Support for people bereaved by suicide

This section focuses on supporting people bereaved by suicide with the aim of reducing the possible negative effects of a suicide. This activity is commonly called ‘postvention’.

Aims of postvention

- An ability to draw on knowledge of the aims of postvention, for example:
  - reducing the incidence of suicide and improving mental health in those who have been bereaved
  - reducing the stigma and isolation experienced by those who have been bereaved by suicide
  - offering bespoke support for those bereaved by suicide (such as support through the legal process)
  - signposting to appropriate sources of support
  - reducing the risk of contagion or the emergence of suicide clusters

Knowledge of bereavement

- An ability to draw on knowledge that the experience of bereavement will be influenced by many factors, including cultural norms, belief systems, faith systems and life experiences
- An ability to draw on knowledge:
  - of psychological models that describe the process of grieving as a series of phases, the order and timing of which will vary from person to person, but which broadly include:
    - initial shock and denial
    - acceptance of the reality of the loss
    - experiencing the pain and distress associated with the loss
    - adjusting to a new reality in which the person who has died is no longer present
  - that it is usual for people to oscillate between a focus on loss and some degree of avoidance
  - that rather than grieving leading to a ‘detachment’ from the person who has died, it usually involves adjusting and redefining the relationship to them, allowing for a continued sense of connection and an enduring bond

Knowledge about the nature of bereavement after a death by suicide

- An ability to draw on knowledge that bereavement after a suicide is often different to bereavement after a death from other causes, arising from survivors' perceptions of, and preoccupation with, issues such as:
  - the degree to which the suicide is seen as an understandable choice (e.g. suicide in the context of a terminal illness as contrasted with a death that is unexpected and not readily explicable)
  - the extent to which the death is perceived as preventable and the survivors' or other people's role and responsibility in relation to it (associated with feelings such as guilt, blame or anger)
  - a sense of stigma or shame (which may lead to a withdrawal from potential sources of support)
  - a feeling of isolation stemming from a loss that they feel others may not understand
- An ability to draw on knowledge that survivors may experience trauma, for example, arising from:
  - ruminating about the intensity of the difficulties that the person who has died may have been experiencing
  - direct exposure, such as witnessing the suicide itself (e.g. discovering the body), visiting the scene of death, being exposed to artefacts related to the suicide or hearing detailed accounts of the death (e.g. in a coroner's court)
  - imagined exposure (creating in imagination, and ruminating on, a mental image of the way in which the person died and the suffering this entailed)
- An ability to draw on knowledge that while grieving, close relatives of the person who has died will face unfamiliar legal and practical challenges (such as the police investigation, identification of a body, the coronial process, delayed registration of death and the person's affairs)
- An ability to draw on knowledge of common reactions in people bereaved after a death by suicide, such as:
  - cognitive and emotional reactions
    - shock and disbelief
    - anguish, longing and searching
    - shame and self-blame
    - despair, depression and sadness
    - a sense of abandonment and rejection by the person
    - blaming others and assigning responsibility for the death
    - trying to make sense of the death in order to restore a sense of order
    - guilt (about actions taken or not taken, and their failure to save the person)
    - anger, often related to feelings of guilt, blame, abandonment and a sense of preventability
    - relief, often accompanied by confusion and guilt (e.g. if the suicide comes after a prolonged period of conflict or need for support)
    - searching for answers (e.g. a preoccupation with learning about what led to the death, difficulty living with ambiguity surrounding the death)
    - fear and anxiety (e.g. that another person close to them may take their own life)
  - physical reactions (often associated with anxiety and/or depression)
    - stomach pains, tightness in the chest, sensitivity to noise, breathlessness, disturbed sleep, poor concentration, lack of energy
  - symptoms of trauma, such as recurring nightmares or flashbacks

Supporting people after a death by suicide

Psychological support

An ability to help to validate and 'normalise' a person's experiences and reactions (e.g. through listening and through psychoeducation about bereavement)
An ability to allow a person to detail the circumstances of the death and its aftermath
An ability to help a person discuss their emotional reactions to the death and thereby:
come to terms with the reality of the death and the meanings associated with it
acknowledge, accept and find ways to manage their emotions
adjust to the inevitable changes associated with the suicide
rebuild connections to the person who has died that are reality based (rather than idealised or excessively denigratory)
An ability to identify whether the bereaved person is themselves at risk of suicide and if so to implement a safety plan
An ability to identify resources and sources of support with legal and practical issues
An ability to enable access to support groups and psychological services for people bereaved by suicide

Peer support groups

An ability for peer facilitators to:
draw on their own lived experience of bereavement by suicide
listen to the stories of others without being immobilised by their own grief
acknowledge that people will have different ways of coping
work with group members whose cultural background and experience is different from their own
respond appropriately to group members with a different suicide experience from their own
work collaboratively with a co-facilitator
maintain the confidentiality of the group
manage challenging group situations in an appropriate manner (e.g. making sure that certain individuals do not dominate the group)
access support if they are finding it difficult to cope with the cumulative effect of supporting others in distress

Organisational competences relevant to postvention

- An ability to draw on knowledge about the structure and content of postvention services set out in public health guidance and the recommendations contained in national suicide prevention strategies
- An ability to gather and interpret local data on death by suicide that can be used to inform the need for postvention, for example:
  - collating demographic data on suicide deaths
  - identifying patterns or trends in data on suicide deaths
  - identifying geographical areas of concern or other evidence of clusters
- An ability to identify current local provision of postvention and the availability of funding for services
- An ability to identify and contract with organisations or agencies with the capacity and ability to set-up and deliver postvention services
- An ability to identify the required characteristics of postvention services, for example:
  - identifying the recipients of services, such as:
    - adults only, adults and children, children and young people only
    - those with close connections to the person who has died, such as next of kin and close family members
    - non-family who were close to the person, such as friends
    - people who knew (but who had variable levels of contact with) the person, such as school friends or work colleagues
  - identifying the ways in which the characteristics of recipients of services will influence service specifications
  - identifying what the service offers to recipients, for example:
    - information and signposting only
    - outreach to the bereaved
    - practical support (e.g. with funerals, legal processes)
    - individual clinical support
    - peer support
    - group support facilitated by professionals or peers
    - referral pathways to other services
    - remembrance services
- An ability to audit the effectiveness of the postvention service (e.g. through feedback from service users and those offering postvention services, or a requirement for formal reporting on uptake and use)