Bereavement round up: Support after suicide bereavement

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Debates about suicide and appropriate responses have frequently centred on prevention. Increasing focus and research on the wider impacts of suicide in recent decades have raised questions about if and how the suicide bereaved differ from other bereaved populations and what support routes are most appropriate to them.

A number of recent studies have addressed aspects of suicide bereavement outcomes and their implications for service provision and future research prioritisation.

Support received after bereavement by suicide and other sudden deaths: a cross-sectional UK study of 3,432 young bereaved adults

Pitman A, Rantell K, Moran P, Sireling L, Marston L, King M, Osborn, D (2017). *BMJ Open* https://doi.org/10.1136/bmjopen-2016-014487

This study investigates the assertion that the suicide bereaved are less likely to seek or receive formal support for their grief.

Pitman *et al* speculate that low uptake of support may be linked to continued social stigma associated with suicide. The impetus for their research comes from the UK suicide prevention strategy recommendations for bereavement support for suicide bereaved. Their approach to the research study was formulated in consultation with bereavement groups, service providers and bereavement service users. ■

Help seeking in the suicide bereaved

The primary focus was to determine through a nationwide study whether suicide bereaved were less likely to receive formal or informal bereavement support and if they received delayed or no support at all. Secondary aims were to investigate whether stigma played a part in in uptake of support and the impact of gender on receipt of support.

To focus on young adults, inclusion criteria age range was determined as 18 – 40. An online survey questionnaire was distributed through 164 UK Higher Education Institutions (HEI). Participants who had experienced bereavement through a sudden death of any kind were included. Sudden death was defined for the purpose of the study as 'a death that could not have been predicted at that time and which occurred suddenly or within a matter of days'. Respondents who had reported bereavements in childhood were excluded. Sudden deaths were sub-divided into suicide bereavement, sudden unnatural death (such as an accident) and sudden natural death (such as cardiac arrest).

Qualitative data on socioeconomic and clinical impacts of the bereavement on respondents were elicited through questions on suicidal ideation, self-harm and mental state pre and post-bereavement. Stigma or perceived stigma related to suicide was measured using the subscale of the Grief Experience Questionnaire. The questions 'how long after the death did you receive help that was valuable to you' and 'What help did you receive after the death', which included the option for 'none', aimed to identify delays in receiving valuable help and incidences where no help was received. They also questioned respondents as to who they received help from, with response options including 'state' and 'other', to ascertain receipt of formal or informal supports. Four secondary outcomes were outlined: no valuable help received, immediate help (determined as help received within 1 week of the loss), delayed help of 6 months or more post bereavement, and exclusive use of formal support. A fifth outcome was to establish whether respondents who attempted suicide following their bereavement sought support prior to the attempt.

Of an initial sample of 659,572 bereaved and non bereaved staff and students at the participating HEIs, 4,314 consented and were eligible to participate and 3,432 had experienced a sudden death. Of these, bereavement by

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suicide affected 18% (n=614) with 21% (n=712) having experienced bereavement from sudden natural or unnatural death.

Overall of the total respondents, 78% received support post loss, with 51% receiving informal support, 14% formal and 35% receiving both. 85% of the total reported some aspect of it to have been valuable to them. Of informal support routes, family and friends were the most valued (by 64% of respondents), funeral directors were cited by 14%, health professionals 13% and 10% reported relying on self-help. Of the total respondents, 6% reported having attempted suicide since their bereavement and of those 67% had not sought help for self-harm. Of those who had sought help for self-harm, 20% received this from a general practitioner.

This is the largest UK national study of the impact of sudden death including suicide. Though significant differences did not exist between bereavement types, the suicide bereaved were less likely to have received informal support or to have received immediate support.

The study illustrates that there is still progress to be made to make real the recommendations of national suicide prevention strategies in relation to bereavement support. The number of respondents reporting self-harm following suicide bereavement and, of those, the high number not seeking help after an attempt is cause for concern. The authors equate this with a failure in policy implementation and an outcome of gaps in service.

As this research shows, suicide bereavement responses and support needs can differ from other sudden bereavement. To fully implement recommendations of national strategies and policies, attention must be given to reducing stigma, normalising support seeking and eliminating gaps in service provision. ■

An evidence and practice informed approach to implementing peer suicide grief support systematically in the United States

Cook F, Langford L, Ruocco, K (2017). *Death Studies,* https://doi.org/10.1080/07481187.2017.1335552

Cook *et al's* study also addresses the importance of national guidelines and policy in citing '*Responding to grief, trauma, and distress after a suicide: U.S national guidelines*' and finding that the suicide bereaved population is largely underserved. An objective of these guidelines is the establishment of national systematic peer support for the suicide bereaved.

The authors draw attention to the under estimation of both the numbers of suicides in the US and the severity of the lasting effects of suicide bereavement. Peer support is put forward as a viable support solution for those bereaved by suicide. ■

Identifying and defining peer support after suicide

This study aims to establish the range of peer support services and identify evidence and principles of an effective peer support program. They define Peer Grief Support after Suicide (PGSS) as involving people with a shared condition and being 'based on relational mutuality and interpersonal connectedness' (2017, p4). They differentiate this specialised peer support as being formal and intentional, as opposed to informal support gained from family and friends. PGSS can occur in different formats and settings from face-to-face or group personal sessions to telephone or online communication and outreach. The authors highlight that although there is a wide range of suicide support groups operating across the United States there is no centralised structure. Many of the more established organisations do offer training and support with varying levels of standardisation.

Despite limited studies focusing on interventions, Cook *et al* identified a number of elements for best practice by identifying themes emergent in several key studies. They drew from studies of general mental health service provision and research outlining successful approaches in addiction treatment. They cite the Consumer-Operated Services training manual's recommendation that service be delivered via peer programmes. The use of qualitative processes initiated by peer helpers and service stakeholders is also a favoured approach, as is the inclusion of mixed methods of review and input from past participants. ■

Identifying an exemplar

They specifically identify the Tragedy Assistance Program for Survivors (TAPS) as an exemplar of best practice in delivering systematic peer support. TAPS is exclusively designed, delivered and managed by peer volunteers. The programme offers a range of services from a telephone line to crisis and trauma care, web chat and group support.

The programme's approach to supporting the suicide bereaved is led by an agreed set of policies and procedures adhered to by both TAPS and the bereaved. A notable component is the assignment of a peer mentor who maintains contact with the bereaved for as long as is required. The peer mentors are in turn supported by clinically trained staff, themselves survivors of suicide bereavement.

The authors, in providing a detailed outline of the work and processes of the TAPS programme, illustrate the practical steps required to realise the recommendations of *Responding to grief, trauma, and distress after a suicide: U.S national guidelines*. While the TAPS programme operates to a gold standard of peer-to-peer service delivery it serves a very specific population (families of military suicide bereaved). Replication of the model of peer support provided by TAPs at national levels would require dedicated national efforts. ■

Current postvention research and priorities for the future: results of a survey

Andriessen K, Castelli Dransart D, Cerel J, Maple, M (2017). *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* https://doi.org/10.1027/0227-5910/a000459

The gap between national and international suicide strategy recommendations and intervention practice is also confronted in Andriessen *et al's* study. While the need for bereavement support for those who experience suicide loss is widely accepted, the extent to which research on successful postvention approaches has influenced practice is limited.

They posit that while suicide bereavement is accepted as different from other forms of bereavement there is insufficient research as to how this manifests. They ask to what extent social and personal factors influence suicide bereavement. In order to better design postvention approaches more robust investigation of the suicide bereavement experience is required. Like Cook *et al* (2017) they cite previous studies calling for the wider involvement of the suicide bereaved and their experiences in research. ■

Taskforce on Suicide Bereavement

The Taskforce on Suicide Bereavement and Postvention Research, established in 2013, aimed to address some of these issues and develop a national research agenda. The Taskforce was developed from a special interest group on suicide bereavement for the International Association for Suicide Prevention (IASP). To develop their research agenda, the Taskforce convened two projects: to map literature on suicide postvention, and to examine current research and illuminate areas for future research priorities on suicide postvention. The Taskforce developed an online survey to identify ongoing research and to invite input on areas for future research.

A 44 question questionnaire was devised of which half the questions were open-ended, half closed. It invited respondents to provide details of current research, details of their research institutes and the methodologies employed. Open-ended questions invited input on postvention research priorities. The survey was distributed through mailing lists and contacts of members of the IASP, the American Association of Suicidology and Suicide Prevention Australia. Taskforce members also distributed the survey through their own contacts.

The questionnaire was accessed 77 times and, of these, a total of 22 responses were suitable for inclusion. A large number (n=55) were not suitable for inclusion due to insufficient or incomplete data or duplication. Of the 22 responses suitable for inclusion, 19 reported conducting current research on suicide bereavement. 13 responses included future research recommendations. The findings on current research and future recommendations were categorised by the taskforce as:

- Defining the characteristics of suicide bereavement (studies examining the experience of suicide grief). These included examinations of specific population groups like the military and veterans and most used mixed method approaches.
- Studies on postvention programmes focusing on support delivery and evaluations. The reported studies were largely focused on postvention in specific settings like schools or workplaces and examined issues like guidelines and formats for support.
- Definitions, theory and epidemiology of suicide bereaved. The need for clarification of the epidemiology of suicide and to accurately identify the suicide survivor populations was highlighted.

The study findings echoed the existing literature in its trends in suicide research focus and prioritisation recommendations. Significant in their summation of findings was the highlighting of the impact of culture and diversity. The majority of respondents (32%) were living in Western countries and most (68%) working in a university or national centre. To counteract the imbalance of suicide research toward Western culture, increased effort toward intercultural collaboration in research projects is recommended. They also advise effort to improve the extent of theory driven research and to foster greater links between theory and practice. ■

Limitations and constraints

Though the authors advise that this is the first study of its kind, the small sample size and response rate does limit the study. The time frame for response and limiting responses to online only were likely to have impacted negatively on the response rate. Similarly, the high number of unusable responses may have been less detrimental to the overall study had a longer time frame and broader range of submission options been applied. Though they report that two respondents indicated difficulty in obtaining funds for postvention research, specific barriers to suicide research were not addressed.

A similar study undertaken over a longer time period and offering multiple response routes (print and online) may yield a more definitive insight into the current state of suicide postvention research. This study does offer a jumping off point from which more in-depth examination of the state of postvention research could be applied. ■

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