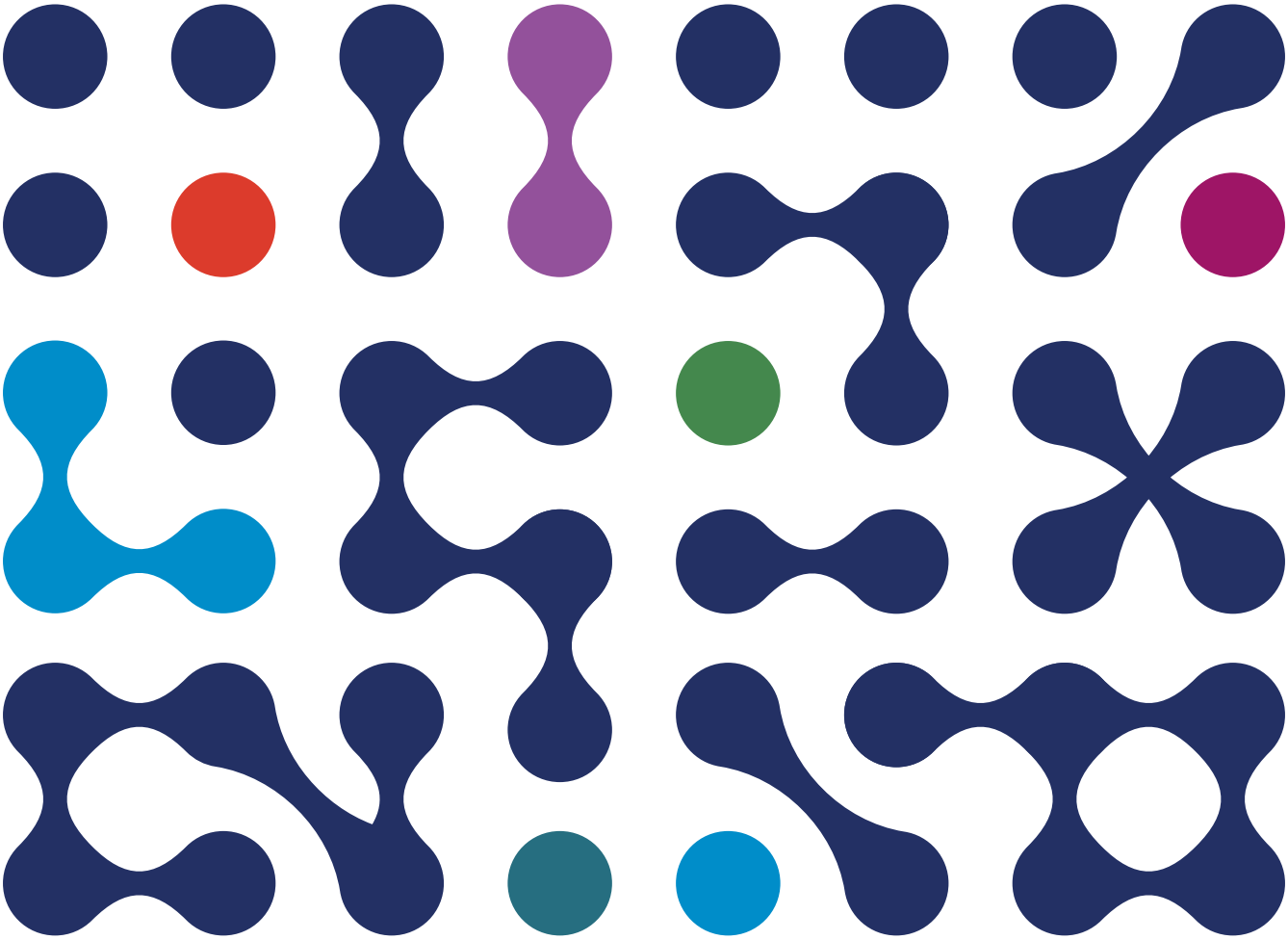
Preventing suicide

How to start a suicide bereavement support group



World Health Organization

International Association for Suicide Prevention

Preventing suicide

How to start a suicide bereavement support group

World Health Organization

International Association for Suicide Prevention

Preventing suicide: how to start a suicide bereavement support group

ISBN 978-92-4-011607-8 (electronic version)
ISBN 978-92-4-011608-5 (print version)

Suggested citation. Preventing suicide: how to start a suicide bereavement support group. Geneva: World Health Organization; 2025. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at https://iris.who.int/.

Sales, rights and licensing. To purchase WHO publications, see https://www.who.int/publications/book-orders. To submit requests for commercial use and queries on rights and licensing, see https://www.who.int/copyright.

Layout by Jennifer Rose Fivefold

Contents

Foreword

Suicide is a serious global public health problem that demands our attention, yet preventing suicide is no easy task. Current research indicates that the prevention of suicide, while feasible, involves a series of activities, including: bringing up our children and young people in the best possible conditions, assessing and addressing mental health conditions and other suicide risk factors, restricting the means of suicide, reporting suicide responsibly in the media, and providing adequate support to people bereaved by suicide. Suicide prevention must be based on human rights, gender equality and health equity – with the goal of promoting the human right to health and ensuring that each person has access to care without discrimination. To that end, awareness-raising and appropriate dissemination of information are essential elements in the success of suicide prevention, which includes supporting those bereaved by a suicide death. Cultural, age- and gender-related variations need to be considered in all these activities.

This resource focuses on people who have lost someone to suicide – also known as "suicide loss survivors" or "people bereaved by suicide". This resource is a revision of *Preventing suicide: how to start a survivors' group*. The resources in the series on preventing suicide are addressed to specific social and professional groups that are particularly relevant to the prevention of suicide. The revised resource is the product of continued collaboration between WHO and the International Association for Suicide Prevention (IASP). It represents a link in a long and diverse chain that involves a wide range of people and groups – including health professionals, media professionals, educators, social agencies, governments, legislators, social communicators, law enforcers, families, colleagues and communities – who are working to prevent suicide and alleviate the impact of suicide bereavement.

Suicide is never an easy topic to discuss or read about. The topic of this resource may be emotionally intense for some people. Take time for self-care and take breaks if needed while reading.

Dévora Kestel
Director a.i.
Noncommunicable Diseases
and Mental Health Department
World Health Organization

Professor Jo Robinson
President
International Association
for Suicide Prevention

Photo: Palms of hands facing upwards, from a diverse multinational group of people standing together. ©Istockphoto/Artem Onoprienko

Acknowledgements

The World Health Organization is grateful to **Dr Karl Andriessen**, University of Melbourne, Melbourne, Australia and Co-Chair of the Special Interest Group on Suicide Bereavement and Postvention of the International Association for Suicide Prevention (IASP), who took the lead for this third edition of the resource (previously titled Preventing suicide: how to start a survivors' group).

Further thanks are due to **Ms Raylee Taylor**, "Survivors after Suicide", **The Salvation Army**, Gold Coast, Australia, and **Mr Jerry Weyrauch** and **Mrs Elsie Weyrauch**, Suicide Prevention Advocacy Network (SPAN), United States of America (USA), all of them suicide loss survivors who drafted the first version of this resource in 2000, and **Dr Karl Andriessen** who in collaboration with the Special Interest Group on Suicide Bereavement and Postvention of IASP led the development of the second edition in 2008. The draft of the current third edition was further revised by **Dr Alexandra Fleischmann** (WHO) and **Dr Sandersan Onie** (WHO).

Initially, the text was reviewed by the following members of the Special Interest Group on Suicide Bereavement and Postvention of IASP

Diego De Leo, Primorska University, Primorska, Slovenia; **William Feigelman**, Nassau Community College, New York, NY, USA (review preceded 20 January 2025); **Laura Hofmann**, Medical School Berlin, Berlin, Germany; **Karolina Krysinska**, University of Melbourne, Melbourne, Australia; **Edouard Leaune**, Centre Hospitalier Le Vinatier, Bron, France; **Yossi Levi-Belz**, Ruppin Academic Center, Emek Hefer, Israel; **Sandra T McNally**, EMPACT Suicide Prevention Center, Tempe, AZ, USA (review preceded 20 January 2025); **Alexandra Pitman**, University College London, London, United Kingdom of Great Britain and Northern Ireland; **Karen Scavacini**, Instituto Vita Alere de Prevenção e Posvenção do Suicídio, São Paulo, Brazil; **Paolo Scocco**, SOPROXI Onlus, Padova, Italy; **Prakarn Thomyangkoon**, Rajavithi Hospital, Bangkok, Thailand.

WHO is equally grateful to WHO specialists and other international experts who reviewed further revisions of the text

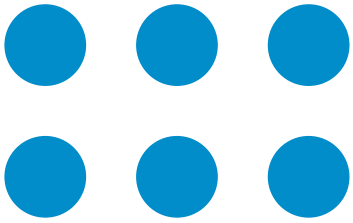
WHO reviewers (WHO headquarters): Ben Adams; Piumee Bandara; Natalie Drew; Michelle Funk; Aiysha Malik, Anushka Patel.

International experts: Hitoshi Akita, Japan Suicide Countermeasures Promotion Center, Tokyo, Japan; **Jason Bantjes**, South African Medical Research Council, Cape Town, South Africa; **Daiane Borges Machado**, Cidacs Fiocruz, Salvador, Brazil, and Harvard Medical School, Boston, MA, USA (review preceded 20 January 2025); **Richard Bryant**, University of New South Wales, Sydney, Australia; **Vladimir Carli**, National Centre for Suicide Research and Prevention, Karolinska Institutet, Stockholm, Sweden; **Fatma Charfi**, Mongi Slim Hospital, University of Tunis El Manar, Tunis, Tunisia; **Katie Dawson**, University of New South Wales, Sydney, Australia; **Björn Eklund**, National Centre for Suicide Research and Prevention, Karolinska Institutet, Stockholm, Sweden; **Guðrún Jóna Guðlaugsdóttir**, Directorate of Health, Reykjavik, Iceland; **Inger Händestam**, Spes Suicide prevention and support of survivors of suicide loss, Stockholm, Sweden; Ahmad Hajebi, Iran University of Medical Sciences, Tehran, Islamic Republic of Iran; **Ali Hasnain**, United for Global Mental Health, London, United Kingdom of Great Britain and Northern Ireland; **Tae-Yeon Hwang**, Korea Foundation for Suicide Prevention, Seoul, Republic of Korea; **Miriam Iosue**, National Centre for Suicide Research and Prevention, Karolinska Institutet, Stockholm, Sweden; **Basudev Karki**, Mental Hospital Lagankhel, Lalitpur, Nepal; **Sarah Kline**, United for Global Mental Health, London, United Kingdom of Great Britain and Northern Ireland; **Kairi Kolves**, Australian Institute for Suicide Research and Prevention, Griffith University, Brisbane, Australia; **Eva Koženevski**, MTÜ Peaasjad, Estonian Suicide Loss Survivors Association, Tallinn, Estonia; **Dinah Nadera**, Ateneo School of Medicine and Public Health, Manila, Philippines; **Joseph Osafo**, University of Ghana, Accra, Ghana; **Hye-sun Park**, Japan Suicide Countermeasures Promotion Center, Tokyo, Japan; **Danielle Marie A Parreño**, University of the Philippines Diliman, Quezon City, Philippines; **György Purebl**, Institute of Behavioural Sciences, Semmelweis University, Budapest, Hungary; **Caroline Mae O Ramirez**, National Center for Mental Health, Manila, Philippines; **Dan Reidenberg**, Suicide Awareness Voices of Education, Minneapolis, MN, USA (review preceded 20 January 2025); **Nicolas Say**, National Mental Health Institute, Prague, Czechia; **Merike Sisask**, Estonian-Swedish Mental Health and Suicidology Institute, Tallinn University, Tallinn, Estonia; **Johana Sládková**, Charles University, Prague, Czechia; **Mai Suganuma**, Japan Suicide Countermeasures Promotion Center, Tokyo, Japan; **Roksana Táborská**, National Mental Health Institute, Prague, Czechia; **Yongsheng Tong**, Beijing Huilongguan Hospital, Beijing, China; **Monica Vera**, Surviving Sunsets, Boracay, Philippines; **Lakshmi Vijayakumar**, SNEHA, Voluntary Health Services, Chennai, India; **Danuta Wasserman**, National Centre for Suicide Research and Prevention, Karolinska Institutet, Stockholm, Sweden.

The collaboration of IASP with WHO on activities related to suicide prevention is greatly appreciated.

This resource is being widely disseminated in the hope that it will be translated and adapted to local conditions, which is a prerequisite for its effectiveness. Comments and requests for permission to translate and adapt the resource will be welcome.

Photo: A diverse group sitting in a circle, discussing, listening, and sharing. ©Istockphoto/Rawpixel



Introduction

What are support groups?

Support groups are groups of people who are directly and personally affected by a particular issue, condition or concern. To ensure there is a structure and order to their sessions, support groups are typically led by facilitators. Facilitators guide the discussions – including moderating the time, providing discussion prompts and guiding the discussion away from potentially harmful topics, such as discussion of suicide methods. When a support group starts meeting, the facilitator may also organize the group. However, as the group evolves, different people may organize the group and facilitate meetings.

Support groups are often organized and facilitated by their members, with those directly affected by the issue guiding the activities and the priorities of their group *(1)*. This may take place in collaboration with professionals (e.g. to assist facilitation or to ensure informed decision-making). **It is important to note that support groups are not a replacement for professional help and that support groups may not be for everyone**. Nevertheless, evidence suggests that support groups can provide support to persons who have lost someone to suicide and who are in a time of suicide bereavement. Support groups can take many forms depending on the local culture; for instance, in some regions, religion and spirituality are important aspects of healing and will naturally be integrated both when conversing about bereavement and in the support group format. More information on the evidence for how support groups can help in a time of suicide bereavement is provided in Annex 1.

Role of support groups

Support groups can be one way for people to help themselves and each other. In many cases the groups can contribute significantly to positive outcomes in mental health and psychosocial well-being for those who participate *(1,2)*. While support groups do not replace professional help, they can complement it by providing a sense of community and belonging, as professional help is typically given one-on-one.

The drive for the establishment of groups has come from two directions:

- from individuals in response to unmet needs; and
- from formal services in order to provide additional support and care.

Suicide bereavement support groups have gained recognition as a potential means of providing for the needs of those bereaved to express or share their grief and to honour their loved ones. The groups can be complementary to, but should not replace, individual support such as counselling or psychotherapy *(3–6)*, providing much-needed community support. In some countries, the groups are partially supported by government funds, but also by nongovernmental organizations (NGOs), religious groups, donations, and the participants themselves.

Photo: Person walking through an industrial warehouse. ©Istockphoto/Tomislav Trajkovski

Importance of support groups for those bereaved by suicide

Grief is as personal as the individual, and different individuals may experience different durations and intensities of the grieving process. While some grief experiences, such as shame and concealing the cause of death, have also been reported in other bereaved people, particularly in those affected by violent deaths, some people bereaved by suicide have reported experiencing higher levels of stigma, responsibility, shame and rejection *(7)*. They also have an increased risk of adverse grief, mental health problems (e.g. depression, post-traumatic stress disorder) and suicidal behaviour, and are more likely to spend a greater proportion of time pondering on the motives of the person who has died by suicide. For many persons bereaved by suicide, the question "why" is continually present.

In many cases, there are taboos surrounding death by suicide which can significantly affect those bereaved by suicide. In some cases, those bereaved by suicide may find it hard to disclose that their loved one has died by suicide *(8)*, and they may blame themselves or may be afraid of being hurt by people who stigmatize suicide *(9)*. Suicide bereavement may disrupt communication and relationships between family and friends. Other people may feel uncomfortable or lack the skills to talk about suicide with the bereaved. Additionally, health professionals may also feel unsure of how to handle the issue. As a result, those bereaved by suicide are often left with few or no safe spaces to talk openly about their experience. The negative impact of suicide can be even greater in countries where suicide is criminalized *(10, 11)*. Overall, those bereaved by suicide may have little opportunity to talk about their grief, which may lead to a lack of social support, feelings of isolation and an increased risk of developing a mental health condition such as depression. More information on the impacts of suicide on different individuals, such as family and friends, is provided in Annex 2.

The coming together of those bereaved by suicide – as organizers, facilitators or attendees – can provide a valuable opportunity to connect with other people who share a similar experience and, therefore, possess a unique understanding. Furthermore, a suicide bereavement support group offers a wide range of benefits that can help individuals to navigate the difficult time following a loss. First and foremost, it provides a chance to break the silence and reduce the stigma surrounding suicide by creating a space where individuals can openly discuss their grief. This openness can counteract feelings of shame or isolation, especially in contexts where such conversations are taboo. The group offers a safe and empathetic environment – a space of community, support and validation – for individuals who may otherwise feel disconnected from the world around them.

In this setting, participants often find a sense of belonging, knowing that others in the room understand their pain in a way that few people can. It also serves as a source of information and psychoeducation about suicide and bereavement, helping participants to make sense of their own and others' experiences. Through these discussions, individuals may begin to challenge and let go of internalized feelings of guilt, shame or failure. In addition, the group can provide guidance on when and how to access professional help to complement the support received in the group setting.

The group can support members through the redefinition of roles and identity following loss – whether it is the loss of a caregiving role, a shift in family dynamics, or a search for renewed purpose. Participants are given the opportunity to develop new coping skills and to make sense of the traumatic event, possibly finding meaning in the loss.

The support group can also help with specific challenges such as navigating difficult anniversaries, handling their loved one's belongings, and expressing emotions such as anger or guilt. The group can serve as a sounding board for fears and concerns, such as worries about suicide risk in other family members, and can help individuals to construct new narratives around what has happened. A commitment to confidentiality, compassion and nonjudgement ensures that everyone feels safe to grieve in their own way, without fear of judgement or pressure to conform.

The group may take on a psycho-educational role regarding the grief process, the facts relating to suicide and the potential roles of health professionals. Another major function is that of empowerment – enabling people to regain agency over aspects of their lives, such as developing a purpose or meaning in their lives and effectively regulating their emotional reactions. One of the most devastating aspects of a suicide, or other traumatic death, is that there is invariably much unfinished business and many unanswered questions and yet the bereaved person can see no way to resolve the situation. The support of a group can often alleviate feelings of hopelessness and can provide the means through which individuals may regain a sense of control.

A suicide bereavement support group offers a wide range of benefits that can help individuals to navigate the difficult time following a loss.

Photo: A young man comforting a distressed woman in a group setting. ©Istockphoto/Wavebreakmedia

Suicide bereavement – surviving a suicide loss

It is important to note that each person's grief journey is different. Nevertheless, there are some experiences that are typically reported by people surviving a suicide loss. In many cases, the experience of a person bereaved by suicide can be painful, confusing, devastating and traumatic. Cultural, religious and social taboos surrounding suicide can affect the grief journey. Location may also play a role, as those who live in geographically remote areas or have poor Internet connections may have less access to support, including to suicide bereavement support groups. An understanding of the factors that contribute to suicidal behaviour may assist the bereaved person along the road to recovery and, in some cases, make the experience less bewildering and less frightening. In some cases, a death by suicide may not have been totally unexpected (e.g. due to previous suicide attempts), but many bereaved persons are faced with an unexpected, sudden and often violent death. In some cases, the initial grief reactions may include shock and disbelief, followed by the reality of loss gradually sinking in, and a variety of feelings will emerge – such as anger, guilt, denial, confusion and rejection. Sometimes, there may be feelings of relief because the suffering of the suicidal person has ended, or gratitude for having known the person. In certain cultural or religious contexts, grief can be further complicated by stigma, which may inhibit open expression of grief, help-seeking or discussing the circumstances of the death. The family of the deceased may be judged, and the deceased may be denied funeral rites, blessings or burial at certain sites. This added layer of complexity can deepen the sense of isolation and hinder the healing process.

Physical, behavioural, emotional and social reactions may remain to varying degrees for months or years. Bereaved persons may strive to "survive", initially from day to day, and eventually learn to live with the loss and adjust their lives accordingly. Shortly after the bereavement, this may seem impossible; suicide loss survivors are often consumed with thoughts of their loved ones and may yearn to join them. This can lead to suicidal ideation, highlighting the need for timely professional support.

It is important to note that each person's grief journey is different.

Over time, suicide loss survivors may experience positive changes in their values or belief systems and emerge from the experience as changed people (12). Post-traumatic growth is a concept that describes positive psychological change experienced as a result of struggling with highly challenging and stressful life events such as the suicide of a loved one. Examples of post-traumatic growth may include a greater sense of personal resilience, a re-evaluation of priorities and values, improved relationships, increased compassion and a stronger sense of appreciation for life. Support is important in this process. More information on where and from whom the bereaved may find support is provided in Annex 3. One may find support by participating in support groups which can assist survivors of suicide loss to grow with the changes that confront them.

Photo: School boy is walking along a road in a rural setting. ©Istockphoto/Chalabala

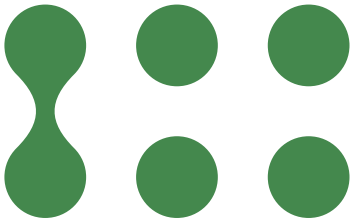
Development of this resource

This resource was written to support persons who seek to initiate a support group for suicide loss survivors. The resource is updated from the WHO publication *Preventing suicide: how to start a survivors' group*, originally released in 2000. The revision was led by the Special Interest Group on Suicide Bereavement and Postvention of IASP, seeking to update the resource on the basis of current evidence, as described in Annex 1. Once a preliminary version was agreed by the Special Interest Group and WHO, the draft was circulated for international review. Reviewers included academic researchers, clinicians, public health professionals, representatives of community organizations, and people with lived experience of suicide bereavement. A full list of reviewers and their affiliations is provided in the Acknowledgements. Following the first round of review, feedback was incorporated by WHO and reviewed by the IASP Special Interest Group. A revised draft was then shared with an enlarged group of reviewers, whose feedback was also integrated. Reviewers considered topics such as the alignment of the resource with human rights principles, feasibility in low-resource settings, equity and cultural relevance.

International reviewers and those from the IASP Special Interest Group submitted to WHO a declaration of interests, disclosing potential conflicts of interest that might affect, or might reasonably be perceived to affect, their objectivity and independence in relation to the subject matter of this resource. WHO reviewed each of the declarations and concluded that none could give rise to a potential or reasonably perceived conflict of interest related to the subject matter covered by the resource.

This resource was written to support persons who seek to initiate a support group for suicide loss survivors.

Photo: Two Asian older women talking in an outdoor setting. ©Istockphoto/CandyRetriever



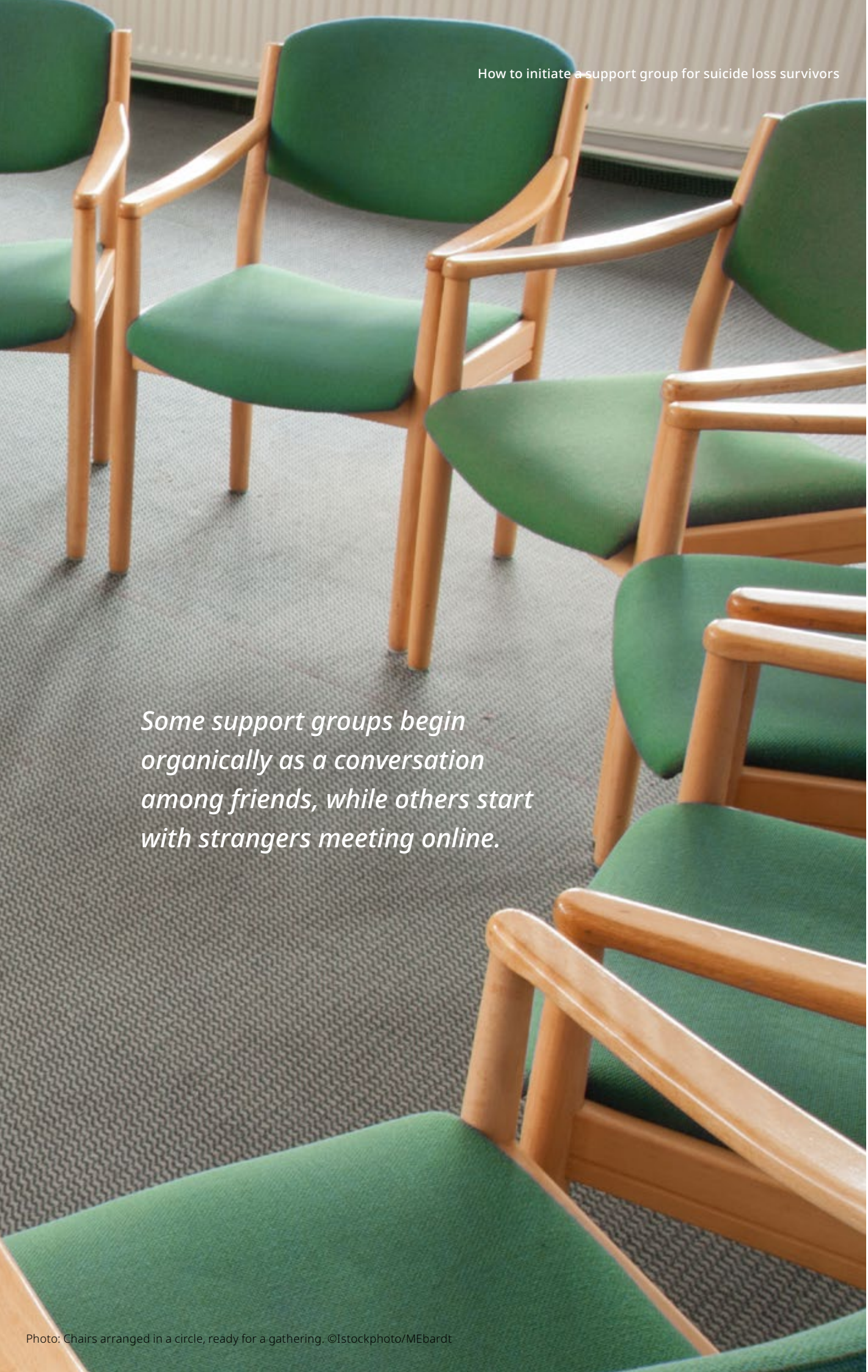
How to initiate a support group for suicide loss survivors

There are no predetermined rules for support groups and no guarantees of success. Cultural diversity, knowledge and attitude will, of course, heavily influence a group's feasibility and operation. For some people, the idea of sharing the very personal feelings evoked by a suicide will be a major barrier to joining a support group. However, if three or more people can find a common basis for sharing their experiences, the group process can begin. Support groups can start in many ways.

Some support groups begin organically as a conversation among friends, while others start with strangers meeting online. Nevertheless, it is important to recognize that sustaining an ongoing support group requires some planning, resources and structure. For example, there may be costs involved (e.g. meeting space, refreshments, mailing of notices, honoraria for professionals). Experience gained by support groups that have functioned for several years suggests that some points merit consideration by those contemplating starting a group (or interested in evaluating an existing group).

Where there is no existing support group for suicide loss survivors and starting one is not feasible, there are other activities that may be helpful to encourage meaningful and appropriate ways of coping. Details can be found in Annex 4.

The following, non-exhaustive points may be helpful when considering starting a suicide bereavement support group.



Some support groups begin organically as a conversation among friends, while others start with strangers meeting online.

Photo: Chairs arranged in a circle, ready for a gathering. ©Istockphoto/MEbardt

Initial considerations for getting started

Who will lead or facilitate the group?

To start the group, a bereaved person may want to join with a mental health professional – where available – to organize and facilitate the meetings. It is critical to arrange for a time and place for meetings, to ensure the emotional safety of the environment, and to manage the group's diversity and dynamic effectively.

While the main goal is to listen and provide support, it is important that group members have access to accurate information about suicide for psychoeducation, for dispelling suicide myths in discussions and because of the increased risk of suicide in suicide bereavement – as well as to look out for signs of suicidal behaviours among the group's participants and those affected and, critically, to know how to respond. Facilitators should know when to refer an individual to professional help, including identifying symptoms consistent with prolonged grief or post-traumatic stress disorder. Facilitators can access this information from reputable sources or by having professional help with the support group. Furthermore, facilitators may benefit from suicide bereavement and psychological first aid training and/or supervision, especially if they are not mental health professionals.

Do you have the energy and time necessary to set up and facilitate the group?

A support group can be led by a person bereaved by suicide or by a professional. However, shortly after the loss, bereaved persons may need all their energy for daily survival. Those who are further along in the grieving process may have more energy, may have made progress in regaining a purpose and meaning in life and may have integrated the loss of their loved one sufficiently to be able to reach out to support others. Facilitating a support group can be challenging, especially for prolonged periods. Groups that have more than one facilitator or that practise co-facilitation can allow facilitators to take breaks and engage in self-care.

While the main goal is to listen and provide support, it is important that group members have access to accurate information

What training can you take to facilitate the group?

During the course of facilitating a support group, challenging situations may arise. For example, a participant may dominate the conversation, may need to be referred for professional help or have an argument with another participant over a sensitive topic. Prior training can be beneficial, not only to anticipate and manage these challenges but also to enhance the effectiveness as the facilitator of the support group. You can check whether local institutes, universities or other reputable providers offer training relevant to starting a suicide bereavement support group – in person or online. You could also talk to professionals in the community about ways to obtain additional skills or assistance. Beyond managing challenges, a support group will need to draw on a pool of skills to function effectively, including organizing small events, scheduling, communicating and budgeting.

What kind of bereavement support groups already exist in your local community?

Prior to starting a support group, you can check online, read local newspapers, talk to your doctor, talk to your community or religious leader, or check the community health centre, community notice boards or your local library for existing support groups. You can then choose to join them or learn from them to start a support group if none are specifically for suicide bereavement.

Photo: Woman selling traditional snacks in Indonesia, commonly eaten in gatherings. ©Istockphoto/MielPhotos2008

Is there an organization in the community that could serve as an umbrella organization for your group?

Operating with the support of a larger structure (e.g. suicide prevention or postvention association, nongovernmental organization, university, local health clinic) may assist in sustaining the group. The larger organization may also provide access to referral services, which may be a bonus. An agreement will need to be reached with the umbrella organization to set out mutually approved aims and objectives for the group, plus an agreement on shared costs. The choice of aligning with one type of organization rather than another can depend on the local context, as people are more likely to attend if the values of the organization more closely align with their own.

Should you consider mental health professional involvement?

A mental health professional might be involved, for instance, for consultation or supervision, as a point of referral for group members to assess the symptoms of mental health conditions (e.g. depression, post-traumatic stress disorder, prolonged grief disorder, burnout), to provide advice or referral to professional care, or to help monitor or evaluate progress. A mental health professional may be invited to facilitate one of the sessions and to answer specific questions.

How do people become members?

There are two main types of support groups: an “open” group allows individuals to come and go, whereas a “closed” group does not allow people to join an established group once sessions have commenced (i.e. they can only join a new group). Some open groups allow people to attend as they please. However, other open groups, and closed groups, require prior registration. For registration, an intake form, on which individuals share their contact details, could be used.

Do you have support from those around you?

In facilitating a support group, there may be frustrations, including the lack of appreciation or attendance by group members, not seeing group members improve as hoped, and feeling that what is being done is not making an impact. These frustrations are normal features of facilitating a support group. You can help mitigate these challenges by ensuring that you have social support from family and friends whom you can lean on when you need support, especially if you are also bereaved, and by having supervision from professionals or a more experienced facilitator.

A mental health professional may be invited to facilitate one of the sessions and to answer specific questions.

Photo: A group of woman gathering in the city of Bissau, Guinea-Bissau, West Africa. ©Istockphoto/Tiago_Fernandez

Identifying needs and defining the structure of the support group

The first step in starting a suicide bereavement support group is to find out if there are other people bereaved by suicide who wish to form such a group. To contact like-minded people and plan a first meeting, some background work will be necessary. For instance:

Purpose of the support group

Provide information that a support group is to be formed for people who have been bereaved by suicide.

Open or closed meeting

Decide whether the meeting will be open to the public or only to those who have confirmed attendance. Will attendance be required at all meetings, or will people be able to attend as they wish?

Size of the meeting

In an ideal situation, a single support group should not grow to a size that does not allow everyone to share, if needed, within the specified meeting time. Often, the preferred size is 10–12 members. Sharing experiences and managing group dynamics can be more challenging in a larger group.

Target audience

Is the support group open to all people (family and friends) who have lost a loved one to suicide, or is it limited to, for instance, parents and/or siblings?

Decide whether the meeting will be open to the public or only to those who have confirmed attendance.

Date of the meeting

Sufficient lead-time (such as 2–4 weeks) should be allowed to enable the information to be communicated.

Time and length of the meeting

The time of the meeting should suit the primary audience and local context. When fixing the time, one should consider working hours, school hours, and local considerations such as the amount of time it takes to travel from one point to another during rush hour. In addition, timing may depend on the affiliated organization. For instance, if affiliated with a religious organization, the support group can be held before or after religious gatherings to save time. Another consideration is the length of the meeting. Most groups find that meeting for one and a half to two hours works well, as this allows time for settling in, running the meeting, socializing and refreshments. A meeting that is longer than this can be too emotionally draining. However, larger groups may need longer meetings. Keep in mind that, if the group is large, it may be advisable to divide it into subgroups for part of the meeting.

Venue for the meeting

You will need to decide where to conduct the meeting and whether it will be in-person, online or hybrid. If it is held in a home, the needs of the family members and the safety and boundary issues related to inviting strangers into the home should be considered. In some settings, public buildings – such as local town halls, community centres, schools, libraries or health centres – may have suitable rooms that can be hired free of charge or at low cost by community members or organizations. The venue should be welcoming, comfortable, safe, enclosed to provide privacy for its members, and ideally free from the distractions of noise and people passing by. Ideally, there should be space for food and drink which are shared in many cultures when people gather. Preferably, it should be located close to public transport and parking facilities.

A contact person for further information

Some individuals may need a lot of courage to come to the group. It may be helpful for them to talk to the organizers of the meeting prior to the date. Friends of the bereaved may also wish to make contact.

Number of facilitators

While it may be easier to start the group with one facilitator, there is benefit in having an alternate. Two facilitators will be able to support each other in facilitating the group. If an event arises where one needs to step out, the other can continue.

Announcement of the support group

The announcement will need to be distributed throughout the community, and the channels of communication will depend on the culture. Announcements can be made through established organizations that may already support the bereaved – such as community health and medical centres, doctors' offices, local hospitals, community centres, funeral homes, frontline responders, religious groups and other support groups. Other channels include the Internet, social or traditional media, local radio stations that make community service announcements, local and regional newspapers, notices in the post office, and newsletters about a related field, such as mental health. In some cultures, word of mouth, instant messaging and referrals are options if large announcements may lead to stigmatization. The channel used will also depend on the intended size of the initial group.

Photo: Tea, coffee, and cups prepared for a gathering. ©Istockphoto/themorningglory

Preparation for the first meeting

Planning for the first meeting is likely to include a series of steps, as follows:

- **Draw up a list** of all the things that need to be done.
- **Book and confirm the meeting place**, keeping in mind the availability of this place and other potential locations for future sessions, if applicable. Meeting consistently at the same place and at the same time every week can help to build group cohesion and promote regular attendance.
- **Prepare an agenda** for the meeting. It is essential that the format of the meeting is planned and that those attending know what to expect (suggestions for a possible agenda are listed below).
- **Prepare written information**, such as contact details for sharing with attendees, lists of local mental health professionals (especially those with experience of working with suicide loss survivors), lists of crisis or support lines, references to books written by suicide loss survivors, and tips sheets for handling difficult situations.
- **Have name tags** available (if this is culturally acceptable).
- **Consider whether the support of a professional** or an experienced group leader or facilitator could help during the first meeting.
- **Consider the frequency of further meetings** (e.g. every two weeks, monthly). If meetings are too frequent, participants may become over-reliant on the group for support or guidance, which could limit their ability to regain independence gradually. While frequent meetings may be helpful in the early stages of grief, it is important to support individuals in re-engaging with their lives outside the group over time. On the other hand, if meetings are too infrequent, it may be difficult to form bonds which are the basis for support in the support group.
- **Think about crisis management**. Given that suicide bereavement is a risk factor for suicide, members themselves are at increased risk of suicidal behaviours. If feasible, work together with a professional on what to do if a group member shares, in private or in public, that they are experiencing suicidal thoughts or have a plan to take their life.

A possible agenda for the first meeting of the support group could be:

- Welcome from the meeting organizer.
- Introductions where those attending may be asked, for example, if they wish to share their first name and how they found out about the meeting.
- Explanation of the purpose of the group.
- Taking turns to share experiences in their grieving journey. (One of the primary goals of a support group is to allow each person to tell their story about the suicide of the person they have lost).
- Topics relating to the formation of the group (see below).
- Refreshments and socializing.

Photo: Woman using a laptop while sitting on a bench outdoors. ©Istockphoto/Mohit Ahuja

Other topics for discussion among participants at the first meeting could include the following:

- Is there sufficient interest in further meetings? Having attended the first meeting, do people wish to continue? Two or three people can support each other and share information and ideas. While some people may prefer a small group of five or fewer so that each person can talk more, others like a larger group where they can "get lost in the crowd".

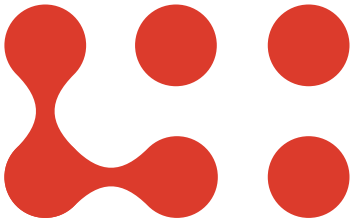
- What are the expectations of those attending? Develop a clear picture of why people are attending. Are their expectations realistic?

- Do participants wish to exchange contact details for support between meetings? Some ground rules should be agreed (see also "Code of ethics" below).

- Agree on confidentiality to ensure that participants feel safe to share experiences.

- What could be a suitable date(s) for the next meeting(s)? How often should the group meet?

Throughout the group's life, these agenda items and topics may shift towards a more organic structure because some cultures find a less structured approach more appealing. However, it may be advisable to begin with some structure to ensure that the group's aims are met.



Develop the aims and structure of the group

While the group's primary goal is to provide "support through community", it will be important to develop its aims and structure to support this goal.

Aims and objectives

The next step is to agree on how the group will operate. As such, the group will need to establish its aims, which should be a statement that describes its overall purpose or vision. Similarly, it should describe its objectives and provide a set of clear statements that define the areas the group wishes to focus on. In many cases, group aims will be similar, such as helping people through suicide bereavement.

Membership and group name

The target audience should be clearly defined. For instance, it can be stated that membership is open to adults who have lost a family member or friend by suicide and that the group is not intended for children as they can be better supported by activities that are specifically designed (e.g. organized by specialized services) to meet their needs. The group can stipulate that this rule is intended to protect all who attend. One should also consider whether members of the same family attending the same group can speak freely. To avoid confusion, the name of the group should clearly indicate its intended audience – i.e. people who have lost someone by suicide – so that it cannot be misinterpreted to include those who have made a suicide attempt, given that individuals who have made a suicide attempt require different kinds of support and management.

While the group's primary goal is to provide "support through community", it will be important to develop its aims and structure to support this goal.

Photo: A group of people holding hands in a circle to show solidarity and support. ©Istockphoto/Paperkites

Establishing the group's structure

The following broad types of structure may be considered:

"Open" and ongoing

"Open" and ongoing, without a set end-point – this means that group members attend and stop attending according to their needs. The group is permanent and meets at certain times throughout the month/year. It becomes known within the community as a resource for individuals to participate in as the need arises.

Advantages
Members can join at any point in time. The group's nature makes it appear open and available to the community in case of need. Members do not need to have an ongoing commitment, which can be too demanding (e.g. in the early stages of grief). Members can instill hope in those who are newly bereaved.

Disadvantages
Maintaining the leadership of an open group over a longer period may be difficult. Effort is needed to recruit and prepare group leaders from the members. The number of members may also fluctuate at times. Spreading the word about the group is a continuing function. The contents of discussions may be repeated when new people attend; they usually need more time, which can be difficult for the "old" members. An open meeting can also lead to more insecurity and less trust.

Closed

Closed" indicates that membership stays the same throughout a specified period, usually over several weeks (e.g. 8–10 sessions). In general, new members cannot join after the second meeting.

Advantages
The time limit clearly defines the beginning and end. People get to know and trust each other as membership is stable, which helps to build strong relationships that may extend beyond the group meetings. Members are encouraged to explore their grief difficulties within the given time in the hope that this aids their healing process. The agenda can be followed easily if there is a programme for every session.

Disadvantages
New members' referrals to the group can be limited because they must wait until the next group starts. In smaller communities, it may be difficult to recruit enough members who are committed to completing a set of closed meetings.

Format for meetings

The following formats may be considered:

Structured or formal

Structured or formal. This format provides for a set procedure to be followed at each meeting. The group will decide on how the meeting will open, what will happen during the meeting, and how it will close. A structured format should not be restrictive but can offer members stability because they know what to expect. An example of a procedure might be as follows:

- Welcome and introductions.
- The "code of ethics" (see below) determined by the group is read out.
- Sharing of experiences.
- Information or education on a prepared topic (depending on group preferences, this can go before sharing of experiences).
- Recapitulation of the content of the meeting and information on the next one.
- Refreshments and socializing.

Unstructured or informal

This format does not have a set agenda or, rather, it loosely adopts the above agenda with the addition of preferred agenda items. The group discusses issues that arise from participants' needs. Nevertheless, it is recommended that steps 1 and 2 of the structured format be adhered to as well.

Photo: Close up of hands holding a booklet. ©Istockphoto/SeventyFour

Photo: A conference room with a long table and chairs, a potential location for a support group. ©Istockphoto/ismagilov

Roles and responsibilities

Tasks will need to be carried out before, during and between meetings. Volunteer members are expected to share these tasks because shared responsibility gives individuals a sense of ownership of the group. This is the core feature of support groups. The skills that members bring to the group will help to determine what role they could volunteer to fulfil.

Tasks before the meeting:

- Finalize and send out announcements to invite participation.
- Confirm availability of the venue along with refreshments, if needed.
- Confirm availability of the facilitator, if it is someone other than the usual one.
- Prepare any materials or handouts, if needed.

Tasks on the day of the meeting:

- Ensure that the venue is available and open.
- Prepare the room and (afterwards) put it back to how it was.
- Arrange the seats and tables.
- Check that the lighting is adequate.
- Welcome participants and check their eligibility as they arrive.
- Hand out name tags (if culturally acceptable).
- Assist with the refreshments, prepare tissues and garbage bags.
- Facilitate the meeting (this role may be shared between members as co-facilitators). The facilitator may be responsible for opening the meeting, sharing the values and guidelines, guiding the proceedings according to the programme, keeping discussions on the subject, reminding members if they exceed their allocated time or interrupt other members, and summarizing and clarifying discussions.
- Prepare and hand out summaries of topics or psychoeducational material.
- Help to advertise the group (e.g. by distributing online or printed materials for subsequent sessions).

Between meetings:

- In between sessions, the organizers/facilitators often need to meet to manage issues as they arise and to plan ahead for future meetings.

Code of ethics

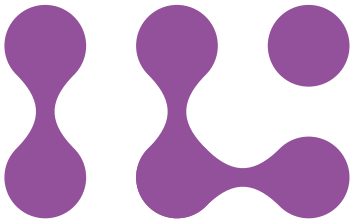
The group will need collectively to establish a code of ethics or a set of ground rules for the conduct of meetings. Fixed boundaries will inform members what to expect and the language that should be avoided, as well as helping to provide a safe meeting space. Within this safe space, members – often with complete strangers – are encouraged to express feelings that are rarely known by anyone else, including their own family members. In an open group format, it may be necessary to read aloud the rules at the start of each session and provide copies to new members. Some sample ground rules for consideration may include:

- Group members attend the meeting on time in order to avoid disruptions during the meeting.
- Group members will respect everyone's right to confidentiality. Thoughts, feelings and experiences shared by group members will stay within the group.
- Group members will recognize that thoughts and feelings are neither right nor wrong and that everybody is entitled to their feelings and opinions.
- Group members will neither judge other members nor force their personal beliefs onto others. They will show tolerance and express themselves constructively.
- Group members have the right to share their grief and/or feelings or not to share. Members can talk about their experience but are equally allowed just to "be there" without speaking up.
- All members have equal time to express themselves without interruption. All members should listen to each other and be silent when someone is speaking.
- A member should not disclose highly graphic or potentially traumatic information related to the death – including mentioning the location, method, or specific dates – unless the other members have consented to this, as these descriptions may trigger post-traumatic stress reactions in other members.
- When a group member has shared personal experiences, group members should first ask if it is acceptable to respond before providing feedback.

- Group members should not attend a meeting when they are under the influence of alcohol or illicit drugs.

- Group members should not attend a meeting when carrying weapons. (There are exceptions to this rule under unique circumstances – e.g. at a military base where they are required to carry weapons. In these circumstances, the rules need to be adapted).

Photo: A diverse group of people sitting in a circle in a support group. ©Istockphoto/Koto



Identifying and accessing information to support the group

A wide range of resources and information can be valuable to the group as a whole and its members as individuals. Gathering information can become a group project, with members following up on specific areas. The information collected can be listed, put into a folder and then placed online or shared on a group drive to build a database.

This may serve a two-fold purpose, namely: 1) increasing awareness of the group among various community sectors while providing valuable information to the group itself; and 2) involving group members in a practical activity that is of value to them individually. The following points may serve as a guide for action:

Gather information

Gather information on and/or contact/visit local community mental and health organizations or services, health facilities and/or emergency clinics/departments.

Cultures and religions

In areas with diverse populations, seminars on the various cultures and religions encountered in the area can be sought, for instance, from universities, colleges, local ethnic associations, or churches.

Identify experts

Identify experts from within the community who can be approached as guest speakers at future meetings. These could include health or mental health professionals, nurses or community health workers, police or parole officers, members of associated groups, educators, businesspersons or financial experts. Guest speakers at support group meetings might address topics such as: facts relating to suicide; the roles of (mental) health professionals; understanding and recognizing depression and other mental health conditions; psychosocial interventions and psychotherapies; understanding grief and prolonged grief disorder; gender differences in grieving; and caring for the carers. The group can prepare questions to discuss with the guest speaker.

Identify professionals

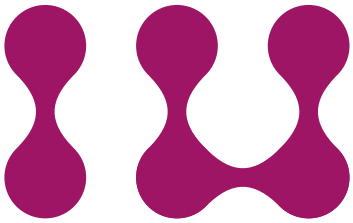
Identify appropriate mental health professionals who could provide training for group facilitators or group members. Possible areas of training could include understanding grief, facilitating groups, communication skills or caring for carers.

Contact libraries and organizations

Contact libraries and related (inter-)national organizations that can advise on books and other reading materials in order to access information on a wide range of topics covering different facets of grief and support after a death by suicide.

A wide range of resources and information can be valuable to the group as a whole and its members as individuals.

Photo: Chairs arranged in a circle, ready for a gathering. ©Istockphoto/Rawpixel



Further considerations in facilitating or organizing a support group

Many factors need to be considered when organizing a support group, especially for the long term. These factors include gauging success, identifying possible tensions and understanding group dynamics. Some of the considerations that commonly emerge in support groups are outlined below.

It is not about numbers

In support groups, success is not about how many members there are but how much the members feel that they have been helped following the suicide of a loved one. An increase in the number of members does not necessarily mean that the number of suicides in the area has increased, that the group's publicity is working or that the members have shared information about the group to others. It could also mean that those bereaved who have stifled their feelings for years are now accessing support. It may be useful to ask new members how they heard about the group and why they are attending. The answers may be helpful in serving the needs of the community.

People sharing their stories

One of the primary goals of a support group is to allow each person to tell their story about the suicide of the person they have lost. Telling the story can be very therapeutic – so long as it does not consolidate unhelpful thoughts or behavioural patterns, and highly graphic or potentially traumatizing information is not shared without others' consent. Members cannot be compelled to tell their story. However, the facilitator can invite members to tell their story, ensuring that revisiting past feelings or events is not continually encouraged and that each person has adequate time to share. The extent to which graphic details of the suicide can be shared should be agreed upon.

Looking back and reflecting

From time to time, it will be helpful to ask members to look back to where they were in their life journey when they first came to the group and where they are now. This will help them to realize that they have evolved, although they may find it difficult to believe this at times. It will also help the facilitator to gain a better sense of the degree to which the group has been successful in supporting the members. This can be useful in encouraging people to look ahead and think about the future, perhaps for the first time. After a suicide it is easy to become stuck in grief and think there is no future.

In support groups, success is not about how many members there are but how much the members feel that they have been helped following the suicide of a loved one.

Supporting others

One of the signs of success of a support group is when members start reaching out to support others, particularly new members. The realization that one's life journey has evolved to the point where one has something useful to share with a newly bereaved person can be an empowering moment. The experience of listening to someone who has been in a similar situation and has lived through it can renew a suicide loss survivor's energy and enthusiasm to keep going and not give up. Reaching that point is a true measure of success for most survivors of suicide loss.

Acknowledging unanswerable questions

All suicide loss survivors have unanswerable questions. Trying to deal with all such questions during meetings can take up a lot of time and can lead to a lack of time to hear from others. Acknowledging such questions as honest and realistic is quite appropriate. Trying to give answers is not. The experience of bereaved persons suggests that listening to the questions and then setting them aside can be helpful. Almost all suicide loss survivors face the unrelenting and unanswerable question "Why did my loved one die by suicide?" At some point in the grief process, most bereaved people can accept the fact that they will never know the answer. Then they can set the question aside. Consequently, one of the signs of a successful group process is when members come to this realization, verbalize it, and show that they are moving on by taking new actions. When this happens, all group members should know that they have played a part, however small, in making this possible.

No timetable for processing grief

Much has been written about "stages" of grief and their expected sequence. Sometimes, bereaved people feel that they should be following some "normal" grief progression. However, experience and research indicate that people develop their own patterns for grieving and healing. There may also be important cultural differences in the ways people progress through their grief.

Give hope to others

People who have been in the group for some time can be a great help, especially to new members – e.g. by telling others how long it has been since their loss to suicide. This may give hope that it is possible to survive, even one hour or one day at a time, until those days add up to weeks and months. Describing successes can be very helpful. For example, someone who tells how they dealt with birthdays, holidays and anniversaries can be a great help to those facing these significant events for the first time.

Tears and hugs

Suicide loss survivors may cry often. People need to know that they are allowed to cry in support groups. Crying may show that the person is struggling to resolve painful issues; it gives other members a chance to reach out and be comforting and supportive to someone else, perhaps for the first time since their loss. Facilitators should have a supply of tissues available at all group meetings. As members assemble for a group meeting, it is possible for hugs to be shared as a sign of welcoming, acceptance and caring. It may convey a message of openness, a quality that bereaved people may appreciate. Nevertheless, facilitators should keep in mind that hugging is a very personal matter; it is culturally sensitive, and not everyone will feel comfortable with sharing hugs. Consequently, consent should be obtained before it is done.

Cultural, linguistic and social diversity

Given that suicide can affect anyone, it should be expected that people from different cultural, linguistic or social backgrounds may attend. This can be a powerful strength as it enhances the opportunity to discuss various coping strategies. However, it can also contribute to misunderstandings between group members. Do not judge people but approach the situation with understanding and acceptance of diversity. The group should invite open communication on how it could function better.

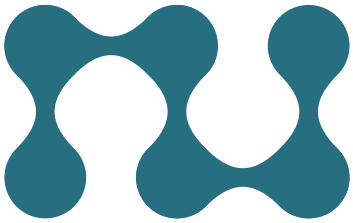
Photo: Son hugs his own father. ©Istockphoto/seb_ra

Knowing when to stop participating in a support group

Members may be able to integrate the support of the group and feel more self-confident and autonomous in their coping, coming back only to visit the group. However, it is important to consider that a person may find that the meetings are not helpful. Other persons may bring negative experiences to themselves or others (e.g. by forming cliques which can cause exclusion), they no longer receive new insights or they have lost interest in listening and supporting new members and have therefore left as a result. The group facilitator will find it useful to speak to members who stop participating and to ascertain the reasons why – such as experiencing discomfort within the group, facing external life changes that make attendance difficult, or encountering group dynamics that hinder their engagement. The facilitator can clarify any misunderstandings that may have occurred. The leader may discuss options to rejoin at a later stage if necessary. In the case of a closed group, it may be important to share the news with the group if a member has chosen to leave. Participants come and go in an open group. If a person has left because they feel their needs have been met and they no longer require the group's support at this time, the news can be shared with the group as positive feedback about the group process. Furthermore, these anonymized stories can be shared with new groups.

Responding to the death of a group member

The death of a group member – whether by suicide or other causes – can have a profound emotional impact on the support group. The death may reignite grief, raise questions about the effectiveness of the group, or evoke feelings of guilt, shock and helplessness among members and facilitators. In such instances, it is important to acknowledge the loss openly within the group, allowing members to express their reactions and emotions in a safe space. Facilitators should offer additional support during this time, such as extending the session, providing individual follow-up, or inviting a mental health professional if needed.



Offering suicide bereavement support groups online

Offering online support groups creates an opportunity to reach a broad group of individuals who may live in geographically remote areas, places where in-person support groups are not being held, and who are isolated or feel unable to attend in person. It may also be convenient for persons with limited mobility, transportation difficulties or scheduling conflicts. Despite the advantages of availability and accessibility, online support entails a few challenges that need to be considered before an online support group is provided.

Lack of monitoring

During online meetings, it can be challenging to monitor the chat for harmful content and to monitor the participants for signs that a member may be distressed, and then to provide support if needed. Furthermore, online forums allow participants to share experiences from the safety of their homes. Some people may take the opportunity to display negative or socially unacceptable behaviours in their interactions, especially if they are not in the same physical location. This can be mitigated by assigning volunteer moderators who communicate with one another if certain behaviours warrant attention or action.

Technical issues

on the part of participants (e.g. problems with the Internet connection or with digital tools) or the online platform can disturb online forums or meetings. It may lead some participants to disconnect. This can be mitigated by testing the platform beforehand and setting it to a lower resolution to use less bandwidth if needed. In some circumstances, audio-only meetings may be required.

Privacy

Privacy may be a concern given that not all individuals who can see and hear the video appear on the screen. This needs to be mitigated by outlining the code of ethics and expectations for the privacy of members at the beginning of each meeting.

Engagement of the participants

Engagement of the participants can vary widely, especially when the meeting is not face-to-face. People might be carrying out other activities during the support group. Furthermore, some participants may be very active at one time and then be absent for weeks. Other participants may be disturbed by these variations as they might experience feelings of abandonment. This can be mitigated by ongoing communication outside of the support group, such as through an email newsletter, or one-on-one online support. The code of ethics for respecting one another's stories can be reiterated at the beginning of each session.

Photo: A group of people in an online video call. ©Istockphoto/nensuria

When planning an online support group, facilitators may benefit from additional training to engage group members effectively in a virtual format. Topics could include how to create a warm and safe setting online, how to conduct opening and closing rituals virtually, and group management in an online environment.

Additional safety measures and group protocols may be considered. The selected virtual platform should allow for maintaining the confidentiality of participants and the login system should be password protected. In addition, a clear registration process will allow facilitators to know who will be joining the group prior to the group starting.

Once an individual has completed a registration form, a welcome letter could be emailed to them, providing the confidential login information, outlining the ground rules, and reiterating that the purpose is to promote a safe and respectful group setting.

Some tips for facilitating online support groups include the following:

- The group will begin and end on time. Remind participants to be punctual in entering the virtual platform.
- Members can dress as they would for an in-person gathering.
- For safety reasons, ask participants to have their camera “on” during the meeting.
- What is said in the group stays in the group. While the group facilitators should take measures to promote safety and confidentiality in the meeting, virtual platforms may not be completely confidential. To help respect the privacy of others, participants should find a quiet, private space so that others in their home environment cannot hear the conversation or participate unless they have registered for the online group.
- Ask participants not to share login information with others.
- Ask participants not to record the meeting by audio or video.
- Ask participants to avoid distractions and interruptions and to refrain from checking emails or text messages, or having other screens open during the online meeting.

- Ask the participants to attend the online group without having used alcohol or illicit drugs.

- If the online platform has automatic audio-captioning in your language, this can be helpful for people who need to listen at a low volume – e.g. if they are attending at a time where others may woken by the sound.

Clear rules on how to use the chat function should be given to all participants, and all participants should consent if the session is to be recorded.

Additional in-person group ground rules can be used for online support groups – such as that only one person should talk at a time, and that others' ideas are to be respected.

It is also important that ground rules are established for facilitators who reach out to members/participants outside of the meeting – particularly if there is concern for someone's well-being – and how this would be addressed.

Programmes that provide suicide bereavement support groups may consider offering both in-person and online options to best meet the needs of the community of suicide loss survivors.

Photo: People holding hands to support one another. ©Istockphoto/crossstudio

References

(1) World Health Organization. Peer support groups by and for people with lived experience. WHO QualityRights guidance module. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO. Available from: https://iris.who.int/bitstream/handle/10665/329594/9789241516778-eng.pdf.

(2) Maass U, Hofmann L, Perlinger J, Wagner B. Effects of bereavement groups: a systematic review and meta-analysis. Death Stud. 2022;46(3):708–18. doi: https://doi.org/10.1080/07481187.2020.1772410.

(3) McIntosh JL. Characteristics and effectiveness of suicide survivor support groups. In: Andriessen K, Krysinska K, Grad O, editors. Postvention in action: the international handbook of suicide bereavement support. Göttingen/Boston: Hogrefe; 2017. p.117–30.

(4) Higgins A, Hybholt L, Meuser OA, Eustace Cook J, Downes C, Morrissey J. Scoping review of peer-led support for people bereaved by suicide. Int J Environ Res Public Health. 2022;19(6):3485. doi: https://doi.org/10.3390/ijerph19063485.

(5) Kaspersen SL, Kalseth J, Stene-Larsen K, Reneflot A. Use of health services and support resources by immediate family members bereaved by suicide: a scoping review. Int J Environ Res Public Health. 2022;19(16):10016. doi: https://doi.org/10.3390/ijerph191610016.

(6) Andriessen K, Krysinska K, Kõlves K, Reavley N. Suicide postvention service models and guidelines 2014–2019: a systematic review. Front Psychol. 2019;10:2677. doi: https://doi.org/10.3389/fpsyg.2019.02677.

(7) Pitman A, Osborn D, King M, Erlangsen A. Effects of suicide bereavement on mental health and suicide risk. Lancet Psychiatry. 2014;1(1):86–94. doi: https://doi.org/10.1016/S2215-0366(14)70224-X.

(8) Onie S, Vina A, Taufik K, Abraham J, Setiyawati D, Colucci E, et al. Indonesian first national suicide prevention strategy: key findings from the qualitative situational analysis. Lancet Reg Health Southeast Asia. 2023;16:100245. doi: https://doi.org/10.1016/j.lansea.2023.100245

(9) Jordan JR. Lessons learned: forty years of clinical work with suicide loss survivors. Front Psychol. 2020;11:766. doi: https://doi.org/10.3389/fpsyg.2020.00766.

(10) World Health Organization. Policy brief on the health aspects of decriminalization of suicide and suicide attempts. Geneva: World Health Organization; 2023. Available from: https://www.who.int/publications/i/item/9789240078796

(11) International Association for Suicide Prevention. The decriminalization of suicidal behaviour. Washington (DC): International Association for Suicide Prevention; 2023. Available from: https://www.iasp.info/decriminalisation/

(12) Levi-Belz Y, Krysinska K, Andriessen K. Turning personal tragedy into triumph: a systematic review and meta-analysis of studies on posttraumatic growth among suicide-loss survivors. Psychol Trauma. 2021;13(3):322–32. doi: https://doi.org/10.1037/tra0000977.

Annex 1. Effectiveness of suicide bereavement support

Suicide bereavement is a risk factor for adverse outcomes related to grief, social functioning, mental health and suicidal behaviour. Several systematic reviews, summarized below, have examined evidence for the effectiveness of support that is offered to people bereaved by suicide.

Intervention studies

A systematic review focused on intervention studies that involved a control group, and reported on grief, psychosocial and suicide-related outcomes *(1)*. The review identified 11 studies published since 1984 that reported on findings from group, family-oriented or individual interventions. Overall, there was some evidence of effectiveness regarding general grief, but no evidence relating to the prevention or treatment of disordered or complicated grief. In terms of psychosocial outcomes, there was evidence of effectiveness from two studies with children/adolescents and two other studies with adults. The interventions were based on psychotherapeutic and psychoeducational approaches. Three studies reported mixed findings regarding suicidal ideation as an outcome, and no study reported on suicidal behaviour *(1)*.

Another systematic review of psychological interventions examined in randomized controlled trials involving people bereaved by suicide included six studies published since 1996 *(2)*. The review found small-to-medium effect sizes for within-group differences but no significant between-group differences for the main outcomes (grief and mental health) of the included studies. The review concluded that interventions can reduce symptoms; however, there was no evidence that an intervention would be more effective than no intervention or an unspecific intervention *(2)*.

While the overall evidence of effectiveness seems limited, the literature identified potentially effective components of interventions *(1)*. These included interventions that were delivered over time (versus single-session interventions), involved trained facilitators, included supportive, therapeutic and educational elements, had manuals or guidelines for facilitators, and involved family members or the wider community. Also, it appeared that grief-specific interventions may yield stronger effects on grief outcomes compared to interventions targeting other outcomes.

Online support

A systematic review of the use and effectiveness of online resources and interventions for people bereaved by suicide included 12 studies (four qualitative, four quantitative, and four mixed methods), mostly of moderate quality, published since 2008 *(3)*. Most of these studies reported findings on online support groups and three studies reported about social media (in which social media were used as an outlet for open discussion regarding the deceased or about suicide). It appeared that online resources are predominantly used by specific groups, including middle-aged women, parents who have lost a child by suicide, and recently bereaved individuals.

There is evidence that online resources offer opportunities for help-seeking around the clock for less educated, more disadvantaged and isolated people *(3)*. The studies reported various benefits of online support, namely: it allows people bereaved by suicide to seek and share support, share and find information, memorialize their loved one and enhance meaning-making. The review also noted the potential negative effects of online sources of support, including discussions on social media that adversely affect mood or become argumentative. Although evidence on the use and benefits of online supports for people bereaved by suicide remains scarce, the review found encouraging results regarding their positive impact on the mental and psychosocial health of the users *(3)*.

Peer-led support and support groups

The literature reports positive findings on support groups for bereaved individuals in general *(4)*, and mixed findings regarding the beneficial effects of peer-led support and support groups for people bereaved by suicide *(5)*. The scarcity of evidence is mainly due to a shortage of high-quality research in this field (e.g. lack of longitudinal designs, and studies involving control groups), as well as the variety of types of groups, target groups and leadership (*5*, *6*). Nevertheless, the literature suggests that peer support groups for individuals bereaved by suicide can be effective for persons who have a need to express or share their grief and can complement individual support such as counselling and psychotherapy *(7)*.

Public health approach to suicide bereavement support

People bereaved by suicide may have different needs which may evolve over time. Thus, support to people bereaved by suicide may need to be diverse in order to address varied circumstances. Successful service delivery may include peer and professional support, in-person and/or online, and can be embedded in the local community *(8)*. Systematic review of the literature identified three components that seem to contribute to effective suicide bereavement service delivery, namely: providing support according to the level of impact of the bereavement, peer involvement, and focusing the support primarily on the grief *(9)*.

Comprehensive suicide bereavement service delivery is based on a public health approach [see ref *(9)* for an overview)]. Such an approach acknowledges that the support needs of bereaved individuals may differ according to the level of impact that they experienced from the suicide, and that the outcomes of the interventions must be clearly defined. Interventions may include:

- providing information and raising awareness about grief and the support that is available to all individuals bereaved by suicide, including those minimally affected by the loss (universal interventions);

- one-on-one counselling or professionally facilitated support groups for individuals experiencing moderate-to-severe grief reactions or a notable impact from the bereavement (selective interventions);

- evidence-based treatments, such as specialized psychotherapy delivered by a qualified mental health professional in individual settings, for those experiencing complex grief reactions or mental health difficulties (indicated interventions).

Comprehensive postvention service delivery requires the training of service providers and rigorous surveillance, research and evaluation of interventions and service delivery. Importantly, organizing suicide bereavement support according to a public health approach would allow further alignment with suicide prevention strategies, which are also organized according to a public health approach *(10)*.

References of Annex 1

(1) Andriessen K, Krysinska K, Hill N, Reifels L, Robinson J, Reavley N, et al. Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. BMC Psychiatry. 2019;19(1):15. doi: https://doi.org/10.1186/s12888-019-2020-z.

(2) Wagner B, Hofmann L, Grafiadeli R. Psychological interventions for people bereaved by suicide: a systematic review. Psychiatr Prax. 2021;48(1):9–18. doi: https://doi.org/10.1055/a-1182-2821.

(3) Lestienne L, Leaune E, Haesebaert J, Poulet E, Andriessen K. An integrative systematic review of online resources and interventions for people bereaved by suicide. Prev Med. 2021;152:106583. doi: https://doi.org/10.1016/j.ypmed.2021.106583.

(4) Maass U, Hofmann L, Perlinger J, Wagner B. Effects of bereavement groups: a systematic review and meta-analysis. Death Stud. 2022;46(3):708–18. doi: https://doi.org/10.1080/07481187.2020.1772410.

(5) McIntosh JL. Characteristics and effectiveness of suicide survivor support groups. In: Andriessen K, Krysinska K, Grad O, editors. Postvention in action: the international handbook of suicide bereavement support. Göttingen/Boston: Hogrefe; 2017. p.117–30.

(6) Higgins A, Hybholt L, Meuser OA, Eustace Cook J, Downes C, Morrissey J. Scoping review of peer-led support for people bereaved by suicide. Int J Environ Res Public Health. 2022;19(6):3485. doi: https://doi.org/10.3390/ijerph19063485.

(7) Kaspersen SL, Kalseth J, Stene-Larsen K, Reneflot A. Use of health services and support resources by immediate family members bereaved by suicide: a scoping review. Int J Environ Res Public Health. 2022;19(16):10016. doi: https://doi.org/10.3390/ijerph19063485.

(8) Abbate L, Chopra J, Poole H, Saini P. Evaluating postvention services and the acceptability of models of postvention: a systematic review. Omega (Westport). 2022;90(2):865–905. doi: https://doi.org/10.1177/00302228221112723.

(9) Andriessen K, Krysinska K, Kõlves K, Reavley N. Suicide postvention service models and guidelines 2014–2019: a systematic review. Front Psychol. 2019;10:2677. doi: https://doi.org/10.3389/fpsyg.2019.02677.

(10) World Health Organization. LIVE LIFE: an implementation guide for suicide prevention in countries. Geneva: World Health Organization; 2021. Available from: https://www.who.int/publications/i/item/9789240026629.

Annex 2. Impact of suicide

The impact of suicide has a ripple effect. It has been estimated that a suicide can affect between five immediate family members and up to 135 community members to varying degrees from very mild to very strongly affected. Suicide may be traumatizing. Each person will need to resolve their feelings at their own pace. What works for one person may not work for another. If suicide loss survivors can gain an understanding of the differing responses to grief that persons may experience, they can be helped by supporting each other. The quality and intensity of the relationship with the deceased person have been identified as key influences on bereavement outcomes. Other important factors include the type of relationship, the age and sex of the deceased and the bereaved person, the trauma of finding the deceased, the role of the person who died by suicide and the resulting role changes for the suicide loss survivors, family traditions, rules, habits and beliefs, expectations of the environment, coping style of the bereaved, and the availability of other support systems.

Among the many problems that can inhibit families from grieving are denying or difficulties in accepting suicide as the cause of death, allowing the suicide to become a family taboo; denying feelings of grief, pain or anger; self-stigma and shame; withdrawal and social isolation from friends and sources of support; immersing oneself intensively in work or a hobby; addictive behaviours such as alcohol or drugs; or attributing blame to family members or mental health workers. The effect of a suicide may differ for each person. The examples presented below, may serve to heighten awareness.

Parents bereaved by the suicide of a child are often overwhelmed by guilt and distress. They may feel that they completely failed as parents. It may lead to marital discord and doubt about their ability to care for their remaining children, if any. Some may become excessively protective towards their remaining children. These reactions can contribute to the children being silent about their grief to avoid worrying their parents. Parents bereaved by suicide may have important needs, including for emotional, practical and parenting support, and a quest for meaning.

Children are often resilient, but a death by suicide (often in the parents/family) can be a very frightening and confusing event for a child. Unfortunately, a commonly held belief in some communities is that children are preserved from the suffering of grief. Even if there is the lack of demonstrable suffering, past studies have revealed that the loss of a loved one is one of the most stressful life experiences for a child.

The natural impulse for the parents or carers is to shield and protect the children. Children often draw the incorrect conclusion that they were to blame for the death. Parents may need to provide reassurance against the possible guilt and comfort for the loss. Parental reaction to death has a strong influence on the child's reactions. At the core of helping children is the need to include children in the grieving process and rituals, to be open and honest to the extent that they can comprehend, and to explore their knowledge and feelings on death and dying. Children need time for their grief, as much as adults do. Information about the suicide and the support provided should be age-appropriate. If the child saw or found the body, specific support should be considered. Children may also reprocess their grief as they grow up and mature. If parents are still alive, the parental sense of safety and security may be protective against mental health problems in children.

Adolescents find themselves in a developmental stage where identity formation and connection with peers are critical. Suicide bereavement can affect these processes, including the adolescent experiencing shame and embarrassment, drawing away or being excluded by others, fear of connection, or even feeling that life is meaningless. Adolescents' grief reactions can differ markedly from those of adults and can often be misinterpreted. Some may adopt a parent-like role not typical of their age group. Others may exhibit behaviours such as aggression, anger, the testing of authority, or substance use. Many may long for comfort and reassurance but find it hard to express their needs or not know where to turn to for support. The family unit can be a main source of support; however, adolescents usually do not grieve in the same way as their parents (e.g. they may be reluctant to share their grief or talk about the deceased person). Adolescents often seek their peers to discuss personal matters, but most of them would not be emotionally equipped to respond to suicide loss. Designated programmes to provide access to peer and professional support would be a viable option.

Siblings can experience the same variety of feelings as described above. Still, specific feelings may appear, such as guilt because of a recent quarrel, feelings of being neglected due to parental grief, or anxiety as their own future looks less secure. Siblings are often overlooked, even though they may have lost a valued confidante or a parental figure. When a child dies, parents often receive the most condolences and support. Siblings may feel isolated or wish to protect their parents by withdrawing themselves.

Spouses/partners can struggle to address their own grief while trying to maintain the family and support their children, if any. They may receive questions about the reasons for the suicide, feel guilty for not having been able to prevent the suicide, and stigma and fear that they would remain alone forever as no one would want to be in a relationship with them. They may worry around financial matters, having to

move out of their home, or having to relocate to a place where there is more support. They may also have worries about a life insurance policy, being able to keep their job, or raising their children, if any, alone.

Older adults, whether as parents or grandparents, will suffer profoundly as they grieve for the loss of their adult child or grandchild. The spouse or partner of the adult child is likely to be the main focus for support which can leave those outside the nuclear family feeling neglected. To grandparents, the death of a grandchild can impose a two-fold grief, as parents for their bereaved son or daughter, and the grief for the loss of their grandchild.

Friends and colleagues can be affected to varying degrees, depending on their relationship to the deceased and the bereaved family. They may feel overlooked as support is often focused on family members, or they may feel they are not worthy of support. Avoidance can occur among friends and colleagues, similar to that occurring in families of bereaved persons. This may be due to social awkwardness or their inability to cope with the feelings that the suicide has raised. Common rationales expressed for not offering proactive support include "I don't know what to say", "What if I say something wrong?" or "They need the help of a professional – there is nothing I can do".

Professionals (such as physicians, psychologists, psychiatrists, social workers, attorneys) who have had direct contact with the person who died can also be impacted by the death. They may feel regret or may be prone to rumination and re-analyse their actions or their role. They may also be afraid to talk about the suicide due to the ethics of confidentiality.

Communities: Suicide does not occur in isolation. Members of groups and organizations (e.g. schools, health services and hospitals, workplaces, religious groups) that are affected by a suicide may benefit from professional assistance of health care workers or trained facilitators providing support and guidance (e.g. sharing information about common grief reactions and support services). Cultural, religious and social beliefs about suicide and bereavement can also be discussed. Enhancing the understanding of the complex circumstances contributing to a death by suicide can contribute to building a safety net to identify those who may be at risk of adverse grief reactions. Those who experience symptoms of depression, post-traumatic stress or other mental health problems may be referred to mental health professionals. A healthy community response considers all sectors after a death by suicide.

Annex 3. Sources of support for the bereaved

Support groups can play an important role in identifying and encouraging members to make full use of the range of support options that may be available. While grief is a natural reaction to the death of a loved one, a death by suicide is often experienced as more traumatic and more stigmatized, presenting greater challenges for adjustment. The needs of people bereaved by suicide are many and can be quite complex. Support and assistance can come from a variety of sources. Each source or contact can play an important role. Bereaved people may consider that seeking help is a strength, not a weakness, contributing to the integration of the deceased person into their life. The examples below indicate the variety of support resources that are potentially available.

Families are often a major source of support and assistance. Families that can share their grief have found this to be a positive factor in finding meaning of and coming to terms with their loss. The sharing of grief can also serve to strengthen the family unit. Factors that may help to achieve this are a family's openness to expressing grief, the absence of secrecy surrounding the death, and the understanding of family members' right to grieve in their own way. Obstacles that may inhibit families from grieving include:

- denying that each individual grieves differently and may have different needs;
- hiding the pain, denying or invalidating one's emotional reactions to the death;
- feelings of guilt and self-blame;
- secrecy and hiding the cause of death;
- maladaptive coping strategies (increased alcohol or drug use, eating disorders);
- avoiding thinking about the suicide;
- physical or social avoidance by escaping from contacts, places and situations that are associated with the deceased;
- blaming other family members for the suicide;
- receiving gratuitous advice (e.g. "you have to be strong");
- dealing with legal or administrative challenges (e.g. police inquiries, insurance).

Support groups can assist group members by sharing and discussing problem-solving strategies as they arise in the family. Suicide is generally perceived as an unnatural death, like homicide or accidental death. As suicides often occur near the home setting, the bereaved person may have found the body. The mental anguish, torment, flashbacks and visualizations may stay with them for extended periods. Professional help such as consulting a general physician can be a first step; referrals can be made as needed.

Friends and colleagues can play a vital role in assisting the bereaved persons. The support and understanding of those in close contact with the bereaved can provide relief and feelings of acceptance. Some of the vital functions of friends may relate to:

- listening and responding with empathy;
- understanding the need to talk and being a sounding board for emotional relief;
- assisting in clarifying concerns relating to family members;
- practical assistance with formalities after a death or in maintaining the home;
- suggesting professional help when appropriate (e.g. when the bereaved person feels suicidal).

Professional support can provide an opportunity for more objectivity in the assistance provided and may be crucial when a person is experiencing prolonged and severe grief reactions that are affecting their daily functioning. In case of somatic problems (e.g. pain, impaired sleep, increased alcohol use), a general physician may provide the care needed, and can discuss general health care with the bereaved or family members.

Professional counsellors specialized in grief issues may support survivors in integrating the reality of the death, seeking meaningful comprehension and understanding the grief process, thereby “normalizing” their feelings and reducing the sense of isolation. Social workers and mental health nurses may help in integrating the social impact of cultural taboos, social supports, professional resources and personal responses in going through the grieving process. For those who are religious or spiritual, a faith leader or community may provide comfort and guidance.

Psychologists and psychotherapists can work with the bereaved in resolving specific problems (e.g. anxiety or panic attacks). They can help in working through blaming and self-blaming, and dispelling any aggressive feelings the bereaved person may have towards others, themselves and/or the deceased, of which they are usually afraid or ashamed. Psychiatrists can play a crucial role in assessing mental health conditions such as depression, prolonged grief disorder or post-

traumatic stress disorder, and can initiate evidence-based treatment. Encouraging bereaved persons to consult specialist mental health services in cases of suicidal crises and/or mental health problems can be of vital importance.

Other resources. People bereaved by suicide may also feel supported by information on grief reactions and suicide (e.g. through reading literature, websites, brochures, or listening to podcasts) as well as by social media groups aimed at survivors of suicide loss.

Annex 4. Other activities for the bereaved

When no support group for suicide loss survivors exists and there are no plans for one, the following non-exhaustive list of ideas refers to activities that may be helpful to encourage meaningful and appropriate ways of coping.

- **Talking**. Talking one-on-one with others provides an opportunity to share feelings and emotions. Finding someone who listens may not be easy but approaching family members, friends and members of religious groups may be good starting points.

- **Writing**. Whether by writing a letter to someone, keeping a journal or just filling a page with thoughts and emotions, many people bereaved by suicide find that this form of self-expression can be helpful.

- **Art forms**. Practising art has been a means of personal expression for centuries. The medium used may be painting, sewing, pottery, woodworking or music, to name just a few examples. Conveying your feelings, thoughts and emotions through some inanimate object can be helpful as it bypasses the need to talk.

- **Gardening**. This can include planting and cultivating plants or trees, or hard work activities that render a visible result like wood chopping, raking leaves, digging, shoveling snow or building something.

- **Joining other groups**. When there are no other suicide loss survivors nearby to connect with, it may be possible to join another type of group activity. This may involve reaching out, and can facilitate the healing process by focusing on others.

- **Meditation or mindfulness**. This activity can help a person or group to better regulate emotions by creating space where one can detach oneself from, and mindfully consider, one's situation and response. This can also facilitate problem-solving.

- **Physical activity**. Sports and exercise, including dancing, can help relieve stress, anger and aggression and can take one's mind off worries. Physical activity has also been shown to improve mental health and can create a social environment.

- **Reaching out**. Reaching out to other suicide loss survivors, for instance by making home visits to someone newly bereaved by suicide, can turn into mutually valuable visits that contribute to the recovery process for new suicide loss survivors.

- **Making presentations or podcasts**. Trained suicide loss survivors can make presentations to community groups, businesses, schools and civic organizations on the problem of suicide, risk and protective factors, approaches to suicide prevention, and where to seek help and support for the bereaved.

- **Joining suicide prevention/suicide loss associations**. These associations can provide information on suicide bereavement and prevention and may offer activities for suicide loss survivors or opportunities to become active in suicide prevention advocacy or programmes. Activities may include awareness or fundraising, creating video messages, participating in community walks, local suicide bereavement conferences, or International Survivors of Suicide Loss Day.

- **Creating lifekeeper memory quilts or jewelry**. Various organizations in the world have adopted the concept of putting pictures of loved ones who have died by suicide on art-quality quilts or to set the symbol in gold or silver jewelry as a reminder to “keep life forever”. This highlights the life lost to suicide and provides a reminder to work for suicide prevention.

- **Volunteering**. Suicide loss survivors may find volunteering in mental health or suicide prevention programmes (e.g. outreach or stigma reduction) of non-profit organizations to be effective ways to make a difference.

World Health Organization
20 Avenue Appia
CH-1211 Geneva 27
Switzerland
Website: http://www.who.int/health-topics/suicide