

SUICIDE POSTVENTION AS SUICIDE PREVENTION: IMPROVEMENT AND EXPANSION IN THE UNITED STATES

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The authors asserted the need for increased postvention efforts for suicide survivors, individuals left behind to grieve the loss of a loved one by suicide, because they have an increased risk for suicide. Indeed, Shneidman (1972) asserted that suicide postvention efforts serve the dual purpose of assisting survivors through the grief process and preventing suicide for future generations. First, the authors briefly discussed the increased risk for suicide among survivors. Second, the authors overviewed the potential benefits of postvention programs and current strategies for suicide postvention in the United States. Finally, they recommended plans for suicide postvention program development such as states should include efforts to create or expand traditional postvention services as well as active survivor outreach to link survivors to these services.

Despite the identification of myriad risk and protective factors and increased prevention efforts, the World Health Organization (WHO; 2002) estimated 815,000 people a year die globally by suicide. These 815,000 deaths leave millions of their loved ones behind to wonder why their suicides were not prevented. Indeed, the global suicide rate increased by 60% over the past 50 years and is expected to continue to increase (WHO, 2006). Given these data, it would be reasonable to examine Shneidman's (1972) assertion that suicide postvention (i.e., activities that come after the suicide to alleviate its impact on survivors) serves the dual purpose of assisting survivors through the grief process and preventing suicide for future generations, explores the benefits of providing postvention to suicide survivors, and reviews current

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postvention efforts and recommend improvements for postvention in the United States.

Suicide Postvention Assists Survivors and Prevents Future Suicides

Inasmuch as suicide postvention might prevent future suicide, relevant issues include why people die by suicide and whether survivors of suicide exhibit risk for suicide themselves. If survivors do exhibit suicide risk, what are the possible contributing factors to their increased risk? How do these contributing factors complicate the grief process for suicide survivors?

Why Do People Die by Suicide?

There are many theories of why people die by suicide; we focus on Baumeister's theory because it applies to suicide survivors. Baumeister (1990) theorized that people use suicide as an escape. Baumeister explained that a person, after experiencing a series of stressful life events (e.g., extreme disappointments, relationship problems, unemployment or other job difficulties, decline in health, death of a loved one), may begin to feel hopeless about the future. Hopelessness results in a numbing of emotions because the person wants to protect him/herself from pain. If positive events or social supports do not intervene, the person may choose suicide as escape.

Either a single or a series of negative life events occur temporally close to death by suicide (e.g., Maltzberger, Hendin, Haas, & Lipschitz, 2003), and these negative life events lead to the buildup that results in the hopelessness so often indicated in suicide (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Applying Baumeister's (1990) theory, suicide survivors may choose suicide as an escape from the hopelessness surrounding the loss of a loved one by suicide. There are several negative life events surrounding the loss of a loved one by suicide: (a) stress before the suicide occurred (e.g., relationship difficulties); (b) the suicide itself; (c) the funeral and settling the estate; and (d) the suicide survivor's grief process including feelings of stigma, shame, isolation, self-blame, and psychache—intolerable psychological pain (Shneidman, 1996).

Suicide survivors often exhibit increased risk for suicide—between 2 and 10 times that of the general population (e.g., Kim et al., 2005; Runeson & Åsberg, 2003). In one study, adolescent survivors were five times more likely to think about suicide than peers who were experiencing grief due to some other loss (Prigerson, 2003). In another study, family members of those who died by suicide had increased risk for suicide independent of the family's history of mental illness (Qin, Agerbo, & Mortensen, 2002). In still another study, the suicide rate was significantly higher among relatives where the death was by suicide as opposed to some other cause of death (Runeson & Åsberg, 2003). In addition, research on suicidal ideation and suicide attempts also support these findings of increased risk (e.g., Prigerson, 2003).

*Factors That Contribute to Suicide Survivors' Increased
Suicide Risk and Complicated Grief*

A discussion of all possible contributing factors to a suicide survivor's increased risk for suicide is beyond the scope of this article. This section discusses why being a suicide survivor contributes to a suicide survivor's risk for suicide and how Baumeister's theory of suicide as escape explains the impact survivorship has on the grief process.

Recurrent themes in the existing survivor literature including shame due to stigma, risk for developing depression and/or post-traumatic stress disorder (PTSD), feelings of abandonment and rejection by the deceased, and a need to answer the question "Why did s/he choose suicide?" (Jordan, 2001, 2003). A suicide survivor's grief, stigma, shame, isolation, and self-blame result in a state of heightened stress. This state of heightened stress may balloon into psychache, a commonly identified trigger of suicide. Heightened stress leads to increased vulnerability.

Baumeister's theory effectively explains how being a suicide survivor may lead to a heightened state of stress because losing a loved one to suicide is a significant negative life event. Often, the negative life event creates in the suicide survivor a need for social support, but prevailing attitudes toward suicide cause the suicide survivor to meet, at worst, animosity, and, at best, glib reassurance. Perversely, this type of social support engenders more stress and isolation. Increased stress and isolation may result in psychache and suicide as escape.

These factors that contribute to a survivor's risk also often negatively impact the survivor's ability to successfully navigate the grieving process, primarily because suicide survivors are frequently blamed for the suicide or intrinsically feel that others blame them (e.g., Dunn & Morrish-Vidners, 1987–1988; Hauser, 1987). Another situation a survivor may encounter involves reactions from others, such as “What a selfish act!”, “He doesn't deserve your tears,” “He couldn't have loved you very much to leave you like that,” “Hasn't he caused you enough grief already?”, and the list continues. Whether the issue is blame for the suicide or others' judgments of the deceased's actions, these factors may prevent survivors from involving others in their grief process. In fact, many survivors experience a heightened sense of uneasiness around people resulting in a closing off from others (Begley & Quayle, 2007). The survivor does not feel free to mourn much like the battered wife who is ridiculed for loving her batterer (Campbell, 2000) and the rape victim who is blamed for her victimization (Herman, 1997). These risk factors often result in an unwillingness to involve others in the grief process, as well as reduced likelihood that survivors will seek help (McIntosh, 1993). Current estimates indicate that only one in four survivors seeks the help desired (Dyregrov, 2002; Provini, Everett, & Pfeffer, 2000).

What Are the Potential Benefits of Providing Postvention Services to Suicide Survivors?

Suicide postvention activities may include but are not limited to individual therapy for survivors, support groups for survivors, and outreach to survivors. The most commonly available and suggested form of postvention is the survivor support group (Reed, 2006). Postvention's primary benefit is alleviating psychache. A secondary benefit is engendering a feeling of belongingness among a cohort of survivors. The limited literature on suicide survivor support groups suggests effectiveness (e.g., Farberow, 1992; Rogers, Sheldon, Barwick, Letofsky, & Lancee, 1982), making the estimate that only one in four survivors seeks help discouraging. In fact, of those that participate in postvention services, anywhere from 65% (Provini et al., 2000) to 88% (Dyregrov, 2002) find these experiences helpful (see Jordan & McMenamy, 2004, for a review).

When Shneidman (1972) suggested that postvention is prevention for the next generation, he likely was working out of his understanding that the psychache present in persons who die by suicide is “inherited” by suicide survivors. As Shneidman explained in a 2003 interview (Carvalho & Branfman, 2003) about the experience of the suicide survivor,

I believe there's no suicide without a great deal of suffering. That's in combination with the notion of death as escape. It's in combination with the thought “I won't take this,” “I don't have to take this,” and suicide is an ending, it's a stopping, it's a stopping of the unbearable flow of consciousness. (p. 11)

Suicide survivors find postvention efforts effective because they provide a safe outlet for the psychache and negative emotions inherited from the person who died by suicide and accumulated from interactions with the suicide survivor's social supports (Jackson, 2003, Myers & Fine, 2006). Joiner (2005) proposed that belongingness is a protective factor against suicide. For example, during times of intense unity in the United States, such as after the assassination of President John F. Kennedy and after the Challenger Space Shuttle crash, the suicide rate decreased during the period immediately following the events (Biller, 1977; Joiner, 2005).

Current Postvention Efforts in the United States and Recommendations

In 1999, the U.S. Department of Health and Human Services (HHS) Office of the Surgeon General, in recognition of the devastating loss of approximately 30,000 lives each year to suicide and the estimated 650,000 who suffer injuries from attempted suicide, issued a call to action for suicide prevention. This call resulted in The National Strategy for Suicide Prevention (NSSP), which has as one of its aims to “reduce the harmful after-effects associated with . . . the traumatic impact of suicide on family and friends” (HHS, 2001, p. 28), an estimated 180,000 people every year who become survivors of suicide (McIntosh, 2007). However, despite this aim, there is no mention of the crucial component of postvention. The state plans for suicide prevention that have resulted to fulfill requirements of the NSSP, are lacking in postvention components. In a review of state plans ($n = 47$) available through

the Suicide Prevention Resource Center's (SPRC; 2008) website, only a little over a half ($n=25$) included efforts to expand services available to suicide survivors. Four states went beyond a general statement about expanding services, addressing the need to train first responders, clergy, and funeral directors on how to respond to survivors immediately following a suicide. Several ($n=9$) postvention plans focused solely on youth, leaving a significant gap in outreach to adult survivors. Although expansion of services available to survivors is a significant step toward reducing the harmful after-effects, all the state plans overlooked a mechanism to link survivors with services.

Typically, strategies to link survivors with postvention services take one of two forms: the traditional model and the active model. The traditional model waits for the survivor to approach the service provider, and with an estimated average of four and a half years for survivors to find services (Campbell & Cataldie, 2003; Campbell, Cataldie, McIntosh, & Millet, 2004). The active model, less commonly used, involves service providers actively reaching out to the newly bereaved in hopes of educating them on what they will experience and where they can go for help. This active model results in an estimated one month between contact and the survivor receiving services (Campbell & Cataldie, 2003; Campbell et al., 2004).

Given that suicide survivors are very likely at an increased risk of suicide and that postvention efforts like the suicide survivor support group are effective, and arguably essential, steps in the grieving process, a necessary concern is linking suicide survivors with postvention services. In addition, more must be done about providing postvention services in the first place. This section of the article discusses first, general guidelines for postvention; second, how an active postvention model meets the need for connecting the survivor to survivor services; and third, offers guidelines to the states on how to include an active postvention model in their suicide prevention plans.

Outreach to survivors at the scene of the death is an example of an active postvention effort that could assist with connecting survivors to much needed services. One promising model for survivor outreach is Campbell's (1997) Active Postvention Model (APM; Campbell et al., 2004) currently being implemented in parts of the United States, Australia, Northern Ireland, and Canada

(F. Campbell, personal communication, September 10, 2007). This model “places a new first responder at the scene of suicides while the body is still present” (Campbell & Cataldie, 2003, p. 36); this person, typically affiliated with the local crisis center where survivor services are housed, is usually a suicide survivor who has been trained to handle the intricacies of intervening during this difficult time for the new survivor. The survivor first responder fills a role that traditional first responders (e.g., police, coroner or medical examiner, fire department, emergency medical service providers) may neither be trained nor have the time to fulfill.

Unintentionally, traditional first-responder activities of securing the scene, ensuring safety, collecting forensic evidence, and determining cause of death leave the survivor reeling and overstimulated with feelings ranging from bewilderment and disbelief, to anger and fear. The responding survivor in the APM can be devoted solely to the new survivors, answering questions, offering comfort, explaining available services, and, most importantly, offering solidarity. This active model increases the exposure of new survivors to individuals whose priority is to respond to their psychological needs. The presence of a senior survivor enhances the environment, providing insulation from stigma, raising the awareness of other first responders of the difficulty in this type of death notification, and resulting in marked reduction in activities that compromise a survivor’s already vulnerable emotional safety (Campbell et al., 2004). This process is akin to what has been found among rape survivors who become advocates accompanying new rape survivors to hospitals for sexual assault exams to gather forensic evidence (Herman, 1997). Logically, it can be extrapolated that part of the preventive nature of postvention, especially where newly bereaved suicide survivors are linked with senior suicide survivors, is in the interconnectedness it engenders, benefiting not only the newly bereaved but also the senior survivor.

Given the benefits to the survivors receiving an active postvention, specifically the shortening of time between death and the receipt of services, and the benefits to the survivors providing the active postvention, the lack of a catalyst between the newly bereaved suicide survivor and the existing or expanding suicide services is a detrimental oversight in the state plans in the United States to prevent suicide. We recommend that not only should states focus on building postvention services but also states should add the

APM to these plans as the mechanism linking survivors with services.

Guidelines for Active Postvention Program Development

To guide postvention implementation, Shneidman (1981) outlined principles of suicide postvention, which Leenaars and Wenckstern (1998) extended and adapted to other traumas. These principles are (a) postvention should begin within 24 hours; (b) survivors may resist postvention efforts; (c) negative emotions are likely but should be addressed later; (d) postvention providers are survivors' links to reality and reason; (e) postvention providers need to be vigilant for changes in survivor physical and mental health; (f) postvention providers should avoid glib reassurance (e.g., "It will get better"); (g) the work that follows immediate postvention, such as counseling and support groups, requires extensive time and effort; and (h) "[a] comprehensive program of health care on the part of a benign and enlightened community should include prevention, intervention, and postvention" (p. 366).

It is important to note that Campbell's APM model meets the majority of these guidelines. Although Campbell's APM model is exemplary, it requires a luxury of resources including cooperation from the coroner's or medical examiner's office, a crisis hotline, and a team of willing and emotionally capable senior survivors to lead the effort. As an alternative, a modified plan implemented at a crisis center in the southern United States serves as a catalyst between the survivor and survivor services yet requires fewer resources.

Like Campbell's APM, this program involves senior survivors who are trained to respond to the needs of the newly bereaved by suicide. The crisis center calls these senior survivor volunteers whenever they receive news of a suicide in the area. However, instead of going to the scene of the death, the crisis center aims to match senior and newly bereaved survivors based on relationship to the deceased. The senior survivor then calls the newly bereaved and arranges a time to talk either in person or over the phone, depending on the newly bereaved person's preference (J. Gush, personal communication, May 16, 2008). This meeting is a time, similar to the intent of Campbell's APM, for the newly bereaved person to link with someone who has shared the tragedy of suicide in a similar way. This meeting fosters the belongingness that is

needed as a protective factor in suicide prevention (Joiner, 2005) and serves as a catalyst for getting the newly bereaved person to survivor services such as a support group.

Conclusions and Recommendations

In strengthening suicide prevention through postvention, there are many things that must be accomplished. First, it is important to implement sound program evaluations of existing prevention efforts. To date, evaluation is lacking (HHS, 2001; for reviews, see Goldsmith et al., 2002, and Maris, Berman, & Silverman, 2000). In addition, it is important to continue to extrapolate from existing knowledge of suicide risk and protective factors what elements are necessary in effective suicide prevention. A largely ignored prevention element is postvention.

To summarize, the authors offer several recommendations. First, in prevention plans, states should include not only efforts to create or expand traditional postvention services but also active survivor outreach such as the APM to link survivors to these services. Second, the SPRC (2004), which has as one of its goals to “Help states and communities increase their capacity to develop, implement, and evaluate suicide prevention programs” (¶1), should provide assistance to states in developing postvention services. Campbell’s APM and similar active models should be implemented and evaluated in other communities; these need to be evaluated further on effectiveness as these exist in current communities and also in relation to communities of differing characteristics (e.g., rural, suburban, urban, and cultural differences). Evaluations should be from the time of outreach and follow the survivors throughout treatment. Comparison groups of survivors not receiving an active model of postvention should be identified to assess whether the presence of the active model of outreach impacts survivors’ healing. Studies need to be conducted on survivors who do not receive any kind of postvention services to identify traits and strengths that may insulate them from the complicated bereavement assumed characteristic of suicide survivorship. Finally, evaluation efforts should use a mixed methodology approach. The existing research on prevention efforts, especially postvention components, has been limited methodologically. As Jordan and McMenamy (2004) and Jordan (2001) highlighted,

mixed methodology studies were more effective through qualitative interviews in identifying nuances missed in quantitative methods. Qualitative methods are particularly appropriate as postvention efforts are likely greatly impacted by the natural setting in which they occur (e.g., crisis centers that host survivor groups, level of social integration in the community, existing suicide prevention efforts). Quantitative methods are limited in teasing out how these contexts of postvention impact the outcomes. Qualitative methods, specifically the phenomenological approach, which seeks to understand the lived experience of the respondents, are inherently designed to assess a phenomenon in its natural setting and context (Moustakas, 1994).

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