Immediate and Follow-Up Support**: The steps for providing immediate and ongoing support to those affected by suicide.
5. **Continuous Evaluation**: Support services must be regularly assessed and adapted to meet the needs of the bereaved.

References:

Hälso- och sjukvårdslagen (HSL)
https://patientsakerhet.socialstyrelsen.se/lagar-och-foreskrifter/centrala-lagar/halso--och-sjukvardslagen

Rutin för efterlevandestöd i Region Kalmar (Kalmar Region Routine for Postvention):
https://vardgivare.regionkalmar.se/vard--behandling/psykiskhalsa/efterlevandestod-vid-suicid/

ELLIPSE Postvention Webbinarium: Efterlevandestöd/Postvention för hälso- och sjukvården och socialtjänsten (ELLIPSE Postvention Webinar - Postvention for Healthcare and Social Care (2024)

Multiple-Choice Questions:

1. What is the primary purpose of the Postvention Support Program in Kalmar County?
A. To ensure financial support to the bereaved
B. To provide a detailed investigation report to the bereaved
C. To identify the needs of the bereaved and offer continuous proactive support
D. To maintain a record of the bereavement process

2. Who initiates the bereavement support process after confirming a suicide?
A. The family of the deceased
B. B. The police or doctor
C. C. The bereavement guide
D. D. The health clinic administrator

3. What is important to emphasize when providing information about the deceased to the bereaved?
A. The personal details and photos of the deceased
B. Suicide victims often suffer from mental disorders, most often depression.
C. The specific method used in the suicide
D. The deceased's achievements and career highlights

4. What should be the focus during the first phone contact with the bereaved?
A. To discuss the financial implications of the death
B. To offer condolences, explain the program, and provide support information
C. To ask detailed questions about the deceased's life
D. To arrange the funeral services

5. How is the effectiveness of the support provided evaluated?
A. By asking the bereaved to write a detailed report
B. By completing a survey and reviewing the support provided during the final contact
C. By observing the bereaved over time
D. By consulting with the Primary Care Navigator (PSN)

6. Answers:
1: C To identify the needs of the bereaved and offer continuous proactive support
2: B The police or doctor
3: D The deceased's achievements and career highlight
4: B To offer condolences, explain the routine, and provide support information
5: B By completing a survey and reviewing the support provided during the final contact

C.02
ESSENTIAL CONSIDERATIONS FOR HEALTHCARE AND SOCIAL CARE WORKERS SUPPORTING INDIVIDUALS AFFECTED BY SUICIDE LOSS

Introductory Question:
What key strategies and considerations should healthcare and social care professionals prioritise when supporting individuals bereaved by suicide?

What You Will Learn:

1. **Gaps in Therapist and Doctor Training:**
   - Importance of sensitive, compassionate interventions.
   - Risks of exacerbating trauma through well-intentioned but inappropriate responses.
2. **Cultivating Empathy in Healthcare Settings:**
   - Necessity of empathetic and individualised care.
   - Impact of dismissive attitudes on the bereaved.
3. **Existential, Spiritual, and Cultural Dimensions:**
   - Embracing diverse coping strategies.
   - Constructing meaningful narratives to address the "Why?" questions.
4. **Emotional Complexities of Suicide:**
   - Addressing feelings of guilt and anger.
   - Importance of the Dual Process Model of Grief.

Introduction:
Supporting individuals bereaved by suicide requires a nuanced and empathetic approach to help them navigate their complex and often devastating grief. This Chapter explores crucial strategies and insights for effectively aiding those who have lost loved ones to suicide. It addresses critical gaps in therapist and doctor training, the importance of cultivating empathy in healthcare settings, and the need to understand the existential, spiritual, and cultural dimensions of suicide bereavement. By examining these factors, healthcare and social care professionals can provide compassionate, culturally sensitive care, fostering healing, resilience, and growth after such a profound loss.

ADDRESSING GAPS IN GRIEF SUPPORT

1. Addressing Therapist Training Gaps:

→ **Example:** "*You're dwelling on this too much.*"

In some instances, therapists equipped with cognitive behavioural therapy techniques may inadvertently prioritise therapy methods over establishing a compassionate, attachment-based rapport with clients who have experienced suicide loss. This approach can lead to disengagement from therapy, resistance to recovery, and a loss of hope in its efficacy (Jordan, 2020).

2. Tackling Doctor Training Gaps:

→ **Example**: "*You need medication.*"
Similarly, clinicians may hastily prescribe antidepressants without adequately acknowledging the nuanced emotions of individuals bereaved by suicide. This oversight can result in non-compliance with treatment, a lack of follow-up, and a diminished belief in the healthcare system's ability to address their trauma (Jordan, 2020).

3. Cultivating Empathy in Healthcare Settings:

→ **Example:** *"You don't need any sick leave. The earlier you return to work, the better you'll feel."*

Patients may encounter dismissive attitudes from healthcare providers who overlook their need for time to process grief. Responses neglecting the importance of patients' preferences can exacerbate feelings of isolation and worthlessness in the bereaved.

4. Timing Considerations for Self-Care Advice:

→ Example: "*Take up Yoga lessons.*"

While well-intentioned, suggestions like engaging in yoga may be overwhelming for individuals still grappling with the aftermath of suicide loss. Focusing on offering support and understanding rather than advice can foster a more potent therapeutic alliance and mitigate feelings of isolation and inadequacy (Jordan, 2020).

5. Addressing Existential, Spiritual, and Cultural Dimensions:

→ Example: *"Suicide is immoral behaviour and a sin."*

After experiencing the suicide of a loved one, individuals may face discomfort within religious communities that stigmatise suicide. This stigma can lead to social withdrawal and exacerbate feelings of isolation and distress. Conversely, supportive communities that discuss existential questions may provide solace and a sense of connection for survivors (Jordan, 2020).

6. Misunderstanding and Non-Acceptance of Diverse Coping Strategies:

→ Example: *"I don't want to talk about it."*

Following the loss of a child to suicide, a mother may seek continuous opportunities to discuss her grief and process her loss with the child's co-parent. At the same time, the partner may feel the need to isolate themselves and adopt a defensive "hibernation" stance. This disparity in coping mechanisms can lead to a disconnect between the couple, where one's approach to integrating the loss opposes the other's. Failure to address and accept these differences in coping strategies may exacerbate turbulence in the relationship, potentially leading to separation or divorce (Jordan, 2020).

7. Constructing a Narrative and Addressing the "Why?" Question:

→ Example: *"Your wife is in a better place."*

A statement like "Your wife is in a better place" may be intended to comfort a suicide loss survivor. However, if the survivor believes that their deceased loved one cannot be in a better place after leaving behind family and children, it may only heighten their frustration. While such messages may solace to some, they may exacerbate distress for others.

"Doctors did what they could, but they could not help. Mental issues can sometimes be as challenging to treat as certain forms of cancer."

When a loved one has been under psychiatric care and the family has been involved in the treatment process, it may be easier for them to accept that everyone made efforts to help their relative. However, accepting such narratives may prove more difficult if the bereaved is not included in the treatment process or disagrees with certain aspects of it (Jordan, 2020).

"One of the key tasks for the bereaved is to develop a narrative that offers some relief from the 'Why?' questions. This often involves constructing a narrative of the death that acknowledges the complexity of suicide, understanding it as the convergence of multiple factors rather than the result of one person's or organisation's mistakes or failures" (Jordan, 2020).

8. Continuing Bonds Theory and "Unfinished Business":

→ Example: "*You should not think about your deceased husband any longer."*

While a helper may advise against dwelling on thoughts of the deceased to express their distress, it can leave suicide loss survivors feeling rejected, intensifying feelings of worthlessness, burdensomeness, and loneliness. The Continuing Bonds Theory suggests that abruptly severing the thoughts of a loved one is challenging. Helping the mourner restore and reconcile their relationship with the deceased, addressing any "unfinished business," is often necessary for healing after a suicide loss. This may involve activities like letter-writing, using the empty chair technique for conversations, or engaging in authentic communication with the deceased (Jordan, 2020).

9. Development of a Lasting Biography of the Deceased:

→ Example: *"You should not talk about him."*

Prohibiting discussions about the deceased can exacerbate emotional distress and hinder the bereaved from integrating the loss into their life narrative. Because suicide is relatively rare and socially stigmatised, narrating the life of the deceased can become focused solely on the mode of death, creating a taboo around discussing other aspects of their life. A lasting biography should encompass who the deceased was, their achievements, and their legacy. This process is facilitated through shared remembering and storytelling among those who knew the deceased, beginning at the time of death and potentially continuing for years (Jordan, 2020).

10. Addressing the Intentionality of Suicide:

→ Example: *"He could not stand it any longer. Suicide was his choice."*

Some mourners perceive suicide as a deliberate choice, while others view it as driven by external circumstances. Believing that someone intended their death can exacerbate feelings of guilt and anger, leading to questions about the reasons behind the decision and whether it could have been prevented. Such beliefs can intensify the emotional response to death (Jordan, 2020).

11. Addressing the Preventability of Suicide:

→ Example: *"Suicide can be prevented."*

While common in suicide prevention programs, statements like *"Suicide can be prevented"* may inadvertently increase guilt and blame among the bereaved. They may question why their loved one died despite efforts to prevent it, leading to feelings of injustice and anger towards others. This can significantly impact the bereaved and strain their relationships (Jordan, 2020).

12. Perceiving Suicide as a Personal Failure:

→ Example: *"If I were in your place, I would have prevented it."*

Suicide is often viewed through the lens of personal failure. A parent who loses a child may feel like they failed as a caregiver, a sibling may question their role as a supportive brother or sister, and a friend may doubt their ability to provide needed assistance. Similarly, healthcare professionals like doctors, nurses, psychologists, social workers, or teachers may undergo profound identity crises, contemplating career changes due to feelings of inadequacy. This sense of failure can lead to overprotectiveness in parents or professionals, impacting their interactions with others.

13. Viewing Suicide as a Healthcare Failure:

→ Example: *"If they had maintained more contact with us, he might still be alive."*

Suicide is frequently perceived as a failure of the healthcare system. Relatives of individuals who had contact with psychiatric services and were on medication may believe that increased communication with healthcare providers could have prevented the tragedy. Similarly, healthcare professionals may harbour guilt for not pursuing alternative suicide prevention methods, feeling that their chosen approach was inadequate. This guilt may manifest in overprotective behaviours towards patients or clients, leading to changes in work practices to prevent future tragedies.

14. Dual Process Model of Grief:

→ Example: *"Time heals all wounds."*

Recently bereaved individuals often experience intense pain that seems unending. Therefore, statements like *"You will feel better with time"* can inadvertently frustrate them further. A therapist's initial goal is to help the bereaved achieve flexible attention, enabling them to navigate between periods of grief immersion and everyday life. The Dual Process Model of Grief (Stroebe and Schut, 2016) suggests that grieving individuals alternate between two orientations: Loss Orientation, where they immerse themselves in grief, and Restoration Orientation, where they adapt to the changed world after the loss (Pearce, Komarony, 2020).

15. Reinvestment in Living:

→ Example: *"Survivors of suicide loss are at a heightened risk of suicide themselves."*

Exposure to suicide, including the loss of a loved one to suicide, can increase suicidal ideation among survivors as they grapple with existential questions and pain. However, not all survivors succumb to this heightened risk; some find reasons to continue living and develop protective narratives. For instance, a young man who once struggled with suicidal thoughts may resolve to live on after losing his only sibling to suicide, motivated by a desire to spare his mother new trauma. These narratives aid survivors in reinvesting in life and fostering positive change.

Conclusion:

In this Chapter, we have explored a range of crucial insights for effectively supporting individuals bereaved by suicide. Through this exploration, several vital conclusions emerge:

Firstly, healthcare and social care workers need to get education in postvention during their studies to address gaps in therapist and doctor training to ensure that they use interventions that are sensitive and appropriate for suicide loss survivors.

Professionals can foster trust and engagement in therapy and treatment by prioritising compassionate, attachment-based rapport over symptom alleviation.

Secondly, cultivating empathy in healthcare settings is paramount, as dismissive attitudes or rushed advice can exacerbate feelings of isolation and worthlessness in the bereaved. Providing sensitive self-care advice tailored to individual needs can foster stronger therapeutic alliances and mitigate distress.

Additionally, acknowledging the existential, spiritual, and cultural dimensions of suicide bereavement is crucial for providing holistic support. By embracing diverse coping strategies and facilitating the development of lasting biographies of the deceased, professionals can foster healing and acceptance.

Furthermore, viewing suicide as a personal or healthcare failure can intensify feelings of guilt and anger, while recognising the complexities of grief through the Dual Process Model can support individuals in navigating their mourning process. Finally, the concept of reinvestment in living highlights the resilience and potential for growth among survivors of suicide loss.

In conclusion, by acknowledging and addressing these essential considerations, healthcare and social care professionals can provide more effective support to individuals navigating the complexities of suicide loss. Professionals can foster healing, resilience, and growth in the aftermath of tragedy through compassionate, culturally sensitive care.

Takeaways:

1. **Therapist and Doctor** Training: Avoid prioritising specific therapeutic techniques over compassionate care (Jordan, 2020).
2. **Empathy in Healthcare:** Sensitive, empathetic interactions are crucial (Jordan, 2020).
3. **Cultural Sensitivity:** Recognize and embrace diverse coping strategies (Jordan, 2020).
4. **Narrative Construction:** Helping the bereaved construct meaningful narratives aids in healing (Jordan, 2020).
5. **Dual Process Model of Grief:** Support flexible attention between grief immersion and everyday life (Pearce & Komaromy, 2020).
6. **Reinvestment in Living:** Foster resilience and reasons for living among survivors (Jordan, 2020).

References:

Jordan J. R. (2020). Lessons Learned: Forty Years of Clinical Work With Suicide Loss Survivors. *Frontiers in psychology*, *11*, 766. https://doi.org/10.3389/fpsyg.2020.00766

Mirick, R. G., McCauley, J., & Bridger, J. (2023, May 1). Integrating Trauma-Informed Principles Into Suicide Prevention, Intervention, and Postvention. Practice Innovations. Advance online publication. https://dx.doi.org/10.1037/pri0000212

Pearce, C., & Komaromy, C. (2020). Recovering the body in grief: Physical absence and embodied presence. Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 26, Article 4. https://doi.org/10.1177/1363459320931914

Stroebe, M., & Schut, H. (2010). The dual process model of coping with bereavement: a decade on. *Omega*, *61*(4), 273–289. https://doi.org/10.2190/OM.61.4.b

Multiple-Choice Questions:

1. What is a common pitfall that therapists may encounter when working with people bereaved by suicide?

A. Prioritising establishing a compassionate rapport over symptom alleviation
B. Focusing on building attachment-based relationships before administering therapy
C. Overlooking the long-term impact of suicide loss in favour of immediate solutions
D. Administering therapy techniques without understanding the client's emotional complexity

2. How might clinicians inadvertently contribute to the distress of people bereaved by suicide?

A. Providing treatment plans based on individual needs
B. Offering supportive advice and understanding
C. Prescribing medication without considering the nuances of grief
D. Collaborating with clients to explore existential questions

3. What challenges might arise when the bereaved exhibit contrasting coping mechanisms?

A. Enhanced mutual support and understanding
B. Increased cohesion and harmony within the relationship
C. Coping asynchrony leading to potential relationship strain
D. Strengthened emotional bonds and resilience

4. Which statement exemplifies a potentially ineffective narrative for suicide loss survivors?

A. "Your loved one is in a better place now."
B. "Doctors did their best, but mental health issues can be challenging to treat."
C. "Suicide can be prevented with adequate intervention and support."
D. "Your loved one's suicide was the result of a complex interplay of factors."

5. Which model of grief suggests that individuals oscillate between Loss Orientation and Restoration Orientation?

A. Kübler-Ross Model
B. Kubler-Dyer Model
C. Dual Process Model of Grief
D. Stages of Grief Model

6. How do some suicide loss survivors cope with the heightened risk of suicide after their loss?

A. By avoiding any discussions about suicide or their deceased loved ones.
B. By taking medication immediately after the loss.
C. By developing protective narratives and finding reasons to continue living.
D. By isolating themselves from their support networks and loved ones.

Answers:

1: D. Administering therapy techniques without understanding the client's emotional complexity
2: C. Prescribing medication without considering the nuances of grief
3: C. Coping asynchrony leading to potential relationship strain
4: A. *"Your loved one is in a better place now."*
5: C. Dual Process Model of Grief
6: C By developing protective narratives and finding reasons to continue living.

C.03
EMPATHETIC CONVERSATIONS: A GUIDE TO SUPPORTING THE BEREAVED

Introductory Question:
How can compassionate communication and empathetic support transform the healing journey of those navigating the aftermath of a suicide loss?

What You Will Learn:
1. **The Role of Compassionate Helpers**: Understand the significance of empathetic support in postvention intervention for suicide loss survivors.
2. **Communication Strategies:** Learn about effective communication techniques that create a safe space for survivors to express their emotions.
3. **Addressing Complex Emotions:** Gain insight into managing feelings of guilt, anger, shame, and being overwhelmed in the context of suicide loss.
4. **The Importance of Anniversary Dates:** Recognize how special dates can intensify grief and how to support individuals during these times.
5. **Fostering Resilience:** Discover ways to help survivors reintegrate into life and embrace their multiple identities beyond the loss.

Introduction:
In the aftermath of a suicide loss, individuals often grapple with intensive complex emotions and overwhelming grief. To navigate this challenging journey, the support of compassionate helpers is invaluable. In this educational excerpt, we witness a conversation between a suicide loss survivor and a volunteer helper, highlighting the importance of effective communication and empathetic support in postvention intervention.

The setting is simple: a table and two chairs. Agnes Bearns, a seasoned volunteer helper, welcomes Chris Dalgren, a grieving individual seeking support. What follows is a poignant exchange that delves into Chris's experiences, emotions, and struggles in the wake of his father's suicide.

Through caring communication and active listening, Agnes creates a safe space for Chris to share his thoughts and feelings openly. She validates his emotions, offering reassurance and understanding throughout their conversation. As they discuss topics ranging from guilt and anger to shame and overwhelm, Agnes provides gentle guidance and compassionate support, helping Chris navigate the complexities of his grief journey.

This conversation exemplifies the vital role of postvention intervention in supporting suicide loss survivors. Helpers like Agnes are crucial in providing comfort and solace to those in need by fostering empathy, understanding, and connection. As we delve into this educational dialogue, we gain insight into the profound impact of compassionate communication in the healing process following a suicide loss.

SCENARIO: INDIVIDUAL POSTVENTION

Here is an educational excerpt from a conversation between a suicide loss survivor and a volunteer helper:

The setting:
Equipment: A table and two chairs.
Personal Grief Facilitator (P-GF): A 60-year-old female named Agnes Bearns (AB).
Help-seeking bereaved (H): A 28-year-old man named Chris Dahlgren (CD).

A Personal Grief Facilitator (P-GF): opens the door in response to a knock and invites the visitor into the room.

STARTING THE CONVERSATION

Situation: Initially, a volunteer introduces herself, inquiries about the visitor's preferred name, expresses gratitude for reaching out to the organisation, provides information on costs and timeframes, and asks about the purpose of the visit.

- P-GF: *Hello! I'm Agnes Bearns.*
- *H: Hi, I'm Chris Dahlgren.*
- P-GF: *Please, have a seat.*
- *H: Thank you.*

→ P-GF: *What should I call you?*
→ *H: Chris.*
→ P-GF: *Thank you, Chris, for reaching out to us.*

FOSTERING SAFETY AND TRUST

Situation: The postvention helper encourages the sharing of feelings and validates the act of seeking help from the organisation. The volunteer employs caring communication to establish a rapport with the help-seeker, fostering a sense of safety and trust.

→ P-GF: *I received your contact information from the police. I understand how difficult it must be for you. Talking about your experience is important, and I'm here to listen.*
→ *H: I appreciate that. It's been tough dealing with this alone.*

CONFLICTING EMOTIONS

Situation: The volunteer sets the stage for discussing grief feelings while demonstrating genuine interest in the help-seeker. The visitor receives reassurance that experiencing conflicting emotions is normal.

→ P-GF: *When did it happen?*
→ *H: It was last December 1st. The memory of that day is still vivid. I was at work when I got the call from the police. They found my Dad. He'd taken his own life.*
→ P-GF: *Losing a loved one to suicide can stir up a mix of emotions. Before we delve into your experience, tell me a bit about yourself.*
→ *H: Of course. I'm Chris, 28, and I live with my girlfriend. I'm a teacher. We were planning to get married, but everything changed after my Dad's death.*

VALIDATING EMOTIONS

Situation: If the help-seeker doesn't initiate discussion about the day of the loss, the volunteer prompts them to share their memories. The volunteer listens attentively, validating the emotions expressed.

→ P-GF: *What stands out to you about that day?*
→ *H: It was a nightmare. My sister found him, and I had to see his body. He'd been struggling since losing his job. The scene was devastating.*

→ P-GF: *That sounds incredibly difficult to go through.*
→ *H: It was beyond words. I still can't shake the memories.*

TALKING ABOUT GUILT

Guilt is a common emotion following a suicide loss, often stemming from feelings of responsibility or the belief that the loss could have been prevented. It's a complex and persistent emotion that varies across cultures and individuals.

→ P-GF: *Do you think you could have saved him?*
→ *H: If only I had been there, I could have saved him. (Longer silence)*

→ P-GF: *Perhaps you believe suicide is a sudden act, and if that were true, maybe you could have intervened. However, suicide typically stems from a longer process. It's not always easy to detect or prevent.*
→ *H: Really?*

→ P-GF: *Yes, suicide involves various phases and complexities. Even professionals can struggle to intervene effectively, especially if the individual doesn't seek help.*
→ *H: I see. He never reached out. He mentioned his struggles with finding work but never asked for help.*

→ P-GF: *It sounds like you cared deeply for him.*
→ *H (tearfully): I did everything I could, even though I was worried about his drinking and the trouble it caused. He didn't drink often, but when he did, it was excessive.*

TALKING ABOUT HELPLESSNESS, LONELINESS, AND ANGER:

Feelings of helplessness, isolation, and anger are common after a suicide loss. These emotions may manifest in various ways, from self-blame to resentment towards the deceased.

→ P-GF: *It seems like your thoughts revolve around your father a lot. Are you angry with him?*
→ *H: Surprisingly, no. Should I be?*

→ P-GF: *It's common for suicide survivors to suppress feelings of anger towards the deceased. However, these emotions can still affect us, even if we don't acknowledge them outright. Have you noticed any signs of anger or resentment in yourself?*
→ *H: I've been trying to stay strong. My parents had a tumultuous relationship, and I often had to intervene. I organised the funeral, but now I feel like I'm reaching my limit.*

PAINFUL REMINDERS, E.G. ANNIVERSARIES:

Special dates intensify grief, serving as painful reminders of the past.

→ *P: Your father passed away on December 1st. Since we have now November 26th, are your emotions heightened because the anniversary is approaching?*
→ *H: I hadn't thought about it, but it's possible now that you mention it. I've been avoiding going out lately. My girlfriend suggested I seek help.*

TALKING ABOUT SHAME:
Shame can lead us to isolate ourselves from others, fearing judgment and rejection.

→ P-GF: *Why do you avoid going out?*
→ *H: I feel ashamed. I think everyone blames me for what happened.*

→ P-GF: *It's understandable to feel that way, but not everyone needs to know about your situation. You have the right to choose who you confide in.*
→ *H: That makes sense. I never considered that I had a say in who I shared my struggles with. But you don't understand how difficult it is. I'll forever be known as the son of a man who took his own life.*

IDENTITY CRISIS:
When overwhelmed by grief, we may become consumed by our loss, neglecting other aspects of our lives.

→ P-GF: *That sounds incredibly burdensome. While you've become the son of a man who died by suicide, you're also much more than that. You're a partner, a sibling, and a friend. There's more to you than this one identity.*
→ *H (tearfully): It's tough, but you're right. I have other roles in life that define me.*

WELCOME IN THE FUTURE, IF YOU WISH TO TALK:
Ending the conversation with an invitation for future support fosters a sense of connection and trust.

→ P-GF: *Thank you for sharing your experience with me. Don't hesitate to reach out if you ever need to talk again.*
→ *H: Thank you for listening. I feel stronger after speaking with you.*
→ P-GF: *It was my pleasure. Remember, we're here for you whenever you need us. Goodbye.*
→ *H: Goodbye.*

Conclusion:

The conversation between Agnes Bearns and Chris Dahlgren underscores the significance of effective communication and empathetic support in post-intervention intervention for suicide loss survivors. Through compassionate dialogue, Agnes creates a safe space for Chris to express his emotions openly, validating his experiences and offering guidance. Their exchange highlights the importance of addressing complex emotions such as guilt, anger, shame, and overwhelming sorrow while emphasising the significance of anniversary dates and the need for self-compassion. Ultimately, the conversation serves as a poignant reminder of the profound impact of empathetic listening and supportive communication in facilitating healing and recovery after a suicide loss.

Takeaways:

- **Empathetic Listening:** Validating the survivor's emotions and providing reassurance can significantly aid their healing process.
- **Addressing Guilt and Shame:** Helping survivors understand the complexity of suicide and that it is not their fault can alleviate some of the burden of guilt and shame.
- **Creating a Safe Space:** A non-judgmental environment encourages survivors to share their feelings and experiences openly.
- **Acknowledging Anniversary Dates:** Recognizing the importance of dates related to the loss can help survivors prepare for and cope with intensified emotions.
- **Encouraging Self-Compassion**: Reminding survivors of their multiple roles and identities can help them see beyond their grief and foster resilience.

Reference:

Baran A., Milewicz T., Stensmark M. (2024). ELLIPSE Postvention Handbook. The Jagiellonian University Publishing House, Cracow.

Course in Suicide prevention ELLIPSE Gatekeeper+ created 2019-2022 during the ELLIPSE project co-funded by European Union Erasmus+ programme (ellipse.12stepsplan.com) Retrieved June 20th, 2024.

Multiple-Choice Questions:

1. What is the primary purpose of the helper initial interaction with the help-seeker?

A. To collect payment for services rendered
B. To establish rapport and provide information about the organisation's services
C. To discourage the help-seeker from seeking further assistance
D. To terminate the conversation prematurely

2. What emotion commonly arises following a suicide loss, often due to feelings of responsibility or preventability?

A. Joy
B. Guilt
C. Apathy
D. Contentment

3. How does the helper address the help-seekers feelings of guilt regarding their father's suicide?

A. By blaming the help-seeker for their father's actions
B. By dismissing the help-seekers emotions as irrational
C. By emphasising that suicide is the result of a longer process and it is not individual fault
D. By avoiding the topic altogether

4. What significance does the helper attribute to the approaching anniversary of the father's death?

A. It is irrelevant to the help-seeker emotional state
B. It may intensify the help-seeker feelings of grief and loss
C. It has no impact on the help-seeker emotions
D. It signifies closure and healing for the help-seeker

5. How does the helper conclude the conversation with the help-seeker?

A. By abruptly ending the discussion without offering further support
B. By expressing annoyance at the help-seeker emotions
C. By inviting the help-seeker to seek support again in the future
D. By criticising the help-seeker coping mechanisms

Answers:

1: B. To establish rapport and provide information about the organisation's services
2: B. Guilt
3: C. By emphasising that suicide is the result of a longer process and it is not individual fault
4: B. It may intensify the help-seekers feelings of grief and loss
5: C. By inviting the help-seeker to seek support again in the future

C.04
FAMILY POSTVENTION: EARLY AND FREQUENT BEREAVEMENT SUPPORT FOR FAMILIES

Introductory Question:
How can you turn the devastating grief of suicide into healing for the bereaved family?

What you will learn:
1. Gain insights into how families help each other cope with suicide loss.
2. A description of the Early and Frequent Bereavement Support model that has been offered to families in Blekinge in the years 2014-2023 to support their path through recovery.
3. How we start and end the conversations in the family group that met together with a Person with Lived Experience of Suicide Loss in the family and what topics the conversations include.
4. How we support silent participants, what they bring to the conversation.
5. How to cope with this enormous loss in the family? Get answers, tips, and tools!
6. The crisis is added to previous conflicts and disagreements that risk reinforcing loneliness and grief, but the family system can change when the family supports each other.
7. Early and frequent bereavement support for families in crisis after suicide loss needs to be a societal concern - thanks to the benefits it would bring to families and society.
8. Like today's debriefing in some professional groups, postvention procedures, including debriefing, are needed to provide families with early support.

Introduction:
By gathering the whole family around a Person with a Personal Experience of Suicide Loss early after the suicide, the suffering is reduced. It makes the life situation more manageable for the bereaved family. The risks of needing support later for post-traumatic stress disorder and depression in the bereaved are reduced. Medicine is not a cure for grief, and survivors should be helped to cope with their loss early in the grieving process. According to statistics, the group of survivors who have experienced the death of a close family member by suicide have a higher suicide risk.

Bringing the whole family together helps the family to find purpose and meaning in life again. Family bonds are created and strengthened, and this gives hope. The aim of support for the whole family is thus to help each other by carrying each other through grief and learning how to cope. This prevents the long-term consequences of prolonged suffering. An essential factor is to feel direct support from those closest to you.

Bereavement support helps those who need to be able to support each other to become more aware of what they are doing. It opens the dialogue by sharing one's experience during the conversation.

Research confirms the appropriateness of family approach, which is based on compassion and caring, through a person with lived experience of suicide loss in the family.

1. HOW A FAMILY HELPS EACH OTHER TO COPE WITH A SUICIDE LOSS

1. A FAMILY POSTVENTION IS A HEALTHY COPING STRATEGY

The overwhelming feelings arise in the body as a natural process after a suicidal loss (separation). To numb this unprecedented state, we must manage the biological processes when the brain lacks feel-good hormones. We do this in diverse ways: by hugging, being in a community, and feeling safe when we occupy our thoughts with something that distracts us from the incredible pain. It happens in some activities, but also when we talk calmly and are there for each other, when we listen and can confirm what each one tells us. This gives us hope that we will be able to cope with the grief and loss. Even during the first conversation, it feels good to meet someone with similar experience. When everyone in the family talks about their grief, the pain-relieving effect increases due to the body's endorphins because of the closeness and safety that the conversation creates among the family members,

who are partly going through the same trauma. This is a positive coping strategy.

Leaving a deeply grieving and shocked person alone with their grief can be life-threatening. The well-being hormone oxytocin and painkilling endorphins decrease, and poor mood and pain increase. If the person does not know how to take care of themselves, there is a substantial risk that they will start their own 'self-treatment' using unhealthy coping strategies to try to reduce their suffering. The self-harming activities aim to restore the level of the body's self-produced painkillers. It becomes a kind of escape from intensely unpleasant feelings through alcohol, drugs, unhealthy eating, self-cutting and abusive behaviours. Both in the short and long term, it harms the person, and in the worst case, it can lead to death.

1. B THE STRUCTURE IS TO MEET VERY EARLY AFTER THE SUICIDE HAS TAKEN PLACE

When the family is informed of the death, a meeting is organised. Thereafter, they meet as often as the bereaved family wishes. This usually leads to frequent conversations between the bereaved, some of whom share the same immense pain and shock. It relieves the worst panic, chaos, and concern for each other and, therefore, reduces their own stress levels.

1. C THE FAMILY MEETS WITH A PERSON WITH OWN LIFE EXPERIENCE OF HAVING LOST A LOVED ONE IN THEIR OWN FAMILY TO SUICIDE.

Early and frequent bereavement support is a simple and feasible way to calm the overwhelming feelings of pain, shock and panic caused by suicide loss.
Survivors may also have painful images of suicide that recurrently disturb them, which need to be replaced by other images, which is one of the techniques taught. It is calming.

After you have finished listening to someone else, you can put a puzzle together by telling them how I experienced this... or how I see it. Different people's perceptions, experiences, or thoughts emerge, meaning they can support and help someone else. And you start to realise and understand what has actually happened.

Many of us spontaneously feel that we want to hug and touch people who are in severe suffering. The bereaved find it easier to open and accept support in the aftermath of a suicide loss or any other challenging life event. This is because the level of the body's natural pain-relieving hormones has been affected, reducing the body's sense of well-being. We can remind ourselves of situations where it feels natural to help ourselves, and it strengthens the family's resources. This is how families have always looked after each other, for example, helping a child injured by hugging, plastering, and blowing on the wounds.

All the families who have received family postvention in Blekinge have found it good to get together and listen to each other after the suicide. It would not be possible to achieve this quality of conversation on your own, where everyone participates and listens with respect each other after the terrible thing that happened. It calms the situation and helps everyone to feel better about themselves.

- The family conversation has been made possible by the participation of an unknown person, an outsider who does not know the family already. Everyone involved in the dialogue is bound by confidentiality.
- It gives hope that someone who has gone through a suicide loss gives compassionate support.
- It feels good to get small tips and simple tools, as it comes naturally in the conversation.
- It is a quick, healthy way to naturally deal with the chemical process that occurs in the brain during suicide loss.
- It usually feels good to know that it is only a few days until we meet again.
- It gives peace of mind to be able to help yourself and help others in the family.
- The family eventually bears each other, with the experience of calmly dealing with the most difficult.
- The knowledge of what helps is in the family.
- The family is a safe place where there is openness to difficult conversations for the future.

2. DESCRIPTION OF THE FAMILY POSTVENTION MODEL

Being able to tell each other in the family about one's suffering makes things easier, relieves people, and gives people safe space and hope. It saves the family an enormous amount of suffering. It is often the case that after a suicide in a family, there are communication deficits or obstacles. By getting a third person, an outsider, involved in this context, these obstacles can overcome, and a balance can be reached as people can talk and have dialogue with each other about the most difficult feelings.

Family support needs to start early**.** It needs to be recurrent and involve the whole family.

So far, survivorship support has taken place during home visits, except in a few cases where the geographically dispersed family has met online.

Firstly, taking care of a family requires balance. There is a need to look after the individuals while at the same time helping the whole family system **to** provide the stability and support that the family needs. Secondly, to recognise the deceased and the role of the deceased in the family so that the suicide can somehow be 'accepted', as it is important part of grief according to some researchers (Kaslow et al., 2011).

How often do we meet? The first time is as soon as possible. The next one can be the day after or two days later. It tends to be very frequent at first, then once or twice a week, after a few weeks, and then even less frequently. Conversations continue according to the family's preferences as long as they express their wish to continue talking.

In some families, the whole family gets together until after the funeral and then perhaps following up on anniversaries and before or after a holiday, when they want to get together and talk again with each other. It is important to ask about feedback from a family about their choices.

Some family members or a part of the family group want to stay in touch for longer. It is not uncommon for support to be ongoing in some form, on a regular basis, over several years, with one or more family members. It is always open to those who want it. Instead of meeting, we can communicate briefly or on a scheduled basis in all other possible ways: email, text, mobile calls, and Zoom.

We meet before or after anniversaries or special occasions because the family needs help figuring out what is happening. They know this is a good way to give support and feel supported.

Usually, we are 5-7 people in a family. If the family is larger or there is some communication problems, we may meet once or twice in a large group. But in between, it is possible to meet around someone with extra needs. It is possible, for example, to meet young cousins with parents separately; young people have been helped enormously by daring to talk about suicide and suicide loss and will be able to speak if they get worried or if they see a friend starting to show a different behaviour, or you are concerned about someone. They can ask questions; they know how to ask because they have been down through the most profound grief themselves.

Family postvention is a simple, direct, healthy pathway reaching people of all ages and genders. The body has an incredible capacity for self-healing, which is positive in the short and long term for our health, even when overwhelmed by feelings of grief after a suicide loss. The well-being hormone oxytocin can help us feel connected to family and friends and increase our identification with people with similar experiences. This effect starts as soon as you step into the hall. The Oxytocin-Dopamin "kick", which we read about in the chapter on Unhealthy and Healthy Coping Strategies, decreases in intensity over time. The need for frequent family meetings naturally decreases as the weeks pass. The whole family then meets less often.

Conversations in the bereaved family later focus less and less on the grief itself and more on life afterwards, on being able to support another family after suicide. We call this ***post-traumatic growth.*** It is about increasing one's ability to cope with the current loss and potential future losses.

Distracting techniques are also useful in family prevention. They help to maintain some control over the intensity of emotions.

- Breathing exercises (Breathe in - count 1,2,3,4 and Breathe out - count 1,2,3,4,5,6,7)
- Techniques for muscle relaxation
- Dip your face in icy water briefly and count to four, then lift your face and count again.

To prevent self-harm and increase the chances of post-traumatic growth, the 12 Steps Safety Plan can help manage challenging emotions, distressing thoughts, and unwanted behaviours. The family is given information about how the web app 12stepsplan.com works and where to find it when the need to manage emotions and thoughts comes up in the family group. There is also the opportunity to help individuals create their 12 Steps Safety Plan. Someone in the family group may help someone else with safety planning.

The Family Postvention method was developed and presented at *Ellipse Postvention's* webinar for health and social care professionals on 11 April 2024 by Maiellen Stensmark, a social worker/community planner, therapist and educator, herself a survivor, who also calls herself a life doula. (A doula's assistance in childbirth leads to far fewer complications without prolonged or more complicated processes.) Family postvention can increase family self-efficacy in dealing with trauma.

3. HOW WE START

The family is gathered in the living room of someone in the 'nuclear family' (which can often be the home of the deceased): parents, children, siblings, cousins, and grandparents. A very close friend of the deceased and the family or a neighbour who lived closely with the family can participate in the meetings if they wish. A grief facilitator with their own lived experience of suicide loss arrives at the appointed time, not earlier and not later, and rings the bell. If you are a grief facilitator, you come in and join the group of mourners.

- Begin very briefly by saying your name, telling them who you lost to suicide when it was and at what age the person died. Say that you are doing the intervention to ease their suffering.
- Tell them in a relaxed way how the conversations usually take place: about the rules of dialogue: listening carefully to each other, keeping everything that is said in the room.
- Who is not here today? Who should have been here? Ask them to invite that person for the next time!
- Feel free to say something spontaneously but wait until the speaker has finished.
- Your job is to tie up loose ends and get back to the person who wanted to say something.

3. A HOW WE START THE FIRST CONVERSATION

- The first question is: *"How are you feeling right now?" "What is most difficult for you right now?"* Ask one of them to start, and have the person say their name and tell how they are related.
- The aim is to build trust and confidence in the family group
- Once the person has told you and you have thanked them for their trust, explain that it can be tricky the first time you answer a question; it can feel unsafe. It will feel better!
- Tell them that you hope that everyone will feel safe and that you are there to help them.
- Tell them that you will leave tips if there is something you want to convey in context.
- Ask (depending on when you meet) if anyone has already spoken with a professional after X's death.
- It is essential always to say the name when talking about the person who has died.

3. B HOW WE CONTINUE THE CONVERSATION

- You can vary the question to the next person and, e.g., ask, *"What is most difficult for you right now?"* or "*What did you think of first when you heard my question? What emotions are you struggling with?"*
- When someone has finished speaking, thank them for what they (say their name) have shared.
- Then, turn to the next person.
- Your task is to capture different feelings and emotions
- You then raise them again to give brief tips on how to deal with these feelings or situations.
- Do this, preferably in the form of open questions to the group. Everyone should get the question and everyone who wants to say something can do so.

3. C ENCOURAGING RESUMING ROUTINES (acronym: SEED)

- S - **Sleep**. Prioritise talking about sleep; you ask everyone if they are sleeping or if they have someone to sleep with so they are not alone. Give each other goodnight hugs! Hug more!
- E - **Engage**. Talk about surrounding yourself with supportive people and positive attitudes.
- ED - **Eat Drink**. Talk about regular healthy food and drink habits. *"Do you cook together?"* "*Does anyone find it/think it will be/is extra difficult now to get food*?" If someone is not getting/has not had food, the group deals with it.

3. D EVERYDAY ACTIVITIES

This is important to emphasise the critical daily routines and habits that need to be attended to after a suicide. *"What did you do before the suicide loss?"* It's important to talk about this: doing things that gave you joy before the worries and grief took over your life, to move forward, also in your thoughts.

- Talk about the importance of resuming activities, such as walking or going to the gym... preferably when it comes up in the conversation.
- Prioritise life-oriented activities to help in the recovery process. This will also legitimise the rest of the family's belief that going to the gym is possible. Be aware that others outside the family may have views—stigmatisation needs to be discussed/found solutions!)
- Talking about feelings, actions, and thoughts (acronym GAPS): Implement strategies to manage and mitigate complicated feelings and thoughts when they come up in conversation:
- How to deal with people who blame and stigmatise the family: if it comes up in conversation.
- How to contact colleagues or the boss before visiting the workplace/having coffee at work/starting work again.
- Discuss what to do/why it is vital to create a sense of safety in the face of events that can be difficult. If the situation is such, offer to go together to the healthcare centre, etc.

3. E SUMMARISE BEFORE ENDING THE MEETING
Go around and ask the question to everyone:

- *"What has felt good to you today?*
- *"What have you got that might be helpful to you until we meet again?"*
- Ensure that the next event is planned, and everyone has noted the place, day and time.
- Just say a simple "*Bye. See you on …"* to them, get up and leave the group.

4. HOW WE SUPPORT SILENT PARTICIPANTS AND WHAT THEY BRING TO THE CONVERSATION

- A silent participant may be afraid of hurting someone else by saying something.
- You emphasise how important it is that everyone talks and that even small things are helpful.
- It is also essential for the others in the group to know how this person is doing.
- Research states that the psychological pain of suicide survivors is different compared to other causes of death. And this is a challenging experience for a person. Intense feelings such as guilt, rejection, abandonment, anger, and shame after death can cause suffering. And you may also feel fear that you were partly responsible for the suicide.
- It is vital to promote protective factors and understand the resources people have that allow them to help themselves through the most difficult grief.

ANSWERING THE QUESTION

How do you cope with this enormous loss?

In summary, the response addresses these key points.

- Understanding the event: How do you talk about or describe the suicide to others? Each person needs to find their own story to discuss the loss with others.

- Increase understanding of suicide and its effects (on grief/trauma, on not letting the magnitude of the problem of suicide dampen the will to spread awareness and help save lives.

- It is crucial for survivors to get answers to their questions /to be able to move from the shock phase - to the grief phase - to personal growth,

- Many people may also have an interest in getting involved with others… so that suicide loss does not happen to anyone else. Their interest needs to be nurtured, safeguarding against their suicidality. Help them grow into prevention volunteering in the region, in the country, or in volunteering to provide bereavement support through home visits at the local and national levels.

- Life will never be the same again; the bereaved describe their new life. It is a matter of resuming caring as a practical act, reinforcing previous positive emotions such as joy and love. It is about personal and sometimes spiritual growth and taking care of yourself.

Suicide is a crisis added to previous conflicts and disagreements that can reinforce loneliness and grief, but the family system can change when the family supports each other in grief.

- If past conflicts come up, let them come. Often, someone will try to explain the situation more as information briefly.
- Many past conflicts have been resolved, and the family can be close together.
- On the other hand, if the family is not provided with family support, conflicts can be amplified so that family ties can be broken completely.
- If suicide is perceived as a ***choice*** by the bereaved, then it leads to more struggle with intense feelings of rejection, abandonment and anger, research says.
- No person who dies by suicide dies of their own free will. Many people in society incorrectly use the expression that someone chooses to take their life. At the appropriate time, it is possible to describe why it ***is not a choice,*** and it can be explained that this approach helps survivors.
- Nor are the words that someone *could not bear life* appropriate to use for the same reason. Neither does the victim of a physical illness or an accident die because one wants to nor because they cannot cope with life (this is a very unfortunate formulation).

Early and close bereavement support for families in crisis after suicide loss needs to be a societal concern. Our experience and research support it, and it is happening worldwide.

Grieving is also thinking about how to prevent similar tragedies in the future. It is part of post-traumatic growth and involves living in a world where a loved one is no longer there and, at the same time, wanting and needing to use one's knowledge and experience to prevent others from suffering suicidal loss. It gives hope that also reduces the intense emotions that still reappear sometimes after a long life and demand their attention.

The possibility of the family bereavement support should be offered to all families immediately after a suicide as it is: strengthening community resources for the bereaved family after a suicide, without having to use much of the healthcare resources.
It increases understanding of suicide and its effects (on grief/trauma), of not letting the magnitude of the problem of suicide dampen the will to spread awareness and help save lives, Family support prevents avoidable mortality and distress.

A Preventive Team should be created in each Region, as postvention is the essential part of prevention.

When a suicide has taken place outside the home or hospital, in Sweden the police go to the nearest family member with the death notice.

- The police may contact the Preventive Team after obtaining the family's consent to call in the Person with Lived Experience of Suicide Loss after a training in family postvention to provide support to the family.
- If suicide occurs in the healthcare sector, that health care unit can contact the Prevention Team and the Police
- Via the Preventive Team, feedback can be given to bring together people who worked directly with the person who died by suicide/ staff in the ward/unit/ workplace/ school where the suicide was witnessed for bereavement support.
- Recurrent bereavement support can also be provided to professionals who have lost a patient/client or a customer in suicide.
- Workplace staff who have lost a patient/client/ customer meet with another professional with lived experience of suicide loss at work for support and to reduce the length of their distress and potential sick leave.
- Witnesses/others can be involved and in need of support after suicide.
- Give feedback after event analysis to organisations where suicide has occurred on how confidentiality/ rules/interventions/previous activities/. It is easier after the family has partially carried out an event analysis in collaboration with the person with lived experience of suicide,
- The Prevention Team compiles retrospective analyses.
- The healthcare finances the time it takes to attend the training, the time spent working with the Prevention Team, and overhead.
- The team can also refer Persons with Lived Experience of Suicide Loss to support school/peers/workplace/ witnesses/people in the immediate environment affected by the suicide.
- The best way to implement family bereavement support in all regions is to invite those bereaved families who wish to do so to a digital training program on bereavement support, where they are trained to develop their conversational skills on diverse topics.
- The bereavement support for families proposes that survivors who previously received family support and who wish to support another family are trained to perform this task. In doing so, the person continues to provide survivorship support to themselves by focusing on the needs of others.
- Persons with Lived Experience can be reimbursed for any direct loss of salary and receive a mileage allowance and a flat-rate allowance per half-day. This is like how jurors in courts are compensated for half or full days, which is another honourable public service to perform.

To establish a PREVENTIVE TEAM in each Region implies a similar procedure for intervention after suicide throughout the country.

- Support after a suicide loss must be based on the same awareness of the actual situation of the bereaved and carried out in the same way across the country.
- Regions can involve suicide loss survivors and it can contribute to their planning of the training, etc.
- The aim is to provide support to professionals after a suicide loss and to reduce their need for sick leave in the workplace where the person who died by suicide worked.
- Earmarked funds for suicide prevention can partly finance the activities from the state, and training can be carried out as bereavement support, as the missions overlap.
- This method could help people in one of the worst situations in their life.

Necessary procedures are needed to provide families with early support, like the debriefing currently practised in some professions, such as firefighters and psychiatrists.

Early and frequent survivor support for the family acts as debriefing for the family. This means being able to talk and support each other.

Evaluation of the families who have participated in family postvention over the years was presented during the ELLIPSE project lecture on 10 September. This material can be found on the websites ellipse.12stepsplan.com and räddaliv.se.

- Most of families wants bereavement support to start on the same day as the suicide loss occurs/is told to them.
- It has a calming effect on everyone, knowing how others are coping with their grief.
- It is good to be able to talk about your own fears or worries about someone else.
- So much comes out that can then be further processed by professionals in the event of grief complications.
- Even those who think they have perfect contact with each other, of the approximately 35 families in Blekinge who participated in the family postvention support, experienced the support as very positive.
- When asked if they could be involved in family postvention in the future, most answered yes, to be able to help someone who has lost a loved one to suicide
- If you seek help, you will feel confident in communicating difficult emotions.
- Otherwise, you need to find a way, a motivating sentence, for how it can work for you!
- We all need to have this readiness and courage to bring everyone together and be able to help all ages at the same time. This prevents suicide and increases the closeness to each other in the family.
- If there is no family support it can lea,d to a total breakdown between the survivors.

Conclusion:

Family bereavement support, as described here, is a critical social issue. It helps family members cope with the overwhelming emotions and chaos that arise when a beloved family member dies.

Family support keeps the family together and strengthens the family's knowledge, awareness, bands and power. It can increase togetherness and give family members hope to get through this most difficult grief and find joy again in their lives. It thus enhances the ability of family members to cope with the grieving process without PTSD problems but with post-traumatic growth. It is through difficulties that people develop and achieve new insights, and it is this gain due to the method for which we are particularly grateful.

It remains for the community to implement this activity in all regions, capitalising on the direct knowledge and interest of family members to one day contribute to suicide prevention by helping suicidal people and saving lives. But also to participate in bereavement support for other affected families. This requires a change in society where the bereaved's knowledge is considered.

Summaries of incident analyses need to be sent from the Regional Teams to an appropriate national responsible authority. This is a huge challenge for society, but it is economically justified, as all these steps today cost society a considerable amount of tax money. An organisation that directly supports the surviving family pays for itself extremely quickly and is worth its weight in gold for survivors, according to participants in Blekinge Family Postvention 2014-2023.

The easiest way to implement family bereavement support in all regions is to invite participants in the bereaved families to attend the online ELLIPSE Postvention Course, provided free of charge. The training also helps participants to develop their conversational skills on diverse topics. The cost of bereavement support for families would quickly pay for itself through the lives that can be saved and the reduced number of visits to health centres and specialist clinics caused by anxiety and suicide crises. According to a US research study, up to 135 people are affected by one person's suicide. Saving one life has a direct impact on many people!

Takeaways:

1. Grief after suicide should be expressed in a safe and supportive environment to facilitate healing.
2. Family postvention needs to start immediately after the suicide loss
3. The family becomes a network of allies, a support system for vital guidance and comfort.
4. Family support helps young people focus on positive behaviours and values, which can help them move from harmful to healing actions. There are more adults to help!
5. Survivors experience a condition that can be managed with the proper support.

Appendix 2.C.03 provides a brief description and an example of the Blekinge Family Postvention method.

References:

Andriessen, K., & Krysinska, K. (2012). Essential questions on suicide bereavement and postvention. *International journal of environmental research and public health*, *9*(1), 24–32.
https://doi.org/10.3390/ijerph9010024

Gruber, K. J., Cupito, S. H., & Dobson, C. F. (2013). Impact of doulas on healthy birth outcomes. *The Journal of perinatal education*, *22*(1), 49–58.
https://doi.org/10.1891/1058-1243.22.1.49

Hans, S. L., Edwards, R. C., & Zhang, Y. (2018). Randomized Controlled Trial of Doula-Home-Visiting Services: Impact on Maternal and Infant Health. *Maternal and child health journal*, *22*(Suppl 1), 105–113.
https://doi.org/10.1007/s10995-018-2537-7

Multiple-Choice Questions:

1. Why is early and frequent bereavement support for the whole family important to offer after a suicide?
A. The family needs help to cope with the suicide loss
B. The family in crisis after a loss asks itself many questions
C. Suicide can increase family conflicts.
D. All three options are correct

2. It is crucial that survivor support is available.
A. It urgently needs to be offered to all families in suicidal loss throughout the country
B. Just as emergency services and health care workers need debriefing, so do families
C. Early bereavement support can help reduce suffering and risks of PTSD and depression
D. All three options are correct

3. What accurately describes this early and frequent family bereavement support method?
A. Everyone in grief after suicide loss can experience beneficial effects of early and frequent bereavement support.
B. Only those who can talk about their pain benefit from these conversations.
C. Silent participants make the conversation more accessible for the others.
D. The approach is to talk about the suicide, not about how the bereaved feel in their grief.

4. Can early and frequent bereavement support be seen as a suicide prevention intervention?
A. Yes, according to statistics and research, survivors of suicide have an increased risk of taking their own lives.
B. No, no one else in a surviving family is at risk of dying by suicide.
C. The person who dies chooses to die by suicide.
D. It is not dangerous to talk about a single cause of suicide.

5. Choose incorrect statement.
A. People who lost a family member in suicide have an increased risk of taking their own life.
B. Adolescents who witness a suicide are at risk for the development of PTSD.
C. No one who dies chooses to die by suicide. (Not even by stroke)
D. The suicide of a family member does not increase the risk of suicide in the bereaved.

6. Gathering the whole family to grieve together, with the help of a person with lived experience:
A. It can strengthen the family ties of the survivors.
B. It helps to find purpose and meaning during this challenging period.
C. This gives hope for coping with the difficult period after the suicide.
D. All three options are correct.

7. Is suicide loss different from other experiences of grief and loss following the death of someone?
A. No, it does not matter how a family member died, it's the same grief and loss.
B. No, death can only affect survivors in one way.
C. Yes, suicide death is often characterised by intense feelings of abandonment, guilt, shame
D. No, all bereaved ipeople have the same needs.

8. How can you promote protective factors and understand what resources you have to have to get out of grief?
A. It is important to learn tactics and tools to manage your grief.
B. Policymakers need to strengthen healthcare services to offer the bereaved more effective postvention strategies.
C. Create prevention teams in each region and provide families with early, close support in a comparable way across the country.
D. All three options are correct.

9. According to researchers, what is the role of the person with lived experience in dialogue with the family?

A. There is a balance between support for individuals and support for the whole family system.
B. Find the structures and improve family dynamics.
C. Provide the stability and support the family needs to recognise the role of the deceased and their grief.
D. All three options are correct.

10. What feelings and thoughts do family postvention/bereavement support aim to influence?

A. How scary suicide is.
B. Reducing anxiety, putting feelings into words, and replacing complex recurring images with manageable ones
C. Family postvention's aim is to talk about suicide.
D. It is dangerous to allow family members to tell each other how they are feeling.

11. Bereavement support for the family needs to start early, already during the shock phase.

A. Communication breakdowns in families need to be addressed so as not to cause more severe suffering.
B. The family needs support, hope, and encouragement to talk to each other about the most difficult feelings.
C. The family needs to be supported as soon as possible after the death through safe, healthy coping.
D. All three options are correct.

12. The later the support comes in, the more complex and prolonged the grieving phase becomes, which means;

A. A person may escape their pain in unhealthy coping, even denying the suicide loss.
B. Serious complications cannot occur if you do not talk to the survivors about how they are feeling.
C. Early bereavement support can reduce family self-efficacy after such trauma.
D. The intensity of pain and suffering may increase in the family receiving early bereavement support.

13. What supports family members who share their grief that opens the door to healing?

A. People start to realise and understand what has happened by listening to each other.
B. Concern for living family members is reduced when they know how they are feeling, thinking and feeling.
C. Listening to other family members helps them to support each other and themselves.
D. All three options are correct

14. What are survivor benefits for survivors?

A. Putting words to paralysing emotions, you calm your feelings by talking about them.
B. About getting tips, about breathing techniques, about how to support children.
C. Dysfunctional family relationships are being sorted out about overcoming the pain and gaining hope.
D. It can be anything from A to C and much more.

15. How to start the conversation with a family in suicidal loss?

A. The support person greets you and tells you very briefly about themselves, about who they have lost to suicide.
B. Talking about the rules of dialogue, no one can disclose what anyone says outside the group.
C. The support person builds trust, explains how the conversations work, and asks how everyone is doing.
D. All three options are correct

16. How do you say to help a silent person not participating in the conversation?

A. *"It is enough for you to listen; you do not need to speak for yourself."*
B. *"If you find it difficult to express yourself, you may as well keep quiet."*
C. *"Sharing complex and intense feelings eases your pain and others' concerns about you."*
D. *"Enough people are talking, so you do not have to say almost the same thing."*

17. What areas do not need to be addressed in the family postvention dialogue?

A. With whom a bereaved person can stay at night time, so that they can feel less lonely
B. The importance of eating and drinking water, cooking and eating together.
C. Details of how the suicide happened.
D. Maintaining/resuming important daily routines/activities since before the suicide loss.

18. Which sentences are proper according to research?

A. Talking about someone's choice to die by suicide can lead to complex feelings of anger, abandonment, and sadness.
B. A person who could not cope with life has chosen to die by suicide
C. No person who dies by suicide dies of their own free will. Suicide is not a rational choice.
D. All three options are correct

19. Has the training helped you? Would you be able to help someone who has lost a person to suicide?

A. Otherwise, you need to find a strategy to be prepared to help a fellow human being!
B. Feel free to retake the training to feel more confident dealing with survivors.
C. Please listen to the Ellipse Postventions webinar again to learn even more.
D. All three options are correct

20. The best thing about early and frequent survivor support for the whole family is that:

A. We can support people of all ages at the same time.
B. It alleviates the bereaved's people of concerns about how others in the family will cope with the suicide loss.
C. We are able to prevent a suicide loss from leading to a total breakdown of the family.
D. All three options are correct.

Answers:

1. D. All three options are correct.
2. D. All three options are correct.
3. A. Everyone in grief after suicide loss can experience the beneficial effects of early and frequent bereavement support.
4. A. Yes, according to statistics and research, survivors of suicide are at increased risk of taking their own lives.
5. D. Research says that suicide of a family member does not increase risk for suicide in the bereaved.
6. D. All three options are correct.
7. C. Yes, suicide death is often characterised by intense feelings of abandonment, guilt, shame.
8. D. All three options are correct.
9. D. All three options are correct.
10. B. Reducing anxiety, putting feelings into words, replacing complex recurring images with manageable ones.
11. D. All three options are correct.
12. A. A person may escape their pain in unhealthy coping, even denying the suicide loss.
13. D. All three options are correct.
14. D. It could be anything from A-C and much more.
15. D. All three options are correct
16. C. *"Sharing complex and intense feelings eases your pain and others' concerns about you."*
17. C. Details of how the suicide happened and how rescue efforts failed.
18. No person who dies by suicide dies of their own free will. Suicide is not a rational choice.
19. D. All three options are correct.
20. D All three options are correct.

C.05
EMPOWERING TOGETHER: GROUP POSTVENTION INTERVENTION

Introductory Question:
How can group postvention interventions effectively support suicide loss survivors in their grief journey and promote healing?

What You Will Learn:
1. The significance of group postvention interventions for suicide loss survivors.
2. The benefits and effectiveness of support groups in promoting healing and growth.
3. Common communication barriers in providing support to suicide loss survivors.
4. Practical considerations for initiating and facilitating support groups.
5. The structure, format, and ethical guidelines necessary for influential support groups.
6. Potential challenges in support groups and strategies to address them.

Introduction:
Despite the profound impact of suicide on family and friends, research indicates that only a fraction of survivors receives the support they desire in the aftermath of loss. This discrepancy underscores the importance of effective postvention interventions, particularly group interventions, in addressing the unique needs of suicide loss survivors. Group support offers a safe space for survivors to navigate their grief journey, share experiences, and access valuable resources and coping strategies.

This text explores the significance of group postvention interventions for suicide loss survivors, highlighting their benefits and effectiveness in promoting healing and growth. Through an examination of research findings and practical considerations for initiating and facilitating support groups, this text aims to equip individuals and communities with the knowledge and tools needed to provide meaningful support to those bereaved by suicide.

Bridging the Gap: Addressing Communication Barriers in Support for Suicide Loss Survivors

Research indicates that only about 25 per cent of 144 next-of-kin survivors surveyed by phone reported receiving any assistance following a suicide, despite 74 per cent expressing a desire for help (Provini et al., 2000).

Common communication barriers often lead family and friends to believe:

- *"I'm unsure of what to say."*
- *"I don't want to exacerbate the situation."*
- *"They already have plenty of support; my presence won't make a difference."*
- *"They require professional help; I cannot offer much."*

Given these challenges, group intervention is crucial. Support groups considered the most prevalent form of intervention for grief due to their accessibility and affordability (Levy, Derby, & Martinkowski, 1993), offer many benefits for those bereaved by suicide.

Self-help support groups for suicide loss survivors can provide:

- A safe space fostering a sense of belonging.
- An environment where confidentiality is upheld, and compassion is embraced.
- A platform to openly discuss fears and concerns.
- An environment where talking about grief is encouraged.
- Assistance in alleviating feelings of hopelessness and regaining a sense of control.
- Insight into behaviours related to avoidance or negativity.
- Opportunities to acquire new problem-solving strategies.
- Psychoeducation, including information on the grief process, suicide facts, and the roles of healthcare professionals.

▶ Guidance in navigating difficult anniversaries or special occasions.

Studies have shown that survivors who participate in support groups find them moderately to highly helpful. These groups offer a valuable resource where individuals can connect with others who share similar experiences, express themselves freely, and receive non-judgmental support (McMenamy, Jordon, & Mitchell, 2008).

Group interventions have demonstrated effectiveness in reducing negative psychological symptoms like depression, anxiety, and PTSD while also promoting positive outcomes such as post-traumatic growth and improved marital satisfaction across diverse populations, including suicide survivors.

A study by Constantino et al. (2001) evaluated the impact of two group interventions, the Bereavement Group Postvention (BGP) and the Social Group Postvention (SGP), on widowed survivors of suicide. Results indicated significant reductions in depression, psychological distress, and grief levels, along with increased social adjustment among participants.

While evidence on the effectiveness of group postvention interventions remains limited, components such as tailored support based on grief level, involvement of trained volunteers or peers, and grief-focused interventions show promise (Andriessen et al., 2019).

Questions Regarding the Formation of the Postvention Support Group:

1. As a potential Group Grief Facilitator of the postvention support group (G-GF), do you know the answers to these ten questions?

1 If you have experienced grief, will you lead the group alone or seek professional assistance to conduct meetings?
2 Are you emotionally ready to commit the necessary energy to establish the group, considering the demands of early-stage grief?
3 Do you possess the commitment to sustain the group over time?
4 Are you familiar with existing bereavement support groups in your local community or online?
5 Have you participated in a bereavement support group yourself?
6 Have you participated in an individual or family grief support yourself?
7 Have you undergone any postvention courses to enhance your knowledge and skills in managing various challenges within the group?
8 Do you possess the necessary skills and knowledge about grief and postvention?
9 Do you have sufficient experience and skills in facilitating and managing group dynamics?
10 Do you have enough support from family and friends to be a group leader?

2. Who will be the target group, and how will you define it?

You can describe the target groups as follows:

For this support group, eligibility extends to adults coping with the loss of a family member or friend due to suicide. However, it's important to note that children under 16 need to find tailored activities better suited to their unique needs.

3. What will the group's structure be: "open" and ongoing, or "closed" and time-limited?

Choosing between an "open" or "closed" structure for a grief support group depends on various factors and the community's specific needs.

Let's weigh the pros and cons of each:

Open Structure:
Advantages:
1. Flexibility: Allows individuals to join and leave the group based on their needs and schedules.
2. Accessibility: Provides a resource for the community that's available whenever someone may need support.
3. Reduced Commitment: Members are not locked into a long-term commitment, which can be overwhelming for some.

Disadvantages:
1. Leadership Challenges: Maintaining consistent leadership and facilitation over an extended period may be difficult.
2. Fluctuating Membership: Membership numbers may fluctuate, affecting group dynamics and cohesion.
3. Stagnation Risk: Some members might become stuck in the group rather than addressing their issues and progressing in their healing journey.

Closed Structure:
Advantages:
1. Defined Timeline: Provides a clear start and end point for members, allowing them to focus on their grief within a specific timeframe.
2. Cohesive Group Dynamics: Members can build strong interpersonal relationships as they go through the program together.
3. Encourages Progression: Encourages members to explore their grief within the allotted time and move forward in their healing process.

Disadvantages:
1. Limited Referrals: New members have to wait until the next group starts, which may limit accessibility.
2. Recruitment Challenges: It may be difficult to recruit enough committed members, especially in smaller communities.
3. Exclusivity: Members who miss the program's start may only be able to join during the next cycle, potentially delaying their access to support.

Ultimately, the choice between an open and closed structure depends on factors such as community needs, available resources, and potential group members' preferences. It is beneficial to assess these factors and offer both options to cater to different preferences and circumstances.

4. What will the group format be: structured or unstructured?

Structured (formal) format: This approach entails a predefined agenda for each session, providing stability for members while ensuring a systematic approach to meetings. A typical session may include welcoming introductions, a review of the group's code of ethics, sharing experiences, an educational segment on a predetermined topic, recapitulation, and socialising.
Unstructured (informal) format: In this setting, discussions flow naturally, addressing topics as they arise based on participants' needs.

5. Will the bereavement group be stationary or online?

For optimal accessibility and safety, the support group will primarily operate online. Participants are encouraged to create a distraction-free environment, use headphones for privacy and sound quality, position their cameras at eye level, and share emergency contacts with facilitators.

6. What will be the frequency of the meetings?

Meetings will occur at a frequency that balances dependency and cohesion, avoiding excessive reliance and difficulty forming bonds. Weekly sessions may foster dependency, while monthly meetings could hinder bond formation.

7. What will be the length of the meeting?

Meetings are typically structured to last one and a half to two hours, striking a balance between meaningful engagement and emotional well-being. This timeframe allows for settling in, the core meeting, and post-meeting refreshments and socialisation. Extending beyond two hours risks emotional exhaustion for participants.

8. What will be the group's Code of Ethics?

A "Code of Ethics" serves as a set of foundational principles guiding the conduct and interactions within the group. Establishing clear boundaries ensures that members understand what is expected of them and fosters a safe environment for expressing emotions that may be unfamiliar to others. These rules should be reiterated at the beginning of each meeting and provided to all attendees for reference. Examples of such ground rules include:

1 **Confidentiality:** Group members pledge to uphold the confidentiality of all shared thoughts, feelings, and experiences, respecting everyone's privacy.
2 **Acceptance:** Members acknowledge that thoughts and feelings expressed within the group are neither right nor wrong, fostering an atmosphere of acceptance and understanding.
3 **Non-judgmental Attitude:** Participants commit to refraining from being judgmental or critical of others' experiences, opting for acceptance and empathy.
4 **Freedom of Expression:** Each member retains the right to verbally share their grief and emotions during meetings, though silent participation is also respected if preferred.
5 **Emotional Expression:** It is acknowledged and encouraged that crying is permissible and often beneficial within the support group setting, recognising that emotional waves can overcome individuals unexpectedly.
6 **Empathy over Sympathy:** Group members strive to show empathy, fully comprehending the impact of each other's experiences rather than merely sympathising with their emotions.

7 **Conflict Resolution:** Recognizing the diversity of personalities and experiences within the group, members pledge to work collaboratively to address any conflicts or tensions that may arise.
8 **Respect for Individual Grief:** Acknowledging the uniqueness of each person's grief journey, members commit to respecting and accepting shared experiences and individual differences within the group.

9. Have you planned the agenda for the First Meeting?

Here is an example of an agenda for the first meeting:
1 Welcome from the meeting organiser.
2 Introductions, with attendees sharing their names and how they learned about the meeting.
3 Explanation of the group's broad purpose.
4 Discussion of topics related to the formation of the group.
5 Refreshments and socialising.

10. Have you planned for coping with some expected challenges?

Here are tips for seven potential challenges and coping Strategies:

1. Members becoming overly reliant on a few individuals for group tasks.
Coping Strategy: Dedicate meeting time to discuss task-sharing and solicit suggestions.

2. One member dominates the meeting.
Coping Strategy: Set clear time limits and remind members of group rules.

3. A member seems stuck in grief, affecting others.
Coping Strategy: Have a private discussion and recommend individual counselling if necessary.

4. Lack of progress or forward movement in the group.
Coping Strategy: Reevaluate group needs and make necessary adjustments.

5. Awareness of the risk of suicide among bereaved individuals.
Coping Strategy: Discuss safety measures and create a crisis plan within the group.

6. Members need education on grief and coping strategies.
Coping Strategy: Provide educational materials and resources on grief management and coping techniques.

7. You feel frustrated, sad, and anxious while leading the bereavement group.
Coping Strategy: Try to search for answers in group dynamics and read about other group leaders' responses and how they learn to tackle them. You can also talk with other Group Grief Facilitators.

Conclusion:

Group postvention interventions offer invaluable support to suicide loss survivors, providing a safe space for sharing experiences and accessing resources. Research demonstrates their effectiveness in reducing negative psychological symptoms and fostering post-traumatic growth. These interventions empower survivors to navigate their grief journey with understanding and hope by prioritising compassionate support and resilience-building. Moving forward, continued investment in group postvention interventions is crucial for addressing the unmet needs of suicide loss survivors and promoting healing and growth in the aftermath of tragedy.

Takeaways:

1. **Group Interventions' Significance**: Group postvention interventions offer crucial support, addressing the unique needs of suicide loss survivors.
2. **Benefits of Support Groups**: These groups provide a safe space, foster belonging, and offer valuable coping strategies, significantly aiding the grief process.
3. **Common Barriers**: Communication barriers often prevent adequate support; understanding these can improve intervention effectiveness.
4. **Practical Considerations**: Initiating and maintaining a support group requires emotional readiness, familiarity with local resources, and commitment.
5. **Group Structure and Format**: Choosing between open/closed structures and structured/unstructured formats depends on specific community needs.
6. **Ethical Guidelines**: A code of ethics is essential to ensure a safe, respectful environment for all group members.
7. **Challenges and Strategies**: Addressing potential difficulties such as member dependency, dominance, and risk of suicide through structured strategies enhances group effectiveness.

Multiple-Choice Questions:

References:

Andriessen, K., Lobb, E., Mowll, J., Dudley, M., Draper, B., & Mitchell, P. B. (2019). Help-seeking experiences of bereaved adolescents: A qualitative study. *Death studies*, *43*(1), 1–8.
https://doi.org/10.1080/07481187.2018.1426657

Andriessen, K., & Krysinska, K. (2012). Essential questions on suicide bereavement and postvention. *International journal of environmental research and public health*, *9*(1), 24–32.
https://doi.org/10.3390/ijerph9010024

Constantino, R. E., Sekula, L. K., & Rubinstein, E. N. (2001). Group intervention for widowed survivors of suicide. *Suicide & life-threatening behavior*, *31*(4), 428–441.
https://doi.org/10.1521/suli.31.4.428.22044

Levy, L. H., Derby, J. F., & Martinkowski, K. S. (1993). Effects of membership in bereavement support groups on adaptation to conjugal bereavement. *American journal of community psychology*, *21*(3), 361–381.
https://doi.org/10.1007/BF00941507

McMenamy, J. M., Jordan, J. R., & Mitchell, A. M. (2008). What do suicide survivors tell us they need? Results of a pilot study. Suicide and Life-Threatening Behavior, 38(4), 375-389.
https://doi.org/10.1521/suli.2008.38.4.375

Provini, C., Everett, J. R., & Pfeffer, C. R. (2000). Adults mourning suicide: self-reported concerns about bereavement, needs for assistance, and help-seeking behavior. *Death studies*, *24*(1), 1–19.
https://doi.org/10.1080/074811800200667

World Health Organization. (2008) . Preventing suicide: how to start a survivors' group. World Health Organization.
https://iris.who.int/handle/10665/44801

Multiple-Choice Questions:

1. What percentage of next-of-kin survivors reported receiving any assistance following a suicide, according to Provini et al. (2000)?

A. 10%
B. 25%
C. 50%
D. 75%

2. Which of the following is NOT a common communication barrier when supporting suicide loss survivors?

A. "I'm unsure of what to say."
B. "I don't want to exacerbate the situation."
C. "I can't provide professional help."
D. "I am too busy to offer support."

3. According to Levy, Derby, & Martinkowski (1993), what is the most prevalent form of intervention for bereavement?

A. Individual therapy
B. Group support
C. Medication
D. Online forums

4. Which of the following is NOT a benefit of self-help support groups for suicide loss survivors?

A. Fostering a sense of belonging
B. Providing financial assistance
C. Offering a platform to discuss fears and concerns
D. Encouraging open discussion about grief

5. What outcome did the study by Constantino et al. (2001) NOT show for group interventions?

A. Increased social adjustment
B. Significant reductions in depression
C. Increased financial stability
D. Reduced psychological distress

6. Which factor is essential to consider when forming the structure of a support group?

A. Location of the group
B. Frequency of meetings
C. Age of participants
D. Cultural background

7. What is one disadvantage of an "open" support group structure?
A. Consistent leadership and facilitation
B. Reduced commitment from members
C. Fluctuating membership numbers
D. Defined timeline

8. Which of the following is NOT typically included in a support group's "Code of Ethics"?
A. Confidentiality
B. Acceptance
C. Financial contributions
D. Non-judgmental attitude

9. What is a potential coping strategy if one member dominates the support group meeting?
A. Ignoring the member
B. Setting clear time limits
C. Encouraging the behaviour
D. Cancelling the meeting

10. Which component is NOT essential for initiating a support group for suicide loss survivors?
A. Commitment to sustain the group
B. Familiarity with local bereavement support groups
C. Professional degree in psychology
D. Sufficient experience in facilitating group dynamics

Answers:
1. B. 25%
2. D. "I am too busy to offer support."
3. B. Group support
4. B. Providing financial assistance
5. C. Increased financial stability
6. B. Frequency of meetings
7. C. Fluctuating membership numbers
8. C. Financial contributions
9. B. Setting clear time limits
10. C. Professional degree in psychology

C.06
TAPS SUICIDE POSTVENTION MODEL™

Introductory Question:
How does the TAPS Suicide Postvention Model™ support suicide loss survivors and professionals in the aftermath of a suicide?

What You Will Learn:
1. The structure and phases of the TAPS Suicide Postvention Model
2. Critical tasks within each phase to support suicide loss survivors
3. Strategies for addressing mental health and trauma
4. The importance of fostering connections and finding meaning in grief

Introduction:
The aftermath of a suicide is an immensely challenging journey, both for those directly impacted and for the professionals and caregivers who seek to support them. In 2008, the TAPS Suicide Prevention & Postvention Department introduced the TAPS Suicide Postvention Model™, a comprehensive framework designed to guide survivors and providers through the aftermath of a suicide with sensitivity, compassion, and effectiveness.

The TAPS Suicide Postvention Model™ is structured around three distinct phases: Stabilization, Grief Work, and Posttraumatic Growth. Each phase is carefully crafted to address the unique needs and challenges faced by suicide loss survivors, providing a roadmap for stabilising individuals, fostering a health-promoting grief journey, and facilitating posttraumatic growth.

Within each phase, specific tasks are outlined to guide survivors and providers in their journey toward healing and growth. These tasks range from immediate interventions to long-term strategies, with a focus on safety, trauma-informed care, and the integration of grief into survivors' lives.

Drawing from research and best practices in the field, the TAPS Suicide Postvention Model™ offers a holistic approach to supporting suicide loss survivors, acknowledging the complexity of grief and the potential for growth amidst profound loss. Through this model, individuals and communities can find hope, healing, and resilience after tragedy.

THREE PHASES OF THE TAPS SUICIDE POSTVENTION MODEL

PHASE I. STABILIZATION
This phase encompasses the immediate aftermath of the suicide, spanning the first hours, days, and weeks following the loss. During this period, survivors experience intense grief and hyper-focus on the details of the death. The primary objective is to minimise suicide risk and promote healing by addressing specific areas. Professionals, caregivers, providers, and other family supporters should prioritise safety. Proactive outreach may be necessary for survivors who are geographically isolated or tend to withdraw from support systems.

Task 1. Mental health assessment, suicide risk assessment, and referrals
Identifying mental health issues and suicide risk in survivors is crucial for connecting them to professional care as needed. Understanding adaptive versus maladaptive coping strategies can help reduce risk in vulnerable individuals. TAPS staff are trained to assess coping strategies and utilise intervention skills such as Applied Suicide Intervention Skills Training (ASIST) and Crisis Response Planning (CRP) to evaluate risk and facilitate connections with professionals.

Task 2. Trauma assessment and referral
Survivors may experience symptoms of posttraumatic stress due to the life-changing nature of the suicide, especially if exposed to graphic details. Trauma and grief often coexist and should be addressed separately. Identifying trauma and connecting survivors to appropriate professional care to treat symptoms is essentia.

Task 3. Addressing suicide-specific issues
Survivors may grapple with complex emotions such as guilt, shame, anger, and rejection. Connecting survivors to peers with similar experiences can normalise emotions and validate the need for additional care. Addressing these issues and facilitating connections with like survivors can help navigate distressing emotions and foster healing.

Answering "why" questions Survivors often seek answers to why their loved one died by investigating various sources of information. This process can uncover secrets and lead to feelings of rejection and anger. Reframing perspectives and gaining new insights can help survivors move from feeling abandoned to understanding their loved one's state of mind at the time. This shift in perspective can facilitate forgiveness and help redefine the deceased's legacy.

Grieving children Survivors may struggle with discussing suicide with their children, impacting their worldview and confidence in decision-making. Offering guidance and support based on best practices can help parents navigate this challenge and provide a healthy foundation for collective family grief.

Religion Survivors may grapple with spiritual grief and face stigma and misinformation regarding funerals and memorial services. Facilitating open discussions about beliefs and connecting survivors to supportive faith communities can be crucial interventions in the stabilisation phase.

Identifying and addressing predominant issues can help suicide loss survivors integrate grief into their lives, reducing the risk of self-destructive coping mechanisms. With proper outreach, assessment, and stabilisation, suicide loss survivors can navigate complex issues and achieve connection, healing, and growth.

PHASE II: GRIEF WORK
Grief isn't a finite event but a lifelong journey. While it may evolve and diminish over time, it often resurfaces repeatedly. TAPS aims to integrate grief into survivors' lives, fostering renewed connections with the departed and helping them embrace grief as an expression of love. During this phase, the focus is primarily on what Stroebe and Schut (1999) termed "loss-oriented" coping, which involves processing emotions directly related to the loss. However, survivors also engage in "restoration-oriented" coping, navigating daily life issues affected by the loss while oscillating between focusing on the loss itself and addressing practical matters.

Task 1. Move away from the cause of death
Survivors of suicide loss may fixate on the circumstances surrounding the death, fearing that it will define their loved one's entire life. Redirecting their attention to celebrating the life lived rather than the final moments can help alleviate this fear.

Task 2. Incorporate grief by finding a rhythm
Establishing a Grief Rhythm Grief can be overwhelming and unpredictable, leading to avoidance and withdrawal. Encouraging survivors to recognise and embrace grief triggers, express their emotions, and find support can help them manage grief's ebbs and flows.

Task 3. Form a new relationship with the deceased
Suicide loss survivors can maintain a connection with their departed loved ones by transforming their love and attachment into a continuing bond. This bond can provide comfort and healing, helping survivors navigate their grief.

PHASE III: POSTTRAUMATIC GROWTH
The Posttraumatic Growth phase represents a positive outcome of grief, following a period where complicating factors surrounding the loss have been mitigated or resolved. By employing problem-focused coping, survivors can shift their focus from past pain to future possibilities, ultimately finding meaning and healing in their grief journey.

Task 1. Find meaning from the loss
Encouraging suicide loss survivors to find meaning in their loss can facilitate growth and alleviate symptoms of complicated grief. They may explore opportunities for life transformations or engage in activities honouring their loved one's memories.

Task 2. Tell and share the story in a hopeful, healing way
Suicide loss survivors can rewrite their stories, incorporating new insights and wisdom from their grief journey. This process allows them to share their stories in a hopeful and healing way, empowering themselves and others.

Task 3. Discover a new appreciation for life
Supported suicide loss survivors may find their lives enriched after loss, experiencing more profound connections with others and a heightened sense of empathy. Embracing this newfound appreciation for life honours the memory of their loved ones, and fosters continued growth.

Conclusion:

By offering The TAPS Suicide Postvention Model™ provides a structured approach to support suicide loss survivors through three phases: Stabilization, Grief Work, and Posttraumatic Growth. By prioritising safety, trauma-informed care, and meaningful interventions, the model provides a roadmap for healing and growth. Through its compassionate and evidence-based strategies, the model empowers survivors to navigate grief, find meaning, and cultivate resilience in the aftermath of tragedy.

The TAPS Suicide Postvention Model™ stands as guidance and support for individuals and communities navigating the aftermath of suicide loss. Through its three-phase approach—Stabilization, Grief Work, and Posttraumatic Growth—the model provides a comprehensive framework for addressing the multifaceted needs of survivors and facilitating a journey toward healing and growth.

Description of TAPS is based on Ruocco, K. A., Patton, C. S., Burditt, K., Carroll, B., & Mabe, M. (2022). TAPS Suicide Postvention Model™: A comprehensive framework of healing and growth. Death studies, 46(8), 1897–1908. https://doi.org/10.1080/07481187.2020.1866241

Takeaways:

1. **Comprehensive Framework**: The TAPS Suicide Postvention Model™ offers a structured approach to support survivors through three distinct phases: Stabilization, Grief Work, and Posttraumatic Growth.
2. **Immediate Support**: Stabilization involves immediate mental health and trauma assessments to minimise risk and promote healing.
3. **Grief Integration**: Grief Work focuses on integrating grief into daily life, moving away from the cause of death, and establishing a continuing bond with the deceased.
4. **Posttraumatic Growth**: Posttraumatic Growth encourages finding meaning in the loss, sharing stories in a healing way, and developing a new appreciation for life.
5. **Addressing Specific Issues**: The model highlights the importance of addressing suicide-specific issues, such as complex emotions and the needs of grieving children.
6. **Empowerment and Resilience**: The model empowers survivors to navigate their grief journey by fostering connections with peers and supportive communities, promoting resilience and healing.

References:

TAPS Suicide Postvention Model™ A Roadmap Toward Post-Traumatic Growth Webinar | TAPS Institute. Retrieved June 20, 2024. https://www.taps.org/webinar/2022/suicidepostvention,

Ruocco, K. A., Patton, C. S., Burditt, K., Carroll, B., & Mabe, M. (2022). TAPS Suicide Postvention ModelTM: A comprehensive framework of healing and growth. Death studies, 46(8), 1897–1908. https://doi.org/10.1080/07481187.2020.1866241

Multiple-Choice Questions:

1. What is the primary objective of the Stabilization phase in the TAPS Suicide Postvention Model™?

A. To encourage survivors to delve into their emotions
B. To facilitate forgiveness and reestablish positive memories
C. To minimise risk and promote healing
D. To identify and address religious concerns

2. According to the text, why is it important to connect survivors with professional care during the trauma assessment and referral task?

A. To facilitate forgiveness and reestablish positive memories
B. To normalise emotions and validate the need for additional care
C. To treat symptoms of posttraumatic stress separately from grief
D. To uncover secrets and uncover the reasons behind the suicide

3. What role does addressing suicide-specific issues play in the Stabilization phase?

A. It helps survivors understand their loved one's state of mind at the time of suicide.
B. It encourages survivors to discuss their emotions openly with peers
C. It facilitates connections with other survivors who share similar experiences
D. It assists survivors in facilitating healing

4. What is emphasised as a crucial intervention in the Stabilization phase regarding religion?

A. Connecting survivors with professional care
B. Facilitating open discussions about beliefs
C. Offering guidance on how to discuss suicide with children
D. Encouraging survivors to delve into their emotions

5. What is the primary focus of Phase II: Grief Work in the TAPS Suicide Postvention Model™?

A. Celebrating milestones of the deceased
B. Shifting focus from the cause of death to celebrating the life lived
C. Finding closure by understanding the details of the death
D. Avoiding grief triggers to minimise emotional pain

6. What does Task 2 of Phase II involve in the TAPS Suicide Postvention Model™?

A. Embracing avoidance and withdrawal behaviours
B. Encouraging survivors to ignore grief triggers
C. Identifying and embracing grief triggers to manage emotions
D. Focusing solely on practical matters unrelated to the loss

7. What is emphasised in Task 3 of Phase III?

A. Maintaining a connection with the deceased through a continuing bond
B. Avoiding any mention of the deceased to move forward
C. Erasing memories of the deceased to find closure
D. Shifting focus from past pain to future possibilities

8. According to the text, what is the purpose of rewriting the narrative in Task 2 of Phase III?

A. To deepen feelings of guilt and regret
B. To avoid addressing the emotional impact of the loss
C. To incorporate new insights and wisdom gained through grief
D. To suppress emotions related to the loss

Answers:

1. C. To minimise risk and promote healing
2. B. To normalise emotions and validate the need for additional care
3. D. It assists survivors in facilitating healing
4. B. Facilitating open discussions about beliefs
5. B. Shifting focus from the cause of death to celebrating the life lived
6. C. Identifying and embracing grief triggers to manage emotions
7. D. Shifting focus from past pain to future possibilities
8. C. To incorporate new insights and wisdom gained through grief

MODULE D

HEALTHCARE SETTINGS

D.01 Enhancing Postvention Practices in Healthcare: Insights from People with Lived Experience of Suicide Loss

D.02 Understanding the Impact of Patient Suicide on Healthcare Professionals: Insights and Challenges

D.03 Nurturing Healing: Postvention Practices in Healthcare Settings

D.04 Compassionate Guidance: Understanding Debriefing Meetings in Psychiatric Care Settings

D.05 Guiding Through Grief: Bereavement Policies for Trainees and Doctors in Healthcare Settings

D.01
ENHANCING POSTVENTION PRACTICES IN HEALTHCARE: INSIGHTS FROM PEOPLE WITH LIVED EXPERIENCE OF SUICIDE LOSS

Introductory Question:
How can healthcare institutions better support bereaved by suicide?

What You Will Learn:
1. The importance of communication between psychiatric services and families about suicidal thoughts and risks.
2. The impact of medication side effects on suicidal behaviour and the necessity of informing families.
3. The need for adaptable healthcare policies that address real-life challenges faced by individuals with suicidal tendencies.
4. The significance of respecting the preferences and expectations of suicide loss survivors in their own healthcare and recovery processes.
5. The critical role of sensitive and appropriately timed communication from healthcare providers to suicide loss survivors post-tragedy.

Introduction:
In the wake of a suicide loss, the healthcare setting plays a crucial role in supporting and guidance of bereaved individuals. However, various challenges and shortcomings in postvention practices can hinder practical assistance. Drawing insights from survivors of suicide loss, this discussion highlights critical areas for improvement within healthcare settings to address the aftermath of suicide better.

INSIGHTS OM POSTVENTION FROM FOCUS GROUP

I. Notification stage
The bereaved who lost their loved one in the first stage after getting the information about suicide can feel disconnected, which impacts strongly on their ability to search for help and to notice that help is accessible, because of an "invisible barrier":

"The first weeks after (my son's) death, for me, was like a daze, and it was like you'd fallen into this big dark hole, and you didn't know how to get out. I couldn't plan… it's like wherever you are, you can have people around you all talking, and it's like you've got an invisible barrier between you, it's like they could reach out and touch you but you can't feel them… and they can't help…it's like walking
through a busy shopping area and feeling isolated, and alone (…)" (Fielden et al, 2003, p.77)

II. Grief stage
Some bereaved are in the Grief stage, with all difficult intensive grief feelings, including anger and much hindsight on what should have been done in a different way. This stage is illustrated by the insights from suicide loss survivors shared during ELLIPSE project focus group interviews (2020-2021), who have memories of not getting adequate information and support from healthcare.

1. Not being informed about suicidal thoughts:
The psychiatric department never told us, his family, we were not told about our son's plan and what he would do (end his life), even though our son gave consent [for them to inform us].

2. Not being informed about suicidal thoughts as side effects of medication.
I was never told that the pills that my brother took had increased suicide risk as a side effect. Afterwards, I thought that I could have taken time off to be with him. But we did not understand how serious it was. We could have planned and split up the time, so someone was always with him. But nowhere in our minds did we think that suicide could happen. Nobody told us that was a possibility.

3. Lack of adjustments of policies for care to real-life challenges

To dampen what he felt, my son slipped onto the wrong path and soon realised that he could dampen it with cannabis and ended up in a vicious circle. Psychiatry did not accept him into treatment if he smoked. It became a "catch-22"; no one wanted to take responsibility [to help him].

4. The importance of respecting suicide loss survivor's preferences and expectations
The only thing I needed as a patient was time, but I didn't get any sick leave. I didn't want to take pills because my brother got sicker because of his pills. No, you won't get sick leave if that is the case. So, I had to quit [my job] instead and got on unemployment and used that time as sick leave. You should not have to stop because they force you to take pills!

5. Dissatisfaction with healthcare contacting suicide loss survivors after suicide
Psychiatry called two days after my son took his life. It was a man who expressed himself very clumsily, a man we had never talked to before, and I did not understand who was calling. (…) The head of the department should not be the one calling people at home; he had not met any of us. It was completely wrong. It became so impersonal. Two weeks after the suicide, the hospital contacted me and wanted me to fill out a questionnaire about why I think my brother took his life. I was completely outraged. They were the ones who discharged him. It was far too early for healthcare to get in touch [with a survey].

III. Growth stage
In this stage, a person may need to move on with life, which can help achieve a change. It can be, e.g., engaging in helping others and suicide prevention. Sharing insight from other stages can also be a signal.

"…but there comes a point where everybody wants to move on and you have to… and I just decided I wanted a life…I wanted my life back, and I focused on doing it." (Fielden et al, p.79)

Conclusions:

Insights from suicide loss survivors shared during the ELLIPSE project focus group interviews highlight significant issues in the communication and practices of psychiatric care. Key concerns include the lack of information provided about suicidal thoughts and medication side effects, the rigidity of healthcare policies that fail to accommodate real-life challenges, and the importance of respecting the preferences of suicide loss survivors. Additionally, the inappropriate and insensitive timing of healthcare provider contact post-suicide can exacerbate the distress of surviving family members. Addressing these issues through improved communication, policy adjustments, and follow-up can significantly enhance support for those affected by suicide.

Takeaways:

1. Effective communication from healthcare providers can help prevent suicide by ensuring families are informed of risks.
2. Understanding medication side effects is crucial for preventing suicide and involving family members in monitoring.
3. Healthcare policies must be flexible to accommodate the unique circumstances of each patient for adequate care.
4. Respecting the autonomy and preferences of suicide loss survivors is vital for their mental health and well-being.
5. Sensitive and timely communication from healthcare providers is essential in the aftermath of a suicide to prevent further trauma.

References:

Fielden, K. (2003). Exploring the formal supports used by people bereaved through suicide: A qualitative study. ResearchGate. Retrieved Aug 23, 2024 from:
https://www.researchgate.net/publication/271927854_Exploring_the_Formal_Supports_Used_by_People_Bereaved_Through_Suicide_A_Qualitative_Study

ELLIPSE Project. (n.d.). E-LLIPSE & ELLIPSE POSTVENTION. Retrieved 24 May 2024 from ELLIPSE Gatekeeper+ Course in Suicide Prevention (https://navoica.pl/courses/course-v1:JagiellonianUniversity+EG_A+2023_2_EN/about).
https://ellipse.12stepsplan.com

Multiple-Choice Questions:

1. What issue did the psychiatric department fail to address, according to survivors of suicide loss?
A. Lack of medication availability
B. Absence of communication about suicidal intentions
C. Inadequate hospital facilities
D. Lack of psychological counselling

2. What action did healthcare services refuse until the patient ceased substance use?
A. Providing emotional support
B. Offering alternative treatment options
C. Admitting the patient for inpatient care
D. Initiating psychiatric treatment

3. Why did the survivor refuse to adhere to medication in the text above?
A. Due to financial constraints
B. Witnessing adverse effects on a family member
C. Lack of trust in healthcare professionals
D. Fear of addiction

4. How did the survivor perceive the hospital's request for a questionnaire about the suicide reasons?
A. As empathetic and supportive
B. As timely and personal
C. As premature and impersonal
D. As helpful in the grieving process

Answers:
1: B. Absence of communication about suicidal intentions
2: D. Initiating psychiatric treatment
3: B. Witnessing adverse effects on a family member.
4: C. As premature and impersonal

D.02
UNDERSTANDING THE IMPACT OF PATIENT SUICIDE ON HEALTHCARE PROFESSIONALS: INSIGHTS AND CHALLENGES

Introductory Question:
How do healthcare professionals cope with the emotional aftermath of losing a patient to suicide?

What You Will Learn:
1. The immediate emotional reactions of healthcare professionals to the suicide of their patients.
2. The long-term psychological effects experienced by healthcare professionals following patient suicide.
3. Reflections and hindsight among healthcare professionals regarding potential prevention strategies.
4. The impact of patient suicide on the professional relationships and interactions of healthcare professionals.
5. Organisational and institutional responses to supporting healthcare professionals bereaved by patient suicide.

Introduction:
The suicide of a patient can profoundly affect healthcare professionals, triggering a range of emotional responses and long-lasting psychological consequences. Understanding these reactions and the challenges faced by healthcare professionals in coping with patient suicide is crucial for improving support systems and postvention strategies within healthcare institutions.

I. INITIAL REACTIONS TO PATIENT'S SUICIDE

I.1 GP'S INITIAL REACTIONS

GPs were deeply affected by the suicide of their patients, experiencing emotions ranging from empathy for the family to personal guilt. One GP vividly felt "kicked in the stomach" upon hearing the news. Another admitted to feeling helpless, only able to offer a hug. Many struggled with inadequacy, questioning what more they could have done. These reactions underscored the profound emotional toll of patient suicide on GPs (Foggin et al., 2016).

"I was terribly distressed. I felt like I'd been kicked in the stomach when I heard that he'd died."(Foggin et al, 2016)

I.2 MENTAL HEALTH PROFESSIONAL'S INITIAL REACTIONS:

Mental health professionals reported a range of emotions, including shock, disbelief, and betrayal. Some felt blindsided despite their awareness of their patients' suicidal tendencies. This shock was likened to that experienced by combat soldiers facing unexpected danger. Shock turned to self-doubt and fear of oversight, with professionals questioning every decision they had made. The loss felt personal, as many had developed close relationships with their patients. Examples taken from (Foggin et al, 2016):

1. *"I found out [about the suicide] when I walked into our morning report to pick up the triage beeper and overheard them talking about suicide. I nonchalantly asked, "Who was it?" and found to my shock that it was [Mr. B]. I must have looked like I had been punched in the stomach because the next question was, "Are you taking care of him now?"*

2. *"I remember sitting at my desk for what seemed like hours just staring into space—it was only minutes. (…) I was not even in the same world with my next few patients and began to question every decision I was making— in between fog coming in and out of my brain …"*

3. *"We had discussed him rather extensively, and we knew a lot about his life […] so you know, we did know him quite well, and in a certain way. So, we were both very sad and very shocked."*

4. *"He had come into the hospital because he was feeling suicidal and depressed, but he said that resolved completely […]. So, I remember, I went on vacation. And when I came back, I discovered that he had died […] My emotional reaction really was shock. And feeling that I had missed something"(Foggin et al., 2016)*

5. *"I felt surprised and betrayed, for I believed that we had been able to establish something of a therapeutic relationship—perhaps the first such connection in this patient's long experience with psychiatrists. Yet, at her most critical moment, she felt unable to contact me…." (Foggin et al., 2016)*

6. *"We would talk about the incident but through the night it seemed that we where just working in autopilot, not much came out. No fear, not sad, nothing." Doctor who witnessed suicide, Quora, https://www.quora.com/Doctors-How-did-you-react-to-the-first-time-one-of-your-patients-died*

7. *"I'm sorry," she said softly. "Becky killed herself last night.". I felt as though underwater, my voice garbled, when I finally managed to say, "Okay, thanks for telling me." The therapist who answered a call from a bereaved family member. https://www.psychotherapy.net/article/client-suicide-article*

II. GRIEF (GAPS-GRIEF FEELINGS)

II.1 GUILT AND BLAME:

1. *"After I got home, I had difficulty falling asleep; the next day, it finally sunk in. I started feeling sad for him and his family. I would run the scenario over and over in my head asking myself what went wrong". Doctor who witnessed suicide, Quora, https://www.quora.com/Doctors-How-did-you-react-to-the-first-time-one-of-your-patients-died*

2. *"It's just that I keep blaming myself, and I can't stop visualising my client's last moments. I can't let it go." Therapist, https://www.psychotherapy.net/article/client-suicide-article*

3. *"I felt like, in a way, like maybe I made a mistake. And like, I was the reason that they died" - Psychiatrist (Foggin et al., 2016)*

4. *"The first thing you think is was it my fault, could I have prevented it, should I have referred him to someone sooner, should I have picked up warning signs, was he on the right medication? Did he take an overdose of his medication, or did I give him the medication he then killed himself with? There is a whole host of things" GP (Pooja et al., 2016)*

5. *'There's always going to be something that you feel you could have done more, or there's something you could have changed, because that's what human nature is, you look for things that … you could have … that could have altered the situation, don't you? Hindsight is an awful thing actually, but we all do it, don't we?' (Foggin et al., 2016, e742)*

II.2 ANXIETY & FEAR

1. *"(…) fear that she died due to some gross oversight on my part which would eventually be discovered" Psychologist.*

2. *"It scared me, terrified me, left me doubting everything I did." Psychologist.*

3. *Every time the phone rang in the middle of the night, I would be fearful that it was bad news concerning suicide." Psychologist (Foggin et al., 2016)*

II.3 ANGER

1. *"(…) Other reactions included anger at having to find out about her death in the manner I did (from her parents a week after her death) (…)*

2. *"I walked to my office in a fog to find that the colonel in charge of our clinic had unlocked my office and was going through my desk to find the outpatient chart. I was too blown away to be angry at the colonel then, but now I'm angry again just writing it down" – Psychiatrist.*

II.4 LONELINESS IN PAIN

"I was very careful about revealing Becky's suicide to others. Thinking back on the entire experience, I feel that isolation was the most pernicious aspect of the ordeal. I now realise that most people could not fathom how wounding it is to lose a patient. The slightest nuance or tone of blame from an esteemed colleague could ruin my day". Therapist, https://www.psychotherapy.net/article/client-suicide-article

II.5 PROFESSIONAL IDENTITY CRISIS

"After a week of feeling like crap over this, I thought I was the only one that was feeling like this and felt like this was not the career I was meant for me". Doctor,

Quora, https://www.quora.com/Doctors-How-did-you-react-to-the-first-time-one-of-your-patients-died

"...a client committed suicide, does that mean that I didn't do my job, does that mean I'm not very good at being a therapist" (Silverthorn, 2005; p. 88).

II.6 SHAME

1. *"(...) embarrassment at having "lost" a patient for whom I felt responsible (...)*

2. *"I was almost embarrassed for both of them [referring to two patient suicides]. I was embarrassed of what my secretary will think of me" - Psychiatrist (Furqan et al, 2023).*

III. GROWTH – LONG-TERM IMPACT ON HEALTHCARE PROFESSIONALS

The aftermath of patient suicide often left mental health professionals traumatised and questioning their abilities. Some therapists even stopped accepting patients deemed at risk of suicide, fearing further loss. The emotional toll persisted, with professionals experiencing fear and self-doubt for years (Hendin et al., 2000). Dreams reflecting feelings of inadequacy and incompetence haunted them, highlighting the enduring impact of patient suicide on their psyche (Foggin et al., 2016). After the suicide of a patient, 10% of psychiatrists stopped accepting patients they deemed at risk of suicide or felt insecure with their usual work activities (Ehrlich et al., 2017). Examples:

1. *"I was more hesitant to discharge people who were suicidal for some time after that and, you know, that's like 60% of my patients" – Psychiatrist (Foggin et al., 2016)*

2. *"I had a series of 'examination dreams.' In these, I was striving to overcome obstacles to my arrival at, or competence in, college or internship duties. I was recurrently getting lost in a series of Kafkaesque corridors, stairways, or meandering trains, hopelessly late, woefully unprepared, or—in one dream—only partly clothed." – Psychologist (Foggin et al, 2016)*

3. *"In the days and weeks after [Ms. C's] suicide my shame about my work as a therapist surfaced as I struggled with a burning sense of being inadequate, of not being good enough or good at all, of not being able to prevent her from dying..."- Psychologist (Foggin et al, 2016)*

4. *"Regarding my work, I have once again recovered my enthusiasm, but it is tempered. I now know that anyone is capable of losing hope at times, and even though I listen carefully to the subtle messages my clients share with me, sometimes they choose to keep parts of themselves completely concealed. I know my limitations and that I can't predict or know what a person will do. And I have to live with that uncertainty and with the consequences that may ensue." Therapist, https://www.psychotherapy.net/article/client-suicide-article*

5. *"I feel like I'm a better clinician at the end of the day. I feel like I do a better safety assessment. So, in a way, her legacy, in my head, is that I'm more careful [...] I'm going through every possible factor to make sure that I'm making the right decision. And that's a good thing." – Psychiatrist in (Furqan et al., 2023)*

In hindsight, many mental health professionals have identified aspects of their treatment they wish they could change to prevent suicide. This reflection often leads to feelings of guilt and self-doubt, contributing to the ongoing emotional turmoil experienced after losing a patient to suicide. Some of the changes that therapists consider in the aftermath of suicide include:

- Adjustments of medications
- Reevaluating the need for hospitalisation of the patient
- Seeking consultations with previous therapists
- Increasing alertness and sensitivity to the possibility of suicide
- Enhancing documentation practices
- Pursuing continuing education on conducting and documenting safety assessments.

IV. RESPONSES FROM COLLEAGUES AND MANAGEMENT

Colleagues' and managers' reactions to therapist suicide loss varied, with some responses perceived as supportive while others felt dismissive or intrusive. Institutional reviews often exacerbated therapists' self-doubt and distress, lacking the sensitivity needed for healing. As expressed by psychiatrists and psychologists in (Furqan et al, 2023):

1. *"All my colleagues looked at me differently and were either supportive to the point of irritation or on pins and needles". – Psychiatrist*

2. *"The M and M [mortality and morbidity] conference was not what I expected - I was angry at how it made a scapegoat of [Mr. B]: "We did a good job on this case, he didn't let us help him," for example" – Psychiatrist*

3. *I've always found them [quality control meetings] to be informative, very helpful and very supportive […] There are no accusations or blame or holding of accountability. And an emphasis, as always, on what can we learn, what can we do different, going forward. – Psychiatrist*

4. *I also spoke with other psychiatrists here about their experiences. That was helpful. - Psychiatrist*

5. *"My sense of living under a microscope was heightened several days after [Ms. C's] suicide when I received a phone call from a mental health official who introduced himself and quickly proceeded to inform me our telephone conversation was being recorded; he was initiating an investigation into my patient's death. I had the right to obtain legal counsel…. I was speechless for a few seconds and stammered that, of course, I would cooperate and, no, I didn't think I would need an attorney. I realised the psychiatry department, the hospital, and the state mental health system would all be scrutinising my work at a moment when I felt most vulnerable and beleaguered…." – Psychologist.*

6. *"(…) many of the most difficult moments I experienced occurred during the psychiatry department's meetings or "postmortems" held to review [Ms. C's] treatment and suicide…. These meetings felt more like a tribunal or inquest. At the end of the first meeting, the clinical director, clearly displeased with the absence of several key people and my sketchy knowledge of [Ms. C's] developmental and treatment history, abruptly ended the meeting and looked around the room and then fixed his gaze on me, proclaimed using words I will never forget. – Psychologist*

7. *"It appears that [Ms. C] died the way she was treated, with a lot of people around her but no one effectively helping her." I have to say this was one of the most helpless moments of my professional life. I remember feeling stunned and angry that his comments were grossly unfair, inaccurate, and downright cruel. Yet I did not respond. I couldn't, either out of anger, guilt, or shame or from sheer emotional exhaustion" - Psychologist*

Furqan et al. (2023) highlight that in certain instances, the institutional response can serve as a positive experience for psychiatrists who are grieving the loss of a patient to suicide. This is particularly true when the healthcare setting includes:

a) Safe spaces designated for debriefing, separate from formal incident reviews,

a) *Emotional support provided by department chiefs or other authority figures,*

a) *Peer support from colleagues who have undergone similar experiences, and*

a) Review processes that are non-judgmental and oriented towards learning and improvement.

V. Interactions with Patients' Relatives:

Therapists often engaged with patients' relatives after suicide, anticipating criticism but often finding relief instead. More extended interactions sometimes reassured both parties, dispelling blame and fostering understanding. Anger or blame from the family contributes to the distress experienced by psychiatrists after patient suicide (Furqan et al., 2023). As expressed by psychiatrists (Hendin et al., 2000):

1. *"The most significant stressor at the time was meeting with the family and not knowing what to expect with them".*

2. *"So that was the discussion that had happened with that mom. And we actually cried and cried over this kid for like 2 1/2 hours, it was very, very, very helpful".*

3. *"(…) the therapist had been persuaded by the patient's mother to encourage the patient's discharge from a group home. Although the patient had responded by informing the therapist of his suicidal plans, the therapist had considered this reaction a problem to be worked through in therapy while planning for discharge continued. The patient then killed himself in exactly the manner he had described. Subsequently, the therapist and the patient's mother spent some months informally discussing the patient's death and suicide in general (…)".*

4. *"It's very likely the parents will sue you for wrongful death. Given what you have told me, they will need someone to blame. Please write up a summary of the incident and let us know if you are contacted regarding a lawsuit. – A Lawyer from a Personal Liability Insurance Company. "Most therapists I know live in fear of being sued. I was no exception. And, of course, that is exactly what happened. Therapist (https://www.psychotherapy.net/article/client-suicide-article)*

5. *"First of all … it's just letting people talk… rather than us just jumping in. Just say, well how do you feel about it? … it's very hard for them to talk to family members because everybody's equally upset." – General Practitioner (Foggin et al., 2016).*

VI. Organizational Support for Bereaved:

Both patients' relatives and healthcare professionals face challenges in accessing adequate support for their grief. Mental health professionals often felt left to navigate their grief alone, hindered by institutional expectations to resume regular duties (Foggin et al., 2016). Efforts to improve support for healthcare professionals bereaved by patient suicide are hampered by fear of judgment and reluctance to change institutional policies. Outside partners knowledgeable about suicide could facilitate open dialogue and promote necessary policy changes to better support grieving professionals and prevent future losses. As expressed by general practitioners in (Foggin et al, 2016):

1. *"People have to try and work things through and then go into a full bereavement counselling situation if they're not making any progress really, but GPs don't have enough time.'* – General Practitioner.

2. *"Typically, if we refer to, Uhm, traditional mental health services, then they're not responsive enough … for this sort of problem."* – General Practitioner.

3. *"Voluntary organisations… have a big part to play…"* – General Practitioner.

4. *"And we all go over things, could I have done … should we have done … could we have done something better? And I wouldn't be able to deal with, well, I don't think you should deal with that yourself; I think you need to share that really."* – General Practitioner.

5. *"I suppose GPs like to be, they're taught to be in control and equally they will think they're probably the best at sorting themselves out, which is, which is, which is wrong. I think it's difficult for a doctor to become a patient … a lot of doctors would rather be in denial over that. I think their "oh, I'm too busy", that's an excuse."* – General Practitioner.

6. *"Although we were both grieving the loss, as a psychiatrist, I was expected to provide support for the primary care physician," (…) "We could have ideally been a mutual support to one another, but the organisation at the time did not structure our interaction in that way. In this situation, I did not prioritise managing my own personal response to the loss." (Yasgur, 2023)*

Conclusion:

The suicide of a patient deeply affects healthcare professionals, triggering a range of emotional responses, including shock, guilt, and feelings of inadequacy. These initial reactions often lead to long-term psychological impacts, such as persistent self-doubt, anxiety, and changes in professional practices. The grief process is complex and can involve intense feelings of guilt, blame, loneliness, and professional identity crises.

Healthcare professionals often face challenges in receiving adequate support from colleagues and management, with some institutional responses exacerbating their distress. Effective support systems are crucial for helping professionals cope, including providing safe debrief spaces, emotional support from authority figures, and peer support from colleagues with similar experiences.

Interactions with patients' relatives can be challenging and reassuring, depending on the circumstances. Organisational support systems play a vital role in helping healthcare professionals navigate their grief, but these systems are often inadequate or underutilised. There is a pressing need for healthcare institutions to implement supportive policies and promote open dialogue about the emotional challenges faced by professionals after a patient's suicide.

Takeaways:

1. **Recognise the Impact:** Acknowledge the profound emotional and psychological impact that a patient's suicide can have on healthcare professionals.
2. **Identify Support Needs:** Understand the critical need for appropriate support systems, including peer support, debriefing sessions, and mental health services, to help healthcare professionals cope with the aftermath.
3. **Promote Open Dialogue:** Encourage open discussions within healthcare institutions about the emotional challenges faced by professionals after a patient's suicide to foster a supportive environment.
4. **Implement Supportive Policies:** Advocate for policy changes within healthcare organisations to provide timely and sensitive support to grieving professionals.
5. **Enhance Professional Training:** Highlight the importance of ongoing education and training for healthcare professionals on managing suicidal patients and coping with the emotional fallout from patient suicide.
6. **Support Mutual Healing:** Foster a collaborative approach to support healthcare professionals and patients' families in grieving.

References:

Foggin, E., Mcdonnell, S., Cordingley, L., Kapur, N., Shaw, J., & Chew-Graham, C. (2016). GPs' experiences of dealing with parents bereaved by suicide: a qualitative study.. The British Journal of General Practice: the Journal of the Royal College of General Practitioners, 66 651, e737-46. https://doi.org/10.3399/bjgp16X686605

Furqan, Z., Cooper, R. B., Lustig, A., Sinyor, M., Nakhost, A., Kurdyak, P., Rudoler, D., Naeem, F., Stergiopoulos, V., & Zaheer, J. (2023). "I was Close to Helping him but Couldn't Quite get There": Psychiatrists' Experiences of a Patient's Death by Suicide. Canadian journal of psychiatry. Revue canadienne de psychiatrie, 68(3), 187–199. https://doi.org/10.1177/07067437221125300

Pooja Saini, Khatidja Chantler, David While, Navneet Kapur, Do GPs want or need formal support following a patient suicide?: a mixed methods study, Family Practice, Volume 33, Issue 4, August 2016, Pages 414–420, https://doi.org/10.1093/fampra/cmw040

Swift Yasgur B. Handling Your Grief After a Patient's Suicide. July 18, 2023. https://www.medscape.com/viewarticle/994491?form=fpf

Teichert, W. M. (2013). The experience of psychologists after the suicide of their patient. https://core.ac.uk/download/43173729.pdf

Qayyum, Z., Luff, D., Van Schalkwyk, G. I., & AhnAllen, C. G. (2021). Recommendations for Effectively Supporting Psychiatry Trainees Following a Patient Suicide. Academic psychiatry: the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 45(3), 301–305. https://doi.org/10.1007/s40596-020-01395-7

Multiple-Choice Questions:

1. What emotions do general practitioners (GPs) commonly experience upon learning about a patient's suicide?

A. Relief and satisfaction
B. Shock and guilt
C. Indifference and apathy
D. Excitement and curiosity

2. How do mental health professionals typically react to the suicide of a patient?

A. They feel a sense of closure and move on quickly.
B. They experience shock, disbelief, and self-doubt.
C. They become emotionally detached and unaffected.
D. They blame the patient's family for the suicide.

3. What percentage of psychiatrists stopped accepting patients deemed at risk of suicide after experiencing a patient suicide?

A. 5%
B. 10%
C. 20%
D. 50%

4. How do therapists typically reflect on their actions following a patient's suicide?

A. They feel confident in their treatment decisions.
B. They experience guilt, self-doubt, and shame.
C. They blame the patient for their actions.
D. They believe they did everything perfectly.

5. What is a typical organisational response to supporting healthcare professionals bereaved by patient suicide?

A. Providing comprehensive counselling services within the healthcare institution.
B. Assigning blame and initiating punitive measures against the professionals involved.
C. Offering peer support and debriefing sessions.
D. Ignoring the event and expecting professionals to resume regular duties immediately.

Answers:

1: B. Shock and guilt
2: B. They experience shock, disbelief, and self-doubt.
3: B. 10%
4: B. They experience guilt, self-doubt, and shame.
5: C. Providing comprehensive counselling services within the healthcare institution.

D.03
NURTURING HEALING: POSTVENTION PRACTICES IN HEALTHCARE SETTINGS

Introductory Question:
How can we transform the aftermath of tragedy into an opportunity for growth and support within healthcare environments?

What You Will Learn:
1. Understand the goals and stages of postvention in psychiatric healthcare settings.
2. Explore the crucial preparations for expected unwanted crisis.
3. Learn about crisis postvention procedures, including notification and communication strategies.
4. Discover the importance of providing support and debriefing sessions for affected individuals.
5. Gain insights into the analysis and growth phase of postvention, focusing on learning from the event and improving future responses.

Introduction:
Navigating the aftermath of a patient's suicide in a healthcare setting is a complex and emotionally challenging task. However, by implementing effective postvention strategies, healthcare professionals can transform this experience into an opportunity for healing, growth, and improved patient care. This guide explores the comprehensive framework of postvention in psychiatric healthcare settings, emphasising the importance of preparation, communication, support, and continuous improvement.

CHECKLIST FOR POSTVENTION IN A PSYCHIATRIC HEALTHCARE SETTING

GOALS:
1. Help survivors cope with trauma and grief and reduce crisis reactions.
2. Limit the risk of further suicide and suicidal behaviour.
3. Restore everyday routines.
4. Assist individuals in returning to their pre-trauma level of functioning or better.

FOUR STAGES OF POSTVENTION IN HEALTHCARE:

Stage I: Preparation for the Postvention Intervention (Expecting The Incident)
Stage II: Notification/Communication
Stage III: Support in Grief
Stage IV: Growth - Analysis & Improvements

DESCRIPTIONS OF STAGES:

Stage I. Preparation for the Postvention Intervention (Before):

- Create a CIT (Crisis Intervention Team) comprising doctors, psychologists, PLEs, counsellors, nurses, and paramedics.
- Prepare protocols for dealing with suicidal behaviour for staff, patients, bereaved family, and the community.
- Develop support information (brochures/leaflets) for various stakeholders.
- Collect anonymised information on suicide attempts and suicides for analysis and assessment.
- Coordinate with hospital management for training schedules.
- Ensure CIT members undergo training at least once per year.

Stage II. Notification/Communication:

- In case of a life-threatening suicide attempt:

1. Call 112.
2. Contact a doctor on duty.
3. Initiate rescue actions and secure the area.
4. Inform the head of the department and the CIT coordinator.
5. Assist CIT in preparing and disseminating information about the event.

- In case of death by suicide:

1. Contact a doctor to determine the cause of death.
2. Notify the CIT coordinator.
3. Notify the police.
4. Arrange support for the bereaved family.

Stage III. Support in Grief:

- Identify individuals in need of support.
- Activate an internal support system.
- Offer materials on coping with grief and procedures after suicide to survivors.
- Conduct debriefing sessions for staff.
- Mobilise support from external resources if needed.

Stage IV. Growth: Analysis & Improvements:

- Conduct event analysis in suicide attempts and suicides.
- Perform retrospective reviews within three months after the incident.
- Involve PLEs in gathering views and experiences of relatives and survivors.

Other Considerations:

- Ensure crisis support is available for witnesses, relatives, and survivors.
- Provide information and support to next of kin regarding the deceased's last contacts with the healthcare system.
- Secure the deceased's belongings and handle outstanding fees.
- Document all actions taken and communicate with co-workers.
- Organise follow-up calls and meetings.
- Engage trained PLEs in CIT work and foster their development.

RESPONSIBILITIES OF THE HEAD OF PSYCHIATRY UNIT AND THE CRISIS INTERVENTION TEAMS:

- Convene employees for a debriefing session to discuss the incident.
- Seek assistance from other departments, such as by requesting additional staff.
- Determine whether and what information/support should be provided to other patients.
- Document all actions taken during and after the incident.
- Inform other coworkers about the incident upon their return to work.
- Ensure that no inpatient bills are issued to survivors.
- Facilitate follow-up calls in the coming days and, ultimately, in two to three months, with support from the Preventive Team as needed.
- Ensure prompt preparation and submission of a report to the manager.

The head of the psychiatry care unit is responsible for ensuring that the unit is prepared to:

- Provide swift crisis support to relatives/survivors.
- Extend support to surviving children.
- Arrange a meeting with the individuals involved or responsible for the patient's treatment (e.g., contact person/treating doctor).
- Delineate tasks in cases where suicides impact multiple care units.
- Document all interactions with relatives, authorities, etc., in the deceased patient's medical record. If relatives/survivors have prolonged contact with psychiatric services following a relative's suicide attempt or suicide, consider establishing their medical record on a case-by-case basis.
- Engage trained Persons with Lived Experience (PLE) in the CIT's work.
- Enhance the competence and skills of CIT members, ensuring they are always readily available for urgent contact.

Conclusion:

In summary, effective postvention in psychiatric healthcare settings requires proactive preparation, structured response protocols, ongoing support, continuous learning, interdepartmental collaboration, accountability, and inclusion of diverse perspectives. By following the outlined checklist and principles, healthcare professionals can navigate the aftermath of patient suicides with compassion, professionalism, and a commitment to healing and improvement.

Takeaways:

1. **Emphasis on Preparation:** The foundation of effective postvention in psychiatric healthcare settings is thorough preparation. Establishing Crisis Intervention Teams (CITs), developing protocols, and providing regular training are crucial steps to ensure readiness for managing post-suicide incidents.
2. **Structured Approach:** The checklist outlines a structured approach divided into four stages: Preparation, Notification/ Communication, Support in Grief, and Growth through Analysis & Improvements. This

structured framework helps streamline the response process and ensures comprehensive support.

3. **Immediate Response Protocols:** Clear protocols for responding to both life-threatening suicide attempts and completed suicides are essential. Immediate actions include contacting emergency services, notifying relevant personnel, securing the area, and providing support to affected individuals and families.

4. **Supportive Environment:** Postvention extends beyond immediate crisis management to ongoing support for those affected. Internal support systems, debriefing sessions, and access to external resources play a crucial role in helping individuals cope with grief and trauma.

5. **Continuous Learning and Improvement:** The commitment to growth through analysis and improvements is highlighted. Conducting event analyses, retrospective reviews, and gathering stakeholder feedback enable healthcare professionals to identify areas for enhancement and refine postvention strategies over time.

6. **Interdepartmental Collaboration:** Effective postvention requires collaboration across different departments within healthcare settings. Coordinating with hospital management, involving Preventive Teams, and seeking assistance from other departments ensure a coordinated response to post-suicide incidents.

7. **Responsibility and Accountability:** Clear delineation of responsibilities ensures accountability at every level, from CIT members to heads of psychiatry care units. Documentation of actions taken, follow-up procedures, and submission of reports contribute to accountability and facilitate continuous improvement.

8. **Inclusion of Lived Experience:** The involvement of Persons with Lived Experience (PLE) in CIT work underscores the importance of incorporating diverse perspectives and insights into postvention strategies. Their involvement enhances empathy and understanding in supporting individuals affected by suicide.

References:

Andriessen, K., Krysinska, K., & Grad, O. (Eds.). (2017). Postvention in action: The international handbook of suicide bereavement support. Hogrefe Publishing. ISBN-1616764937, 9781616764937

Andriessen, K., Krysinska, K., Hill, N. T., Reifels, L., Robinson, J., & Reavley, N. (2019). Effectiveness of interventions for people bereaved through suicide: A systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. BMC Psychiatry, 19(1), 49. https://doi.org/10.1186/s12888-019-2020-z

Brock, S. E. (2002). School suicide postvention. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson (Eds.), Best practices in school crisis prevention and intervention (pp. 553-575). National Association of School Psychologists. ISBN-0-932955-84-3

Cerel, J., & Campbell, F. R. (2008). Suicide survivors seeking mental health services: A preliminary examination of the role of an active postvention model. Suicide and Life-Threatening Behavior, 38(1), 30-34. https://doi.org/10.1521/suli.2008.38.1.30

Linde, K., Treml, J., Steinig, J., Nagl, M., & Kersting, A. (2017). Grief interventions for people bereaved by suicide: A systematic review. PLoS ONE, 12(6), e0179496. https://doi.org/10.1371/journal.pone.0179496

Schut, H., & Stroebe, M. S. (2005). Interventions to enhance adaptation to bereavement. Journal of Palliative Medicine, 8(sup1), S140-S147. https://doi.org/10.1089/jpm.2005.8.s-140

Shneidman, E. S. (1981). Postvention: The care of the bereaved. *Suicide and Life-Threatening Behavior, 11*(4), 349–359. https://doi.org/10.1111/j.1943-278X.1981.tb01011.x

Zimmerman, M. S. (2023). The information seeking behaviors and needs of suicide survivors during bereavement. *Libri, 73*(1), 25-35. https://doi.org/10.1515/libri-2021-0119

Multiple-Choice Questions:

1. What are the primary goals of postvention in a psychiatric healthcare setting?

A. Only to limit the risk of further suicide
B. To restore everyday routines
C. To help suicide loss survivors deal with trauma and grief
D. None of the above

2. What is the primary purpose of debriefing sessions for staff?

A. To assign blame for the incident
B. To avoid discussing feelings and reactions
C. To create a safe space for reviewing the incident
D. To prioritise patient care over staff well-being

3. Who typically coordinates the Crisis Intervention Team (CIT) in healthcare?

A. The hospital management
B. The head of the psychiatric care unit
C. The local police department
D. The attending physician

4. What is the purpose of retrospective reviews in postvention procedures?

A. To reconstruct the suicidal process
B. To assign blame to healthcare providers
C. To initiate legal proceedings against the deceased
D. To avoid any further analysis of the incident

5. How can support efforts be adapted to the needs of individuals in crisis?

A. By providing standardised support materials only
B. By avoiding any direct contact with the bereaved
C. By medicalising the grief experience
D. By tailoring support to each person's specific needs

Answers:

1. C. To help survivors deal with trauma and grief.
2. C. To create a safe space for reviewing the incident.
3. B. The head of the psychiatric care unit.
4. A. To reconstruct the suicidal process.
5. D. By tailoring support efforts to individual needs.

D.04
COMPASSIONATE GUIDANCE: UNDERSTANDING DEBRIEFING MEETINGS IN PSYCHIATRIC CARE SETTINGS

Introductory Question:
What insights can we gain about the role of debriefing meetings in providing support to individuals impacted by suicide within psychiatric care settings?

What You Will Learn:
1. The purpose and significance of debriefing meetings in psychiatric care settings.
2. Critical considerations for organising and conducting practical debriefing sessions.
3. Strategies for creating a supportive and non-judgmental environment during debriefing meetings.
4. The importance of addressing grief reactions and providing appropriate resources to survivors.
5. Ways to engage and support family members through debriefing sessions.

Introduction:
In psychiatric healthcare settings, supporting individuals affected by suicide is paramount. This guide explores the essential strategies and protocols for effective postvention, focusing on crisis intervention, debriefing meetings, and ongoing survivor support. By understanding the responsibilities of healthcare leaders and leveraging the expertise of trained professionals, psychiatric care units can create a supportive environment for those impacted by suicide.

LIST OF INDIVIDUALS REQUIRING SUPPORT IN THE EVENT OF A PATIENT'S SUICIDE

1. Immediate Family Members of the Deceased
2. Key Care Providers (Psychiatrists, Psychologists, Psychotherapists, Managers)
3. Trainees and Junior Staff
4. Primary Caregivers (Nurses) who had significant interaction with the patient
5. Personnel who formed a significant bond with the patient or provided specialised attention
6. Discoverers of the deceased patient's body
7. Fellow Patients who may have been impacted by the event, ensuring they have time and resources for expression
8. Relatives of the Patient, particularly crucial in cases involving child psychiatry, ensuring compassionate communication and provision of support materials
9. Support Staff who developed a rapport with the patient
10. Absent Staff (e.g., due to illness, vacation) who may require support upon returning to work

STAFF DEBRIEFING MEETINGS:

1. The primary objective of the debriefing is to establish a safe environment for reviewing the incident and facilitating an open dialogue among all involved employees.
2. Initially, the debriefing should be limited to clinical staff present on the ward during the incident.
3. It is advisable for the debriefing to occur off-site and promptly following notification of the event, preferably within 24 hours.
4. Debriefing sessions aid in clarifying staff roles, determining immediate actions, and provide a platform for openly discussing their emotions and reactions in a non-judgmental setting.
5. Maintain focus on support and learning during discussions, avoiding any blame.
6. Utilise open-ended questions to encourage staff participation, such as "Who? What? When? Where?"
7. Refrain from delving into specific details of the incident to prevent the spread of speculation and rumours.
8. Establish the duration of the meeting, typically ranging from 30 to 60 minutes.
9. Before the debriefing, acknowledge personal feelings and reactions, as the demeanour of the facilitator often

sets the tone for subsequent discussions.

10. Anticipate diverse reactions from participants, including no response, and address these sensitively, ensuring everyone feels heard.

11. Encourage attentive listening and follow-up inquiries.

12. Expressing grief reactions is considered healthy and necessary, typically not requiring intervention from Occupational Health Services or medication. Utilise resources like the 12-Step Safety Plan and provide brochures on grief management after suicide.

DEBRIEFING MEETINGS FOR BEREAVED FAMILIES

1. Family debriefing sessions, also known as Family Postvention, offer individuals an opportunity to express initial emotions and provide mutual support.

2. Survivors should be offered support directly related to the event, fostering a sense of safety and connection.

3. Familiar feelings of guilt among family members should be addressed, allowing individuals to articulate their emotions and receive assistance in managing them.

4. Group and individual support sessions are crucial for creating a safe environment for interaction among family members.

5. Family debriefing meetings should be held regularly and in a location chosen by the family, with the presence of People with Lived Experience (PLE) providing hope to survivors.

6. Families should be equipped with coping tools, such as self-help techniques, tailored to individual needs to avoid medicalising grief.

7. The CIT coordinator should facilitate initial meetings, focusing on the survivors' grief, and encourage open dialogue among participants.

8. Participants are encouraged to share their experiences and emotions related to the incident while refraining from assigning blame and collectively exploring potential reasons for the suicide.

Conclusion:

Effective postvention in psychiatric healthcare settings requires structured protocols, empathetic support, and proactive leadership. Debriefing meetings serve as a vital component of postvention in psychiatric care, offering support and guidance to individuals navigating the aftermath of suicide. By fostering open dialogue, addressing grief reactions, and providing resources, these sessions contribute to the healing process for staff and survivors. By implementing strategies such as debriefing meetings and engaging trained Persons with Lived Experience (PLE), healthcare professionals can navigate the complexities of supporting survivors and promoting healing after a suicide event.

Takeaways:

1. **Debriefing Meetings' Purpose:** Understand that debriefing meetings in psychiatric care settings serve to establish a safe space for reviewing incidents and fostering open dialogue among staff.
2. **Target Audience for Support:** Recognize the diverse range of individuals requiring support post-suicide, including immediate family, care providers, trainees, and others involved or impacted by the event.
3. **Logistics of Debriefing:** Note the importance of promptly organizing off-site debriefing sessions within 24 hours, maintaining focus on support and learning, and refraining from assigning blame.
4. **Communication with Bereaved Families:** Acknowledge the significance of family debriefing sessions in providing mutual support, addressing feelings of guilt, and offering coping tools tailored to individual needs.
5. **Inclusion of Lived Experience:** Engage Persons with Lived Experience (PLE) in facilitating debriefing meetings to provide hope and empathy to survivors.
6. **Prevention of Medicalization of Grief:** Ensure that support efforts for survivors and families avoid medicalizing grief and instead focus on fostering connections and providing coping tools.
7. **Open Dialogue and Support:** Emphasize the importance of open dialogue, attentive listening, and refraining from assigning blame during debriefing meetings to promote healing and support among participants.

References:

Grieving a Suicide Loss: Eight Things I Know For Sure - Rertieved June 24, 2024 from https://afsp.org/story/grieving-a-suicide-loss-eight-things-i-know-for-sure

Harder, N., Lemoine, J., & Harwood, R. (2020). Psychological outcomes of debriefing healthcare providers who experience expected and unexpected patient death in clinical or simulation experiences: A scoping review. *Journal of clinical nursing*, *29*(3-4), 330–346. https://doi.org/10.1111/jocn.15085

NYS Office of Mental Health's Suicide Prevention Center (May 2022). The Impact of Suicide On Professional Caregivers. Retrieved June 2024 from: https://omh.ny.gov/omhweb/suicide_prevention/omh_postventionguide.pdf

Multiple-Choice Questions:

1. What is the primary objective of debriefing meetings for staff in psychiatric healthcare settings?

A. Assigning blame
B. Creating a safe space for open dialogue
C. Avoiding discussion of emotions
D. Limiting participation to select individuals

2. Who should facilitate initial debriefing meetings for bereaved families?

A. Hospital management
B. Trained Persons with Lived Experience (PLE)
C. External consultants
D. Staff members who were present during the incident

3. What is a vital responsibility of the head of the psychiatry care unit or the Crisis Intervention Team?

A. Ensuring survivors receive inpatient bills
B. Documenting all actions taken after an incident
C. Assigning blame to staff members
D. Avoiding communication with other departments

4. How should staff members prepare for debriefing meetings?

A. Avoid acknowledging personal feelings.
B. Focus on assigning blame.
C. Identify personal feelings and reactions.
D. Refrain from asking follow-up questions.

5. What role do Persons with Lived Experience (PLE) play in postvention interventions?

A. Providing medical treatment
B. Leading debriefing meetings
C. Offering support and understanding
D. Avoiding communication with survivors

Answers:

1. B. Creating a safe space for open dialogue.
2. B. Trained Persons with Lived Experience
3. B. Documenting all actions taken after an incident.
4. C. Identify personal feelings and reactions.
5. C. Offering support and understanding.

D.05
GUIDING THROUGH GRIEF: BEREAVEMENT POLICIES FOR TRAINEES AND DOCTORS IN HEALTHCARE SETTINGS

Introductory Question:
How can healthcare institutions effectively support trainees and doctors who are bereaved by the suicide of a patient?

What You Will Learn:
1. The significance of bereavement policies for trainees and doctors in healthcare settings.
2. Critical considerations for healthcare institutions when developing bereavement policies.
3. Strategies for supporting trainees and doctors bereaved by a patient's suicide.
4. Practical accommodations and support options are available to bereaved trainees and doctors.
5. The importance of self-care and self-compassion in coping with grief and loss.

Introduction:
The experience of patient suicide is not uncommon for psychiatrists and trainees, highlighting the necessity for robust bereavement policies in healthcare settings. In this exploration, we delve into the essential components of bereavement policies and examine strategies to effectively support trainees and doctors navigating the aftermath of patient suicide.

The checklist below is based on recommendations in the article of Qayyum Z et al. (2021). Recommendations for Effectively Supporting Psychiatry Trainees Following a Patient Suicide. Academic psychiatry: the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 45(3), 301–305. https://doi.org/10.1007/s40596-020-01395-7

CHECKLIST: BEREAVEMENT POLICIES FOR TRAINEES AND DOCTORS IN A HEALTHCARE SETTING

1. What support can trainee/doctor bereaved by suicide of a patient be offered at the time of notification?
- Receive notification from a supervisor or training director.
- Ensure direct contact with supervisors for support and guidance.
- Establish a designated point of contact for trainee/doctor to receive immediate support.
- Offer guidance on how to navigate the initial stages of grief and shock.
- Provide resources for coping strategies and self-care practices.

2. Can a supervisor set aside time to debrief with trainee/doctor bereaved by the suicide of a patient?
- Schedule dedicated debriefing sessions to address trainee/doctor's emotions and concerns.
- Encourage open communication and empathy during debriefing sessions.
- Encourage reflection and processing of emotions in a supportive setting.

3. Can the trainee/doctor bereaved by suicide of a patient have the possibility to:
- Receive workload accommodations to manage stress and emotional strain?
- Adjust on-call schedules to allow for adequate time for self-care and recovery?
- Obtain reassurance about workload management to alleviate anxiety and uncertainty?
- Participate in immediate debriefing sessions with a supervisor for immediate support?
- Engage in a thorough case review and documentation process with guidance from experienced colleagues?

- Join debriefing sessions with the clinical team under the supervision of a mentor or supervisor?
- Access written resources on grief, bereavement, and coping strategies for healthcare professionals?
- Obtain information about internal and external support services available for T/D.
- Connect with peer support groups or networks to share experiences and receive validation?
- Seek guidance and support from experienced doctors or supervisors who have dealt with similar situations?

4. What can the healthcare setting offer a trainee/doctor bereaved by the suicide of a patient?
- Provide comprehensive support services tailored to the needs of staff and trainees.
- Offer counselling, therapy, or mental health resources.
- Facilitate access to peer support groups or support networks.
- Ensure confidentiality and privacy in dealing with sensitive issues.

5. What arrangements are currently in place?
- Review existing bereavement policies and protocols.
- Assess the effectiveness of current support systems.
- Identify areas for improvement based on feedback from trainee/doctor and staff.

6. How flexible can your workplace be?
- Evaluate the flexibility of scheduling and workload management.
- Consider the feasibility of accommodating individual needs and preferences.
- Explore options for remote work or telecommuting if necessary.

7. In what ways can you meet the practical needs of support?
- Provide practical assistance with administrative tasks or paperwork.
- Offer financial support or reimbursement for counselling services.
- Arrange for temporary relief from clinical duties if required**.**

8. Is the policy written in a clear and accessible way for staff?
- Ensure that bereavement policies are clearly documented and easily accessible.
- Communicate policy updates or revisions effectively to all staff members.
- Provide training or informational sessions on the implementation of bereavement policies.

7 TIPS FOR SUPPORTING TRAINEES/ DOCTORS (T/D) BEREAVED BY A PATIENT'S SUICIDE

1. **Creating the Safe Space**
- Foster an environment of trust and confidentiality where trainee/doctor feel comfortable expressing their emotions.
- Encourage open dialogue and active listening during interactions with T/D.
- Provide a supportive presence without judgment or criticism.

2. **Support for Communications with the Patient's Family**
- Initiate proactive contact with families for support and grieving.
- Facilitate respectful and empathetic communication between T/D and the patient's family.
- Offer guidance on how to navigate difficult conversations and address sensitive topics.
- Provide resources for effective communication strategies and conflict resolution techniques.

3. **Thoughtful Disclosure**
- Acknowledge shared experiences and feelings to alleviate isolation.
- Share personal experiences and vulnerabilities to foster connection and empathy.
- Validate the trainee/doctor's feelings of grief, guilt, and self-doubt by acknowledging similar experiences.
- Provide reassurance and encouragement during moments of doubt or uncertainty.

4. **Validating the Emotional Struggle (Grief and Mourning)**
- Normalise the range of emotions experienced by the trainee/doctor, including shock, sadness, anger, and guilt.
- Encourage expression of feelings and reassure trainee/doctor about common experiences.
- Embrace self-expression and introspection as integral components of the journey towards healing.
- Offer validation and support without minimising or dismissing the trainee/doctor's feelings.

5. **Restoring Confidence**
- Clarify the multifaceted nature of patient suicide and the complex factors contributing to it.
- Shift the focus from individual blame to institutional accountability and systemic factors.
- Clarify institutional responsibility and address feelings of guilt and responsibility.

- Reinforce trainee/doctor's professional competence and dedication to patient care.

6. **Learning Experience**

- Encourage the trainee/doctor to view the experience as a learning opportunity for personal and professional growth.
- Facilitate discussions on lessons learned and insights gained from the experience.
- Emphasise the importance of self-reflection and continuous learning in healthcare practice.

7. **Self-Care and Self-Compassion**

- Promote self-compassion and self-care practices to prevent burnout and compassion fatigue.
- Provide resources and tools for stress management, relaxation, and mindfulness.
- Encourage trainees/doctors to prioritise their well-being and seek support when needed.

Grief Preparation: Mentally prepare yourself for a challenging conversation.

Conclusion:

Bereavement policies tailored to the needs of trainees and doctors play a crucial role in providing compassionate support and guidance following the suicide of a patient. By implementing the checklist and tips, healthcare institutions can better support trainees and doctors navigating the complexities of grief following a patient's suicide. By offering practical accommodations, facilitating open communication, and promoting self-care, healthcare institutions can help mitigate the emotional impact of patient suicide on their staff.

Takeaways:

1. **Importance of Bereavement Policies:** Understand the significance of robust bereavement policies tailored to trainees and doctors in healthcare settings to support them following the suicide of a patient effectively.
2. **Components of Bereavement Policies:** Recognize essential components of bereavement policies, including immediate support at notification, dedicated debriefing sessions, workload accommodations, and access to resources for coping and self-care.
3. **Flexible Workplace Accommodations:** Evaluate the flexibility of workplace scheduling and workload management to accommodate individual needs and preferences, including options for remote work or telecommuting if necessary.
4. **Supportive Communication:** Foster a safe space for open dialogue, active listening, and empathetic communication to validate the emotional struggle of trainees and doctors bereaved by a patient's suicide.
5. **Learning and Growth:** Encourage trainees and doctors to view the experience as a learning opportunity for personal and professional growth, emphasizing self-reflection and continuous learning in healthcare practice.
6. **Self-Care and Compassion:** Promote self-compassion and self-care practices to prevent burnout and compassion fatigue, providing resources and tools for stress management, relaxation, and mindfulness.
7. **Preparation and Validation:** Prepare for challenging conversations with bereaved trainees and doctors, acknowledging shared experiences, validating emotions, and offering reassurance and encouragement.

By implementing these strategies and understanding the complexities of grief following a patient's suicide, healthcare institutions can better support their staff and mitigate the emotional impact of such events.

Reference:

Qayyum Z et al. (2021). Recommendations for Effectively Supporting Psychiatry Trainees Following a Patient Suicide. Academic psychiatry: the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 45(3), 301–305. https://doi.org/10.1007/s40596-020-01395-7

Multiple-Choice Questions:

1. What are the primary components of bereavement policies for trainees and doctors following a patient's suicide?

A. Immediate support, remote work options, financial compensation
B. Dedicated debriefing sessions, workload accommodations, access to resources for coping
C. Mandatory counseling sessions, shift adjustments, disciplinary actions
D. Increased workload, limited communication, reduced support resources

2. What is the purpose of creating a safe space for open dialogue in supporting trainees and doctors?

A. To assign blame and criticism
B. To validate emotions and experiences
C. To avoid discussing sensitive topics
D. To restrict communication and interaction

3. How can healthcare institutions facilitate self-care and compassion among bereaved trainees and doctors?

A. By minimising breaks and increasing workload
B. By providing resources and tools for stress management
C. By restricting access to support networks and resources
D. By ignoring emotional needs and concerns

4. What is the significance of flexibility in workplace accommodations for bereaved trainees and doctors?

A. It allows for stricter policies and disciplinary actions.
B. It enables remote work options and schedule adjustments.
C. It restricts access to support services and resources.
D. It increases stress and emotional strain on staff members.

5. What role do dedicated debriefing sessions play in supporting bereaved trainees and doctors?

A. They assign blame and criticism to staff members.
B. They provide a safe space for processing emotions and concerns.
C. They limit communication and interaction among staff.
D. They avoid discussing sensitive topics related to the incident.

6. What is the ultimate goal of implementing bereavement policies for trainees and doctors in healthcare settings?

A. To minimise support and resources for staff members
B. To foster a culture of blame and criticism
C. To provide compassionate support and guidance
D. To increase workload and stress on bereaved individuals.

7. Answers:

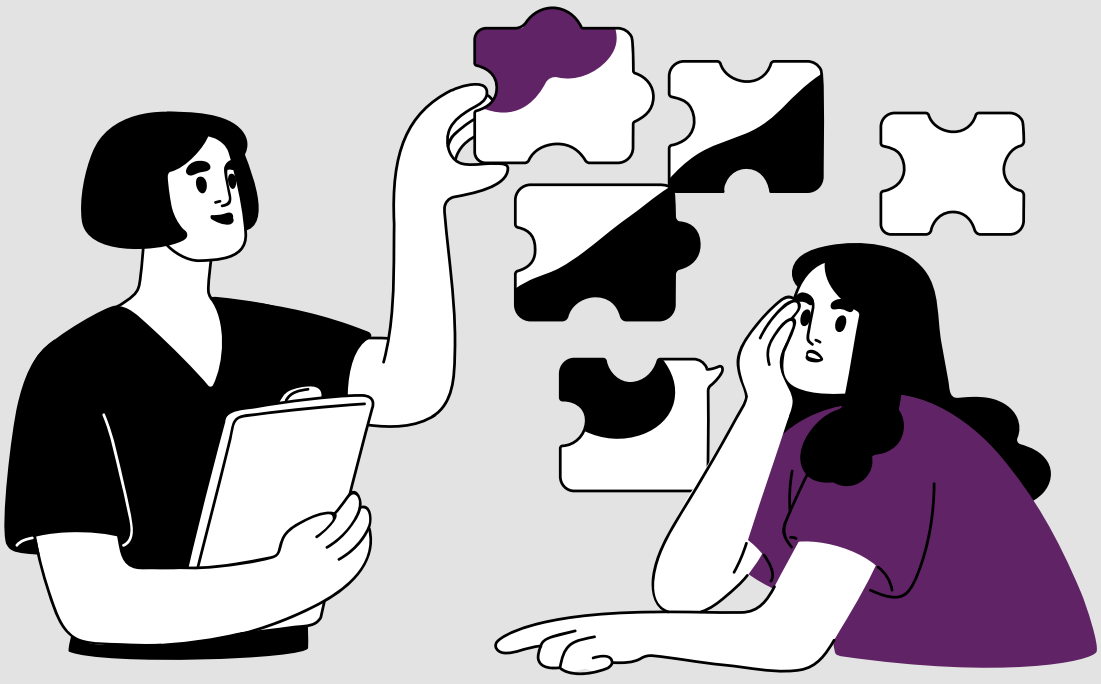
1. B. Dedicated debriefing sessions, workload accommodations, access to resources for coping
2. B. To validate emotions and experiences
3. B. By providing resources and tools for stress management
4. B. It enables remote work options and schedule adjustments.
5. B. They provide a safe space for processing emotions and concerns.
6. C. To provide compassionate support and guidance

MODULE E

SOCIAL CARE SETTINGS

E.01 Understanding Suicide Loss: Insights from a Social Worker's Perspective

E.02 How Can Social Care Setting Effectively Support Social Workers Who Are Bereaved by Suicide of A Client?



E.01
UNDERSTANDING SUICIDE LOSS: INSIGHTS FROM A SOCIAL WORKER'S PERSPECTIVE

Introductory Question:
How do social workers navigate the complex emotional terrain following the loss of a client to suicide?

What You Will Learn:
1. The emotional impact of suicide loss on social workers.
2. Common feelings experienced include shock, sadness, guilt, anger, and fear.
3. Coping strategies employed by social workers, such as seeking reconciliation and gaining insight into personal limitations.
4. Changes in practice and the importance of ongoing education and support.
5. Factors influencing social workers' responses to suicide loss include personal experiences, exposure to trauma, and feelings of powerlessness.

Introduction:
In this lesson, you will gain insights into the grief reactions and coping mechanisms of social workers who have experienced the suicide of a client.

The loss of a client to suicide is a profound and complex experience for social workers, impacting them emotionally, personally, and professionally. Through qualitative research and first-hand accounts, we delve into the multifaceted nature of social workers' reactions to suicide loss and explore how they navigate the aftermath of such a tragic event. This lesson draws upon research by Sanders, Jacobson, and Ting (2005) to investigate the profound effects of client suicide on social workers. Additionally, it incorporates findings from previous studies to comprehensively understand this underrepresented topic in social work education and practice.

HOW TO SUPPORT A FRIEND OR A FAMILY MEMBER AFTER SUICIDE LOSS

Prevalence of Client Suicide:
Sanders, Jacobsen, and Ting (2005) conducted a survey among a random sample of mental health care social workers, revealing that nearly 55% of participants had encountered a client suicide attempt, while 31% had experienced a completed suicide within their practice. Jacobson et al. (2004) conducted a groundbreaking study, revealing that 33% of mental health social workers had experienced a client suicide, consistent with rates reported by psychologists and psychiatrists, which range between 20% to 62% (Pope & Tabachnick, 1993). Between 51 and 82% of psychiatrists (Castelli Dransart et al., 2017), 46.9% of psychiatric trainees (Leaune et al., 2019), between 22 and 39% of psychologists (Castelli Dransart et al., 2017), 55% of nurses (Takahashi et al., 2011) and 33% of social workers (Jacobson et al., 2004) will experience patient or user suicide during their training or career.

A minority of professionals will show adverse personal and professional outcomes and are sometimes named "second victims," professionals exposed to adverse medical events in patients (Scott, 2019). Risk factors for victimisation are a lack of support and training, the lack of support in the aftermath of suicide, a closeness to the deceased and a high level of the professional-client relationship (Leaune et al, 2020). Despite the high prevalence of suicide as an issue for mental health social workers, Ruth et al (2012) found that most graduate social work programs offer less than four hours at the topic of suicide prevention. Gurrister and Kane (1978) highlighted the lack of attention given to client suicide in social work education.

1. **Emotional Reactions:**
Social workers commonly experience shock, sadness, guilt, and anger following a client's suicide. These emotions stem from feelings of trauma, personal loss, and professional self-doubt, often exacerbated by external pressures and blame from others.

Guilt and self-blame: Social workers often grapple with feelings of professional failure and self-blame after a client's suicide. They may question their competence and feel ill-prepared to handle such situations. This internal struggle leads to increased stress and emotional distress. Social workers ponder what they could have done differently to change the outcome potentially:

1. *"I questioned my skills with assessment. I also questioned the client's original diagnosis."*

2. *"I felt responsible, inadequate, fraudulent, absolutely stupid for not picking up the clues. I contemplated leaving the profession." (Haines, 2019)*

3. *"I don't believe I could have done anything differently. While I was aware he would consider suicide, he wasn't suicidal when I saw him. I couldn't have hospitalised him involuntarily because he did not fit the criteria. He became suicidal between sessions."*

Anger: Many social workers experience anger following a client's suicide, directing it towards the deceased, themselves, or the system:

1. *"I was angry, guilty, and sad."*

2. *"I was horrified at the way he killed himself, but very angry with the guards and counselors who were on duty and did not respond."*

Anxiety/Fear for the future: Social workers express concern and fear that can affect their ability to work with clients who have depression effectively:

→ *"I was so scared other clients with depression would start killing themselves."*

Shock: Social workers often describe feelings of trauma and disbelief upon learning about a suicide:

1. *"I was shocked! I wondered if I could have detected it or done more to prevent it but found out he had left me no clues. I was at a conference at the time, and he had given the psychologist no indication about his suicide plan for that evening."*

2. *"I was briefly disorganised and confused."*

3. *"I had trouble conceiving that he had actually followed through."*

Sadness: Following a suicide, social workers experience deep sadness and depression. This sadness stems from the realisation that their efforts as therapists may not always yield the desired outcome. Additionally, the personal connections formed with clients and their families intensify the sense of loss. One social worker expressed:

1. *"I was sad not only for myself but also for her best friend who I was also seeing in the clinic."*

2. *"What I've observed is that the individual had been planning this for a few weeks, perhaps even longer. We had a meaningful conversation, both individually and with their family. The person expressed profound gratitude, which I found perplexing. Yet, shortly after… It's a challenging experience to comprehend, knowing they had been planning this for some time and yet expressed gratitude for the support. It's the kind of experience that resonates deeply, reflective of the complexities inherent in both professional work and life itself".*

These emotional responses highlight the complex challenges social workers face in the aftermath of a client's suicide, underscoring the need for comprehensive support and resources within the profession.

2. Coping Mechanisms:

To cope with the aftermath of client suicide, social workers may seek reconciliation (reconciliation demonstrates personal and professional growth following a client's suicide, often viewed as a critical learning experience or an event that enhances professional practice), acknowledge their limitations, and obtain additional education about suicide prevention. Some draw upon personal experiences and focus on the positive lessons learned from their clients. Jacobson et al. (2004) found gender differences in how social workers responded to clients' suicidal behaviours. Females reported higher levels of intrusion, whereas males showed higher levels of avoidance.

1. *"What did I miss? What did I not see? And I don't trust my own assessments probably for about 3 weeks, 4 weeks, and I let my colleagues know, right … and say, listen, can you do a second run on this person? Because I'm not trusting my own judgement" (Duffy, 2018; Hanif, 2018)*

2. *"It was a critical learning experience, an event that improved my practice".*

3. *" I trust myself more because I had a vague, gut feeling about the client, so I listen to my intuition more." (Haines)*

4. *"I have acknowledged that I cannot possibly save all my clients. I try to do my best always and be on top of things." (Daiffy, 2018; Causer et al, 2019)*

5. *"A lot is not under our control " (…).*

3. Impact Over Time:
Feelings of intensity and disturbance persist over time for many social workers, with memories of the event often triggering visceral reactions and even suicidal ideation. However, the intensity of emotions may decrease with time, although the impact remains significant regardless of the time elapsed since the suicide.

1. *"You can also end up in a situation where you yourself struggle with suicide thoughts. This is not be something that is just about someone else, but oneself as well, to be able to dare to approach one's own pain as well". - Social worker, during ELLIPSE focus groups interview (April 2020)*

2. *"Perhaps this was the most traumatising experience in 20 years as a therapist and supervisor." (Hanif, 2018)*

3. ***"****Feelings had become less intense the farther I move from it."*

4. *"I still feel sorry that she is gone. Still occasionally go over and over the events leading up to the suicide wondering if I could have done something different." (Causer et al, 2019).)*

4. Challenges and Need for Support:
Social workers face challenges such as blaming from others, lack of support, inadequate training, and exposure to traumatic experiences, which contribute to stress and burnout. Social work programs and organisations must address these stressors and provide adequate support and resources for professionals in the field.

1. *"I feel insecure about addressing suicide, having received no formal education on the topic".*

2. *"The suicide was your fault and should be on her conscience for life"*

3. *"I hope you are prepared for court and your professional liability."*

4. *"After he disclosed his molestation, I consulted with my employer and was urged to report him. Right after that I saw him, and he reported being "relieved" and agreed to cooperate with children's services. Approximately one week after, he (took his life) on his ex-wife's lawn".*

5. *"I [don't] like the debriefings that happen. Because they seem more like cover your butt on the institutions part. People don't feel free to talk because of management being there; they fear being judged, um, by colleagues, or managers, or the higher-ups, or whoever. So, they don't talk about it." (Duffy, 2018)*

6. *"We don't have a postvention protocol here, at all. (…) everything's kinda, what we think we should do as co-workers, and stuff, and … I'm pretty sure I went home that day, usually that's what we do around here, is we, you go home, even if you think you're fine. … But somebody has to take charge, there could be practical things like, if my co-worker comes in at 8:30, she could have a client sitting there, and so, we have to deal, like there's things that need to happen, like there's supporting the worker, there's dealing with the clients that are coming in, there's cancelling appointments, there's um, the wider agency kind of things … there may be some information gathering (…)" (Duffy, 2018)*

Conclusion:

Social workers navigate client suicides with a variety of emotional reactions, constructive coping mechanisms, specialised training, comprehension of client intricacies, and management of self-destructive tendencies. Nonetheless, they also encounter adverse effects and may need increased support. Suicide loss deeply affects social workers, triggering a range of intense emotions and challenging their professional confidence. It also gives opportunities for personal and professional growth, as social workers learn to reconcile and incorporate their experiences into their practice. Moving forward, social work programs and organisations must prioritise training and support to help mitigate the adverse impacts of suicide loss on social workers and promote their well-being.

Takeaways:

1. Client suicide is a significant but often overlooked aspect of social work practice.
2. Social workers commonly experience shock, sadness, guilt, and anger following a client's suicide.
3. Coping mechanisms include seeking reconciliation, acknowledging limitations, and obtaining additional education.
4. The impact of client suicide persists over time, necessitating ongoing support and resources for social workers.
5. Addressing challenges such as lack of support and exposure to trauma is essential for promoting the well-being of social work professionals.

References

Causer, H., Muse, K., Smith, J., & Bradley, E. (2019). What Is the Experience of Practitioners in Health, Education or Social Care Roles Following a Death by Suicide? A Qualitative Research Synthesis. *International journal of environmental research and public health*, *16*(18), 3293. https://doi.org/10.3390/ijerph16183293

Causer, H., Spiers, J., Efstathiou, N., Aston, S., Chew-Graham, C. A., Gopfert, A., Grayling, K., Maben, J., van Hove, M., & Riley, R. (2022). The Impact of Colleague Suicide and the Current State of Postvention Guidance for Affected Co-Workers: A Critical Integrative Review. *International journal of environmental research and public health*, *19*(18), 11565. https://doi.org/10.3390/ijerph191811565

Castelli Dransart, D. A., Heeb, J. L., & Gulfi, A. (2020). Mental Health and Social Care Professionals After a Patient Suicide: Interrelation Between Support Needed, Sought, and Received. *Journal of psychiatric practice*, *26*(4), 263–272. https://doi.org/10.1097/PRA.0000000000000477

Dransart, D. A. C., Treven, M., Grad, O. T., & Andriessen, K. (2017). Impact of client suicide on health and mental health professionals. *Postvention in action: The international handbook of suicide bereavement support*, 245-254.

Christianson, C. L., & Everall, R. D. (2009). Breaking the silence: School counsellors' experiences of client suicide. British Journal of Guidance & Counselling, 37(2), 157–168. https://doi.org/10.1080/03069880902728580

Gulfi, A., Castelli Dransart, D. A., Heeb, J. L., & Gutjahr, E. (2010). The impact of patient suicide on the professional reactions and practices of mental health caregivers and social workers. *Crisis*, *31*(4), 202–210. https://doi.org/10.1027/0027-5910/a000027

Jacobson, J. M., Ting, L., Sanders, S., & Harrington, D. (2004). Prevalence of and Reactions to Fatal and Nonfatal Client Suicidal Behavior: A National Study of Mental Health Social Workers. *Omega: Journal of Death and Dying, 49*(3), 237–248. https://doi.org/10.2190/HPKQ-T700-EPQL-58JQ

Leaune, E., Ravella, N., Vieux, M., Poulet, E., Chauliac, N., & Terra, J. (2019). Encountering Patient Suicide During Psychiatric Training: An Integrative, Systematic Review. *Harvard Review of Psychiatry*, 27, 141–149. https://doi.org/10.1097/HRP.0000000000000208

Duffy, A. (2018). Exploring the impact of client suicide on social workers: A phenomenological study.

https://yorkspace.library.yorku.ca/server/api/core/bitstreams/5cc2a6e4-98d1-477e-9d33-36e46179bf2e/content

Pope, K. S., & Tabachnick, B. G. (1993). Therapists' anger, hate, fear, and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice, 24*(2), 142–152. https://doi.org/10.1037/0735-7028.24.2.142

Ruth, B. J., Gianino, M., Muroff, J., McLaughlin, D., & Feldman, B. N. (2012). You can't recover from suicide: Perspectives on suicide education in MSW programs. *Journal of Social Work Education*, *48*(3), 501-516. https://media.wbur.org/wp/2016/04/MSW-suicide-courses.pdf

Takahashi, C., Chida, F., Nakamura, H., Akasaka, H., Yagi, J., Koeda, A., Takusari, E., Otsuka, K., & Sakai, A. (2011). The impact of inpatient suicide on psychiatric nurses and their need for support. *BMC Psychiatry*, 11, 38 - 38. https://doi.org/10.1186/1471-244X-11-38.

Mirick, R. (2023). Strategies for Teaching Suicide Content in Social Work Education: A Survey of Social Work Instructors. *Journal of Teaching in Social Work*, 43, 305 - 323. https://doi.org/10.1080/08841233.2023.2207090

Scott D. A. (2019). Suicide and second victims. *Anaesthesia*, *74*(11), 1351–1353. https://doi.org/10.1111/anae.14763

Sanders, S., Jacobson, J., & Ting, L. (2005). Reactions of mental health social workers following a client suicide completion: A qualitative investigation. Omega: Journal of Death and Dying, 51(3), 197–216. https://doi.org/10.2190/D3KH-EBX6-Y70P-TUGN

Sanders, S., Jacobson, J., & Ting, L. (2008). Preparing for the Inevitable: Training Social Workers to Cope with Client Suicide. Journal of Teaching in Social Work, 28, 1 - 18. https://doi.org/10.1080/08841230802178821

Sherba, R. T., Linley, J. V., Coxe, K. A., & Gersper, B. E. (2018). Impact of client suicide on social workers and counselors. *Social Work in Mental Health*, *17*(3), 279–301. https://doi.org/10.1080/15332985.2018.1550028

Ting, L., Sanders, S., Jacobson, J. M., & Power, J. R. (2006). Dealing with the aftermath: a qualitative analysis of mental health social workers' reactions after a client suicide. *Social work*, *51*(4), 329–341. https://doi.org/10.1093/sw/51.4.329

Ting, L., Jacobson, J., & Sanders, S. (2008). Available supports and coping behaviors of mental health social workers following fatal and nonfatal client suicidal behavior.. Social work, 53 3, 211-21 . https://doi.org/10.1093/SW/53.3.211

Wagner, N. J., Grunhaus, C. M., & Tuazon, V. E. (2020). Agency Responses to Counselor Survivors of Client Suicide. *Professional Counselor*, *10*(2), 251-265. https://files.eric.ed.gov/fulltext/EJ1259780.pdf

Multiple-Choice Questions:

1. What percentage of mental health social workers reported experiencing a client suicide, according to Sanders, Jacobsen, and Ting's study?

A. 20%
B. 33%
C. 55%
D. 62%

2. How do social workers typically describe their feelings in the aftermath of a client suicide, based on the text?

A. They express relief and satisfaction with their interventions
B. They report feeling emotionally detached from the event
C. They describe intense emotions such as shock, sadness, guilt, and anger
D. They remain unaffected and continue with their work as usual

3. According to Ruth et al. (2012), how many hours of suicide-related instruction do most graduate social work programs provide?

A. Less than one hour
B. Less than two hours
C. Less than three hours
D. Less than four hours

4. What aspect of social work education and training is highlighted as crucial for addressing the stressors associated with client suicide?

A. Providing access to personal therapy
B. Emphasising self-care practices
C. Offering specialised training in suicide prevention
D. Encouraging social workers to avoid client interactions

5. 5. What are some common emotional reactions experienced by social workers following a client's suicide?

A. Happiness and relief
B. Shock, sadness, guilt, anger, and fear
C. Apathy and indifference
D. Excitement and motivation

6. 6. How do social workers cope with the aftermath of client suicide?

A. By ignoring their emotions and carrying on with work
B. By seeking reconciliation, acknowledging limitations, and gaining additional education
C. By blaming others and avoiding self-reflection
D. By distancing themselves from clients and avoiding future interactions

7. What impact does client suicide have on social workers over time?

A. Emotions gradually fade, and social workers return to normal functioning
B. Memories of the event become less intense, but the impact remains significant
C. Social workers experience heightened emotions indefinitely
D. Social workers become immune to emotional reactions over time

8. What challenges do social workers face following a client's suicide?

A. Overwhelming support from colleagues and supervisors
B. Blaming from others, lack of support, inadequate training, and exposure to traumatic experiences
C. Minimal emotional impact and personal growth opportunities
D. Increased confidence and professional competence

Answers:

1. C. 55%
2. C. They describe intense emotions such as shock, sadness, guilt, and anger
3. D. Less than four hours
4. B. Emphasising self-care practices
5. B. Shock, sadness, guilt, anger, and fear
6. B. By seeking reconciliation, acknowledging limitations, and gaining additional education
7. B. Memories of the event become less intense, but the impact remains significant
8. B. Blaming from others, lack of support, inadequate training, and exposure to traumatic experiences

E.02
HOW CAN SOCIAL CARE SETTING EFFECTIVELY SUPPORT SOCIAL WORKERS WHO ARE BEREAVED BY SUICIDE OF A CLIENT?

Introductory Question:
How can social care settings effectively support social workers who are bereaved by the suicide of a client?

What You Will Learn:
1. The significance of bereavement policies for social workers in social care settings.
2. Critical considerations for social care institutions when developing bereavement policies.
3. Strategies for supporting trainees and social workers bereaved by a client's suicide.
4. Practical accommodations and support options are available to bereaved trainees and social workers.
5. The importance of self-care and self-compassion in coping with grief and loss.

Introduction:
The experience of client suicide is not uncommon for social care workers and trainees, highlighting the necessity for bereavement policies in social care settings. In this exploration, we delve into the essential components of bereavement policies and examine strategies to effectively support trainees and social workers navigating the aftermath of client suicide.

PREVALENCE

33% of social workers (Jacobson et al., 2004), between 51 and 82% of psychiatrists (Castelli Dransart et al., 2017), 46.9% of psychiatric trainees (Leaune et al., 2019), 55% of nurses (Takahashi et al., 2011), between 22 and 39% of psychologists (Castelli Dransart et al., 2017) will experience patient or client suicide during their training or career.

While most professionals navigate the impact of patient and user suicide positively, viewing it as a learning experience and avenue for professional growth, a minority may suffer adverse personal and professional outcomes and are sometimes referred to as "second victims," akin to professionals exposed to adverse medical events in patients (Scott, 2019). Risk factors for victimisation include lack of support and training, absence of support post-suicide, as well as closeness to the deceased (Leaune et al, 2020).

Some professionals may experience what is known as "disenfranchised grief," where the grief is not acknowledged due to its unrecognised impact by peers, superiors, or society (Doka, 1989). The emotional impact encompasses shock, guilt, sadness, anger, failure, shame, and anxiety. Traumatic reactions may manifest as acute stress or posttraumatic stress disorders. Professionally, patient or client suicide can induce fear and avoidance of individuals with suicide risk, impair professional decision-making, and diminish work performance.

A crucial aspect of postvention policy involves delineating when and how professionals receive information about a client's suicide. Sometimes, social workers learn about suicides through phone calls, whether at home or work. Professionals may even receive such calls after work hours, adding to the emotional burden. Social workers often feel pressured or obligated to resume providing services immediately after such incidents. For example, one social worker learned about a client's suicide just before beginning an appointment with another client, without any consideration for the support or time needed to process the information. This pressure to carry on with their day as usual can lead to feelings of invalidation and a perceived lack of support from colleagues and supervisors (Duffy, 2018).

Checklist: Bereavement Policies for Trainees and Social Care Workers in a Social Care Setting

1. What support can Trainees and Social Care Workers bereaved by suicide a client be offered at the time of notification?

- Receive notification from a supervisor or a manager

of a social care setting.

- Ensure direct contact with a supervisor for support and guidance.
- Establish a designated point of contact for Trainees/ Social Care Workers to receive immediate support.
- Offer guidance on how to navigate the initial stages of grief and shock.
- Provide resources for coping strategies and self-care practices.

2. Can a supervisor set aside time to debrief with Trainees/Social Care Workers bereaved by the suicide of a client?

- Schedule dedicated debriefing sessions to address Trainees/Social Care Workers's emotions and concerns.
- Promote open communication and empathy during debriefing sessions.
- Encourage reflection and processing of emotions in a supportive setting.

3. Can the Trainees/Social Care Workers bereaved by the suicide of a client have the possibility to:

- Receive workload accommodations to manage stress and emotional strain.
- Obtain reassurance about workload management to alleviate anxiety and uncertainty.
- Participate in immediate debriefing sessions with a supervisor for immediate support.
- Engage in a thorough case review and documentation process with guidance from experienced colleagues.
- Join debriefing sessions with the clinical team under the supervision of a mentor or supervisor.
- Access written resources on grief, bereavement, and coping strategies for healthcare professionals.
- Obtain information about internal and external support services available for T/SCW.
- Connect with peer support groups or networks to share experiences and receive validation.
- Seek guidance and support from experienced Trainees/ Social Care Workers or supervisors who have dealt with similar situations.

4. What can the social care setting offer a Trainees/ Social Care Workers bereaved by the suicide of a client?

- Provide support services tailored to the needs of professionals.
- Offer counselling, therapy, or mental health resources, if needed.
- Facilitate access to peer support groups or support networks
- Ensure confidentiality and privacy when dealing with sensitive issues.

5. What arrangements are currently in place?

- Review existing bereavement policies and protocols.
- Assess the effectiveness of current support systems.
- Identify areas for improvement.

6. How flexible can your workplace be?

- Evaluate the flexibility of scheduling and workload management.
- Consider the feasibility of accommodating individual needs and preferences.
- Explore options for remote work if necessary.

7. In what ways can you meet the practical needs of support?

- Provide practical assistance with administrative tasks or paperwork.
- Offer financial support or reimbursement for counselling services.
- Arrange for temporary relief from clinical duties if required**.**

8. Is the policy written clearly and accessible to staff?

- Ensure that bereavement policies are clearly documented and easily accessible.
- Communicate policy updates or revisions effectively to all staff members.
- Provide training or informational sessions on the implementation of bereavement policies.

7 TIPS FOR SUPPORTING TRAINEES/ SOCIAL CARE WORKERS BEREAVED BY A CLIENT'S SUICIDE

1. Creating the Safe Space

- Foster a secure and confidential environment where Trainees/Social Care Workers feel comfortable expressing their emotions, ideally in settings outside the workplace to enhance privacy (Williams et al, 2022)
- Encourage open dialogue and active listening during interactions with Trainees/Social Care Workers.
- Provide a supportive presence without judgment or criticism.

2. Support for Communications with the Trainees/ Social Care Workers's Family, if needed

- Initiate proactive contact with families for support and grieving.
- Facilitate respectful and empathetic communication between Trainees and Social Care Workers and the client's family.
- Provide strategies for navigating challenging conversations and address sensitive topics.

- Provide resources for effective communication strategies and conflict resolution techniques.

3. Thoughtful Disclosure

- Acknowledge shared experiences and feelings to alleviate isolation.
- Share personal experiences and vulnerabilities to foster connection and empathy.
- Validate Trainees/Social Care Workers's feelings of grief, guilt, and self-doubt by acknowledging similar experiences.
- Provide reassurance and encouragement during moments of doubt or uncertainty.

4. Validating the Emotional Struggle (Grief and Mourning)

- Normalise the range of emotions experienced by Trainees/Social Care Workers, including shock, sadness, anger, and guilt.
- Encourage expression of feelings and reassure Trainees/Social Care Workers about everyday experiences.
- Embrace self-expression and introspection as integral components of the journey towards healing.
- Offer validation and support without minimising or dismissing Trainees/Social Care Workers's feelings.

5. Restoring Confidence

- Clarify the multifaceted nature of suicide and the complex factors contributing to it.
- Move the focus from blaming individuals to holding institutions accountable and addressing systemic factors in social care practice.
- Clarify institutional responsibility and address feelings of guilt and responsibility.
- Reinforce Trainees/Social Care Workers's professional competence and dedication to patient care.

6. Learning Experience

- Encourage Trainees/Social Care Workers to view the experience as a learning opportunity for personal growth.
- Facilitate discussions on lessons learned and insights gained from the experience.
- Emphasise the importance of self-reflection and ongoing professional development in social care practice.

7. Self-Care and Self-Compassion

- Promote self-compassion and self-care practices to prevent burnout and compassion fatigue.
- Provide resources and tools for stress management, relaxation, and mindfulness.
- Encourage Trainees/Social Care Workers to prioritise their well-being and seek support when needed.

Conclusion:

Bereavement policies tailored to the needs of trainees, social care workers, as well as other staff members working with clients play a crucial role in providing compassionate support and guidance following the suicide of a client. By implementing the checklist and tips, social care settings, like healthcare settings, can better support trainees and trainee, social workers (as well as psychologists, doctors, and nurses working in a social care setting, navigating the complexities of grief following a client's suicide.

By offering practical accommodations, facilitating open communication, and promoting self-care, social care institutions can help mitigate the emotional impact of client's suicide on their staff.

Takeaways:

1. Bereavement policies. Bereavement policies are indispensable tools for social workers operating within social care settings, acknowledging the prevalent occurrence of client suicide and its profound repercussions on professionals.

2. Emotional support. Social care institutions are tasked with crafting robust bereavement policies that encompass emotional support, practical assistance, and ongoing education, catering to the multifaceted needs of their staff.

3. Debriefing sessions. The effective support of trainees and social workers grappling with the aftermath of a client's suicide entails prompt intervention, structured debriefing sessions, and the provision of diverse coping resources.

4. Accommodations. Offering practical accommodations, such as workload adjustments and access to therapeutic services, is essential to aid bereaved trainees and social workers in navigating their grief while maintaining professional responsibilities.

5. Self-care. Promoting self-care and fostering a culture of self-compassion among social workers are paramount for cultivating resilience and well-being amid the challenging landscape of client suicides within social care settings.

References:

Duffy, A. (2018). Exploring the impact of client suicide on social workers: A phenomenological study. https://yorkspace.library.yorku.ca/server/api/core/bitstreams/5cc2a6e4-98d1-477e-9d33-36e46179bf2e/content

Dransart, D. A. C., Treven, M., Grad, O. T., & Andriessen, K. (2017). Impact of client suicide on health and mental health professionals. Postvention in action: The international handbook of suicide bereavement support, 245-254.

Doka K. (1989). *Disenfranchised Grief: Recognizing Hidden Sorrow.* New York, NY: Lexington Books.

Jacobson, J. M., Ting, L., Sanders, S., & Harrington, D. (2004). Prevalence of and Reactions to Fatal and Nonfatal Client Suicidal Behavior: A National Study of Mental Health Social Workers. *Omega: Journal of Death and Dying, 49*(3), 237–248. https://doi.org/10.2190/HPKQ-T700-EPQL-58JQ

Leaune, E., Ravella, N., Vieux, M., Poulet, E., Chauliac, N., & Terra, J. (2019). Encountering Patient Suicide During Psychiatric Training: An Integrative, Systematic Review. Harvard Review of Psychiatry, 27, 141–149. https://doi.org/10.1097/HRP.0000000000000208

Ruth, B. J., Gianino, M., Muroff, J., McLaughlin, D., & Feldman, B. N. (2012). You can't recover from suicide: Perspectives on suicide education in MSW programs. Journal of Social Work Education, 48(3), 501-516. https://media.wbur.org/wp/2016/04/MSW-suicide-courses.pdf

Sanders, S., Jacobson, J., & Ting, L. (2005). Reactions of mental health social workers following a client suicide completion: A qualitative investigation. Omega: Journal of Death and Dying, 51(3), 197–216. https://doi.org/10.2190/D3KH-EBX6-Y70P-TUGN

Takahashi, C., Chida, F., Nakamura, H., Akasaka, H., Yagi, J., Koeda, A., Takusari, E., Otsuka, K., & Sakai, A. (2011). The impact of inpatient suicide on psychiatric nurses and their need for support. BMC Psychiatry, 11, 38 - 38. https://doi.org/10.1186/1471-244X-11-38.

Qayyum, Z., Luff, D., Van Schalkwyk, G. I., & AhnAllen, C. G. (2021). Recommendations for Effectively Supporting Psychiatry Trainees Following a Patient Suicide. *Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry*, *45*(3), 301–305. https://doi.org/10.1007/s40596-020-01395-7

Multiple-Choice Questions:

1. What is a key consideration for social care settings in supporting social workers bereaved by a client's suicide?
A. Providing financial compensation
B. Offering counselling services
C. Implementing bereavement policies
D. Organising team-building activities

2. What strategy is mentioned for creating a safe space for bereaved social workers?
A. Encouraging judgment and criticism
B. Promoting open dialogue and active listening
C. Minimising interactions outside the workplace
D. Ignoring the emotions expressed by social workers

3. What is essential to supporting communications with the bereaved social worker's family?
A. Avoiding contact with the family
B. Facilitating empathetic communication
C. Discouraging difficult conversations
D. Minimising shared experiences

4. What is emphasised as integral to the journey towards healing for bereaved social workers?
A. Suppressing emotions
B. External validation
C. Self-expression and introspection
D. Dismissing feelings of grief and guilt

5. What is a recommended practice for restoring confidence in bereaved social workers?
A. Focusing on individual blame
B. Emphasising systemic factors
C. Disregarding feelings of guilt
D. Reinforcing blame on the individual

Answers:
1: C. Implementing bereavement policies
2: B. Promoting open dialogue and active listening
3: B. Facilitating empathetic communication
4: C. Self-expression and introspection
5: B Emphasising systemic factors

MODULE F

EDUCATIONAL SETTING

F.01 Rising Together: Healing After Losing Someone to Suicide in School

F.02 The Heartbreaking Reality of Student Suicide: Insights from Teachers' Experiences

F.03 Postvention Policies in Educational Settings: Best Practices for Supporting Students and Preventing Youth Suicide

F.04 Navigating Tragedy: A Trauma-Informed Approach to School-Based Postvention Services

F.05 Navigating Sensitive Conversations A Guide to Suicide Prevention Interviews in Media

F.01
RISING TOGETHER: HEALING AFTER LOSING SOMEONE TO SUICIDE IN SCHOOL

Introductory Question:
What lessons can we draw from the experiences of students who have lost a classmate to suicide?

What You Will Learn:
1. Impact of Suicide Loss: Explore firsthand experiences of students grappling with the aftermath of a classmate's suicide.
2. School Responses: Understand how schools address suicide clusters and provide support to grieving students.
3. Coping Mechanisms: Learn about common grief reactions and cultural rituals following a suicide loss.
4. Warning Signs and Prevention: Discover students' perceptions of causes and the role of parents, schools, and communities in suicide prevention efforts.
5. Comparative Studies: Examine research findings on the effects of suicide loss on student mental health and coping strategies.

Introduction:
In schools, where students come to learn and grow, there is a hidden struggle with the pain of losing someone to suicide. Module F offers guidance on how to deal with this challenging situation.

It is tough to see, but many high school students have lost a peer to suicide. This does not just affect the students—it also has a significant impact on teachers and counsellors. Girls might feel the loss more in their personal lives, while guys might struggle more with PTSD.

Kõlves et al. (2016) reported that 36% of teachers were exposed to at least one student's suicide. The most recent suicide of a student had a significant impact on the lives of 76% of teachers personally and 85.7% professionally. The effect on personal life was higher for female teachers.

After a student's suicide, 27.1% of teachers exposed to suicide felt that they needed more support (Kõlves et al., 2016).

Teachers need to recognise and help students who might be at risk of suicide. Teachers are often the first to notice when students are having emotional problems. They can help by referring students to school counsellors or other resources. Schools are where students get the most help for emotional issues (Stephan et al., 2007).

Adolescents who experience the suicide death of a peer are more likely to have suicidal thoughts, make suicide attempts, and die by suicide, a phenomenon that is referred to as suicide contagion (Gould et al., 2018). The cultural script that forms after a suicide can unintentionally normalise the idea of suicide as a way to solve the problem that others perceive as the "cause" of the person's suicide (e.g., break-up, bullying, academic pressure), increasing the risk of suicidal behaviours (Mueller & Abrutyn, 2016; Kleinman, 2015).

More than 13% of adolescent suicides are potentially explained by clustering (Swansson et al., 2013). Adolescents and young adults are more vulnerable to suicide after exposure to a suicide loss or a suicide attempt (Abrutyn & Mueller, 2014).

Teachers and counsellors often feel alone and unsupported after a student's suicide. They need more training and support to help them cope.

Training is essential. When teachers and counsellors know how to deal with challenging situations, they can handle them better. However, right now, more attention should be given to training them.

Let us support each other through the tough times. Together, we can heal and grow stronger after losing someone to suicide.

In the wake of a classmate's suicide, students are thrust into a whirlwind of emotions, grappling with grief, guilt, and unanswered questions. Through their narratives, we gain invaluable insights into the profound impact of suicide loss on individuals and communities. Every narrative provides insight into the intricate emotions and hurdles confronted by those who remain, from the immediate aftermath to the enduring effects.

Narrative 1: Reflects on the profound impact of losing a classmate to suicide, highlighting feelings of guilt and questioning past interactions.

"I wish I spoke to them. (…) You just question every past move you have made in the vicinity of that person." Reddit User.

"Surreal. It just happened last week to me. I do not think I've ever had a whole conversation with them, so I was not close to them or their friends, but it still impacted me. Reddit User.

I had one class with them, and a few weeks ago, they stopped showing up, not sure if it was related to the depression or moved out of class or something completely unrelated, but I did not notice until this Friday when the teacher broke us the news. (…)
At first, I didn't have much of a reaction besides the natural "that's awful and depressing", but as the minutes went by, we started to deteriorate, even us that did not know the person that died. Just the whole idea of it was so sad, and we had seen them in the halls before, so much goes through your mind. "What if I had a conversation with them once?"
"I wish I spoke to them." "If I asked, maybe something could be different" You just question every past move you have made near that person, but it is too late. It hurts a lot and still does"
Quora User

Narrative 2: Discusses a series of suicides at a school, illustrating the initial shock, subsequent numbness, and school's response, including increased counselling and mental health discussions.

Suicide cluster at school
My school had five suicides in 3 years. The first one was spoken in hushed tones. I believe there was an announcement about it, too. The second was someone in my grade, and it came out of nowhere; he was popular and well-liked. No one expected a thing; I had found out the evening of because his friends posted tributes on Instagram. There was an announcement at the beginning of the day, and some of my teachers talked about it at the beginning of class since, you know, he was in some of them. The next three were basically treated the same way (…) There would be whispers of what happened before school officially started, a morning announcement, and sometimes a teacher or two would just let us sit for a minute and talk. I believe our school hired more counsellors, and there was a more open discussion about mental health at our school after the third suicide. I know we had some motivational speakers come in, too. It was just a blur, to be honest. The last three happened in the span of like 6, 7 months, and we were just kind of numb at that point, to be honest. Reddit User.

Narrative 3: Describes the common grief reaction of crying, self-accusing, and praying in school after a suicide loss, with minimal emotional support from teachers.

Crying - one of the common grief reactions at school after a suicide loss
When I was in middle school, someone committed suicide. I didn't know him but I started to cry. A lot of people did. The teachers didn't show any emotion but they let us just do whatever in class which was us mostly crying. Quora User

"It caused us much pain"
I was personally pained. (…) But then I remember one day in my room before I slept, I prayed. I prayed to God to give me the power and ability to communicate with ghosts so that I can talk to him and can pass messages through to others". (Shilubane et al, 2018, p.3)

"I also felt guilty…"
"I also felt guilty because there was a time when he wanted to be my friend, but I was not interested in making the friendship with him. When I learned about his death, I thought maybe I did something that made him to think that I hate him, and then felt lonely after I refused to be his friend, and this made me feel bad" (Shilubane et al, 2018, p.3)

Narrative 4: Shares personal struggles with attending mourning rituals, highlighting the trauma it can cause in children. Mentions experiences with suicide loss in college.

Being obliged to a culture-specific mourning ritual can increase trauma in children.
(…) We are to go to her wake to pay our respects. I did not want to go because dead people freaked me out. My parents also agreed that I shouldn't go. My dad offered to go on my behalf. But being in high school, I was afraid of what my classmates might say about me (being a coward and disrespectful, etc..).
So I went with a bunch of classmates. (…) Her father was sitting by the door half crying and half cursing his wife, who is crying quietly while greeting us at the same time. I was so afraid my mother had to sleep in my bed with me for the next 2 months. Quora User

Narrative 5: Explores the concept of "silent suicidality" and the hidden struggles of individuals who may not show outward signs of distress.

"Silent suicidality" – when no warning signs are noticed (like a "silent" heart attack, which has few, if any, symptoms, or symptoms not recognised as a heart attack).

"She may not have thought people cared about her, but she touched more lives than she may have ever known. In a world of jerks and blue meanies, I can remember how kind she was to me and everyone she came in contact with. She was also an incredibly talented artist. She wanted to be a graphic designer and chose that major. Quora User

You would have never known she was suffering. She didn't let anyone know. You would have thought she was the happiest person you had ever met. You just don't know what people are going through."

Narrative 6: Reflects on how a student's suicide can temporarily change the campus mood, but life eventually returns to normal for most students.

A suicide can change the mood of the campus for about a week, then life goes on:
A student of mine killed himself 4 months before graduation. (He was being bullied over his weight). It totally changed the mood of the campus for about a week. We had discussions, counsellors, crisis teams, etc. then life went on for most people. His best friend mourned for him for nearly two years after. Most of the other students - including other classmates and teachers never really openly thought about it much afterwards. (Shilubane et al, 2018, p.4)

Narrative 7: Discusses the impact of suicide loss on individuals who were not personally close to the deceased, highlighting the unexpected emotional toll. **"Disfranchised grievers"** – people affected by suicide who are not listed as being at risk for complicated grief.

" (…) I did not know her personally, but from what I had seen of her, she seemed like one of those unfailingly kind and genuine people. She had just posted on Facebook in January that "this year is looking up so far", and she was very involved in university organisations - I had seen her face on posters around the school. I do not know any of her friends or family, so I have no one to offer my condolences to. I'm not sure why this news hit me so hard since I didn't really know her. Quora User
Supportive comment: *"First of all, let me just start by saying I am sorry you're going through this. Even if you never talked to him, having a classmate die, especially of something as sudden as a suicide, can be a huge shock to our system. This is especially true when we are quite young, as students tend to be, and may have never experienced loss in our social surroundings before. Therefore, while you may not feel the loss at a personal level (and even if you do that's okay), it is certainly understandable if you have feelings of loss, sadness, fear or any of a hundred others that can come about with grief" Quora User*

Narrative 8: Explores the complex emotions of individuals with suicidal ideation triggered by news of another's suicide, emphasising the need for understanding and support.

"Werther effect" – increased risk for suicide in the community where a suicide happened.

(…) "I can't stop blaming myself. Three weeks ago, he told me he wanted to commit suicide, but he was too scared. I did not think he would do it. He also wrote to me saying if we would meet, he might not want to kill himself. I keep reading those messages. I can't get it out of my head. I scream every night and tell myself that I'm a murderer. I feel like I need to die for making him die, and have never been in so much pain in my life. I am someone who suffers from depression and have been suicidal as well. My mom is staying home with me".
(https://www.nexusfamilyhealing.org/advice/my-friend-died-suicide-there-any-way-i-could-get-through-pain)

"Hearing that someone passed away from depression just feels awful, but this makes me feel more compelled

to do it. I don't know what to make of this. I knew this person for 10 years and now they're gone. Just doesn't feel right for me to be on this planet and they not being here anymore. I don't know if that makes me selfish to say this but it feels like the universe is telling me that I should go too. That person had a wonderful smile, and it feels like people don't take your issues seriously unless you end your life yourself". Quora User

Comment 1: "I had my battle with depression and suicide as well. I once had some legal issues and (…) ate all the pills. I passed out in the stairway of my apartment and someone found me and called 911. (…) Once in the hospital, they pumped my stomach, and I spent some time in a suicide ward. I talked to a lot of counsellors who gave me some good advice. At first I was hard headed and didn't think they could help me out. I got help, and now I try to help others when I can. I couldn't help any of my friends because they never said anything. If you want to talk about your problems then you can dm me and I will listen". Quora User

Comment 2: "(…) He was my first love. He had no enemies, and he also had a wonderful smile. Before that, it was my grandmother. It hurts so bad. I won't erase that. Please know I identify with you. But it's not a sign to die. If anything, it's a sign to live." Quora User

Conclusion:

The narratives presented here offer a deep dive into the multifaceted nature of the emotional turmoil experienced by students after the suicide of a classmate. This profound loss triggers a whirlwind of emotions, including grief, guilt, confusion, and a pervasive sense of helplessness. These reactions highlight the need for schools to develop comprehensive and compassionate bereavement policies that provide immediate and long-term support for students.

The first narrative reveals how even students with minimal interaction with the deceased can be deeply affected. Feelings of guilt and self-questioning are common, as students often wonder if their actions could have made a difference. This underscores the importance of schools recognising and addressing these complex emotions rather than expecting students to move on quickly.

The second narrative depicts a school grappling with multiple suicides over a short period. The initial shock and subsequent numbness experienced by the students illustrate the severe emotional toll such events can take. The school's response—hiring more counsellors and promoting open discussions about mental health—demonstrates the necessity of proactive and sustained mental health support in mitigating the impact of such tragedies.

The third narrative emphasises the common grief reactions, such as crying and self-accusing, especially in environments where emotional support from teachers is minimal. This highlights the need for teachers and staff to be more actively involved in providing emotional support and creating a safe space for students to express their grief.

Another narrative discusses the trauma induced by attending culturally specific mourning rituals, showing how these practices can sometimes exacerbate the emotional distress of young individuals. This points to the need for sensitivity and flexibility in allowing students to grieve in comfortable ways.

The "silent suicidality" concept in the narratives underscores the hidden nature of some individuals' struggles, reminding us that outward appearances can be deceiving. This calls for heightened awareness and a more nuanced approach to identifying and supporting at-risk students.
Further, the narratives address the phenomenon of "disfranchised grievers"—individuals affected by suicide who are not typically recognised as being at risk for complicated grief. Their experiences highlight the unexpected emotional toll on those not directly connected to the deceased, reinforcing the need for inclusive support mechanisms.

Moreover, the emotional reactions of individuals with suicidal ideation triggered by news of another's suicide, known as the "Werther effect," emphasise the critical need for careful and supportive communication in the aftermath of a suicide. This helps prevent the risk of contagion and supports those who might already be vulnerable.

In conclusion, the narratives demonstrate that the loss of a classmate to suicide affects the entire school community, with rippling effects that can last long after the initial shock. Schools must prioritise mental health education, provide accessible support services, and foster a culture of empathy and open dialogue. By doing so, they can help students navigate their grief, build resilience, and prevent further tragedies. Creating a supportive and understanding environment is crucial for healing and ensuring the well-being of all students.

Takeaways:

1. **Profound Emotional Impact:** The loss of a classmate to suicide profoundly affects all students, even those who were not personally close to the deceased, leading to feelings of guilt, grief, and self-questioning.
2. **Need for Supportive Responses:** Schools must provide immediate and ongoing emotional support, including counselling and open discussions about mental health, to help students process their grief and prevent additional trauma.
3. **Importance of Open Dialogue:** Creating an environment where mental health issues are openly discussed and addressed can help destigmatise these issues and encourage students to seek help before a crisis occurs.
4. **Complex Grief Reactions:** Reactions to a classmate's suicide can vary widely, from crying and numbness to increased suicidal ideation among vulnerable individuals, highlighting the need for personalised support and intervention.
5. **Long-term Community Resilience**: Fostering a culture of empathy and understanding within the school community is crucial for building resilience and supporting long-term healing after a suicide loss.

References

Abrutyn, S., & Mueller, A. S. (2014). Are Suicidal Behaviors Contagious in Adolescence?: Using Longitudinal Data to Examine Suicide Suggestion. American Sociological Review, 79(2), 211–227. https://doi.org/10.1177/0003122413519445

Andriessen, K., et al. (2017). Prevalence of exposure to suicide: A meta-analysis of population-based studies. Journal of psychiatric research, 88,113–120. https://doi.org/10.1016/j.jpsychires.2017.01.017

Mueller, A. S., & Abrutyn, S. (2016). Adolescents under pressure: A new durkheimian framework for understanding adolescent suicide in a cohesive community. *American Sociological Review, 81*(5), 877–899. https://doi.org/10.1177/0003122416663464

Kleiman E. M. (2015). Suicide acceptability as a mechanism of suicide clustering in a nationally representative sample of adolescents. Comprehensive psychiatry, 59, 17–20. https://doi.org/10.1016/j.comppsych.2015.02.002

Kõlves, K., Ross, V., Hawgood, J., Spence, S. H., & De Leo, D. (2017). The impact of a student's suicide: Teachers' perspectives. *Journal of affective disorders*, *207*, 276–281. https://doi.org/10.1016/j.jad.2016.09.058

Swanson, S. A., & Colman, I. (2013). Association between exposure to suicide and suicidality outcomes in youth. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, *185*(10), 870–877. https://doi.org/10.1503/cmaj.121377

Stephan, S. H., et al. C. (2007). Transformation of children's mental health services: the role of school mental health. Psychiatric Services (Washington, D.C.), 58(10), 1330–1338. https://doi.org/10.1176/ps.2007.58.10.1330

Friends in Grief

Multiple-Choice Questions:

1. How did students describe their emotional response to losing a classmate to suicide?

A. Indifference
B. Overwhelming sadness and guilt
C. Relief
D. Happiness

2. What measures did schools take in response to suicide clusters, according to student narratives?

A. Ignoring the issue
B. Providing additional counselling and mental health discussions
C. Blaming the students
D. Cancelling classes

3. How did students perceive the role of parents in suicide prevention, according to research findings?

A. Parents should avoid discussing complex topics with their children
B. Parents should communicate openly and respectfully with their children
C. Parents should encourage their children to keep their feelings hidden
D. Parents should blame their children for their struggles

4. According to research, what was one common warning sign observed among peers who died by suicide?

A. Increased academic performance
B. Engagement in extracurricular activities
C. Unusual behaviour or statements indicating suicidal thoughts
D. High levels of social popularity

5. What was a key finding of the comparative study by Gould et al. (2018)?

A. Students at schools with recent suicide losses showed lower rates of depressive symptoms.
A. Students who were close friends of the deceased had the lowest risk of suicidal ideation.
B. Exposed schools had less adaptive attitudes toward help-seeking.
C. Students in exposed schools had an elevated risk of severe suicidal ideation/behaviour, particularly when experiencing adverse life events concurrently.

6. Answers:

1: B. Overwhelming sadness and guilt
2: B. Providing additional counselling and mental health discussions
3: B.Parents should communicate openly and respectfully with their children
4: C. Unusual behaviour or statements indicating suicidal thoughts
5: D Students in exposed schools had an elevated risk of severe suicidal ideation/behaviour, particularly when experiencing adverse life events concurrently.

F.02
THE HEARTBREAKING REALITY OF STUDENT SUICIDE: INSIGHTS FROM TEACHERS' EXPERIENCES

Introductory Question:
How do teachers navigate the devastating aftermath of losing a student to suicide?

What You Will Learn:

1. **Profound Emotional Impact on Teachers:**
Teachers experience deep grief, guilt, and confusion following a student's suicide, illustrating the significant emotional toll. Personal narratives from teachers reveal the immediate and long-term emotional challenges they face.

2. **Importance of Postvention Strategies:**
Effective communication and support systems are crucial in managing the aftermath of a student's suicide in schools.
Schools need clear procedures to address such crises compassionately and efficiently.

3. **Challenges in Recognizing Warning Signs.** Identifying and interpreting warning signs of suicidal tendencies can be difficult, leading to guilt and self-blame among teachers.
Reflection on missed indicators highlights the need for better awareness and training.

4. **Role of Support Systems.** Coordinated responses from counselling teams and school administrations are essential for supporting affected individuals.

5. **Coping Mechanisms and Emotional Resilience.** Teachers find various ways to cope, including remembering positive moments and expressing care daily to their students.

6. **Impact of Teacher-Student Relationships**:
The narratives highlight the significant impact of a teacher's words and actions on their students, even in everyday interactions. Expressing affection and support regularly can have a profound and lasting effect.

Introduction:
Grieving a suicide loss is deeply personal, and The tragedy of student suicide casts a long and painful shadow over the educational community. Teachers, often seen as pillars of support and guidance, are left grappling with profound grief, guilt, and confusion. Although there are currently no qualitative research studies explicitly addressing the aftermath of student suicides in educational settings, personal narratives shared by teachers offer invaluable insights. These stories highlight the emotional toll on teachers and underscore the critical need for adequate school postvention strategies. By examining these heartfelt accounts, we can better understand the multifaceted impact of such tragedies and explore ways to support educators and students during these challenging times.

Narrative 1.
The anonymous teacher's account provides a vivid depiction of the immediate aftermath of a student's suicide within a school setting. The procedural elements, such as the announcement and the gathering of teachers, illustrate the school's response to the crisis. The narrative captures the collective shock and grief among students and staff and the teacher's struggle to maintain composure and provide support. This story emphasises the importance of having clear, compassionate communication strategies and support systems to help manage such tragic events.

"I will go anonymous on this one simply out of respect for the family. We lost a student last year. She was a beautiful vibrant almost 16 year old girl who was popular and well loved. And one Monday morning before school (…) She had mental health issues for years - that was well known. But she appeared to be on the improve at the time she died.
What was it like? Horrible. Confusing. And seared into my memory.

It started like a typical Monday morning. Roll call, class, same ol same ol. At 9:50 am an announcement came

over the PA asking all students to go to roll call and all teachers to come to the school office.

This seemed very weird but we went.
I was one of the first to the office and I was handed a small piece of paper and told to read it to my roll class.

'(Name of student) of Year 10 passed away this morning. If you have any questions or need to talk. There are councillors available. '

I walked into my roll call class in a daze. There will kids still arriving and they kept asking me what was wrong. I didn't reply - I didn't want to say this news more than once. I didn't want to say it at all - but I had to. Finally they were all sitting down. I stood up and said "I have some bad news." Then I read what was on the paper.

The kids were stunned. Two girls burst into tears straight away - both of them were friends with the girl who had died. In retrospect it seems like a needlessly cruel way for them to find out. Eventually the bell went again and we were told to go back to class. I had a Year 9 class next. The kids were all clearly stunned. I tried talking to them about what was happening but I don't think they had processed it yet. All the while in my mind I was thinking about the boys on my football team who I knew were in the same class as the girl who died. I was very worried about them - boys tend not to cope in situations like this and footy boys especially.

I tried reading a book to my class - one we were supposed to be reading. At one point I just stopped and said "Guys I don't remember anything I've just read and I don't think you've heard a word anyway.
Is it ok if we just sit here?" It was.

The rest of the morning is a blur. I found out later that the reason they told the whole school at once is because some of the kids had started to receive text messages saying that she had died and word was rapidly spreading through the school. About one hundred kids went home straight away.
I think for me the hardest part was trying to figure out what to do. As a teacher, we're supposed to have all the answers, but in this case, I was struggling just as much as the kids. All around me I could see grief and shock. I knew the girl, not massively well but I knew her.

That afternoon, I got a message to come up to the office. The foster brother of the girl who died had come up to school and he was asking to talk to me. I quickly got another teacher to cover my classes and went up to the office. The brother was there along was his friend. I knew both boys, had taught both of them and knew their families a bit.

The next two hours were basically just spent with me listening, and he poured out his story. He was the one who found her, (...) and who tried to save her life. It was gut-wrenching and stunning and also a little bit remarkable - this fourteen-year-old kid who had just been through this horrific experience, and he was somehow still standing.

I don't know how he wasn't crying in a heap. Yet somehow he wasn't.

And I guess that's pretty much what I learned over the following days, weeks and months. How teenagers who at times seem so one dimensional and so selfish and so immature can shock me with their depth, their compassion and their understanding". Quora User

Narrative 2.
This narrative reveals the chaotic and self-blaming emotions that follow a student's suicide. The teacher's reflection on missed warning signs, such as poems and messages, underscores the difficulty in identifying and interpreting such indicators. The story also touches on the strained relationships that can result from suicide, as illustrated by the teacher's interactions with the student's father. The recurring dreams of the student smiling suggest a complex process of grief and the longing for closure.

"(...) It was really devastating and chaotic. I blamed myself for not being there, for not seeing the signs, for turning a blind eye. I should have seen it in the poems he wrote, in the messages he sent, in the wounds he once showed me when he was still alive. I was there when his father dismissed my concern about him being sad (...)
His parents never spoke to me after that. Even to his friends, especially his father. He blamed them for everything, perhaps, including me. I never got the courage to face him and tell him that he didn't listen to me when I told him about his son. Until this day, I grieve.

His death anniversary is just more than a month away. I would never forget his smile. A couple of times I dreamt about him. In both dreams, he was smilimg at me but never talking. It was as if he was telling me he was fine." Quora User

Narrative 3.

This brief yet touching narrative emphasises the importance of expressing care and affection to students daily, as illustrated by the teacher's last words to the student. The teacher's coping mechanism of remembering the joy and love shared with the student highlights a positive approach to dealing with grief. This story serves as a reminder of the profound impact of a teacher's words and actions on their students, even in seemingly ordinary moments.

"(…) She was dismissed early on her last day for a "doctor appointment," and the last thing she said to me was, "But this is fun! I don't want to go yet!" (We were in the middle of some math games, and math was her favorite.)
**To my everlasting gratitude, my last words to her were, "See you soon, sweetheart! I love you!" Because of (…), I say that now to all (…) at the end of every day, because you never know.*
(…) How do I cope? By always remembering them, and by treasuring the time I had with them. There was so much joy and love that can't be erased by the sorrow." Quora user

Narrative 4.

The narrative of the teacher who received the devastating news about a friend's son illustrates the immediate personal and professional challenges teachers face in the wake of a student's suicide. The principal's swift mobilisation of counselling resources reflects the importance of a coordinated community response. This story also highlights the delicate balance needed when discussing suicide to prevent additional harm. The extensive support provided by the counselling team underscores the crucial role of mental health professionals in the postvention process.

"My friend's 14yo son took his own life. The family lived in a small country town, where I worked at the local primary school. I had previously taught his younger brother at a different school in the larger town nearby (before shifting to the local school where the boys had previously attended). I got the call (the worst phone call I'd ever taken) at about 8am and ran out of my classroom in a panic to go and be with my friend. On my way I saw my principal, who had taught the boy several years ago, and blurted it all out. On reflection, it was an awful way to break the news to her, but I wasn't thinking clearly. I told her I had to go but would be back as soon as I could. She told me to take my time.

I went round to my friend's house (very close to the school) and did what little I could to comfort her until others from her support network arrived to be with her. It was terrible. I then went back to school.
I found that in the 2 hours I'd been gone, my principal had immediately contacted the local high school (the boy didn't actually attend this school, but she felt they would need to know as, coming from a very small town, they were a tight-knit community). They had got their counselling team together and arranged to rally around all the kids from this little town to make sure they heard the news as gently as possible before being confronted with it on social media. They had also sent a counsellor across to my school just to support me.

In the days and weeks that followed, they continued to provide support for students close to the boy. There's a fine line to walk when discussing these issues, as there can be a flow-on effect which can potentially lead to more suicides/self-harm harm, etc. I am very thankful for the counselling team who went above and beyond to support those kids and the wider community. They even put on an event in our small town inviting kids (and adults) from the boy's sporting team, to offer them support and counseling too. Quora User

Narrative 5

Jessica Lyons' experience is a poignant illustration of the profound emotional impact a student's suicide can have on a teacher. Her narrative underscores the immense guilt and helplessness teachers often feel despite their efforts to foster a supportive environment. This story highlights the critical need for ongoing mental health advocacy and the importance of providing teachers with the tools and support to recognise and address student distress effectively.

Here are excerpts from Jessica Lyons' LinkedIn article published on April 13, 2023, titled "The Heartbreaking Guilt and Reality of Losing a Student to Suicide" (https://www.linkedin.com/pulse/heartbreaking-guilt-reality-losing-student-suicide-jessica-lyons):

"As a teacher with many years of experience, I have seen my fair share of tragedies and heartbreaks, but nothing could have prepared me for the news that one of my students had committed suicide today. It is a loss that will forever be etched in my heart and soul.

I have always been an advocate for open communication about mental health. I have stressed to my students the importance of seeking help when they are struggling, and I have worked to create a safe and supportive environment where they feel comfortable

doing so. However, despite my efforts, I can't help but feel a deep sense of guilt. It feels like a punch to the gut, and I'm left feeling absolutely shattered. How could someone so young and full of promise be gone so suddenly? As I sit here trying to come to terms with the tragedy, I can't help but wonder if I had missed any warning signs. Had I failed to recognise the signs of distress that he was experiencing? Could I have done something more to help prevent this tragedy?

The guilt I feel is overwhelming. As a teacher, I have a responsibility to ensure the safety and well-being of my students. My job is to create a validating and nurturing environment where students feel at ease sharing their struggles. I can't help but feel like I had somehow failed this student.

I am told that suicide is such a complex issue that it is expected to leave those affected feeling a range of emotions, from confusion and guilt to sadness and anger. I am told that as a teacher, it is normal for us to have an especially difficult grappling with the news of a student's suicide (…). I am told it is normal to wonder how this could have happened and why this student was unable to get the help they needed.

None of this feels normal.
"To my student who took his own life, I want you to know that you were loved and valued. Your potential was limitless, and it breaks my heart to know that we will never see the full extent of it.

You were a bright and curious student, eager to learn and explore. You had a smile that lit up the room and a contagious laugh that brought joy to those around you.

It is tough to comprehend how someone so young and full of promise could be gone so suddenly. You had a future full of possibilities, and it is heartbreaking to know that we will never see the full breadth of your potential. (…)
Your tragic death has only strengthened my resolve to fight for suicide prevention. I will continue to advocate for mental health awareness and work to create a safe environment where students feel comfortable seeking help. I will fight to prevent this tragedy from happening to anyone else, and your memory will serve as a constant reminder of the importance of this work. Rest in peace, dear student. You will be deeply missed, but your memory will live on forever."

Conclusions

Despite the lack of specific qualitative research on the aftermath of student suicides in educational settings, personal narratives from teachers offer invaluable insights into this deeply personal and painful experience. These stories emphasise the profound emotional impact on teachers, who often grapple with grief, guilt, and confusion. They highlight the critical need for effective postvention strategies in schools, which include clear and compassionate communication procedures and robust support systems.
The narratives reveal the challenges teachers face in recognising warning signs of suicidal tendencies, often leading to feelings of self-blame. This underscores the necessity for improved awareness and training to help educators identify and interpret these indicators more effectively. Community and professional support is also crucial, as illustrated by the coordinated responses of counselling teams and school administrations in providing much-needed assistance to affected individuals.

Furthermore, the stories demonstrate various coping mechanisms teachers employ, such as remembering positive moments and expressing daily care to their students, which aid in building emotional resilience. The significant impact of teacher-student relationships is evident, highlighting the importance of regular expressions of affection and support, which can have a lasting effect.

Overall, these narratives stress the need for enhanced postvention strategies, ongoing mental health training for teachers, and a strong support network involving mental health professionals and the community. The personal accounts also underscore the importance of fostering positive teacher-student relationships, which can be crucial in preventing and recovering from such tragic events.

Takeaways:

1. Emotional Impact on Teachers: Teachers experience profound grief, guilt, and confusion after the suicide of a student. These emotions can be overwhelming and long-lasting, affecting their professional and personal lives.
2. Challenges of Identifying Warning Signs: Despite their efforts, teachers often struggle with guilt and self-blame, questioning if they missed any warning signs or could have done more to prevent the tragedy.
3. Coping Mechanisms: Teachers cope with the loss of

a student in various ways, from seeking support from colleagues and counselling services to holding on to positive memories of the student. These strategies are essential for their emotional healing and continued ability to support their students.

4. Importance of Mental Health Advocacy: Teachers like Jessica Lyons emphasise the necessity of advocating for mental health awareness and open communication. Fostering a supportive environment where students feel at ease seeking help is vital.

5. Role of Support Systems: Effective postvention strategies, including immediate communication, counselling, and community support, are vital in helping both teachers and students cope with the loss. Schools must have robust systems in place to address the emotional needs of the educational community.

References:

Peace, J. L. (2016). Suicide Postvention: How to Help the Bereaved Move Forward. https://core.ac.uk/download/200292351.pdf

Lyons J. LinkedIn "The Heartbreaking Guilt and Reality of Losing a Student to Suicide" published on April 13, 2023. (https://www.linkedin.com/pulse/heartbreaking-guilt-reality-losing-student-suicide-jessica-lyons)

Multiple-Choice Questions:

1. In Narrative 1, how did the school initially inform students about the death of their peer?

A. Through an email
B. A phone call to each parent
C. Via a public announcement and a note read by teachers
D. By a school assembly

2. In Narrative 4, what immediate action did the principal take after hearing about the student's death?

A. Cancelling all classes for the day
B. Contacting the local high school for support
C. Ignoring the news
D. Sending all students home

3. What common theme is expressed by the teachers in all narratives after the loss of a student to suicide?

A. A sense of personal failure
B. A feeling of triumph
C. A belief in inevitable fate
D. A sense of professional success

4. According to Jessica Lyons, what is a significant emotional response she feels after losing a student to suicide?

A. Anger
B. Relief
C. Guilt
D. Indifference

5. What has Jessica Lyons always advocated for in her teaching approach?

A. Strict discipline
B. Open communication about mental health
C. Academic excellence
D. Competitive spirit

6. What postvention methods can be found in narratives 1-5? Check all the correct answers.

A. Implementing a policy for informing students about the death
B. Listening to students who seek someone they trust to talk to
C. Increasing the number of counsellors available to anyone who wishes to speak about their grief
D. All the above

Answers:

1: C. Via a public announcement and a note read by teachers
2: B. Contacting the local high school for support
3: A. A sense of personal failure
4: C. Guilt
5: B. Open communication about mental health
6: D. All the above

F.03
POSTVENTION POLICIES IN EDUCATIONAL SETTINGS: BEST PRACTICES FOR SUPPORTING STUDENTS AND PREVENTING YOUTH SUICIDE

Introductory Question:
How can schools effectively support students and prevent further tragedies in the aftermath of a suicide?

What You Will Learn:

1. **Importance of Building Relationships and fostering Connectedness:** Social-emotional learning and school connectedness protect against suicide by fostering students' sense of belonging and nurturing connections with adults and the community.
2. **Postvention Practices Tailored to Different Age Groups:** Understanding how students at different developmental stages process and react to suicide is crucial for effective postvention.
3. **Significance of a Postvention Plan:** A well-prepared postvention plan helps restore equilibrium, promote healthy grieving, commemorate the deceased, and minimise adverse outcomes.
4. **Trauma-Informed Response to Suicide Death:** Implementing trauma-informed principles, such as ensuring safety, trustworthiness, collaboration, empowerment, and cultural sensitivity, guides the school's response to suicide.
5. **Integrating Suicide Prevention into School Curriculum and Crisis Response Training:** Post-suicide, integrating suicide prevention programming into the curriculum encourages open discussions about mental health and a crisis response plan, with staff trained in suicide prevention and postvention.

Introduction:
Youth suicide is a deeply distressing and multifaceted challenge, profoundly affecting not only schools but also families and communities. Given that students spend a substantial portion of their time in educational environments, schools hold a pivotal position in postvention efforts—providing essential support to those impacted by suicide while striving to prevent future tragedies. This article explores the best practices for postvention in schools, drawing on research and real-life narratives to illustrate effective strategies and their importance.

Building Relationships and Fostering Connectedness

Muller and colleagues (2022) underscore the significance of cultivating strong connections with parents, guardians, and community stakeholders. Before any crisis planning or suicide postvention, establishing collaborative efforts and cohesion among these groups is critical for suicide crisis preparedness and active postvention response (Cerel & Campbell, 2008; Williams et al., 2022).

Proactive integration of social-emotional learning in schools not only fosters student well-being but also serves as a vital foundation for future initiatives aimed at suicide prevention and postvention. Protective factors encompass students' sense of belonging within their school community, nurturing connections with adults and the broader community, and cultivating effective coping mechanisms. School connectedness serves as a protective shield against the risk of suicide (Marraccini & Brier, 2017). Building strong, positive relationships between students, social workers, teachers, and other school staff is essential. So that students can trust adults to speak to during postvention crises (King, 2001). Proactive implementation of social-emotional learning in schools promotes student well-being and supports future suicide postvention efforts. (Weare & Nind, 2011).

Postvention Practices in Different Age Groups

Preschool: Students display "magical thinking" with little understanding of the permanence of death, sometimes seeming "casual" or even excited about rituals surrounding death.

Postvention: Description of positive memories of the deceased and concrete pictures or mementoes.

Elementary: Students are developmentally self-focused and may worry about how suicide may impact them or their families.
Postvention: Reassurance that students are safe and their families will not substantially change.

Middle School: Students are beginning to individuate and are more peer-centric as they separate from their parents. They may feel concern or guilt that they should have foreseen or prevented the death.
Postvention: They may benefit from discussing the facts surrounding the death, information they may not have had, and addressing feelings of responsibility. They may require more intensive counselling if they had significant conflicts with the deceased before the suicide.

High School: Students can recognise the finality of the person's death and understand that this will be the person's "identity" in life.

Postvention: Discussing the meaning of the student's life and what will persist after the funeral. Considering the nature of interpersonal relationships between the deceased and peers is essential, as these factors might contribute to others' vulnerabilities.

Why a Postvention Plan is Helpful

Aim: Postvention services aim to restore equilibrium to the school, promote healthy grieving, commemorate the deceased, minimise adverse outcomes, provide psychoeducation, and increase empowerment and mutual support for the community (Berkowitz et al., 2011). Having best practices for postvention is crucial to prevent youth suicide. Since young people spend a significant portion of their lives in schools, these institutions play a vital role in postvention efforts (Wyman, 2014).

Time: All crisis plans should be developed in advance to enable a swift staff response and reduce the severity and duration of negative impacts (Owens, 2014). A readily available postvention plan helps guide survivors and provides hope for moving forward. An essential benefit of postvention services is connecting survivors with support groups.

Theoretical Model: "The school crisis plan should be based on a theoretical model and address the uniqueness of the school's location and student population" (Owens, 2014; Pearce, 2016).

When to Start Postvention

"In working with survivors, it is best to begin postvention as soon as possible after the tragedy, within the first 24 hours if possible" (Leenaars & Wenckstern, 1998; Williams & Wexler et Muelle, 2022).

Active postvention starts the healing process by reaching out to suicide survivors immediately or soon after a suicide occurs with in-person support.

"Interaction with individuals who respond first to a suicide is crucial as it can influence the way that the bereaved move forward in the grief process" (McKinnon & Chonody, 2014; Peace, 2016).

Practical Coping Skills (Aaron et al., 2018)

- Use simple relaxation and distraction skills, such as taking three deep breaths, counting to ten, or picturing a favourite calm and relaxing place.
- Engage in favourite activities or hobbies, such as music, talking with a friend, reading, or watching a movie.
- Engage in physical exercises and training.
- Reflect on how they have coped with difficulties and remind them that they can use those coping skills now.
- Write a list of people they can turn to for support.
- Write a list of things they are looking forward to.
- Focus on individual goals, such as returning to a shared class or spending time with mutual friends.

Telephone Conversation with Parents of the Deceased Student

- Start by expressing your condolences.
- Ask the student's family about their wishes on how to inform the school about the death, including what to say and what not to say.
- Explain that rumours can be worse than reality and that providing students with information will give them more support for coping with the loss.
- Respect their decision about what information they want shared.
- Ask if they know any students with whom the deceased was in contact, as these individuals may require more support.
- Inform them that they can receive support for themselves and their children from a grief therapist who will be available at the school.
- Explain that help-seeking can be hindered by shame but that overcoming this shame can bring relief and initiate recovery after the loss.
- Emphasise that adults who know how to talk about complex issues and understand the mourning process can best support their children experiencing grief.

- Reference Collins' (1990) interaction ritual chain theory posits that re-engaging and restoring group solidarity leads to "emotional energy."

Trauma-Informed Response to Suicide Death

The described postvention activities use SAMHSA's trauma-informed principles to frame the school's decision-making, actions, and support for youth (Mirrick et al., 2023). These principles guide the school's response:

- Physical and emotional safety.
- Trustworthiness and transparency.
- Collaboration and mutuality.
- Empowerment, voice, and choice.
- Peer support.
- Attention to cultural, historical, and gender issues.

Integrating Suicide Prevention into School Curriculum

Following a suicide, many schools work to integrate suicide prevention programming into the curriculum and culture, encouraging open discussions about mental health. Schools may include suicide prevention content in health classes, hold annual mental health awareness days, or create school-wide education on mental health, resilience, and suicide (e.g., Question Persuade Respond (QPR), SOS Signs of Suicide (SOS), Youth Aware of Mental Health (YAM)), possibly including universal screening for behavioural health concerns (Singer et al., 2019).

Schools may also develop ongoing support systems through partnerships with community agencies, which can alleviate the pressure on school staff to be the sole support system for youth. Schools can participate in community coalitions focused on suicide prevention and fostering resilience, promoting mental health as a shared community responsibility.

Crisis Response Plan and Training

Only half of school psychologists report that their schools have a crisis response plan (O'Neill, 2017). To provide high-quality postvention services, all schools should ensure a crisis response plan that follows best practices and transparent policies, ensuring consistent responses to all types of death (AFSP, 2018). State educational policies requiring schools to do this work provide systemic support for high-quality postvention services.

School staff, including administrators, should attend routine training on mental health, suicide, and postvention (Diefendorf et al., 2022). Many mental health staff are unprepared for postvention work; in one study, 70% of school psychologists reported being not knowledgeable about suicide contagion (O'Neill, 2020). Social workers also lack preparation, with only one in four MSW practice instructors teaching about postvention (Mirick, 2022).

Strategies for Building a Supportive Culture

Along with continuing education, schools can build a supportive culture through:

- Yearly universal screening for depression and suicide.
- Including mental health in health classes.
- Universal education on depression and supporting peers.
- Open conversations about suicide and stigma.
- Creating strong relationships with community organisations.
- Research and Best Practices

A significant limitation in postvention work is the lack of research on postvention activities (Williams et al., 2022). Research is essential to ensure current practices meet students' needs and support staff and administration through suicide loss (Williams et al., 2022). Best practices will evolve as risk factors, students' expectations, access to social media, and needs change. Future research should explore how best practices can be effectively applied in various settings following a suicide so that social workers in all types of agencies are better prepared to provide support and guidance.

Conclusion:

Grief Implementing comprehensive postvention policies in schools is essential for supporting students and preventing further incidents of suicide. By fostering a connected and supportive environment, engaging in proactive social-emotional learning, and collaborating with community stakeholders, schools can create a safe space for students to grieve, heal, and find hope. Continuous education and research on postvention practices are vital to adapting to the evolving needs of students and ensuring the effectiveness of support systems.

Takeaways:

1. Importance of Postvention Plans: Having a crisis response plan in place helps schools respond quickly and effectively to a suicide, minimising negative impacts.
2. Supportive Environment: Creating a school environment where students feel safe, connected, and supported by trusted adults is crucial in reducing suicide risk and aiding postvention efforts.
3. Community Collaboration: Building relationships with parents, guardians, and community stakeholders

enhances the effectiveness of suicide postvention and prevention.

4. Proactive Social-Emotional Learning: Implementing social-emotional learning programs supports student well-being and prepares schools for effective postvention.

5. Trauma-Informed Care: Applying trauma-informed principles in postvention responses ensures that the needs of bereaved students are met with sensitivity and support.

References:

AFSP. (2018). After a suicide: A toolkit for schools (2nd ed.). American Foundation for Suicide Prevention. Retrieved June 24, 2024 from https://afsp.org/after-a-suicide-a-toolkit-for-schools/

Aluri, J., Haddad, J. M., Parke, S., Schwartz, V., Joshi, S. V., Menon, M., & Conrad, R. C. (2023). Responding to Suicide in School Communities: An Examination of Postvention Guidance from Expert Recommendations and Empirical Studies. *Current psychiatry reports*, *25*(8), 345–356. https://doi.org/10.1007/s11920-023-01431-x

Berkowitz, L., McCauley, J., & Mirick, R. [n.d.]. Riverside Trauma Center postvention guidelines. Retrieved June 20, 2024 from http://traumacenter.wpengine.com/wp-content/uploads/2015/03/Postventionguidelines.pdf

Cerel, J., & Campbell, F. R. (2008). Suicide survivors seeking mental health services: a preliminary examination of the role of an active postvention model. *Suicide & life-threatening behavior*, *38*(1), 30–34. https://doi.org/10.1521/suli.2008.38.1.30

Collins, R. (1990). Interaction ritual chains. American Sociological Review, 55(5), 765-780. Retrieved June 2024 from https://doi.org/10.1515/9781400851744

Diefendorf, S., et al. (2022). Continuing education and training for school staff on mental health and postvention. Retrieved June 14, 2024 from https://link.springer.com/chapter/10.1007/978-3-031-06127-1_6

King K. A. (2001). Developing a comprehensive school suicide prevention program. *The Journal of school health*, *71*(4), 132–137. https://doi.org/10.1111/j.1746-1561.2001.tb01310.x

Leenaars, A. A., & Wenckstern, S. (1999). Suicide prevention in schools: The art, the issues, and the pitfalls. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 20*(3), 132–142. https://doi.org/10.1027/0227-5910.20.3.132

Marraccini, M. E., & Brier, Z. M. F. (2017). School connectedness and suicidal thoughts and behaviors: A systematic meta-analysis. *School psychology quarterly : the official journal of the Division of School Psychology, American Psychological Association*, *32*(1), 5–21. https://doi.org/10.1037/spq0000192

McKinnon, J. M., & Chonody, J. (2014). Exploring the formal supports used by people bereaved through suicide: A qualitative study. Social Work in Mental Health, 12(3), 231–248. https://doi.org/10.1080/15332985.2014.889637

Mirick, R. G., et al. (2023). Implementing trauma-informed postvention in schools. Retrieved from https://schoolcrisishealing.org/wp-content/uploads/2023/09/Trauma-Informed-School-based-Postvention-Services-Clinical-Social-Work-Journal34.pdf

O'Neill, J. C., Marraccini, M. E., Bledsoe, S. E., Knotek, S. E., & Tabori, A. V. (2020). Suicide postvention practices in schools: School psychologists' experiences, training, and knowledge. *School psychology (Washington, D.C.)*, *35*(1), 61–71. https://doi.org/10.1037/spq0000331

Owens, C., Owen, G., Belam, J., Lloyd, K., Rapport, F., Donovan, J., & Lambert, H. (2011). Recognising and responding to suicidal crisis within family and social networks: qualitative study. *BMJ (Clinical research ed.)*, *343*, d5801. https://doi.org/10.1136/bmj.d5801

Peace, J. L. (2016). Suicide postvention: How to help the bereaved move forward. https://anyflip.com/aqgq/unub/basic/51-68

Pearce C, (2019) The Public and Private Management of Grief Recovering Normal. ISBN 978-3-030-17661-7 ISBN 978-3-030-17662-4 (eBook) https://doi.org/10.1007/978-3-030-17662-4

Pearce, S., & Pickard, H. (2013). How therapeutic communities work: specific factors related to positive outcome. *The International journal of social psychiatry*, *59*(7), 636–645. https://doi.org/10.1177/0020764012450992

Sokol, R. L., Heinze, J., Doan, J., Normand, M., Grodzinski, A., Pomerantz, N., Scott, B. A., Gaswirth, M., & Zimmerman, M. (2021). Crisis Interventions in Schools: A Systematic Review. *Journal of school violence*, *20*(2), 241–260. https://doi.org/10.1080/15388220.2021.1879098

Singer, J. B., Erbacher, T. A., & Rosen, P. (2019). School-based suicide prevention: A framework for evidence-based practice. *School mental health*, *11*, 54-71. https://doi.org/10.1007/s12310-018-9245-8

Weare, K., & Nind, M. (2011). Mental health promotion and problem prevention in schools: what does the evidence say?. *Health promotion international*, *26*(suppl_1), i29-i69. https://doi.org/10.1093/heapro/dar075

Williams, D. Y., Wexler, L., & Mueller, A. S. (2022). Suicide Postvention in Schools: What Evidence Supports Our Current National Recommendations?. *School social work journal*, *46*(2), 23–69.

Wyman P. A. (2014). Developmental approach to prevent adolescent suicides: research pathways to effective upstream preventive interventions. *American journal of preventive medicine*, *47*(3 Suppl 2), S251–S256. https://doi.org/10.1016/j.amepre.2014.05.039

Multiple-Choice Questions:

1. What is the primary aim of postvention services in schools?
A. To punish those responsible for the tragedy
B. To restore equilibrium, promote healthy grieving, and support the community
C. To provide academic support
D. To ignore the incident and move on

2. When should postvention efforts ideally begin following a suicide?
A. Within the first 24 hours
B. After one week
C. After one month
D. Whenever convenient

3. Which strategy is NOT mentioned when creating a supportive school environment?
A. Yearly universal screening for depression
B. Holding an mental health awareness day
C. Ignoring students' mental health needs
D. Promoting open conversations about suicide and stigma

4. What role do community stakeholders play in suicide postvention?
A. They are not involved.
B. They help build a foundation for collaborative efforts and provide additional support.
C. They only criticise the school's efforts
D. They replace the school's responsibilities

5. Why is ongoing education important for school staff in postvention?
A. To maintain their teaching licenses
B. To stay informed about best practices and support students effectively
C. To prepare for non-suicide-related crises
D. To ensure they follow administrative orders without question

Answers:
1: B. To restore equilibrium, promote healthy grieving, and support the community
2: A. Within the first 24 hours
3: C. Ignoring students' mental health needs
4: B. They help build a foundation for collaborative efforts and provide additional support
5: B.To stay informed about best practices

F.04
NAVIGATING TRAGEDY: A TRAUMA-INFORMED APPROACH TO SCHOOL-BASED POSTVENTION SERVICES

Introductory Question:
How can schools effectively support students and staff in the wake of a tragic suicide, fostering healing and preventing further trauma?

What You Will Learn:
1. Identifying the role of a school crisis team in managing post-suicide responses.
2. Strategies for effective communication and rumour control.
3. Identifying and supporting at-risk students.
4. Involving families and the school community in the healing process.
5. Long-term support and prevention strategies to build resilience.

Introduction:
The unexpected suicide of a student is a profound tragedy that can profoundly affect a school community. In such a critical moment, the school crisis team must act swiftly and compassionately to support students, staff, and families. This case study by Merrick et al. (2023) illustrates a trauma-informed approach to school-based postvention services, offering a roadmap for crisis intervention, communication, and long-term support. Through the coordinated efforts of the crisis team, this approach aims to foster a sense of safety, address grief, and prevent further trauma within the school community.

EXAMPLE OF POSTVENTION IN EDUCATIONAL SETTING

Situation: A social worker (SW), the coordinator of a school crisis team, was informed by a manager about a student's suicide just as she was about to leave work at 4:00 pm. This was her first experience dealing with such trauma, and she felt overwhelmed.

The SW took a few deep breaths to calm herself.

I. Day 1 (Day of Notification)

A. Acute Crisis Team Meeting

The SW called an urgent crisis team (CT) meeting for 5:00 pm. She began the meeting by reviewing the school's crisis plan and listing tasks for the team:

- Introduce clear communication to limit rumours.
- Create a safe space and support for affected students. This included calling for additional mental health support from other schools and agencies in the district.
- Create a list of students most likely to be traumatised by the student's death, including friends, chess teammates, classmates, and students with a history of trauma, recent loss, or suicidal thoughts and behaviours.

List of people who may need postvention

1. Siblings and friends
2. First responders or those who discovered the body
3. Resident life staff who knew the deceased or had dealt with other campus tragedies
4. Academic and student affairs staff who had close relationships with the student
5. Students struggling with psychiatric symptoms exacerbated by the event
6. Students who knew the deceased student: dorm mates, academic department peers, club/activity members, teammates, high school peers, or those from the same hometown
7. Students who identify with the deceased (e.g., athletes, artists)

The crisis team used the "Circles of Vulnerability" model to assess the emotional impact on community members, considering:

- Psychosocial proximity
- Geographic proximity
- Populations at risk

Symptoms indicating PTSD include avoidance of reminders, negative cognitions, re-experiencing the event, increased arousal, poor concentration, or sleep disruption a month after the event. Students showing these symptoms should be referred for individualised treatment and screened for depression.

- Assign an adult with a relationship with the student (e.g., teacher, coach, guidance counsellor) to check in individually with each student on the list. Be observant of additional vulnerable students who may not be on the list.

B. Visiting the Deceased Student's Family

After the meeting, a team manager and the school principal visited the deceased student's parents and siblings. They offered condolences and discussed how the parents wished to share information about the death. Initially, the parents did not want the death identified as a suicide.

The SW explained that identifying the death as a suicide could facilitate conversations about mental health and suicide prevention at school. Eventually, the parents agreed, and the school could inform students about the suicide.

C. Preparation of Notification Statements

The crisis team manager drafted statements for notifying:

Teachers:
"With great sadness, we inform you that [name], one of our [role], has died. A meeting will be held on [date] at [time] in [place] to provide details and support."

Students:
"I am sorry to inform you that [name] died yesterday. Let us honour their memory with a moment of silence. [Further details about support and next steps.]"

Parents:
"Dear Parents, we regret to inform you about the suicide of [name], a member of our school community. [Details about support and resources for students.]"

II.Day 2: Notifying Students & Restoring Equilibrium

1. **Before-School Staff Meeting:**
The Crisis Team leader holds a meeting to check in with staff and plan for the day. Teachers are asked to postpone tests and homework but maintain a routine to create feelings of safety and predictability.

2. **Student Station Support:**
The Crisis Team leader organises a support space in the library for distressed students, staffed with counsellors from nearby schools and community clinics. Different stations were set up for students to create cards and messages for the deceased student's family.

3. **Notifying Students and Class Support:**
Teachers read the notification statement to students, answer questions, and identify those needing additional support. The Crisis Team leader attends classes to support teachers and students. They address rumours, provide psychoeducation about grief after suicide, and emphasise the importance of open communication.

4. **Mitigating Rumors on social media:**
The Crisis Team leader acknowledges rumours and provides transparent, factual information, emphasising mental health support and help-seeking behaviour. If the family does not want the cause of death disclosed, staff acknowledges the rumours and focuses on supporting students' emotional needs.

5. **Individual Student Support:**
Student A: Struggles with anxiety and restlessness. A Crisis Team member reassures him that different reactions to trauma are normal.
Student B: Expresses concern for a classmate's social media post. A Crisis Team member meets with the student to assess the suicide risk and provides support.

Other issues:
1. **Normalising Grief Responses:**
The school counsellors promote healthy grieving, addressing the various ways grief can manifest. Counsel**l**ing staff helped shift the narrative to normali**s**e different grief responses and cultural variations in grief.

2. **Participation in Funeral:**
The Crisis Team leader contacted the funeral director and informed parents about the funeral, recommending that students attend with a caregiver. Caregivers supported students who might have found the funeral triggering.

3. **Psychoeducation:**

- **Evening Forum for Parents:** The school organised an evening forum to educate parents about supporting their children and the school's postvention plan.

- **Evening Forum for Youth Education:** Students learned about grief, trauma, and suicide bereavement, avoiding triggering details and normalising their responses.

- **Evening Forum for Teacher Education:** Staff received training on coping with grief and supporting students.

4. **Commemorating the Deceased:**
Senior students propose a memorial bench, but the Crisis Team leader suggests alternative ways to commemorate their friend that would not be triggering or contribute to suicide contagion. They agree to plan an event to promote Safety Planning instead. The Crisis Team balanced students' grieving needs with preventing suicide contagion, avoiding permanent memorials and focusing on the life of the deceased. The Crisis Team leader highlights the complexity of suicide and the importance of help and hope, shifting the narrative to reduce contagion risk.

5. **Long-term Support - Empowering Students:**
The school integrated mental health, suicide prevention, and healthy coping into the curriculum. Students formed a club focused on resilience and school connectedness, meeting monthly to monitor prevention efforts and foster community support.

Conclusion:

The trauma-informed approach to school-based postvention services outlined in this case study provides a comprehensive framework for schools dealing with the aftermath of a student's suicide. Schools can navigate these difficult situations more effectively by focusing on clear communication, identifying and supporting at-risk students, involving families, and fostering long-term resilience. Implementing these strategies can help mitigate the impact of such tragedies and support the school community's overall mental health and well-being.

Takeaways:

1. Clear Communication: Establishing clear and compassionate communication channels is crucial to limit rumours and providing accurate information.
2. Support for At-Risk Students: Identifying and supporting students most affected by the tragedy helps address immediate mental health needs.
3. Family Involvement: Engaging with the deceased student's family and respecting their wishes plays a vital role in the community's healing process.
4. Psychoeducation: Providing education on grief, trauma, and mental health to students, staff, and parents fosters understanding and reduces stigma.
5. Long-Term Resilience: Integrating mental health and suicide prevention into the school curriculum promotes a culture of open conversation and support.

References:

Abrutyn, S., & Mueller, A. S. (2014). Are suicidal behaviours contagious in adolescence? Using longitudinal data to examine suicide suggestion. American Sociological Review, 79(2), 211–227.
https://doi.org/10.1177/0003122413519445

American Foundation for Suicide Prevention (AFSP). (2018). After a suicide: A toolkit for schools (2nd Ed.). Education Development Center.
https://afsp.org/after-a-suicide-a-toolkit-for-schools

Andriessen, K., et al. (2016). Pre-and post-loss features of adolescent suicide bereavement: A systematic review. Death Studies, 40(4), 229–246.
https://doi.org/10.1080/07481187.2015.1128497

Berkowitz, L., McCauley, J., & Mirick, R. [n.d.]. Riverside Trauma Center postvention guidelines. Retrieved June 20, 2024 from http://traumacenter.wpengine.com/wp-content/uploads/2015/03/Postventionguidelines.pdf

Diefendorf, S., et al. (2022). Continuing education and training for school staff on mental health and postvention. Retrieved June 14, 2024 from https://link.springer.com/chapter/10.1007/978-3-031-06127-1_6

Ackerman, J. P., & Horowitz, L. M. (2022). *Youth suicide prevention and intervention: Best practices and policy implications* (p. 169). Springer Nature.
https://library.oapen.org/bitstream/handle/20.500.12657/58358/1/978-3-031-06127-1.pdf

Gould, M. S., et al. (2018). Exposure to suicide in high schools: Impact on serious suicidal ideation/behaviour, depression, maladaptive coping strategies, and attitudes toward help-seeking. International Journal of Environmental Research and Public Health, 15, 455–472.
https://doi.org/10.3390/ijerph15030455

Jordan, J. R. (2017). Postvention is prevention—the case for suicide postvention. Death Studies, 41(10), 614–621.
https://doi.org/10.1080/07481187.2017.1335544

Jordan J. R. (2020). Lessons Learned: Forty Years of Clinical Work With Suicide Loss Survivors. Frontiers in psychology, 11, 766.
https://doi.org/10.3389/fpsyg.2020.00766

Jordan, J. R. (2012). "Guided imaginal conversations with the deceased," in Techniques of Grief Therapy: Creative Practices for Counseling the Bereaved, ed. R. A. Neimeyer (New York, NY: Routledge), 262–265.

Leaune, E., Cuvillier, B., Vieux, M., Pacaut-Troncin, M., Chalancon, B., Perez, A. F., Haesebaert, J., Chauliac, N., Poulet, E., & Durif-Bruckert, C. (2020). The SUPPORT-S Protocol Study: A Postvention Program for Professionals After Patient or User Suicide. Frontiers in psychology, 11, 805.
https://doi.org/10.3389/fpsyg.2020.00805

McGill, K., Bhullar, N., Batterham, P. J., Carrandi, A., Wayland, S., & Maple, M. (2023). Key issues, challenges, and preferred supports for those bereaved by suicide: Insights from postvention experts. *Death studies*, *47*(5), 624–629.
https://doi.org/10.1080/07481187.2022.2112318

Mirick, R. G., et al. (2018). Lessons learned from ten years of using school-based screenings for suicide postvention. School Social Work Journal, 43(1),20–37.
https://eric.ed.gov/?id=EJ1206799

Mirick, R. G., Bridger, J., & McCauley, J. (2022). Trauma-Informed Clinical Practice with Clients with Suicidal Thoughts and Behaviors. *Smith College Studies in Social Work*, *92*(3), 169–184.
https://doi.org/10.1080/00377317.2022.2104778

Mirick, R. G., & Berkowitz, L. (2023). School-Based Postvention Services: Exploring the Perspectives of Students. Children & Schools, 45(4), 233–242.
https://doi.org/10.1093/cs/cdad020

O'Neill, J. C., Marraccini, M. E., Bledsoe, S. E., Knotek, S. E., & Tabori, A. V. (2020). Suicide postvention practices in schools: School psychologists' experiences, training, and knowledge. *School psychology (Washington, D.C.)*, *35*(1), 61–71.
https://doi.org/10.1037/spq0000331

Singer, J. B., Erbacher, T. A., & Rosen, P. (2019). School-based suicide prevention: A framework for evidence-based practice. *School mental health*, *11*, 54–71.
https://doi.org/10.1007/s12310-018-9245-8

Substance Abuse and Mental Health Services Administration [SAMHSA] (2023) Practical Guide for Implementing a Trauma-Informed Approach.
https://store.samhsa.gov/sites/default/files/pep23-06-05-005.pdf

Substance Abuse and Mental Health Services Administration [SAMHSA] (2014). Trauma-informed care in behavioural health services: Tip 57.
https://store.samhsa.gov/sites/default/files/d7/priv/ sma14-4816.pdf

Survivors of Suicide Loss Task Force (2015). Responding to grief, trauma, and distress after a suicide: U.S. National Guidelines. Action Alliance for Suicide Prevention.
https://theactionalliance. org/sites/default/files/inline-files/NationalGuidelines.pdf

Swanson, S. A., & Colman, I. (2013). Association between exposure to suicide and suicidality outcomes in youth. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, *185*(10), 870–877.
https://doi.org/10.1503/cmaj.121377

Shneidman, E. S. (1981). Postvention: The care of the bereaved. *Suicide and Life-Threatening Behavior, 11*(4), 349–359.
https://doi.org/10.1111/j.1943-278X.1981.tb01011.x

Shear, K., & Shair, H. (2005). Attachment, loss, and complicated grief. Developmental Psychobiology, 47(3), 253-267.
https://doi.org/10.1002/dev.20091

Stroebe, M., & Schut, H. (2010). The dual process model of coping with bereavement: a decade on. Omega, 61(4), 273–289.
https://doi.org/10.2190/OM.61.4.b

Tedeschi, R. G., & Calhoun, L. G. (2008). Beyond the concept of recovery: growth and the experience of loss. Death studies, 32(1), 27–39.
https://doi.org/10.1080/07481180701741251

Tedeschi, R. G., and Calhoun, L. G. (2003). Helping Bereaved Parents: A Clinician's Guide. New York, NY: Brunner-Routledge, 188.

Tumbo helps. Death in the School Community – A Guide for Teachers (Tumbo pomaga. Śmierć w społeczności szkolnej. Poradnik dla Nauczycieli.).
https://www.tumbopomaga.pl/dla-nauczycieli/smierc-w-spolecznosci-szkolnej-poradnik-dla-nauczycieli

Multiple-Choice Questions:

1. What is the first step the social worker (SW) takes upon learning about the student's suicide?
A. Calls the student's family
B. Reviews the school's crisis plan
C. Takes a few deep breaths to calm thoughts
D. Informs the media

2. What is the purpose of the urgent meeting called by the SW at 5:00 pm?
A. To plan a memorial service
B. To review the school's crisis plan and assign tasks
C. To inform the student's family
D. To call the media

3. Why is it important to identify students who might experience the student's death as especially traumatic?
A. To exclude them from classes
B. To provide individualised support and prevent further trauma
C. To involve them in the funeral arrangements
D. To notify the media

4. What is the role of the school principal and team manager when visiting the deceased student's family?
A. To offer condolences and discuss how to share information about the death
B. To request a donation for the school
C. To organise a press conference
D. To plan the funeral service

5. Why are memorial activities, such as permanent memorials, approached with caution?
A. They are too expensive
B. They might increase the risk of suicide contagion
C. They are not allowed by school policy
D. They do not honour the student properly

Answers:
1: C. Takes a few deep breaths to calm thoughts
2: B. To review the school's crisis plan and assign tasks
3: B To provide individualised support and prevent further trauma
4: A. To offer condolences and discuss how to share information about the death
5: B They might increase the risk of suicide contagion

F.05
NAVIGATING SENSITIVE CONVERSATIONS: POSTVENTION IN MEDIA

Introductory Question:
What is the primary focus that should be emphasised in interview settings when discussing suicide prevention?

What You Will Learn:
1. Strategies for prioritising message clarity over personal perception in suicide prevention interviews.
2. Understanding the importance of expanding journalists' competencies in suicide prevention communication.
3. Navigating challenges in providing comprehensive information amidst media preferences.
4. Recognising the difficulty in preventing suicide and the need for research-based, cautious approaches.
5. Addressing specific considerations when discussing individual suicides, including protecting privacy and providing context.

UNDERSTANDING THE IMPORTANCE OF EFFECTIVE COMMUNICATION IN MEDIA SETTINGS

In an interview, we should focus primarily on what message we want to convey regarding suicide prevention (without focusing on how we might be perceived, which will allow us to keep our distance). A journalist's knowledge in the field of suicide prevention is not based on experience, so suicide prevention and postvention experts needs to expand their competencies.

Another difficulty is to include complete information in one's message, which may sometimes result from the media representative's desire to impose their preferences in assigning importance to specific problems. In such a situation, it is worth referring to the recommendations and the fact that preventing suicide is complex and requires research and caution in approaching the topic. The degree of difficulty is demonstrated by the fact that, despite the efforts made, suicide rates in many countries remain high.

SUPPORTING A JOURNALIST IN WRITING INTERVIEW ABOUT A SPECIFIC SUICIDE

If the conversation is to concern a specific suicide, you need first consider how to present this event to "not harm" ("Primum non nocere").

Information about a person who died in suicide:
Information about a person who died in suicide should be as general as possible. Warn the journalist about the inappropriateness of providing the victim's data, photos, characteristics, and description of the person.

It is good to emphasise the scientific data that in approximately 90% of cases, suicide victims suffer from mental disorders, most often depression (however, considering the entire population of people with mental disorders, most of them will not die in suicide). Psychological and pharmacological treatment helps to cope with the disease; however, sometimes hospital treatment is insufficient. It is similar to other diseases. Similarly, it can happen that despite our best efforts, we sometimes lose the fight against the disease. However, we can save our lives even in the worst suicidal crisis if we follow our safety plan, e.g., 12-Steps Safety Plan (https://12steps.plan.com).

Information about people who have experienced suicide in their immediate environment - provide as general information as possible.

The journalist can provide information that the immediate surroundings are mourning and trying to cope with this "unnecessary" tragedy.

The journalist can mention that cooperation with the Police is ongoing, factors that may have contributed to the incident are analysed, and actions will be taken to reduce the risk of a similar event.

The journalist can provide ways of dealing with the problem/problems, which is precious, as for many people confronting the tragedy, extreme stress leaves them helpless and in shock.

Information about motives:
There are many risk factors for suicide, including stressful factors that the person was unable to cope with immediately before the suicide. However, it is also worth paying attention to the possible biological basis of suicides (Jollant et al., 2011), which is very rarely talked about or written about in the media. According to this theory, people with suicidal behaviour are much more likely to have changes in the brain that determine excessive reactions to problems. This means that sometimes minor difficulties become impossible for them to overcome. At the same time, they cannot generate alternative solutions, which leads to impulsive behaviour.

The father of suicidology, Edwin Shneidman (1980), emphasised that people have different sensitivity to pain (pain tolerance), influencing their decisions. Satisfying their frustrated, critical need, even to a small extent, can reduce this pain/make it easier to tolerate, and thus often prevent suicide. He warned not to confuse events that frequently co-occur with suicides (changes in the brain, psyche, interpersonal relationships, in society) with necessary events - necessary for a suicide crisis to occur.

According to the interpersonal theory of suicide (Joiner, 2005), the desire to die by suicide results from the feeling of being a burden to others, perceived burdensomeness, and threatened belongingness. The accepting attitude towards suicide is the most significant factor associated with future suicide intention (Jeon et al., 2013). The media can influence the formation of such an attitude, but the media can also help promote an attitude that completely denies suicidal behaviour as a solution to any problem.

Journalists often ask how to help a person in crisis (including a suicide crisis), so it is worth preparing an answer to such a question in advance, e.g. that you should try to establish contact with such a person, listen to their feelings, tell them that you want to help her that there is hope, try to find something with her that is important to her, that can help her through difficult times, as well as take action to ensure her safety and contact other sources of support, e.g. the Crisis Intervention Center. The answer should also be adapted to the situation.

And so, when we talk about the dangerous impact that the Netflix series "13 Reasons Why" may cause, we can inform the media that particularly susceptible people, i.e., young people who have experienced sexual violence, mobbing, are experiencing unhappy love or suffer from depression, should avoid watching the series, or watching it with someone they trust, and seeking help if their mental condition deteriorates.

It should be emphasised that people around you often feel helpless, do not know how to help and are afraid of harming others, saying the wrong thing, or, despite their help, the person will take their own life. Therefore, it is worth it that the media informs about how the environment can help people in crisis. This may be as important as life-saving emergency first aid for such a person.

Information about the method and location:
The journalist should be informed about the method as generally as possible. It is worth emphasising the dangers associated with providing descriptions/information about a suicide method, especially one that is new for a region. Research indicates that such information typically contributes to an increase in the number of suicides committed using the same method. The most significant risk is in the initial period, immediately after reports and publications in the media. An example of this could be the recording of tapes suggested by the film series "13 Reasons Why", accusing people around them of contributing to suicide.

The journalist should mention the location only in general terms (e.g., voivodeship or point...).

These rules also apply to the method in the case of extended suicides (the biggest problem with the spread of extended suicides and suicide pacts was and still is in Japan, a country with one of the highest suicide rates in the world) and homicide-suicide (e.g., when a mother in post-partum psychosis kills her newborn child). However, Australia has also had negative experiences in this regard. During the period that coincided with the introduction of recommendations for the media, in one of the Australian cities, a mother took the lives of five children, which was widely and sensationally commented on in the media. After a week in the same city, a father killed himself and his four children (Pirkis, Blood, 2001). Only over time did media representatives recognise the importance of what they reported and how they reported it. It is worth taking advantage of these foreign experiences and carefully writing about extended suicides in the media. If you suspect that extended suicide was/may have been related to postpartum psychosis, it is worth sensitising your

loved ones about this problem and informing them where to seek help. When it is necessary to mention the method, it is worth adding that this method of suicide causes not only suffering and pain for the person concerned but also for the closest people and that it can almost always lead to brain damage, a state of vegetation or permanent disability. You can advise the journalist to write about a person/s who dealt with a similar situation, e.g., mobbing, or unhappy love, and describe in detail how they did it (promoting the phenomenon of growth through crisis/s). This may further strengthen the message that in such situations, you should always ask for help or signal that you need it, which will help you survive the crisis. However, no important decisions should be made under the influence of temporary strong damaging emotions/crisis/alcohol or drugs.

Information about the consequences of suicide/ suicide attempt:
It should always be emphasised that the experience of suicide is a tragedy and trauma for the rest of one's life for the immediate family and surroundings. Sometimes, it can lead to "infection" with the problem to someone around you and, as a result, to another suicide. It is worth noting that, as in the case of other diseases or their complications, taking appropriate steps at the right time often leads to suicide being prevented. It is crucial to read the warning signs and take appropriate action properly. In addition, it is essential to provide information that most patients who attempt suicide or are depressed do not take their own lives later.

POST-INTERVIEW RECOMMENDATIONS AND REFLECTIONS

Immediately after the interview, you should consider what elements of the quoted statements had preventive value and whether anything is worth changing or needs to be corrected.

Before reading the text we should receive for authorisation, it is worth recalling the abbreviated recommendations for the media, making it easier to check whether the final form of publication is consistent with these recommendations.

If contrary to our intentions, the recommendations are not followed in the text, point out to the journalist which recommendations for the media need to be followed and propose corrections.
If we find that the journalist's general approach to the topic and the words used interchangeably to describe suicide are too sensational, glorifying the suicide victim and may encourage suicide - specific corrections should be made to the text.

Particular attention should be paid to the title, whether it in any way encourages a person of a given age and with a given problem to commit suicide. Sometimes, a sensational title can "lure" recipients into an article that is written in a prudent and preventive way. Nevertheless, we should also follow the recommendations for the media in the title.

Ask the journalist/editor to provide, below the article or at the end of the program, the telephone numbers of institutions where you can seek help in a mental or suicidal crisis, as well as in the case of a specific problem discussed, e.g., depression or postpartum psychosis, violence, cyberbullying, etc.

Currently, recipients can often comment on each article online. There are situations where the comments contain a lot of "hate", which is because the issue of suicide triggers strong emotions, often negative. Unfortunately, it is not a good standard to look for a "scapegoat". To protect yourself and your loved ones from this phenomenon, it is worth considering asking to deactivate the "Comments."

Conclusion:

Suicide prevention is a complex and challenging endeavour that requires effective communication strategies, especially in media interviews. Despite efforts to prioritise prevention messages, challenges such as media sensationalism persist. However, adhering to guidelines and emphasising the importance of responsible reporting can mitigate these challenges and contribute to prevention efforts worldwide.

Takeaways:

1. Prioritise conveying the message about suicide prevention over personal perceptions in interviews.
2. Emphasise clear and informative communication strategies to expand journalists' knowledge base.
3. Navigate challenges such as media sensationalism by adhering to guidelines and responsible reporting practices.
4. Emphasise the complexity of suicide prevention efforts despite ongoing research and caution.
5. Address specific considerations when discussing individual suicides, such as privacy protection and context provision.

References:

Baran A., Gmitrowicz A., Pawelec R. Working Group on Prevention of Suicide and Depression at Public Health Council Ministry of Health. The role of media in mental health promotion and suicide prevention. Guide for people speaking with the press. Warsaw 2018
https://suicydologia.org/wp-content/uploads/2016/09/Guidelines-People-talking-to-media-about-suicide-PL-1.pdf

Jollant, F., Lawrence, N. L., Olié, E., Guillaume, S., & Courtet, P. (2011). The suicidal mind and brain: A review of neuropsychological and neuroimagingstudies. World Journal of Biological Psychiatry, 12(3), 320-339.
https://doi.org/10.3109/15622975.2011.556200

Joiner, T. E. (2005). Why people die by suicide. Harvard University Press.
https://www.hup.harvard.edu/books/9780674025493

Jeon, H. J., Lee, J. Y., Lee, Y. M., Hong, J. P., Won, S. H., Cho, S. J., Kim, J. Y., Chang, S. M., Lee, D., Lee, H. W., & Cho, M. J. (2010). Lifetime prevalence and correlates of suicidal ideation, plan, and single and multiple attempts in a Korean nationwide study. *The Journal of nervous and mental disease*, *198*(9), 643–646.
https://doi.org/10.1097/NMD.0b013e3181ef3ecf

Pirkis, J., & Blood, R. W. (2001). Suicide and the media: Part I. Reportage in nonfictional media. Crisis, 22(4), 146-154.
https://doi.org/10.1027//0227-5910.22.4.146

Preventing suicide: a resource for media professionals, Update 2017. Geneva: World Health Organization; 2017 (WHO/MSD/MER/17.5). Licence: CCBY-NC-SA 3.0 IGO (
https://www.who.int/publications/i/item/WHO-MSD-MER-17.5)

Shneidman, E. S. (1980). Voices of death. Harper & Row. http://www.suicidology-online.com/pdf/SOL-2010-1-5-18.pdf

12-Steps Safety Plan. (n.d.). Accessed 20 July 2024. Retrieved 24 June 2024 from
https://12steps.plan.com

Working together in a media agency

Multiple-Choice Questions:

1. What should be the primary focus in interview settings concerning suicide prevention?
A. Personal perception
B. Conveying the message about suicide prevention
C. Journalist's experience
D. Media preferences

2. What should be the goal of communication about suicide in media?
A. To prioritise personal perceptions
B. To expand the knowledge base
C. To prioritise media preferences
D. To reduce suicide rates.

3. What is one of the main challenges when delivering comprehensive information about suicide prevention in the media?
A. Lack of audience interest
B. Overemphasis on personal perception
C. Limited access to research data
D. Inadequate journalist training

4. What is the primary consideration when presenting information about a specific suicide case?
A. Providing personal details
B. Offering general information
C. Emphasising media preferences
D. Excluding scientific data

5. What should be done immediately after an interview concerning suicide prevention?
A. Evaluate media preferences
B. Assess the preventive value of statements
C. Ignore adherence to guidelines
D. Avoid proposing corrections

Answers:
1. B. Conveying the message about suicide prevention
2. B. To expand the knowledge base
3. B. Overemphasis on personal perception
4. B. Offering general information
5. B. Assess the preventive value of statements

APPENDICES

APPENDIX 1. A.01

Basic Information about Grief After Suicide

1. Grief is deeply personal and varies from person to person based on the unique relationship they had with the deceased. It can manifest as feelings, distressing thoughts, or actions.
2. The aftermath of losing someone to suicide suicide can be excruciating due to the multiple roles the person may have played in our lives.
3. People cope with grief in different ways—some may do so alone, others seek information online, and some turn to peers with lived experiences of suicide. In contrast, others may require professional support from psychologists, nurses, or doctors.
4. Grief follows no set pattern or timeline. It often feels like navigating a winding path with unpredictable twists and turns. Setbacks can be part of the process and may indicate progress.
5. Adjusting to life without the deceased takes time and patience.
6. The goal of grieving is not to erase the pain but to find ways to integrate it into everyday life. While grief is enduring, it should not consume one's existence entirely. Allow yourself to grieve and recognise the importance of living in the present.
7. Choosing not to disclose the cause of death can lead to isolation from potential sources of support, like family and friends. Rather than focusing on the stigma associated with suicide, prioritise your healing journey.
8. Over time, the intensity of pain and sorrow typically lessens, allowing you to rebuild your life gradually.
9. It's normal for intense feelings of grief to resurface at various times, often unexpectedly.
10. Holidays and special occasions may trigger renewed grief, so preparing for these moments is helpful as feelings, distressing thoughts, or actions.

APPENDIX 2 A.07
12 Steps Safety Plan in Postvention

STEP 1	STEP 2.a	STEP 2.b	STEP 3	STEP 4.a	STEP 4.b
S - Situation	**E - Emotions**	**E - Physical Experiences**	**A - Activities (behaviours)**	**T - Thoughts**	**T - Thoughts**
What happened?	How do we react? Emotions	How do you react? Physical experiences	How do you react? Activities/ Behaviours	How do you react? Thoughts - statements & beliefs	How do you react? Thoughts - questions
Suicide Loss	Shock	Feeling of the unreality	I am not doing anything. I'm just at home, in bed.	It can not be true. It is impossible.	Why did I / he / she / they fail to protect him / her?
Auto-pilot reaction	Denial	Feeling that the person is present	I'm trying to do something all the time.	It has happened. I can not do anything about it.	Why did he/she not tell me?
	Anxiety	Feeling of emptiness	I am crying constantly. The tears just flow.	Nothing matters anymore. There is no joy. I've lost everything and I can not get him / her back. I have lost the most important thing in my life.	Why do I feel what I feel? Who I can talk to? What can I say about my loss?
	Concern	Sleep: insomnia, nightmares.	I seek the company of others. I can not be alone.	I'm not worth anything. I can not take care of myself, experience joy...	How can I do without him / her?
	Guilt	Restlessness, irritability	I stay away from others. I isolate myself.	Everything feels meaningless. I feel completely empty and very lonely. No one can understand what I feel.	What will others think of me/our family?
	Shame	Feeling of being powerless, paralyzed, passive	I meet those who have experienced the loss of a loved one. They can understand how I feel.	I can not do anything about what has happened, but I try to live. The best I can. I know he/she would like that. He/she did not want to hurt me.	Will they think it's my fault? Do they accuse me?
	Anger	Concentration difficulties	I am looking for information about circumstances that led to his / her death.	I have to take care of Y, otherwise I will lose her / him / them too.	Who is to blame? Who is responsible?
	Helplessness	Hypersensitivity to sound, light, words	I talk to school, friends, doctors, the workplace, etc. to describe what happened.	I will remember X as... (we tend to idealize the person, who we lost what usually makes missing and feelings more painful and intense)	Should I blame myself? Is anyone else from the family or friends to blame?
	Hopelessness	Pain (abdominal pain, nausea, headache, muscle aches)	I engage in suicide prevention.	I can not focus on anything. I lost all my interests	Should we blame the hospital staff? Should we blame a doctor? System? Institutions? The whole society?
	Emptiness	Difficulty breathing	I engage in actions againts bullying, as I know it was the reason for his death.	I can not read a book, watch the news.	How could God allow for that?
	Lone-liness	Heart palpitations	I'm lighting candles.	I can not work. I cannot clean the room or do the dishes.	They met X and it... How could X do as he/she did?
	Abando-nment	Appetite (loss or increased appetite)	I'm looking at photos.	I cannot eat. I cannot sleep.	How could he/she do that to me / to his children? We loved him / her.
	Burden	Weight (loss or weight gain)	I am asking myself many questions.	I will never know for sure why it happened. I will never forgive myself that I did not do more. I am a failure.	How can I ever forgive myself/them? How can I remember him/her?

	STEP 5	STEP 6	STEP 7.a	STEP 7.b	STEP 8
How to make situation a bit better? (1)	Distract	Improving Coping	Avoid making the situation worse (Complicated Grief)	Connect with protective factors e.g. creating a new mission (Posttraumatic Growth)	Connect with protective factors - creating a narrative increasing self-forgiveness
Self-care to improve self-esteem & control	I will use a 4x4 breathing method.	I will try to find out so much information as it is possible.	I will avoid alcohol/ drugs.	Create a mission e.g. I wish help others in a situation of suicide loss.	Suicide happens as we do not have enough knowledge and skills to prevent every suicide.
	I will use muscle relaxation.	I will write all I know on a paper/in computer.	I will avoid subjects, activities, places and friends that can be dangerous for me.	Create a mission e.g. I wish to learn about how to prevent suicide.	Suicide is a result of biological dysfunctions, similarly to heart attack or stroke.
	I will go for a walk.	I will write a report with all things that could result in that suicide.	I will avoid blaming and accusing others, as it will make them only to feel worse.	Create a mission e.g. I wish help other parents	If suicide happened to my child, it doesn't mean I am a bad parent and a failure.
	I will make some exercises to calm down.	I will write down all things that could be done in the other way.	I will avoid isolating myself from others, as it is not so helpful.	Create a mission e.g. I wish help other professionals in a situation of suicide loss.	If suicide happened to my student/ patient/client/ employee, it doesn't mean I am a bad teacher/doctor/ therapist/ manager and a failure.
	I will use cold water skill to calm down.	I will read about someone who also had a similar experience.	I will avoid accusing myself.	Create a mission e.g. I wish find out more about how to prevent suicide in research.	I did what I could do at that moment taking into account information, skills and knowledge I had.
	I will listen to the music.	I will go a webinar/ course. I will attend a conference.	I will avoid hating and self-harming myself.	Create a mission e.g. I wish to introduce suicide prevention policies at my hospital.	Even if I did something else, it is not sure that it would save his/her life.

	STEP 9	STEP 10.a	STEP 10.b	STEP 11	STEP 12
How to make situation a bit better? (2)	Write	Talk/Call	Talk/Visit	Stay Safe In a Safe Place	Call 112 and wait for help
Connect to help yourself & others in coping	You can send sms that you need acute help	You can talk with someone who is also affected by this suicide to get more info	You can visit your family or your friend	You can stay with your friend/family at their home	If you see your or someone's life is in acute/imminent danger, call 112.
	You can chat about how you feel with NGO	You can talk with someone who you know can make you feel better	You can make a virtual visit to your friend/family	You can invite your family/friend to stay in your place	Your own ideas:
	You can send mail to an expert organisation in suicide prevention	You can talk to an expert to have somenone's else perspective	You can visit NGO organisation (physically or virtually)	You can go to the hospital, if you feel so bad that you are ancioux that you may harm yourself or someone else!	

APPENDIX 3 B.05 (1)
Physical and Emotional Wounds Healing

Phase 1. NOTIFICATION

- *Death not only ends the life of one person but, at the same time, starts a new post-traumatic reality for many other people and organisations, starting a number of different processes.*
- *As many details from the moment of getting the information about death will be remembered forever, the fact that this message is communicated to the family and others with sensitivity and care is of paramount value.*
- *The question "What was the cause of death?" is one of the first questions of key value for the bereaved family, as well as different settings and communities.*
- *Not knowing what to do and getting into a situation we cannot control are aspects that must be addressed when dealing with the notification.*
- *Takeaway: Learning about what to do (where we can find necessary information, who can help us) in such a situation in case we will have to deal with it can decrease future costs and decrease the intensity of the distress.*

Phase 2. GRIEF

DEALING WITH PRACTICAL ISSUES

1. ***Cleaning of the place (if suicide was at home)***
2. ***Getting a death certificate from a doctor/healthcare***
3. ***Registering of death and getting confirmation that death is registered (Skatteverket in Sweden, Urząd Stanu Cywilnegon in Poland/***
4. ***Planning and organising funeral***
5. ***Taking care of financial issues.***
   a. *Learning about estate, estate inventory, and inheritance.*
   b. *Ending mobile services,*
   c. *Closing bank accounts, and payment of debts.*
   d. *Taking care of different insurances.*
   e. *Closing other media, electricity, water, etc.*

DEALING WITH MENTAL ISSUES
Emotions, Thoughts and Activities

1. ***Guilt***
2. ***Anxiety***
3. ***Anger***
4. ***Alone (Loneliness)***
5. ***Pain***
6. ***Price (Worthlessness)***
7. ***Shame***
8. ***Sadness & sorrow***

SUPPORTING DEBRIEFING
Emotions, Thoughts and Activities

Giving an opportunity for Debriefing for: professionals (emergency workers, healthcare social care staff, educational setting)

Debriefings for families and relatives

Phase 3. GROWTH

PERSONAL & FAMILY/FRIENDS GROWTH

1. *Decrease access to lethal means for a person in a suicidal crisis and mental health distress at home*
2. *Keep contact with the healthcare to improve communication & bonds*
3. *Increase access to "safe" people and places ("safe ports in the stormy weather")*
4. *Contact trained PLE (organisations)*
5. *Create own/family step-by-step Safety Plans*
6. *Increase access to social & healthcare consultations and places for people with special needs (e.g. hospitals, retreats)*
7. *Participate/initiate the Research*
8. *Participate/create in the educational opportunities*
9. *Communicate preventive content in media*
10. *Help diagnose the cause of the death (registries)*
11. *Advocate for better financing of postvention and suicide prevention*
12. *Prevent: Nothing can be done. It is a hopeless/helpless/worthless attitude at home.*

ORGANISATION/COMMUNITY GROWTH

1. *Decrease access to lethal means for a person in a suicidal crisis and mental health distress in hospital & community (laws for safe infrastructure, medications, alcohol, drugs)*
2. *Keep contact with the family to improve communication*
3. *Talk with patient/client and their relatives about a need to Increase access to "safe" people and places ("safe ports in the stormy weather")*
4. *Increase access to trained PLEs supporting in specific difficult life situations, e.g. divorce, death (organisations)*
5. *Create own/organisation step-by-step safety Plans*
6. *Improve policies on access to social & healthcare consultations and places for people with special needs (e.g. hospitals, retreats)*
7. *Participate/initiate the Research on Postvention/Prevention according to organisation/setting/community/regional/country research plan*
8. *Participate/create educational opportunities for different clients: individuals, relatives, different groups of professionals & settings*
9. *Communicate preventive content in social and public media*
10. *Help diagnose the cause of the death (registries)*
11. *Adjust optimally financing of postvention and suicide prevention.*
12. *Prevent stagnation and development of hopeless/helpless/worthless attitudes in different settings, communities and media.*

APPENDIX 4 B.05 (2)
Building a Safe Narrative Around Suicide

Phase	Topic	*How to build save, health & life-oriented narrative?*	*What to avoid while building a safe, health & life-oriented narrative?*
		What can we tell?	***What should we avoid doing?***
NOTIFICATION How to notify about suicide to decrease risk of contagion?	What happenned?	*X died in suicide.*	*We should avoid saying: X killed himself. X commited suicided. X chose to end his life. X was tired with life.*
	How did it happen?	*Researchers recommend not to talk about a method, so we want to follow these recommendations not to increase risk for contagion..*	*We don't inform about how exactly it happened. We avoid being specific about a method of suicide.*
	Where and when did it happen?	*At home/At hospital/It did not happen at home/at hospital.*	*We avoid being specific about a place of death.*
	Why did it happen?	*There are many causes of each suicide. We don't really know why it happened.* *In general a person feels extremely Alone, Burden for others and believes that the only thing to do do is suicide. So, if you ever feel so, it's a signal to focus on a healthy coping: distracting, talking to someone, go to a place where there are people, avoid anything harmful, not to make it worse, or just contact a nearest hospital. It is a state of mind caused by a critical bio-psychological insufiency of coping mechanisms.*	*We avoid focusing on any specific cause of death, to decrease risk of association: relative common psychosocial problem/stressor (for example loss, separation, stigmatisation) - suicide. Suicide is not a solution to a problem.* *Problems/stress should trigger healthy coping, as it is really healpful, and do not result in even bigger problems, costs, and threat to health and life of many people as in suicide clusters.*
	Who/what is to be blamed?	*X was in a hospital, but they unfortunetely did not manage to save his/her life. It is similar to other health problems as stroke, heart attack, sepsis. Many people will be helped, but there are some with such injuries/wounds/ complications that they die.*	*We avoid blaming, accusing, attacking specific place (e.g. hospital), treatment, profession or a person, to avoid negative association "hospital/psychiatry/therapy-suicide", as it can potentially decrease help-seeking. You are not motivated to seek help if you hear that something was not helpful to someone.*
	Where is the deceased now?	*When a child or other adults give us that question it is best to answer where is the body of the deceased e.g. at the hospital, in a funeral agency, at the cemetery.*	*We should avoid saying that a person is in heaven, as we do not know that, and then a child will be asking if he/ she also get there to be with the beloved person. The association beloved -heaven-suicide can be a dangerous, as this person may be thinking that he/she needs to die in suicide to be with the beloved person.*

Phase	Topic	*How to build save, health & life-oriented narrative?*	*What to avoid while building a safe, health & life-oriented narrative?*
		What can we tell?	*What should we avoid doing?*
GRIEF (loss-orientation). How to grieve after suicide to decrease risk of contagion?	Do you feel guilt?	*I feel guilt that I did ...../that I didn't ..... However I know that there were many other factors. We can't control or predict what other person will do.*	*Avoid blaming/accusing/ attacking: It was only my fault. I will never forgive myself. It was his/her/their fault.*
	Do you feel shame?	*I feel shame that I did ...../ that I didn't ..... However I know that there is no reason to be ashamed of, similarly as if I lost him/her in stroke or complication of diabetes or infection.*	*I feel shame. I will never tell about my feelings to anyone, as they will be only laughing at me, and I will feel only worse.*
	Do you feel anxiety?	*Yes. It is common to feel anxiety, as our life changes dramatically, when someone dies, especially if he/she dies in suicide. We questioned what we have done/ what we should have done, and if we will be accused, attacked by others. We lose a part of our role/function as eg. being a helper, supporter for someone. We feel helpless.*	*I feel uncontrolled anxiety. It will never be better. I am helpless – I cannot do anything. No one can do anything. It will never be better. I feel anxiety, as I know they will be blaming me. I have to avoid talking to people. I will stay in my room, as it is the only place, I can feel safe. It is unsafe for me to go to school/to go to work.*
	Do you feel anger?	*I feel so angry that he/she didn't ask me for help, he/she just left me and rest of family without thinking how it will affect us, even if I know it was a depression/destructive impulse. I work on my own ways of safe expression of my anger. I do some physical exercises, I walk in the nature, and it really helps me!*	*I will focus on accusation and blaming, It's only my fault! Or It's only their fault. I will destroy them. Only then I can feel better.*
	Do you feel pain?	*I feel such a pain, that I am not able to think clearly. When I do things for others, I feel a bit less pain, as I focus on others suffering instead of my own. It is helpful to me.*	*I feel pain, and I will feel it all the time, as I have no right to be free from it. I will suffer for the rest of my life. Nothing will ever change that. I have no control over my pain.*
GRIEF (loss-orientation). How to grieve after suicide to decrease risk of contagion?	Do you feel sadness?	*I feel enormous sadness, as we will never be able to talk, to smile, to go out together. We had so many memories. It is a wound, and it will take time to heal.*	*I feel sadness, and it will never be happy again. I cannot smile. I can only cry. Life is so sad. Nothing can make me smile again.*
	Do you feel relief?	*I feel relief and I am really ashamed that I feel so, even if logically I understand that I feel so as we had an extremely tuff period in our life. However his/ her death makes it in a way much worse. His/her thinking that it will be better when he/ she dies was completelly wrong. How could he/she even think so? I will never understand that.*	*I know that psychologically feeling of relief is understandable, as I felt a victim because he was so abusive towards me. But I will never forgive myself, that I left him, and that I felt relief after his/her death, when I should feel sorrow. I feel now so guilty. I am so bad person. And now he and some nice moments are gone forever.*
	Do you have difficult to say what you feel?	*I don't feel anything/I am kind of numb/I have many feelings, but I cannot sort them out. It is not uncommon to feel a lot of feelings/feeling numb or not being able to name what one feels.*	*I feel numb. I don't have any feelings. It is something wrong with me. I am such a bad person as I do not think any sadness after his/her death.*

Phase	Topic	*How to build save, health & life-oriented narrative?*	*What to avoid while building a safe, health & life-oriented narrative?*
		What can we tell?	***What should we avoid doing?***
GROWTH (future-orientation) What have we learned?	What have I learned?	I*t depends on where you live. Different cultures and societies has own rituals. In many countries, after one gets information that a person died, one informs e.g. in Sweden a Tax Agency, than Priest to talk about funeral service and Funeral Agency to discuss details of the funeral, Than person's things are shared according to the will of the deceased.* It is something you can also explain to a child, if he/she asks what will happen with a deceased.	*To avoid funeral is not recommended as this ritual is important to be able to comprehend that a person is not longer alive. However, if a family member expresses a wish not to participate in it, it is important to respect it as well. It is important not to avoid information about what one needs to do step-by-step, as it helps in mourning.*
	What have I learned?	*Funeral is a ceremony where a body is put to grave. We need to put to grave symbolically (or say farewell or put to grave some of our emotions that we share with the deceased) as well. We can talk about them, or just write them as a note, letter, and put it to grave or to a special memory box, where we will put some precious things associated with the deceased/that will remind us of special moments we had together.*	As most of us, usually want to say farewell to the deceased, to avoid saying/expressing our individual "emotional farewal" is not recommended, as it may later take form of ruminations, constant recurring thoughts associated with feelings triggered by different things that will remind us about the deceased.
	What have I learned?	*Research shows that we can shape memories to some extent. It is important to shape narrative and form memories of the beloved person in a way it can help us to cope with life without that person. Put a note in a file in our computer, or as a letter on a paper that we put to the Memory Box, it will be easier to collect our memories, and even chose precious memories we want to remember.*	*I will avoid learning/remembering/overfocusing on things that can make me feel bad, decrease my self-esteem, self-care, and help-seeking. I will avoid self-harming with my thoughts and behaviour. I will not forget about adding helpline to my Memory Box that I can always use in an emergency situation.*
	What have I learned?	*Every loss including loss in suicide leaves us with some thoughts, insights, reflections. We can build a narrative about a suicide = I is an emotional and financial cost. It is a great lifelong pain/trauma. It teaches me how important is self-care, Safety Plan, so that I know how to react when I feel alone, a burden and if suicide thoughts would appear.* *All the feelings, even if extrememly intensive, are temporary, and will go over sooner or later, and if it becomes a threat to my life I talk with someone I know or a volunteer, or contact hospital, exact in the same way I and my family/ friends would react if they noticed symptoms, that could signalise that I fick stroke or heart attack. Sharing with others awareness of a recovery and healling narrative can help others to survive the difficult time, grieve and even grow by supporting others in the future.*	*I will avoid focusing on lessons that impose danger and threat to my health and life.* *Example of such harmful lesson is:* *I cannot take medication as drugs can result in my death.* *I cannot seek help as no one will help me anyway.* *Another lesson is to acquiring different myths and spreading them. Suicide can affect 135 people and more.* *It can affect negatively coping mechanisms so that persons starts self-harming hoping that it will help them not to feel pain.* *It is crucial to avoid all self-harm and harm as it will make the situation much worse, and it can even add building a narrative that will result in spreading the trauma, instead of spreading the information on how to survive and recover from emotional wounds caused by suicide.*

APPENDIX 5. C.03

BLEKINGE FAMILY POSTVENTION (BFP): SHORT DESCRIPTION WITH AN EXAMPLE

Introduction:
By helping families understand and navigate their grief, the BFP aims to help them regain balance and recover from their loss.

Developed in 2015 by Maiellen Stensmark, a Swedish teacher and social worker who tragically lost her daughter to suicide, the method is a beacon of hope for families struggling with the devastating aftermath of suicide.

Through open discussions, practical help and emotional support, bereavement counsellors provide a safe space for families to process their grief, express their feelings and gradually rebuild their lives after a loss.

Objectives:
The primary goal of Blekinge Family Postvention is to help family members cope with their grief while minimising the potential long-term effects that grief can have on their well-being. Given that all family members affected by suicide can struggle and feel overwhelmed, it is essential to support them in finding stability and healing.

Number of participants
When working with families, it is usually most effective to start with the immediate nuclear family, consisting of a maximum of 5-7 people. After that, additional family members, such as siblings of the deceased, can be included in the meetings, resulting in larger groups of 10-14 people. However, it is vital to ensure that each participant receives sufficient attention, especially in larger gatherings, where it is important to facilitate meaningful communication between everyone.

Frequency of meetings
The first meetings are held every two or three days and then move to weekly meetings for the first 5-6 weeks. Some people may want to stay in touch with the facilitator for a more extended period, up to a few years, in which case communication takes place via phone calls, text messages or emails. The frequency of contact may vary depending on individual needs and circumstances.
Maiellen Stensmark's approach to providing early support to survivors of suicide has been shown to ease the pain, anger and suffering of affected families. Families seeking support often find Maiellen through the SPES Blekinge Association's online platform, where she is considered their 'doula'. Although there is no specific research on Blekinge Family Postvention, studies have shown that interpersonal support during times of crisis can have a protective effect.

Evidence
For example, Gruber et al (2013) found that mothers who received help from doulas during pregnancy were less likely to experience complications, suggesting that supportive communication and encouragement can boost confidence and improve outcomes. Hans et al (2018) also found that integrating doula services into postnatal home visiting programmes can provide additional health benefits to families. Similarly, the support provided by a bereavement facilitator after a suicide loss can strengthen family members' self-efficacy to cope with trauma, reducing suffering.

Creating a safe environment for grief and suffering
When intervening after a suicide, the grief counsellor visits the grieving family's home to provide support and create a safe environment for processing grief and suffering. Through open discussions, families are encouraged to share their experiences, feelings and thoughts, with a focus on gradually reintroducing activities that they enjoyed before the loss.

Support for practical issues
In addition to emotional support, practical help can be provided to deal with various logistical issues following a suicide, such as cleaning and restoring the place of death, dealing with the deceased's personal belongings, funeral arrangements, and legal and financial issues.

Contact with professionals and survivors
Early contact with police officers, doctors, forensic experts, and religious leaders can significantly impact survivors. Compassionate and knowledgeable people can provide important information and connect families with additional resources, such as family prevention leaders, contributing to their support and well-being. Thanks to Kalmar, Routine survivors can get help finding appropriate support.

TALKING TO THE GRIEVING FAMILY: EXAMPLE

The place: A living room with five people sitting around a table.
→ F-GF: *Are we all present? Is there anyone who has yet to be able to attend? Have any of you sought support, perhaps from a professional, after X's death?*

→ F-GF (at the beginning of the meeting): *Good morning, everybody. My name is MS, and I lost my daughter to suicide 21 years ago. I have been providing support to families who have experienced similar losses for years now. Please remember that everything said in this room is confidential. Before we start our introductions, where you introduce yourselves and your relationship to the deceased, I want to make sure that everyone has had their say. Does anyone need to inform us of their absence today?*

→ *P1: Aunt Sofie couldn't come. She doesn't feel like seeing anyone right now.*
→ *F-GF: Understood. There are times when it feels impossible to reach out. But circumstances can change. Can someone contact Aunt Sofie or someone close to her and tell her about today's meeting and invite her to the next meeting? Should we plan such a meeting?*
→ *P1: Of course. I have a good relationship with Aunt Sofie, and I don't want her to go through this challenging time alone.*
(An F-GF listens attentively to each participant and sometimes asks short follow-up questions without dominating the conversation).

ROUND 1. PRESENTATION OF THE PARTICIPANTS

→ *F-GF: Let's start with our round of introductions. Your words have meaning not only for yourself but also for others present. Start by telling us your name, your relationship with (name of the deceased) and how you are dealing with your feelings right now.*
→ *P1: My name is (name), (name of the deceased) was my father. I feel overwhelmed and have difficulty finding words.*
→ *F-GF: Thank you very much. Feeling lost in the face of such a deep loss is entirely normal. What is the most challenging aspect for you right now?*
→ *P1: That he is no longer with us.*
→ *F-GF: Your turn. (GF gestures to the person sitting next to the speaker).*
→ *P2: My name is (name), (name of the deceased) was also my father. I am also struggling with overwhelming emotions and wrestling with the question of why he left us.*
→ *F-GF: Can you go deeper into the feelings you experience?*
→ *P2: I am filled with sadness and anger and wrestling with the decision he made to leave us.*
→ *F-GF: Thank you very much. It's common to hear that suicide victims "chose" to end their lives, but in fact, it's often fuelled by a sense of hopelessness or impulsiveness. Studies show that even a short delay can prevent such tragedies. We move on to the next participant.*
→ *P3: My name is (name), (name of the deceased) was my son. I cannot shake the memory of our last interaction. He wanted to visit, but I turned him away because I had other plans. If I had only invited him, things would have been different. I will carry this guilt as long as I live.*

→ *F-GF: Your feelings of guilt are understandable. Often, we only realise the seriousness of a situation when it's too late. P3: Yes, that's exactly how I feel.*
→ *F-GF: Many of us struggle with guilt after the suicide of a loved one and wonder if we could have done more to prevent it. Let's hear from the next participant.*
→ *P4: My name is (name), (name of deceased) was my husband. I am also struggling with guilt, especially after our last argument. Our relationship had been strained in the weeks before his passing. F-GF: Thank you for sharing your thoughts. Discussing these feelings is challenging but essential to process the grief and find comfort in each other's support.*
→ *F-GF: It is vital to continue to express your feelings and thoughts, as they vary in intensity. Sharing them can lessen their burden and remind us that we are not alone in our struggles. Before we continue, does anyone have additional feelings or thoughts to share after this tragic loss?*
→ *P4: Yes, I am worried about revealing the cause of my husband's death to my colleagues. Should I tell them about his suicide, or will they blame me?*
→ *F-GF: Your concerns are justified. (GF addresses the group) How would you like to discuss your loss with friends or colleagues?*
→ *P1: Honesty is important. I have already been open about the circumstances. Some offered support, while others seemed unsure how to react.*
→ *F-GF: Exactly. Sharing your truth can lead to understanding and support, although reactions may vary.*
→ *F-GF: Thank you all for opening. It's important to continue this dialogue as our emotions evolve. When emotions become overwhelming, sharing them or focusing on breathing can be a relief. Breathing exercises are particularly effective in dealing with anxiety. Let's try a simple technique: place your hand on your stomach, inhale three times, hold your breath three times and then exhale six times. Remember, you are not alone on this journey. (GF demonstrates the breathing exercise).*

Comment from the Family Care Leader: This introductory segment aims to validate the feelings of the participants and foster connections within the group affected by loss by suicide. Each member is given an opportunity to share, which promotes a supportive environment.

ROUND 2. QUESTIONS ABOUT SLEEP

→ *F-GF: Now, sleep is a basic need often overlooked under extreme stress. Have any of you been able to sleep since X's passing?*
→ *P1: It's easier to distract myself during the day, but evenings are challenging. I've had trouble sleeping the last few nights.*
→ *F-GF (turning to the next person): What about you?*
→ *P2: I have slept a lot and had vivid dreams. I even dreamt that I had a conversation with (the deceased's name), but I don't remember the details.*
→ *P3: I have been sleeping excessively, sometimes up to 12-14 hours. I feel constantly tired and can't focus.*
→ *P4: I wake up several times at night thinking about what could have happened.*
→ *F-GF: Thank you for sharing. Some of you are struggling with sleep. I have a suggestion that may help. It is comforting not to have to face this difficult time alone. Sleeping in the presence of a loved one, like (wife's name), can alleviate feelings of loneliness that often accompany loss. Knowing that family members are nearby and supporting each other's well-being provides a sense of security.*
→ *P4: That sounds like a wonderful idea. You are more than welcome to stay here.*
→ *P1: I don't mind. I'll spend a few nights with you.*
→ *P2: Count me in. I can offer a night or two, too. You can also reach out to me anytime.*
→ *GF: Excellent. Knowing that P4 will have company for the first few nights is reassuring. Do you have someone you can call for support or company during sleepless nights?*
→ *P3: Yes, I have a close friend, J. We talk about everything.*
→ *F-GF: Thank you for taking care of yourself in this way. Feeling safe and supported is important to sleep better and recover from this shock.*

Comment from the family grief counsellor: It is important to address sleep problems as they are common after a traumatic loss and can become chronic if not addressed. Encouraging companionship during sleep and fostering support networks within the family are effective strategies to address this. For couples, spouses or children, a counsellor may suggest seeking physical comfort, such as holding each other, as this can promote safety and relaxation.

ROUND 3. QUESTIONS ABOUT EATING HABITS

→ *F-GF: Now, let's focus on your eating habits, often neglected under stress. P4, how is your appetite? Have you eaten today?*
→ *P4: No, I have not felt like eating. I need more energy to prepare a meal.*
→ *P3: I have little appetite - just some fast food to keep me going.*
→ *F-GF (addressing P1): How are you? P1: Same as P3 and P4.*
→ *F-GF: Do you usually eat alone or together?*
→ *P4: I used to cook and eat together with my husband. But now it doesn't feel necessary.*
→ *F-GF (addressing P4): If someone brought you food, would you eat with them?*
→ *P4: I am still determining. I haven't tried it yet.*
→ *F-GF: Which of you can help prepare meals?*
→ *P2: I can help with the cooking. Eating together is much nicer than eating alone. We can discuss the details later. GF: Is there anyone who likes to cook?*
→ *P2: Yes, I do. P4: I used to like it too, but not since he passed away.*
→ *F-GF: What about drinking? Hydration is often overlooked during stressful periods.*
→ *P1: I have been drinking at least 1-1.5 litres of tea and juice daily.*
→ *P4: Same here. P3: Me too. I start the day with coffee; then I switch to water or juice.*
→ *P2: When you mentioned drinking, I thought of my cousin, who may be drinking too much alcohol, especially now that (name) has passed away.*
→ *F-GF: Eating and drinking properly, even during grief, is crucial. As P2 mentioned, some may turn to alcohol to cope with grief, which is risky. Maintaining healthy habits and supporting each other through this time is important. I suggest you invite your cousin to our next meeting to discuss this further. What do you think about that?*
→ *P2: That's a good idea. I'll talk to him about it.*
→ *F-GF: Wonderful! I'm glad to see the support you give each other. Remember that nourishing your body with the right food and drink, even simple meals, is important for physical and emotional well-being.*

Grief counsellor commentary: Focusing on everyday activities such as eating helps to redirect attention from grief to daily routines. Emphasising the importance of these routines can provide structure and stability for grieving family members and contribute to their recovery. Starting the conversation with this reminder emphasises the importance of self-care during difficult times.

ROUND 4. QUESTIONS ABOUT INTERESTS AND HOBBIES

→ *F-GF: Sleep and food are important, as are interests and hobbies. Do any of you have a particular interest or hobby?*
→ *P4: Yes, but I haven't gone to the gym since my husband passed away.*
→ *F-GF (addressing P2): How are you?*
→ *P2: I have never had any special interests. I focus on my job and my family.*
→ *P3: I have my dog, so I walk him 3-4 times a day.*
→ *P1: I used to like swimming, but it's been a while since I did it.*
→ *F-GF (to P4): Why haven't you gone to the gym since your husband passed away?*
→ *P4: I didn't want to see anyone.*
→ *F-GF: Have you confided in your friends about your grief? P4: No.*
→ *F-GF: So you have not been able to seek support from them? If they knew how you were feeling, you could talk to them if needed. It is important that you resume your hobby. It would be best if you did so as soon as possible. Going to the gym, walking, meeting friends or playing the piano (or any other hobby) can help you fill your time*

with something you enjoyed before (name) died. It helped you cope with stress then, and now it is essential for dealing with your loss and the accompanying feelings and thoughts. You need to regain as much pleasure as possible from activities that you enjoyed before the grief, loss, and suffering took over.

→ *P4: I felt better after going to the gym. It helped me to relax.*

→ *F-GF: And resuming exercise can significantly improve your well-being. Do you need more energy, or are you afraid of how your friends will react when they see you at the gym or walking? Are you worried about their questions?*

→ *P4: It's a little bit of everything.*

→ *F-GF: Yes, it's natural to feel uncomfortable that others know.*

→ *P4: Sometimes I avoid the gym to avoid questions. People often don't know how to talk to me or react to my grief. GF: It can help if you prepare answers to their questions in advance or go with someone who can support you. P4: Yes, I've done that a couple of times before. I can try again.*

→ *F-GF: Excellent! And what about you? Can you find an activity that helps you deal with difficult emotions? Swimming? Walking? Gym workout? Something else?*

→ *P2: I am still deciding. My job and my family take up a lot of my time.*

→ *P1: I could try swimming again. I used to find it relaxing.*

→ *F-GF: Okay. Let's check in at our next meeting to see if you've been able to engage in any activity to relieve stress. Even if it seems insignificant, it can make a significant difference in redirecting your focus towards a healthier lifestyle.*

Grief Family Counsellor Commentary: Focusing on interests and hobbies can provide a welcome distraction from grief and help prioritise life-oriented activities for recovery. The role of the family counsellor in asking about these activities underlines their importance.

ROUND 5. LISTEN, NORMALISE EMOTIONS

→ *F-GF: As we approach the end of our meeting, I would like to hear your thoughts on our discussion and whether you would be interested in meeting again in a few days.*

→ *P1: Yes, at first I didn't understand why we were talking about eating and sleeping, but now I know how important it is during difficult times.*

→ *P2: For me, the most crucial thing was to discuss our feelings. P3: I found it valuable to have the opportunity to talk openly.*

→ *P4: Thank you very much. Yes, this meeting has helped me a lot. You are welcome to revisit us next Friday.*

→ *F-GF (closing the meeting): It may have felt strange answering my questions for the first time, but it usually feels more comfortable with each meeting. Let's continue to meet as long as it is good for you. I will continue to support you by asking about your feelings and offering tips and tools that have helped me and others. I hope you also feel supported by this. It's also a chance to share tips on how to deal with distressing thoughts and intense emotions. P5 and P6, whom we discussed earlier, are welcome to join us next Friday.*
I look forward to seeing you then.

NORMALISATION OF GRIEF REACTIONS:

When summarising a participant's contribution, the family facilitator can say:

- *Many victims of suicide go through similar feelings.*
- *Try not to dwell on other people's perceptions of you; such worries can cause unnecessary stress. What we need now is to reduce stress.*
- *It is important to articulate and discuss the different aspects of grief, however uncomfortable they may seem.*
- *Everything discussed here, even the most minor details, is crucial for post-traumatic recovery.*
- *Remember that it is okay and normal to experience a range of emotions. If not expressed, they can cause harm, so it is important to express them safely.*

A family facilitator may say to a silent participant:

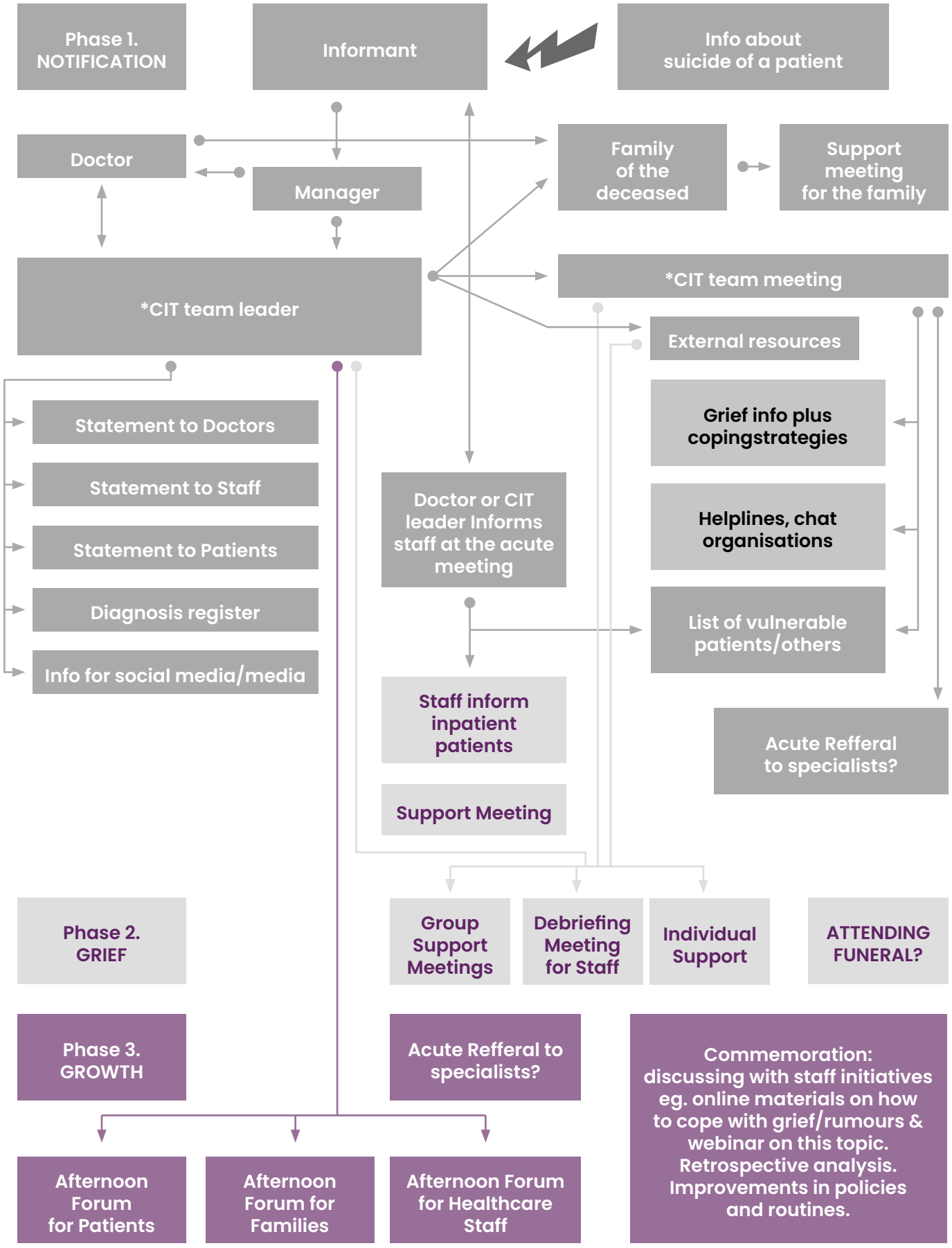
- *You haven't talked much. Do you feel it's not important? Or maybe you're worried about hurting someone with your words? Or maybe it feels strange to express your feelings.*
- *Every contribution, no matter how small, is valuable in the journey towards recovery.*
- *Refraining from reacting is fine, but it may hamper our efforts to support you. We are all concerned about your well-being.*

Often, a silent person starts speaking later, especially when others share their thoughts. Some people need more time to open up or are hesitant to express themselves openly. Increased comfort may encourage them to participate. When one person shares their thoughts, others follow suit.

EIGHT TIPS FOR FAMILY POSTVENTION:

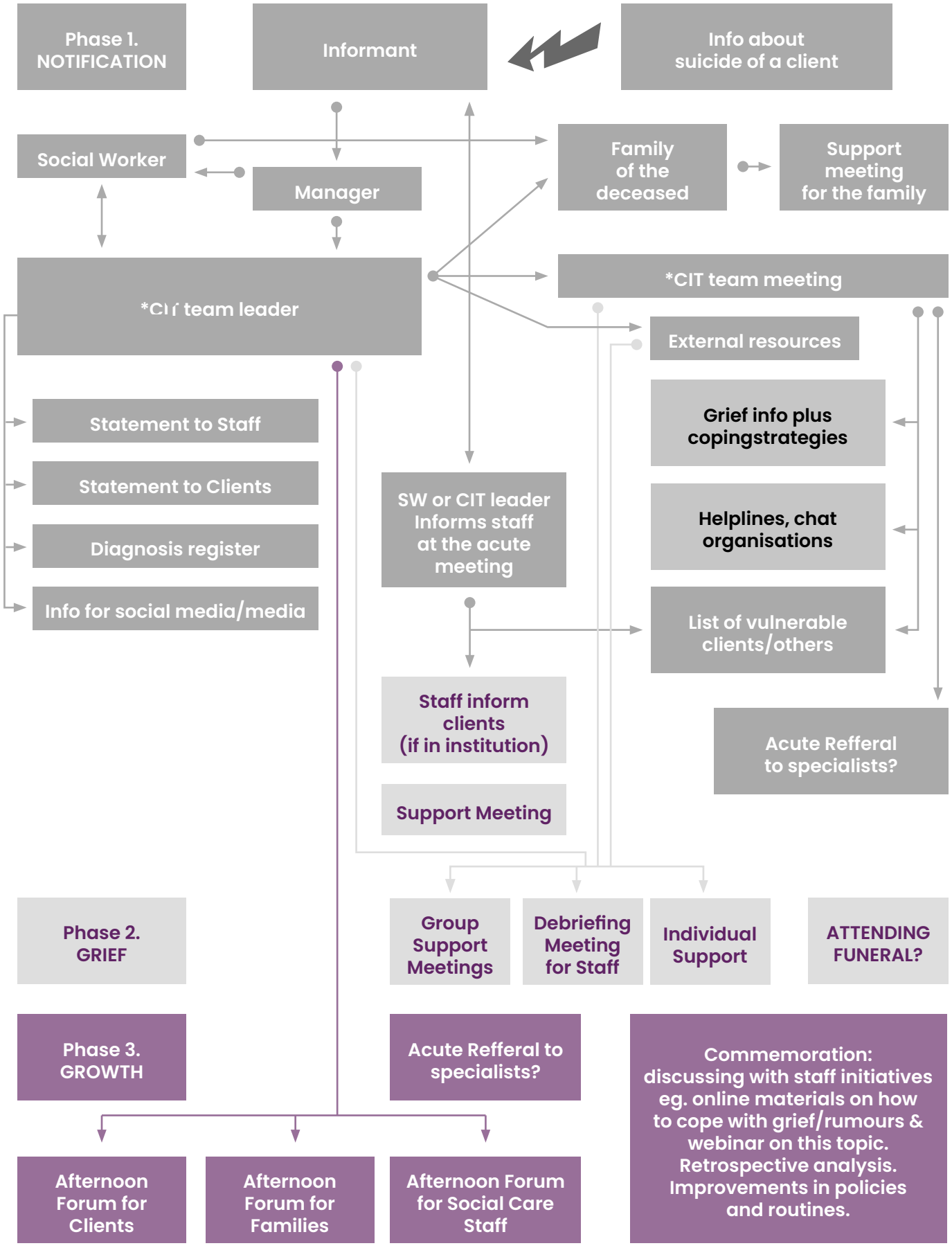
1. Show interest in each person
2. Reinforce critical points for the benefit of all.
3. Help participants understand the 'why' behind their feelings.
4. Help individuals deal with feelings of guilt, shame and blame.
5. Emphasise that even deep grief has its healing process.
6. Helps participants to process traumatic memories and images.
7. Encourage openness about feelings of grief, including anxiety.
8. Promote a balance between supporting others and oneself.

APPENDIX 6 D
Postvention in Action: **Healthcare Setting**



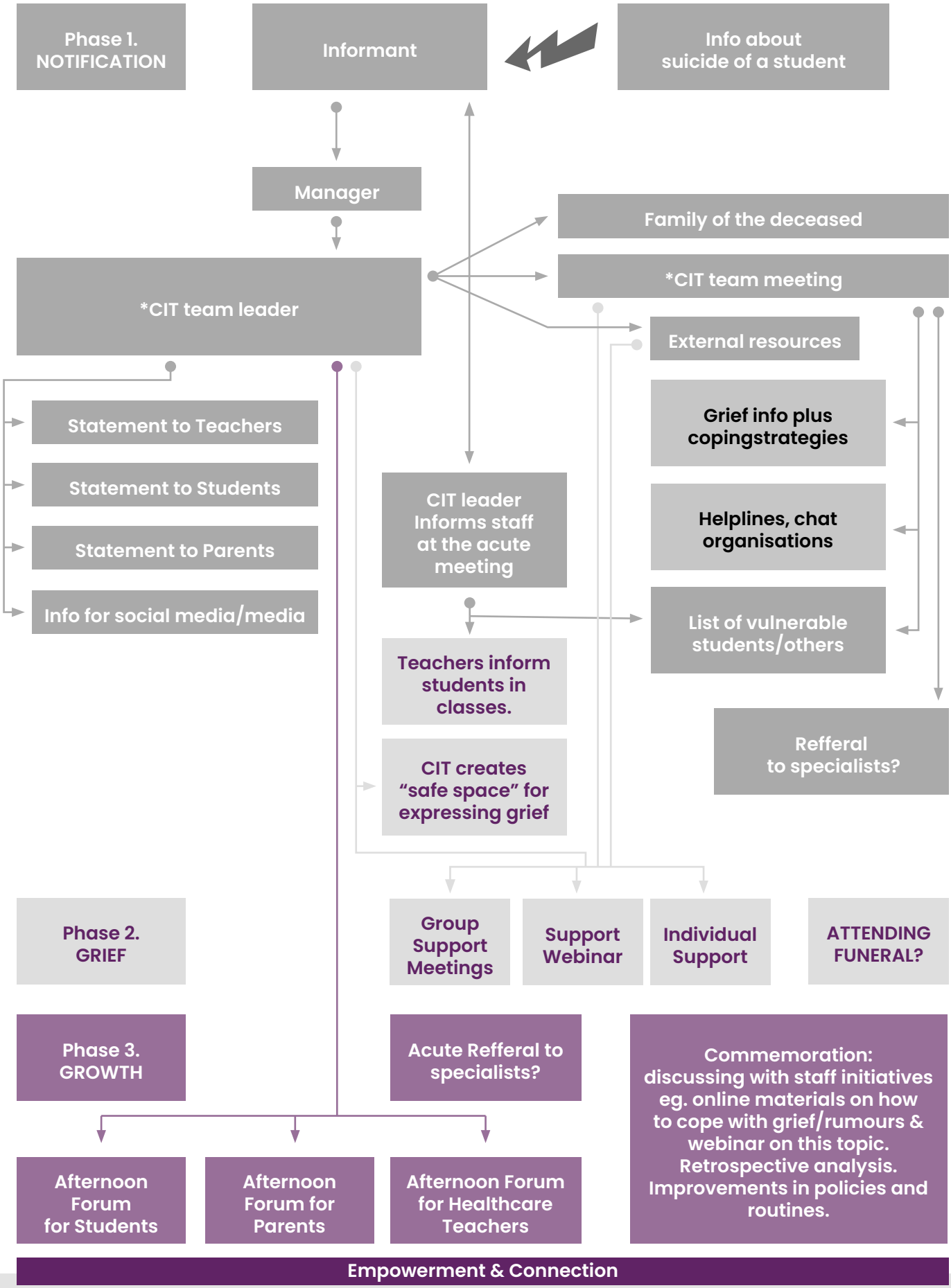
*CIT – Crisis Intervention Team

APPENDIX 7 E
Postvention in Action: **Social Care Setting**



*SW – Social Worker
*CIT – Crisis Intervention Team

APPENDIX 8 F (1)
Postvention in Action: **Educational Setting**



*CIT – Crisis Intervention Team

APPENDIX 8 F (2)
Postvention in Action: **Educational Setting**

CHANGING NARRATIVES:
INTERDISCIPLINARY EDUCATION IN SUICIDE POSTVENTION IN ACTION

Doctors, psychologists, nurses, social workers, public health managers, managers, police, firefighters, rescue workers,
journalists, priests, teachers, volunteers, court staff, military etc.

Phase 1. Protocols/Policies	1	Educational setting: Creating courses for suicide preventions and other resources
Phase 2. Shaping preventive attitudes/habits/priorities	2	Educational setting: Eucation and training in suicide prevention in higher education
Phase 3. Work Experience (Notification-Grief-Growth)	3	Listening to experiences of people with lived experience. professionals, students and teachers.
Phase 4. Analysis/Research Understanding Dissemination Implementation	4	Educational setting: Analysis/ research of students' teachers & graduates' experiences
Phase 5. Lifelong learning	5	Educational setting: Adjusting resources in postvention and suicide prevention for all target groups

GROWTH (results, feedforward, quality & cost-effectiveness)

Challenges:
1) lack of protocols at work & lack of programs including suicide prevention in educational settings
2) inadequate attitudes, habits & unawareness of the need of education in suicide prevention,
3) inability to learn from experience & not listening to students, graduates & professionals,
4) underfunded & unstructured research,
5) lack/insufficient life-long learning of teachers & others professionals &
6) insufficient growth assessed by results, quality, feedforward & efficiency of processes and cost-effectiveness).

REVIEWS

Professor Agnieszka Gmitrowicz, *MD, PhD, Medical University of Lodz, Poland. Vice president of the Polish Association of Suicidology and chair of the Working Group on Prevention of Suicide and Depression at the Public Health Council of the Ministry of Health. Co-creator of the Polish program for the prevention of suicidal behaviours described in the National Health Program for 2021-2025. Author and co-author of many publications on suicide prevention.*

The reviewed publication "ELLIPSE Postvention Handbook" by Baran A., Milewicz T., and Stensmark M., developed as part of a Swedish-Polish project, co-funded by the European Union, takes the form of a guide. The issues discussed focus on postvention - the interventions after a sudden suicide death. Despite being an essential element of suicide prevention, postvention is often treated marginally. The death of someone we know in such tragic circumstances is usually a burden for society; it evokes powerful emotions (including a sense of guilt, confusion, and immense loss), which can even contribute to another tragedy. Therefore, practical skills and knowledge about providing support to bereaved people, families, and people close to the suicide victim are crucial.

The reviewed publication is a valuable source of information in the postvention field and an excellent example of a coherent, methodologically correct, and effective way of education. It is written in an accessible, concise language enriched with a visual message (illustrations) adequate to the content. The manual contains six modules. Each begins with a question, confronting the reader/course participant/training with the scope of knowledge they have or lack thereof. The first two modules concern general knowledge about mourning after death due to natural causes and suicide. Their value increases case descriptions and a safety plan. The third module presents various forms of support for people experiencing mourning after a sudden suicide death in their close environment. The following modules are dedicated to professionals who may have contact with sudden suicide deaths within three systems: health care, social care, and education. Modules are supplemented with appendices and can be treated as a separate whole. The presented techniques/methods of coping with loss have a preventive and universal nature. The publication's authors provide the opportunity to check and consolidate the acquired knowledge through questions, ending each module chapter with the correct answers.

Conclusions:

- The discussed handbook/guide has a high practical value.
- In terms of content, it is a concise summary of the current knowledge in the field of postvention.
- It can supplement teaching in the pre-graduate curricula of medicine, pedagogy, psychology, and sociology students and the post-graduate curricula of doctors, nurses, psychologists, school and university teachers, and social workers.
- It is an essential source of important knowledge on coping with the loss of a loved one due to natural causes and complicated mourning after a sudden suicide, as well as a guide for employees of critical systems - education, social care, and health care, in which suicide may significantly affect their functioning.

Dr. Regina Seibl, *mental health professional and suicide postvention expert.*
Facilitator of a suicide survivor support group for 15 years, since 2002 working with pro mente tirol, a mental health care agency in Innsbruck, Austria, since 2016 providing in-house postvention for colleagues after client suicide. Member of the SUPRA panel (SUicide PRevention Austria) and head of SUPRA´s working group on postvention. Trainer for suicide postvention (for family loss survivors/clinician survivors) (trained around 500 mental health professionals).

Losing someone through suicide is an intensely painful, extremely challenging, and potentially traumatic experience for those left behind. Their pain has often been even exacerbated by the history of stigma and shame around suicide and a profound lack of understanding of suicide bereavement within society. The ELLIPSE Postvention Handbook has been designed with a clear intention to substantially change that for the better. Using a language that is clear and easy to understand as well as a compassionate and encouraging tone, this comprehensive handbook full of information addresses the stigma by its very existence, sheds light on the complex nature as well as different aspects of grief after suicide and raises awareness around who may be impacted by its ripple effects. This includes families, friends, mental health, and school settings. The book provides useful postvention approaches for several different settings. It is well-researched and thoughtfully composed and creates a truly valuable learning opportunity for family suicide loss survivors, those who care for them, as well as mental health professionals who support the bereaved or who have lost a patient to suicide. It is aimed to empower and encourage all survivors of suicide loss to take care of themselves, navigate their difficult journey through grief towards healing and eventual posttraumatic growth, reach out for support whenever necessary and most importantly - never lose hope.

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E-Lifelong Learning in Prevention of Suicide in Europe
POSTVENTION

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