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Family issues in suicide postvention

Louise Flynn & Elly Robinson

Every year in Australia, the suicides of thousands of individuals leave behind family members and friends to cope with the aftermath. The event of suicide is not uncommon; over 2,000 people died as a result of suicide in 2005, contributing significantly to mortality rates across all ages, and the numbers are likely to be higher, due to issues such as problems with coding the cause of death (Australian Bureau of Statistics [ABS], 2007a). Prevention and early intervention strategies to reduce the rate of suicide appear to have had some effects over the previous decade (Morrell, Page, & Taylor, 2007), but less attention has been paid to post-suicide outcomes for those closest to the one who died, particularly family and friends (Ratnarajah & Schofield, 2007). These outcomes are explored in this paper and strategies to support and counsel the suicide-bereaved are outlined. Recent national initiatives that guide postvention activities are also discussed and relevant resources provided.

"Postvention" is the term used to indicate activities that assist those bereaved by suicide to cope with what has occurred (Beautrais, 2004). In the 1970s, psychologist Edwin Shneidman (1972) described postvention as "prevention for the next generation", as postvention work is intended to help the suicide-bereaved to live longer, more productively and less stressfully than they would be likely to do otherwise. A similar definition states that postvention encourages healing within a community affected by a suicide, and lessens the risk of suicide contagion (Laux, 2002).

The family, friends and significant others who have experienced a death by suicide are often called "survivors" (Vessier-Batchen & Douglas, 2006). Beautrais (2004) points out that the term, which is American in origin, can be confused with survivors of suicide attempts, and that the term "bereaved by suicide" is more generally used in New Zealand. This paper will use the term "suicide-bereaved" to describe people who have experienced a death by suicide.[1]

The number of people who are suicide-bereaved at any given time is difficult to quantify. The generally accepted estimate is six suicide-bereaved for each suicide, but it is likely there are more (Beautrais, 2004). Beautrais believes it may not be a realistic goal to establish an accurate estimate, suggesting that those who identify as such is what matters. This raises the question, though, of those affected who do not identify as such and may not recognise their potential needs. If the estimate of six suicide-bereaved is used as a minimum, however, and given that the number of apparent deaths by suicide has remained consistent at around 2,000 in the 10 years to 2005 (ABS, 2006b), we can assume that approximately 120,000 individuals have been bereaved by suicide in the past decade in Australia.

1 The term "survivor" may be used at times to maintain consistency in the discussion of research findings.

Australian Government

Australian Institute of Family Studies
Australian Family Relationships Clearinghouse

The Australian Family Relationships Clearinghouse (AFRC) is an information and advisory unit funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs. The Clearinghouse aims to enhance family relationships across the lifespan by offering a resource and a point of contact for providers of family relationship and support services, policy makers and members of the research and broader communities. The Clearinghouse collects, synthesises and disseminates information on family relationships and facilitates networking and information exchange.

Contents

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Given the age profile of people who died by suicide in those years, it is likely that many were parents of dependent children. According to the ABS, almost 5,000 men aged between 30 and 49 years died in 2005 (ABS, 2006a). Suicides in this age group of men range from 10% to 25% of all male deaths, or up to 1,250 deaths. This is for a single year only, and does not include statistics for suicides completed by females, who may have been mothers, due to their lower suicide rate (ABS, 2007b). As a result, many Australian children have had a parent who has suicided over the course of their lifetime, and are dealing with the aftermath.

Effects of a suicide death on family

How suicide bereavement differs

While a limited amount of research has focused on the effects of suicide on families, there is a growing indication that suicide bereavement is different from bereavement associated with other forms of death. Suicide-bereaved people tend to struggle more with the meaning of the death, guilt, blame (from self and others) for not preventing the death, feelings of rejection (Clark & Goldney, 2000), isolation and abandonment, anger towards the deceased (Jordan, 2001), and complicated grief (Provini, Everett, & Pfeffer, 2000), and experience slower recovery (Beautrais, 2004). There may be a relief effect if there has been a long history of problems with the deceased, with the death not necessarily being unexpected (Jordan, 2001). Bereavement is also influenced by factors such as the age of the deceased, quality of the relationship with the bereaved prior to death and cultural beliefs (Hawton & Simkin, 2003). To date, however, the limited number of studies that have focused on the longer-term effects of suicide bereavement have yielded conflicting results (Jordan 2001).

Jordan (2001) stated that there is evidence that suicide bereavement may differ in terms of qualitative or thematic elements; for example, survivors struggle more with the meaning and motives behind the death. Other reports also indicate a range of "unique" reactions associated with suicide bereavement (Beautrais, 2004; Harwood, Hawton, Hope, & Jaccoby, 2002) that may be less likely to be picked up by quantitative research (Ratnarajah & Schofield, 2007). This does not necessarily indicate, however, that the consequences are harder to deal with than deaths by other means (Murphy, Clark Johnson, & Lohan, 2003).

One of the most significant issues in suicide deaths that is less likely to occur for other means

of death is stigma. Whether for religious or cultural reasons, there have been historical examples of a negative societal response to suicide; for example, the confiscation of the property of the deceased, body mutilation, and ostracism of families (Cvinar, 2005; Vessier-Batchen, & Douglas, 2006). Studies indicate that this stigma is still felt today (Beautrais, 2004; Harwood et al., 2002; Jordan, 2001), although the responses are more subtle; survivors tend to indicate that, due to stigma, they prefer to seek out informal rather than professional assistance (Vessier-Batchen & Douglas, 2006), report feelings of rejection, isolation, lack of social support and blaming by family members and communities (Clark & Goldney, 2000; Jordan, 2001; Ness & Pfeffer, 1990), and are subject to family myths about method of death (Mitchell et al., 2006). Lack of information about available services, shock, exhaustion or a loss of confidence in reaching out for help can also reduce the amount of support received by the suicide-bereaved (Wilson & Clark, 2005).

Suicide-bereaved family members may also be at a heightened risk for premature death, including suicide, yet the reasons for this remain unclear (Ness & Pfeffer, 1990). Clark & Goldney (2000) describe those bereaved by suicide as an at-risk group, not necessarily due to the mode of death, but because "suicide identifies the vulnerable" (p. 470). Wilson and Clark (2005) describe this as the high prevalence of risk factors, rather than the mode of death itself, accounting for increased risks of depression and suicide in those who are suicide-bereaved. There is also some indication that genetic factors predispose suicide in a family (Cerel, Fristad, Weller, & Weller, 2000; Jordan, 2001). Other sociocultural factors associated with suicide may pre-exist within the family; for example, one study showed suicide-bereaved families as experiencing higher rates of mental health treatment and general psychosocial stressors, including divorce, most of which had occurred prior to the suicide (Cerel et al., 2000). Family members of suicidal people have been shown as having more disturbed interaction styles and attachment disruptions, meaning that pre-suicide family interactions may be different, with suicide contributing to further disruption, increasing the risk of further suicides (Jordan, 2001).

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Suicide-bereaved parents

While there is some indication that suicide-bereaved parents have higher levels of guilt than parent survivors of other modes of death (Vessier-Batchen & Douglas, 2006), there has been no empirical establishment of suicide bereavement as being more problematic for long-term adjustment in suicide-bereaved parents. Murphy et al. (2003) suggest that some parents maintain the experience of a "bond" with a child who died by suicide, with the relationship taking a new form rather than the parents "letting go", as proposed by traditional models of bereavement. This may protect parents in some way from a more difficult, if not different, bereavement.

Suicide-bereaved children

A limited amount has been written about the effects of parental suicide on children and adolescents, including bereavement responses through to adulthood (Ratnarajah & Schofield, 2007). The results of such studies are inconsistent. Children of parents who died by suicide showed significantly more behaviour and mood disorder problems when compared with children whose parents died by other means in one study, although the sample was small. There was some indication, however, that these problems pre-dated the suicide or may have been attributable to disruption in the home (Cerel et al., 2000). Ness & Pfeffer (1990) indicated that pre-existing conditions were a confounding problem for many studies in their review of the literature on bereavement after suicide.

Significant disruption may occur for children as a result of changes to living standards or financial security due to the suicide, at a time when security and consistency of routine are paramount (Ratnarajah & Schofield, 2007).

Cultural differences

Few studies exist that have examined different cultural responses to suicide. In particular, while the rate of suicide of Indigenous Australians is estimated to be two to three times higher than

that of non-Indigenous Australians (Tatz, 2001), postvention programs have been limited (Elliott-Farrelly, 2005). This is of concern, given the frequent witnessing of suicides, commonality of clusters of suicide, and the ongoing grief felt by many in affected communities (Elliott-Farrelly, 2004). Tatz (2001) expresses the need for a separate Aboriginal suicidology that addresses the differences in understanding of and responses to suicide in Aboriginal communities, compared to non-Indigenous communities. This could subsequently be used to better inform research, development and direction of future suicide initiatives (Elliott-Farrelly, 2004).

The high rate of suicide in rural and remote areas compared to urban areas (Caldwell, Jorm & Dear, 2004) may also indicate a need for targeted postvention initiatives.

Practice issues

A South Australian study indicates that the need for effective help, support and information for the suicide-bereaved is at present largely unmet, with less than half of the study's participants who identified a need for help actually receiving it, and over half of those who did receive help describing it as unsatisfactory (Wilson & Clark, 2005). In view of the above examination of suicide-bereaved people's experiences, and the impact on their health and wellbeing, it appears important to highlight how these factors can be considered in support and counselling strategies.

Methods of bereavement support may need some adaptation to cater for the specific needs of the suicide-bereaved, or specific services may need to be designed (Jordan & McMenamy, 2004). Children may need particular consideration in terms of their developmental needs, both immediately post-suicide and in the years beyond. Drawing on the work of Support After Suicide, a project of Jesuit Social Services, and the relevant literature, this section explores some ways of adapting or implementing practice to respond to the unique needs of the suicide-bereaved.

Information, resourcing and education

One of the more effective ways of responding to the suicide-bereaved is to provide information and education about grief, bereavement, and suicide bereavement in particular, as part of the counselling process. Dunne (1992) suggests that a psychoeducational or educational approach is helpful, particularly initially. While this may appear to be a simplistic strategy, it serves a critical role in helping the bereaved understand themselves and their responses. The level of disruption to many aspects of life and functioning, and the debilitating effect of the trauma and grief, will be beyond what most people have experienced in their lives. Many clients express fear and concern about how they are coping in terms of emotions, thinking and behaviour, and may, for example, wonder if they are going mad or if the grief is taking too long.

Barlow and Morrison (2002) emphasise the importance of recognising the role of post-traumatic stress. Grief following suicide has many features commonly associated with trauma and post-traumatic stress. Educational and informational approaches providing knowledge about the typical responses to suicide, and what is known about strategies for coping can have a powerful, healing and normalising effect. An example of this educational approach has been developed in the Support After Suicide project. During the course of an eight-week support group, an additional session is scheduled in which group participants invite friends and family to attend. This is an education session that provides information about suicide, the unique issues and experiences of the bereaved following suicide, and how to care for and support the bereaved. Another example is the range of Information Sheets developed in the Support After Suicide project, with themes such as "Grief and suicide" and "Understanding suicide".

Working with the family

Bereavement counselling with the entire family can facilitate the grieving process. Given the increased risk of additional suicides, and the potential for damaging implications for family communication and developmental processes, family work is a key response to suicide bereavement (Jordan, 2001). It is also important to inform and educate family members about the differing ways in which individuals may experience and deal with grief and to facilitate understanding between family members. Members may need to re-negotiate roles and expectations, with the counsellor helping to ensure that no family member is expected to fill the

void created by the family member who has died. There may be a need for more practical or financial assistance; for example, help with funeral arrangements and expenses, child care and home help (Wilson & Clark, 2005).

Parents may also experience difficulty in attending to the needs of bereaved children when they themselves are in the depths of their own grief. It may be necessary, while providing effective and empathic support to parents, to gently remind them that their children will tend to follow the pattern set by them in coping with the suicide (Jaques, 2000).

Another important element of postvention work identified by Jordan (2001) relates to the elevated risk of suicidality associated with suicide bereavement. He maintains that an effective response to the bereaved must include "proactive monitoring of the risk for psychiatric disorder and suicidality". Given the increased risk of additional suicides, the damaging consequences on communication and development within the family and the particular difficulties children face, the facilitation of effective and appropriate family functioning is crucial (Jordan, 2001).

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Children

When planning and developing interventions, it is important to consider a child's readiness to respond to the traumatic death of a parent to suicide. The primary concerns are those experiences that indicate a disruption to the child's social, emotional, mental or physical development, such as the child's ability to carry out his or her usual activities (Webb, 1993).

Methods of communication with children regarding a suicide appear important, with Ratnarajah and Schofield (2007) suggesting that in families where discussion about the suicide does not occur, emotional and social development is likely to be significantly disrupted. Mitchell et al. (2006) indicate that although explanations need to be age-appropriate, a family's reluctance to use the word "suicide" can lead to family myths about death, compounding grief reactions. If children are not allowed a realistic and coherent explanation of the death, they may construct their own truth, which may be far worse than the reality. Talking about the suicide needs to happen over time and be considered a process rather than an event, in keeping with the child's level of maturity (Mitchell et al., 2006; Ratnarajah & Schofield, 2007). Surviving parents may need information that helps them discuss the death with their children (Provini et al. 2000).

Other relatives and friends

A qualitative study of suicide-bereaved individuals (Wilson & Clark 2005) found that second- and third-degree relatives and non-relatives of the person who died by suicide often had great difficulty finding support for themselves and information on helping others. One respondent indicated that there was no information on "how to be a friend" (p. 116) or what to expect. The report encourages services to offer specific assistance and advice that will help relevant individuals, in turn, offer support, which may reduce the social stigma and blaming that some suicide-bereaved individuals report (Clark & Goldney, 2000; Jordan, 2001).

Group work

There is little empirical research into group work for suicide-bereaved people, and even less exploring the needs of special populations, such as children, young people and different cultural groups. Nevertheless, Jordan (2001) suggests that additional social support can be provided to suicide-bereaved people by connecting them with others who are dealing with the same issues. In this way, support may be provided at a time when the suicide-bereaved need it most, but are less likely to receive it effectively from their social network. This may have a powerful impact on recovery by reducing the stigma often associated with suicide (Dunne, 1992), and social support is seen as a strong protective factor against high levels of distress (Callahan, 2000). Support groups may also benefit children by allowing them the opportunity to talk with others who share the unusual and disruptive experience of parental suicide (Mitchell et al., 2007).

Group work for children, where children are among bereaved peers, seems to assist them in the development of satisfying relationships and in gaining potential benefits, such as lessened social anxiety, increased self-esteem, and a decreased need for self-concealment, as disclosure does not result in abandonment or ridicule (Mitchell, 2007). As mentioned previously, care must be taken to accommodate the level of cognitive development of the child.

Issues for the counsellor/therapist

Counsellors can find themselves challenged in responding to the circumstances of the death, for example, when it is children who find the deceased. In order to ensure that they do not contribute to the stigmatisation of their clients, those working with the suicide-bereaved must be aware of their own attitudes to suicide, and to families where a suicide has occurred. Therapists working with suicide-bereaved families need to consider their own beliefs about and reactions to death and suicide, and how these are influenced by gender, culture and religion (Jaques, 2000) and their beliefs about families who are bereaved by suicide (Barlow & Morrison, 2002). This self-examination is critical for effective and empathic work.

Some clients will tend to characterise the one who suicided in particular ways, for example as weak or strong, selfish or selfless, courageous or cowardly. However, it does not appear to be helpful when working with the bereaved to join with these characterisations of the deceased. A therapeutic approach is hindered by simplistic notions about suicide, which can include viewing families and loved ones as responsible for the death (Dunne, 1992)

As with any counselling, sensitivity to language is important in suicide-bereavement counselling. In the Support After Suicide project, counsellors tend not to use the term "committed" suicide. Some clients use these words themselves; however, others find it distressing and inappropriate. It harkens back to the time when suicide was a crime and so, for some, reinforces the stigma and taboo associated with suicide.

A mistake that some therapists make is to generalise from other situations, such as more 'usual' bereavement or the experience of those who have survived other sudden, unexpected deaths.

A mistake that some therapists make is to generalise from other situations, such as more "usual" bereavement or the experience of those who have survived other sudden, unexpected deaths (Dunne, 1992). However, as described in the first section, suicide bereavement is likely to be qualitatively different from other forms of bereavement, and people are likely to bereave in different ways. This needs to be recognised in practice.

National postvention initiatives

Commonwealth Government initiatives that help to ensure a consistent, good-practice approach to supporting and counselling the suicide bereaved are increasingly informing postvention activities in practice, as well as driving priorities for what activities receive funding. A number of initiatives are described below.

National Suicide Bereavement Framework

In 2006, the Federal Department of Health and Ageing funded a project to look at postvention and suicide bereavement activities across Australia. One of the outcomes of this project was the development of a National Suicide Bereavement Framework. This is not published as yet, but related material was presented at the Inaugural Postvention Conference in Sydney in May 2007 (Krauss & Bycroft, 2007).

According to the project scope, funds have been allocated for initiatives for those bereaved by suicide since mid-2005; for example, the establishment of a national reference group to provide advice on activities targeting people who are suicide-bereaved. An evaluation of the *Information and Support Pack for Those Bereaved by Suicide and Other Sudden Death* was completed, and a scoping study examined the available literature, programs, support and resources relating to bereavement by suicide.

More specifically, the project focused on mapping current suicide bereavement activities across Australia. The project went on to develop a conceptual framework to inform good practice in postvention activities, and a framework of core concepts and terminology. Advice on national

standards and guidelines was provided, with the aim of supporting nationally consistent suicide bereavement/postvention initiatives. Options were also outlined for the national coordination of suicide bereavement activities.

The essential objectives of the project were to develop and implement evidence-based theory and practice, to improve suicide prevention through building strength, capacity and resilience, to implement pathways to care, to promote appropriate service provision that meets the needs of the bereaved, and to coordinate and manage learning, service standards and service quality.

National Suicide Prevention Strategy (NSPS)

In the latest round of funding from the NSPS, postvention activities received a larger proportion of funds, and acknowledgement was given of the role of providing support to the bereaved as a suicide prevention activity. The postvention models funded by the NSPS vary in their approach, and a sample of these are described in brief below.

In **South Australia**, Anglicare received funding for the Living Beyond Suicide program. This is a volunteer-based service providing support to bereaved families immediately following a suicide. It is a statewide service that aims to offer immediate emotional and practical support, guide families through the range of systems and services that they encounter at this time, and facilitate referrals to relevant services. There is a focus on increasing sensitivity to the suicide-bereaved in service agencies and the community. Their website can be found at: www.anglicare-sa.org.au/services/lbs.html

In **Queensland**, the Standby Response Service, a program of United Synergies, received funding to continue and expand its model of service. Originally in the Sunshine and Cooloola Coast areas of Queensland, the Standby Response Service was developed in 2002. It provides a 24-hour coordinated response to families, friends and associates who have been bereaved by suicide. The aim of the service is to reduce adverse health outcomes, and assist in addressing further suicide risk for the bereaved. It does this by providing an integrated and comprehensive response using existing services and agencies in the region. This includes emergency services and community agencies such as the police, ambulance, coronial services, community groups and health services. Information on the project can be found at: www.unitedsynergies.com.au/index37.php

An evaluation of the Standby Response Service suggests that the model is effective in meeting the aim of reducing adverse health outcomes, and reducing costs to the community and other agencies providing health support. The Standby Response Service is currently being established in three other regions—Canberra, North Brisbane and Cairns.

In **Western Australia**, an outreach service is provided in the southern metropolitan area of Perth for people bereaved by suicide. ARBOR (Active Response Bereavement OutReach) began operation in October 2007 and aims to help those newly bereaved to access the support, resources and assistance they need, while reducing the isolation discussed as an issue earlier in this paper. ARBOR is an active outreach service that aims to make contact with people in the critical first days of bereavement when people are most likely to be overwhelmed. Experienced counsellors and trained peer support volunteers, who have themselves been bereaved by suicide, provide the initial support. Their website can be found at www.mcsp.org.au/arbor

In **Victoria**, the Support After Suicide project received funding to expand its range of suicide-bereavement activities. This program aims to improve services available to the suicide-bereaved by building the capacity of existing services and agencies to respond effectively and appropriately. This involves the provision of secondary consultation, information, resources, and education and training to other professionals working with the suicide-bereaved.

The Support After Suicide project also provides services, information and resources directly to the bereaved. This includes counselling individuals, families, children and young people, as well as group support. An eight-week group for adults has been developed, which is followed up with a monthly group. Support services tend to be provided early in bereavement and be of a short duration, so the monthly group is an acknowledgment and recognition that bereavement following suicide is a prolonged and difficult experience. Group programs for children and young people are being developed and will be conducted in early 2008.

Another innovation being developed and trialled by the Support After Suicide project is a group program for parents of suicide-bereaved children and young people, which focuses on parenting issues following suicide. This is to improve bereavement outcomes for children and young people, as there is some evidence that parenting support improves mental health outcomes for parentally bereaved children and young people (Haine et al., 2006; Sandler et al., 2003). The Support After Suicide project is also developing a comprehensive suicide bereavement website to be launched in early 2008.

Conclusion

It makes intuitive sense that a suicide will impact significantly on individual and family functioning. The body of evidence that describes what these impacts are and how practitioners can respond effectively, however, is limited. In particular, an understanding of the responses to suicide of children and culturally diverse groups, and effective ways of resourcing them to cope, has been largely ignored.

The national initiatives described in the paper will assist in raising the profile of suicide bereavement as an important issue for prevention and early intervention initiatives that address health and wellbeing. Further research is urgently needed to focus on the qualitative aspects that differentiate suicide bereavement from other forms of bereavement, and effective responses to different target groups. An important aspect of this is addressing the stigma that still surrounds the act of suicide, so that those most affected are better protected from the fallout that surrounds such a traumatic event.

Useful websites and resources

National Suicide Prevention Strategy

www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-suicide-overview

South Australian Suicide Postvention Report (Anne Wilson and Sheila Clark)

Includes information on issues and needs of the bereaved, agencies and service providers, and an 'Ideal Model of Suicide Postvention Services'. http://digital.library.adelaide.edu.au/dspace/handle/2440/24871

Australian Centre for Grief and Bereavement

Comprehensive links throughout Australia and worldwide. www.grief.org.au

Grieflink

Comprehensive information, links and support information, including fact sheets about loss, grief and bereavement. www.grieflink.asn.au

Lifeline—Postvention Resources

Including links to the *Information and Support Pack for Those Bereaved by Suicide or Other Sudden Death* for each state and territory. www.lifeline.org.au/find_help/suicide_prevention/suicide_prevention_resources_and_links

For children and young people

Skylight Trust—www.skylight.org.nz

Kids Helpline—www.kidshelp.com.au

Winston's Wish—www.winstonswish.org.uk

Cruse Bereavement Service—www.rd4u.org.uk

The Dougy Centre—www.dougy.org

Reach Out—www.reachout.com.au

Head High—www.headhigh.org.au

References

Australian Bureau of Statistics. (2006a). *Deaths, Australia, 2005*. (Cat. No. 3302.0). Canberra, ACT: Author.

Australian Bureau of Statistics. (2006b). *Suicides, Australia, 1994 to 2004*. (Cat. No. 3309.0). Canberra, ACT: Author.

Australian Bureau of Statistics. (2007a). *Information paper: External causes of death. Data quality, 2005*. (Cat. No. 3317.0.55.001). Canberra, ACT: Author.

Australian Bureau of Statistics. (2007b). *Suicides, Australia, 2005*. (Cat. No. 3309.0). Canberra, ACT: Author.

Barlow, C., & Morrison, H. (2002). Survivors of suicide: Emerging counseling strategies. *Journal of Psychosocial Nursing and Mental Health*, *40*(1), 28–40.

Beautrais, A. (2004). Suicide postvention: Support for families, whanau and significant others after a suicide. A literature review and synthesis of evidence. Wellington: Ministry of Youth Development.

Caldwell, T., Jorm, A., & Dear, K. (2004). Suicide and mental health in rural, remote and metropolitan areas in Australia. *Medical Journal of Australia*, *181*(7), S10–S14.

Cerel, J., Fristad, M., Weller, E., & Weller, R. (2000). Suicide-bereaved children and adolescents: II. Parental and family functioning. *Journal of the American Academy of Child and Adolescent Psychiatry*, *39*(4), 437–444.

Clark, S., & Goldney, R. (2000). The impact of suicide on relatives and friends. In K. Hawton & K. van Heeringen (Eds.), *The international handbook of suicide and attempted suicide* (pp. 467–484). Chichester, UK: John Wiley & Sons.

Cvinar, J. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care*, *41*(1), 14–21.

Dunne. E. (1992). Psychoeducational intervention strategies for survivors of suicide. *Crisis*, *13*(1) 35–40.

Haine, R., Wolchik, S., Sandler I., Millsap, R., & Ayers, T. (2006). Positive parenting as a protective resource for parentally bereaved children. *Death Studies*, *30*(1), 1–28.

Harwood, D., Hawton, K., Hope, T., & Jacoby, R. (2002). The grief experiences and needs of bereaved relatives and friends of older people dying through suicide: A descriptive and case-controlled study. *Journal of Affective Disorders*, *72*, 185–194.

Hawton, K., & Simkin, S. (2003). Helping people bereaved by suicide: Their needs may require special attention. *British Medical Journal*, *327*, 177–178.

Jaques, J. (2000). Surviving suicide: The impact on the family. *The Family Journal: Counseling and Therapy for Couples and Families*, *8*(4), 376–379.

Jordan, J. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behaviour*, *31*(1), 91–102.

Jordan, J., & McMenamy, J. (2004). Interventions for suicide survivors: A review of the literature. *Suicide and Life-Threatening Behaviour*, *34*(4), 337–349.

Krauss, I., & Bycroft, P. (2007, May). *National Suicide Bereavement Framework*. Workshop presented at Living Hope Postvention Conference, Sydney, 24–26 May, 2007.

Laux, J. (2002). A primer on suicidology: Implications for counselors. *Journal of Counselling and Development*, *80*, 380–383.

Mitchell, A., Dysart Gale, D., Garand, L., & Wesner, S. (2003). The use of narrative data to inform the psychotherapeutic group process with suicide survivors. *Issues in Mental Health Nursing*, *24*(1), 91–106.

Mitchell, A., Wesner, S., Brownson, L., Dysart-Gale, D., Garand, L., & Havill, A. (2006). Effective communication with bereaved child survivors of suicide. *Journal of Child and Adolescent Psychiatric Nursing*, *19*(3), 130–136.

Mitchell, A., Wesner, S., Garand, L., Dysart Gale, D., Havill, A., & Brownson, L. (2007). A support group intervention for children bereaved by parental suicide. *Journal of Child and Adolescent Psychiatric Nursing*, *20*(1), 3–13.

Morrell, S., Page, A., & Taylor, R. (2007). The decline in Australian young male suicide. *Social Science and Medicine*, *64*, 747–754.

Murphy, S., Clark Johnson, L., & Lohan, J. (2003). Challenging the myths about parents' adjustment after the sudden, violent death of a child. *Journal of Nursing Scholarship*, *35*(4), 359–364.

Provini, C., Everett, J., & Pfeffer, C. (2000). Adults mourning suicide: Self-reported concerns about bereavement, needs for assistance and help-seeking behavior. *Death Studies*, *24*(1), 1–19.

Ratnarajah, D., & Schofield, M. (2007). Parental suicide and its aftermath: A review. *Journal of Family Studies*, *13*, 78–93.

Sandler, I. N., Ayers, T. S., Wolchik, S. A,. Tein, J-Y., Kwok, O-M., Haine, R. A. et al. (2003). The Family Bereavement program: Efficacy evaluation of a theory-based prevention program for parentally bereaved children and adolescents. *Journal of Consulting and Clinical Psychology*, *71*(3), 587–600.

Shneidman, E. S. (1972). Foreward. In A. Cain (Ed.), *Survivors of suicide*. Springfield, Ill: Charles C. Thomas.

Tatz, C. (1999). *Aboriginal suicide is different: A portrait of life and self-destruction*. Canberra: Aboriginal Studies Press.

Vessier-Batchen, M., & Douglas, D. (2006). Coping and complicated grief in survivors of homicide and suicide decedents. *Journal of Forensic Nursing*, *2*(1), 25–32.

Webb, N. (1993). *Helping bereaved children: A handbook for practitioners*. New York: The Guilford Press.

Wilson, A., & Clark, S. (2005). *South Australian Suicide Postvention Project: Report to Mental Health Services, Department of Health*. Department of General Practice, University of Adelaide. Retrieved 19 November, 2007, from http://digital.library.adelaide.edu.au/dspace/handle/2440/24871