# Best Practice Strategies for Postvention
## 2014

## Abstract

The aftermath of suicide is a devastating and sometimes frightening issue. If not handled well, postvention strategies may actually contribute to the spread of suicide, so consideration of best practice is essential. Young people are at particularly high risk of considering suicide when one of their peers dies by suicide. This highlights the importance of postvention strategies to support the bereaved in dealing with the effects of suicide.

This paper sets out best practice strategies for people working with young people who have experienced another's suicide. Best practice appears to involve managing contagion through recognising and referring young people at high risk, collaborating with the media toward responsible reporting, and considering the specific needs of the suicide bereaved and how these differ from regular bereavement.

## Population stats

- On average, 5 immediate family members, 15 extended family members, 20 friends, and 20 co-workers and classmates, are directly affected by a single suicide [1]
- Across the world, this is upwards of 6 million lives affected by suicide each year
- An estimated 65,000 lives have been affected by suicide in New Zealand alone over the past 25 years [2]

## Overview

Young people who experience a peer's suicide are at increased risk of considering suicide themselves [3]. Because of this, postvention plays an important role in wider suicide prevention strategies.

**What is postvention?**

Postventions offer assistance to those affected by suicide as well as their support providers. Strategies typically serve three purposes [4; 2; 5]:

- managing the immediate crisis of suicide and reducing the likelihood of further suicides
- helping the bereaved cope with the immediate and long term effects of suicide
- returning schools and communities to their regular routines

Best practice is essential when applying postvention strategies. Postvention strategies that have not been informed by best practice have actually increased the risk of suicide for young people in a school setting [4]. This paper would be best considered alongside The Ministry of Education's, *managing emergencies and traumatic incidents—the guide*, which sets out specific planning and response practices for schools and communities [6].

**Suicide bereavement**

In New Zealand, the people whose lives have been affected by suicide are commonly referred to as the suicide bereaved. For someone to be affected by suicide, they do not necessarily have to have been close to the deceased. Even those who merely know of the suicide can be deeply affected, even if they do not experience the severity of the suicide first-hand [7]. Common experiences for the suicide bereaved include [2; 8; 9; 10]:

- guilt
- neglect
- abandonment
- rejection
- shame
- anger
- distress
- traumatic grief
- helplessness
- mental ill-health
- family and relationship dysfunction
- social stigma
- physical symptoms

International survey research suggests that the bereaved may want more help than they are actually accessing [11]. Perceptions of guilt and stigma in particular, prevent some people from accessing support even though they may want it [8; 10; 12]. Suicide can also affect the bereaved in more material ways, particularly young people, where they may be dependent on the deceased for housing and monetary support [3].

To cope with suicide, some young people may prefer [10]:

- to cope by themselves, while others prefer the help of others
- the help of individuals, while others prefer the help of a group
- help from other bereaved, while others prefer the help of a professional

## Vulnerability and risk

The knowledge of another's suicide is likely to influence a young person's risk of suicide [13; 11; 3], especially if they are already vulnerable [14; 15; 16]. The 'spread' of suicide is referred to as contagion and can result in suicide clusters where one or more suicide attempts closely follow the first [16].

There appear to be many factors that increase the risk of suicide for a deceased person's peers. Vulnerability and risk factors associated with suicide are outlined in Youthline's *Best Practice Strategies for the Prevention of Suicide*. Social helplessness, stigma associated with suicide, and the inability to ask for help also increase the risk of suicide for the bereaved.

### Social helplessness

Some bereaved report 'social helplessness' in which they feel that their social networks have difficulty in appropriately supporting them [10]. Some bereaved have reported that [10]:

- the support they expected did not appear
- people have tended to stay away from them, sometimes by physically crossing the street
- others actively avoid talking about the suicide, avoid using the deceased's name or stop talking when the name is mentioned
- they received only short-term social support

- their grief was sometimes made worse by comments they found thoughtless, such as "you have more children"; "God's purpose"; "as he was such a problem, it must be a relief"
- some of the advice given was unhelpful, such as "you have to forget and go on in life"; "you ought to sort out his room now"; "you should not visit the grave as much as you do"

Some bereaved experience unhelpful reactions from the people in their social networks, leaving them feeling rejected or neglected [10]. Other bereaved may initially receive some support closely after the suicide, but find this disappears over the following months [10]. Many bereaved may experience the expectation of others that they get on with their lives and continue as normal, which may interfere with their grieving process [12].

### Stigma associated with suicide

Some bereaved avoid talking about the deceased or the cause of death because of the stigma they perceive as attached to suicide [10]. The avoidance of discussion around suicide, or the deceased, limits opportunities for the bereaved to talk about their experiences and may worsen their feelings of shame, guilt and blame [12].

### Inability to ask for help

Many bereaved have reported not having the ability to be open about their experience or ask for support [10]. Reasons include [12]:

- fear of stigma
- loss of energy and exhaustion
- shame
- guilt
- perceived prejudice
- depression
- lack of information

Because of this, many bereaved have stressed the importance of outreach support [12].

## High risk groups

Contagion and cluster suicides are much more likely to occur in young people than in older age groups [13], with higher levels of suicidal behaviour

being reported by school-mates than by their non-immediate peers [16]. When a young person dies by suicide, their friends may experience [16]:

- guilt for missing the warning signs
- anger for not intervening
- posttraumatic stress
- depression
- suicidal ideation

Research suggests that some young people continue to show symptoms of posttraumatic stress and grief, six months after a classmate's suicide [14]. This highlights the need for continued long term monitoring and support for bereaved young people [16]. Research has also warned of the possibility of 'reverse stigma', where a young person's suicide may become romanticised and idealised by young people [4]. Some young people may also identify with the deceased and value the possibility of escape from difficult lives [4]. Because of the increased attention received by the deceased, the deceased's closest friends and other young people at risk, some young people may use the situation to draw attention to themselves through suicidal behaviours and threats [4].

Suicide contagion has also been observed to be more likely in high risk groups such as indigenous communities [17; 18] and those experiencing mental health issues [19; 20].

## Resilience

Resilience factors against suicide are covered in Youthline's *Best practice Strategies for the Prevention of youth Suicide*. Research suggests that better outcomes for the bereaved (i.e. fewer stress-related illnesses and fewer days absent from work) are associated with healthy lifestyle behaviours, particularly [21]:

- eating a balanced diet
- not smoking
- low alcohol consumption
- weekly exercise and leisure
- active and expressive coping

## Best practice

Because of the damaging effect that stigma can have on the bereaved and on their ability to grieve openly and seek help, advocates have argued that consideration should be given to the language that is used when talking about suicide [22; 23; 24]. Specifically, it has been argued that saying someone 'committed' suicide brings with it associations of criminal offence; 'successful' suicides or failed' suicide attempts may suggest that suicide is positive, rather than a tragedy, and something to be strived for [22; 23; 24]. The following table summarizes stigmatizing phrases and suggests replacements that may be helpful in talking about suicide in ways that avoid negative associations and accusations [22; 24].

| Stigmatising phrases | Suggested phrases |
|---|---|
| Committed suicide | Died by suicide |
| Successful suicide | Suicided |
| Completed suicide | Ended his/her life Took his/her own life |
| Failed attempt at suicide | Non-fatal attempt at suicide |
| Unsuccessful suicide | Attempt to end his/her life |

*Talking about suicide* [24]

Best practice strategies for supporting young people who may be considering suicide, are covered in Youthline's *Best Practice Strategies for the Prevention of youth Suicide* paper. Further considerations for young people experiencing another's suicide are outlined below.

### Factors relating to the bereaved

*Reactions to suicide*

Not all people react the same way to suicide [10; 25]. Reactions to suicide may be influenced by culture, societal beliefs, personal values, norms and relationships [12]. These influences may affect a young person's expression of grief and the length of time they may grieve for [12]. The needs of the bereaved

may differ depending on their own personal needs [12] and on the meanings attached to suicide within their context. Suicide bereavement may also differ from general bereavement, in which people may [9; 12]:

- struggle to find meaning in the suicide
- experience guilt around not preventing the death
- experience high levels of abandonment by the deceased
- encounter stigma associated with suicide

These differences highlight the specific need to address themes of shame, guilt, stigma and isolation that are significant to bereavement associated with suicide [25].

*Gender*

Men may use different strategies than women to cope with suicide bereavement [11]. As such, interventions or support systems that focus on self-disclosure may be less effective with particular coping styles, such as instrumental or avoidant styles typically associated with men [11]. This could go some way to explain why some postvention strategies have been found to be effective with women, but not with men [11]. Expressive writing interventions have been found to be helpful in relieving grief associated with suicide, and may be particularly useful when working with those—men in particular—who may not be very forthcoming with disclosing traumatic experiences to others [11].

*Openness*

Some bereaved have found that being open about the details of the deceased's death in general has helped to prevent untrue rumours, allow them to express their feelings, receive more sensitive advice and reduce social helplessness [10]. However, this is not experience of every bereaved, with some strongly opposing openness about suicide [10]. When being open about the suicide, some people may feel that they are being controversial and risky, which reflects the pervasiveness of stigma around suicide [10]. This suggests that the willingness to be open about suicide will vary from person to person.

**Counselling factors**

*Characteristics that may influence outcomes*

Counselling distressed young people within groups or over long sessions may worsen young peoples' anxiety or the sense of romanticism and melodrama sometimes associated with youth suicide [4]. One successful postvention strategy found that individual counselling, and being flexible around the length of counselling sessions, resolved this issue and helped to calm distressed young people [4]. Research suggests that better outcomes could also be expected from more highly trained professionals, greater numbers of counselling sessions and treatment that starts closer to the death [11].

*Family therapies*

Family-based postvention strategies have been found to result in improvements in depression and anxiety symptoms, as well as grief, psychological distress and posttraumatic stress, which were still evident at a one-year follow-up [26]. Bereaved mothers have reported improvements in psychological distress, posttraumatic stress in particular [26]. However, bereaved fathers have benefited in regards to psychological distress, but not symptoms of posttraumatic stress or grief [26].

*Bereaved strategies and needs*

In general, the bereaved have reported wanting [10]:

- respect
- tact
- to be taken seriously
- time and space to mourn
- information about the death and about suicide in general
- help with administration and bureaucracy issues
- awareness of the experiences of the bereaved
- professional advice
- to meet other people with experiences of the grief process

In regards to counselling, some bereaved have reported the need for [10; 11]:

- follow-up at later stages
- carers skilled in suicide bereavement
- on-demand and after-hours support
- outreach, rather than expecting the bereaved to reach out for help
- help with supporting young people, particularly younger children
- help in addressing intrusive memories and images

It is advised that the coping needs of any particular bereaved be assessed and addressed.

*Peer Support*

The bereaved may not want solely professional or social support, but rather may benefit from the way each support system addresses different needs [12]. The most important social characteristics rated by the bereaved appear to be that their networks care about them, make contact, are available, are patient, listen, show empathy and are okay in talking about the deceased [12]. Family and close friends appear to comprise the most important part of a supportive social support network [12].

Some bereaved do report receiving valuable information from social support networks, particularly if their peers have experienced suicide-related bereavement, themselves [12]. Meeting experienced bereaved may also give them hope for the future [12]. Experienced bereaved may find meaning in supporting others [12].

*Parents*

Parents may experience feelings of guilt around not fulfilling their role as a parent, and may also perceive that others blame them for not intervening in their child's death [8]. Parents may also wonder whether or not they are doing the 'right thing' and want professional help in improving family dynamics and supporting their children [12]. Young people, on the other hand, have reported wanting their needs addressed as independent individuals, reporting also that their parents and younger siblings should be receiving help with coping so that young people would not be burdened with this responsibility [12].

In the past, not reporting minor incidents of suicidal ideation has been found to create a sense of secrecy and melodrama, and contribute to contagion [4]. Reporting even minor incidents to parents may encourage the involvement of parents and the resolution to home conflicts which have been contributing to a young person's risk [4].

**Postvention and the media**

The media has been found to play a potential role in suicide contagion, with already at-risk youth more likely to attempt suicide, following media portrayals of suicide [15]. Certain details that are presented in the media may increase the chances of further suicides [16]. These include [13]:

- presenting the picture of suicide as simple or the result of a single cause
- long-term coverage which maintains a continued focus on suicide
- sensationalising the suicide and heightening public preoccupation with suicide
- reporting on specific details or exact methods of the suicide
- presenting suicide as a coping strategy used in response to personal problems
- glorifying the deceased or their families

To reduce the risk of contagion, research recommends that a representative from an affected school or community be appointed to work with the media [13]. It may be helpful for them to consider that [13; 5]:

- the media will pay attention to, and report on suicide, so attempts to prevent it may not be effective
- providing 'no comment' prevents the opportunity to promote responsible and accurate media reporting, and the ability to guide media coverage
- time should be taken to explain to media representatives the reasons for not reporting on the methods of the suicide as well as the obligation for responsible reporting to reduce contagion
- the media may be helpful in spreading the details of local mental health and support services

## Summary

The main aims of postvention are to support the bereaved through an extremely difficult time, while also preventing further suicides. Young people are at increased risk of suicide contagion, particularly if they have existing mental health or family issues. Because postvention strategies are closely linked to prevention strategies, this paper is best considered alongside Youthline's *Best Practice Strategies for the Prevention of Youth Suicide* as well as *Best Practice Intervention Strategies for Depression*.

While some bereaved may fall back on their social networks and receive helpful support, others may not and may feel isolated from these networks as a result. This presents a niche for people working with young people to offer their patience, sympathy and compassion, while also monitoring a young person's health, particularly in regards to signs of depression of suicidal ideation. Best practice involves managing contagion through recognising and referring young people at high risk, collaborating with the media toward responsible reporting, and considering the specific needs of the suicide bereaved, how these differ from regular bereavement and how they can be applied in practice.

### *Strategies that work*

- ✓ Considering postvention as an extension of wider prevention strategies

- ✓ Recognising that not all young people will react to suicide in the same way

- ✓ Recognising and being sensitive to the fact that the bereaved will have varying levels of comfort in talking about suicide

- ✓ Being aware of the potential effects of stigma

- ✓ Addressing the specific needs of the suicide bereaved and the specific issues that are associated with suicide

- ✓ Helping young people to have their own voices heard and addressing their needs as individuals within a safe environment

- ✓ Helping the media and guiding them toward responsible reporting

- ✓ Facilitating networks of the bereaved who can support and help each other

- ✓ Involving parents in disclosure and treatment processes

- ✓ Providing support for parents to support young people

### *Strategies that don't work*

- ✕ Assuming a one-size-fits-all approach

- ✕ Treating suicide bereavement as regular bereavement

- ✕ Pressuring young people to 'get over' the suicide and continue their lives as they had before

## Recommended referrals

### In an emergency

Police/ambulance services    111

### Youthline counselling services

Helpline                    0800 376 633
Text counselling            234
Face-to-face counselling    (09) 361 4168

### Planning postvention strategies

Ministry of Education       www.minedu.govt.nz
Traumatic Incident Team     0800 TI TEAM
                            (0800 848 326)

### Local mental health service providers

211 information line        0800 211 211
Family services directory   www.familyservices.govt
                            .nz/directory

### Training and seminars

Youthline                   www.youthline.co.nz

### Advice for friends and colleagues

*Help is at hand: a resource*    Available free, online.
*for people bereaved by*
*suicide and other sudden,*
*traumatic death*

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