Suicide Postvention[1]

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A term first coined by Shneidman (1981), the American Association of Suicidology (1998) defines suicide postvention as "the provision of crisis intervention, support and assistance for those affected by a completed suicide" (p. 1). "Affected" individuals include classmates, friends, teachers and family members, and are often referred to as "survivors" of suicide (Knieper, 1999). This article's examination of suicide postvention begins by exploring the consequences of being a survivor and the goals of postvention. Next, the special issues generated by a suicide death, and the topics of preparing for, providing, and evaluating suicide postvention are reviewed. Finally, this article concludes with a brief comment on future directions in the development of suicide postvention programs.

The Consequences of Being a "Survivor" of Suicide

Reactions. A variety of emotional, behavioral, and physical reactions are observed among individuals affected by the suicide of a friend or loved one. They include: shock; anger toward the suicide victim and others judged responsible for the suicide; loss of interest in work; increased absences; disrupted sleeping and eating patterns; and feelings of grief, helplessness, abandonment, isolation, loneliness, shame, and guilt (Clark, 2001; Loo, 2001). While the eventual outcome of suicide bereavement does not appear to be significantly different from that observed following other forms of death (Clark, 2001), a suicide does generate a group of survivors who may have greater difficulty with the grieving process (i.e., individuals who are more likely to have grieving complications such as suicidal ideation, physical illness, depression, posttraumatic stress, exacerbation of preexisting conduct and substance abuse disorders, and family problems) (Brent, et al. 1992; Gould & Kramer, 2001; Loo, 2001; U.S. Department of Health and Human Services, 1999). Given the number of adverse reactions associated with suicide survivor ship, an immediate suicide postvention response is prudent (Brock, 2002).

Experiences. Complicating these reactions are the findings that survivors experience less support than they judge necessary and/or are unaware of the support available to them following a suicide (Clark, 2001; Roberts, Lepkowski, & Davidson, 1998; Wagner & Calhoun, 1991). Suicide is surrounded by social stigma, taboo, and avoidance (Knieper, 1999). Given this fact it is not surprising that "… there is considerable evidence that suicide survivors are viewed more negatively by others and by themselves" (Jordan, 2001, p. 94). Especially when combined with the emotional reactions of guilt and shame, the social stigma of suicide results in survivors feeling uncomfortable and awkward within naturally occurring social support systems (Knieper, 1999). It has been suggested that because of the social stigma associated with suicide and with suicide survivorship in Western culture it is possible that without a postvention suicide survivors would not obtain needed grieving process assistance (Leenaars et al., 2001).

The Goals of Suicide Postvention

The primary goals of suicide postvention include (a) assisting the survivors of suicide with the grief process, and (b) identifying and referring those survivors who may be at risk for negative outcomes such as depressive and anxiety disorders, and suicidal behavior (Gould & Kramer, 2001). Contagion of suicidal behavior, while rare, is a central concern of suicide postvention programs. As a result, most postvention protocols also emphasize strategies designed to reduce identification with the suicide victims and the modeling of such behavior. Additional goals include providing appropriate and accurate information about the suicide (and doing so in a manner that minimizes contagion) and providing a structure that facilitates ongoing suicide prevention efforts (Graham et al., 2000).

Special Crisis Intervention Issues

Suicide contagion. One of the more frightening issues confronting those who conduct suicide postvention is the potential for imitative behaviors or "suicide contagion" (Brock, 2002). Numerous documented cases of suicide clusters thought to be due to contagion have been identified (Poland, 1989), and the potential for imitative suicidal behavior appears to be greatest among the adolescent population (Davidson, 1989; Phillips & Carstensen, 1986).

Developmental understanding of suicide. It has been suggested that it is not until the fifth grade that students have a clear understanding of what the term "suicide" means. While younger children appear to understand the concept of killing oneself, they typically do not recognize the term suicide and generally do not understand the

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[1] Citation: Brock, S. E. (2003, May). *Suicide postvention.* Paper presented at the DODEA Safe Schools Seminar. Retrieved March 10, 2006, from http://www.dodea.edu/dodsafeschools/members/seminar/SuicidePrevention/generalreading.html#2

dynamics that lead to this behavior (Mishara, 1999). Thus, the postvention for younger students needs to take into account their understanding of suicidal behavior (Brock, 2002).

Development and suicide risk. Although estimates vary, it is generally agreed that child suicide is relatively rare (Diekstra & Garnefski, 1995; Moscicki, 1995). As youths enter adolescence, however, the risk of suicide increases. After the age of 10, suicide becomes a leading cause of death. Currently, suicide ranks as the fourth leading cause of death in the 10- to 14-year-old age group (exceeded by accidents, cancer, and homicide) and as the third leading cause of death among 15- to 24-year-olds (exceeded by accidents and homicide; National Center for Injury Prevention and Control, 1998). When combined with the finding that the potential to imitate suicidal behavior appears to be a unique issue for teenagers (Davidson, 1989), these data mean that postvention for older students should include relatively greater concern regarding contagion. Conversely, contagion would not be as significant a concern when working with younger, elementary-grade children.

The influence of culture. Arguably, the most important cultural issue regarding suicide postvention is the fact that attitudes toward such behavior vary. While some cultures view suicide as appropriate under certain circumstances, others have strong sanctions against these behaviors (Ramsay, Tanney, Tierney & Lang, 1996). Postvention needs to be sensitive to these differences. For example, the bereavement process will be complicated among individuals who have deep religious beliefs and/or moral convictions that suicide is wrong or sinful. These individuals not only have to deal with their grief, but also have to cope with the sanctions imposed on them and/or the descendent by the given belief system. On the other hand, because of their beliefs and/or convictions, the risk for imitative suicidal behavior among such a group is reduced. Conversely, when working with individuals who have attitudes that are more permissive toward suicide, the grieving process will not be as complicated by culturally imposed sanctions; however, they might be considered at greater risk for suicide contagion (Brock, 2002).

Preparing for Suicide Postvention

Ideally, suicide postvention protocols are developed well in advance of a suicide (Brock & Sandoval, 1997; Brock, Sandoval, & Lewis, 2001; Gould & Kramer, 2001). Key preparedness activities include: (a) school-community collaboration, (b) development of a written postvention protocol, (c) training of a postvention team, (d) development of procedures for notifying family and friends about a suicide death, (e) the establishment of communication guidelines that assist the postvention team in disseminating the facts (and dispelling rumors) about the suicide and guide media relations, (f) identification of appropriate postvention (debriefing or crisis intervention) facilities, (g) development of procedures for identifying and referring at-risk individuals, and (h) establishment of procedures to evaluate the effectiveness of each postvention response (Celotta, 1995; Leenaars et al., 2001; Loo, 2001).

Providing Suicide Postvention

Before initiating a suicide postvention, a postvention team should make sure that their services are truly needed. Unfortunately, suicide is a common occurrence in our society, with 30,000 Americans killing themselves each year (U.S. Public Health Service, 1999). Obviously, not all of these suicides have the same impact, and providing postvention when it is not needed runs the risk of sensationalizing these behaviors. According to Brock (2002), when determining the need for postvention services, the key question is whether problems generated by the suicide present coping challenges. This question can typically be answered by examining who committed suicide and the circumstances of the death. If the decedent was well known (e.g., a popular student or a teacher) and/or the suicide was public (e.g., occurring at school), then a postvention will be needed. On the other hand, if students are not likely to become aware of a given suicide, postvention should not be provided. Commenting on this very issue Ruof and Harris (1988) state: “Suicidal behavior is only contagious if other people know about it. We agree that if you can keep knowledge of attempts out of a school building it is probably wise to do so” (p. 8). If a postvention is provided when it is not required it will bring undue attention to the suicide and may send the message that suicide is a way to be noticed. At the same time, however, it is important to acknowledge that an environment that denies the need for postvention assistance when it is truly needed, represent a worst case crisis intervention scenario.

Postvention activities. Once the decision to initiate postvention is made, this intervention should make efforts to normalize the anger that is often directed at the deceased. Failure to do so can result in self-blame and depression. In addition, helping survivors to find some meaning in the suicide victim’s life and from the coping activities that arise from the postvention can be helpful (Clark, 2001).

Things to avoid. It is important to acknowledge that suicide postvention, when not appropriately implemented, does have the potential to do harm (i.e., to increase the risk of contagion). To minimize such risk it is

recommended that these interventions avoid (a) sensationalizing the death, (b) glorifying or vilifying the suicide victim, and (c) providing excessive details about the suicidal act (Gould & Kramer, 2001).

Avoiding sensationalism, glorification, and vilification essentially means making sure that unnecessary attention is not given to this act and that information about the death is not presenting in such a way that individuals might identify with the suicide victim. Among other things this includes discouraging permanent physical memorials recognizing a suicide death and requesting that the media to downplay the incident.

To reduce the risk of imitative behavior following a suicide, it is recommended that excessive detail not be reported (Poland & McCormick, 1999). In addition, the school should avoid releasing details such as the time or circumstances of the death (Garfinkel et al., 1988; Poland & McCormick, 1999). The contents of a suicide note should not be revealed.

A suicide postvention protocol. For detailed information regarding the specific elements of suicide postvention the reader is referred to Brock (2002), who describe a school postvention protocol. Briefly, this protocol includes the following activities.

a. Contact the coroner's office to verify that a death has occurred and that it is a suicide death.
b. Mobilize the crisis response team, which should include crisis intervention specialists, a media liaison, and security personnel.
c. Assess the impact of the suicide on the school; determine if students are likely to learn about the death, and the extent to which knowledge of such a death will present coping challenges.
d. Contact the family of the suicide victim to express sympathy, offer support, verify facts, and identify those students who are most likely to be affected by the suicide death.
e. Determine what information about the death can or should be shared. Ensure that facts are verified, rumors addressed, and excessive detail about the mode of suicide avoided.
f. Determine how to share information about the suicide. Ensure that the act is not sensationalized, and that the victims is neither glorified nor vilified.
g. Identify target populations of student who are most likely to be affected by the suicide. Typically this includes those who were physically proximal to the death and/or who were emotionally close to the suicide victim.
h. Initiate crisis intervention services. These services may include walking through the victim's class schedule, meeting separately with the victim's close friends, establishing drop-in counseling centers, and facilitating disidentification with the suicide victim.
i. Address the need for, and appropriateness of, memorial activities. Ensure that such activities do not romanticize or sensationalize the death. Students should not view suicide as a way to obtain incredible amounts of attention.

Evaluating Suicide Postvention

Every suicide postvention is unique and presents its own special challenges. Given this reality, evaluation of each postvention response is an important and valuable activity. From such evaluation future postvention responses will be improved. Specific evaluation areas, suggested by Loo (2001), include (a) identification of areas in need of improvement, (b) recognition of effective postvention efforts (including stakeholder satisfaction), (c) assessment of the cost/benefit ratio of the postvention response, (d) consideration of any relevant legal and/or ethical issues, and (e) examination of the fit between postvention procedures and the organization's other policies and procedures.

Future Directions in Suicide Postvention

While the number of postvention programs has increased significantly in recent years, there is very little research in this area. In particular, it appears that the study of school-based programs is limited (Gould & Kramer, 2001). Thus, it is suggested that the future of suicide postvention must include systematic empirical evaluation of this special form of crisis intervention. Given the prevailing belief that when it comes to crisis intervention "one size does not fit all" (National Institute of Mental Health, 2002) it seems probable that not all suicide survivors will equally benefit from different types of postvention activities. Identification of what specific activities are most effective for which groups of suicide survivors is critical.

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