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ABSTRACT

As detailed in the lead article in this Special Issue, the Survivors of Suicide Loss Task Force of the National Action Alliance for Suicide Prevention in the United States has recently worked to formulate national guidelines to mitigate the harmful aftereffects of suicide in social and family systems. In the present article, we elaborate on one of four strategic directions addressed by the Task Force, namely, the development of goals and objectives for surveillance, research and evaluation of the impact of suicide loss. By emphasizing methodological guidelines for the conduct of future studies and illustrating progressive programs of investigation as leading exemplars, we hope to contribute to the sophistication of research on public health initiatives, peer support and professional intervention with communities, families and individuals affected by suicide loss.

As documented by initiatives in several nations, increasing attention is being paid internationally to curbing the incidence of suicide throughout the world (Fleischmann & De Leo, 2014; Hawton, 2014; WHO, 2014). Historically, however, less attention has been given to suicide loss in the lives of those communities, workplaces, families, and individuals who remain. In light of estimates that 800,000 people die by suicide each year (WHO, 2014), and evidence that 5–15 nuclear to extended family members are "intimately and directly affected" by each death (Berman, 2011), 4 to 12 million people may suffer suicide bereavement annually worldwide. When one considers effects beyond immediate family (e.g., in the extended family, friendship networks, church, school, or workplace), the impact of suicide loss is obviously much larger. Cerel and colleagues have found that nearly half of community members report knowing of the suicide of a personal acquaintance, with almost 20% of the population identifying as a "survivor," that is, as someone significantly affected by a suicide death (Cerel, Maple, Aldrich, & van de Venne, 2013; Cerel, Maple, van de Venne, Moore, Flaherty, & Brown, 2016). Moreover, some subgroups within the population will have significantly higher exposure to suicide, including indigenous people, culturally and linguistically diverse communities, and those identifying as sexually diverse (Maple et al., 2016). Taking into account the pervasiveness of suicide, theorists have recently emphasized a "continuum model" that acknowledges the impact of such tragic deaths on social systems and individuals (a) exposed to suicide, (b) affected by suicide, (c) bereaved by suicide and suffering short-term effects, and (d) bereaved by suicide with serious long-term consequences (Cerel, McIIntosh, Neimeyer, Maple, & Marshall, 2014).[1] If public health initiatives are to be developed to define "best practices" to reduce the negative effects of suicide loss at all of these levels, they need to be informed by high-quality research that clarifies its consequences and how they can be mitigated through primary, secondary, and tertiary intervention, as detailed in the guidelines formulated by the National Action Alliance for Suicide Prevention (Action Alliance) Survivors of Suicide Loss (SOSL) Task Force, under the auspices of the U.S. Department of Health and Social Services (see lead article in this Special Issue for details). The present article seeks to contribute to this mission by offering additional commentary on those recommendations relevant to the fourth strategic direction addressed in the guidelines, namely, those focused on surveillance, research, and evaluation efforts concerning suicide loss. We will therefore briefly recap the fundamental goals and objectives in the document addressing this aim, offering additional suggestions in simple bullet point form for implementation in future studies and occasionally pointing readers to relevant exemplars of such research, including some projects that are currently under way.

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[1]For more detail on this latter point, see the full guidelines document, p. 10, accessible at http://actionallianceforsuicideprevention.org/task-force/survivors-suicide-loss.

Strategic direction 4: Surveillance, research, and evaluation

Goal 11: Design studies of suicide loss survivors using appropriate scientific methods.

Objective 11.1: Improve the general methods used in suicide bereavement research, including using samples of sufficient size, valid and reliable instrumentation, and clear descriptions of relevant sample characteristics (e.g., kinship relationship or psychological closeness to the deceased, time since the death).

Comments:

- Studies of suicide loss too often rely on small convenience samples, limiting confidence in results and generalizability of conclusions. Future studies need to recruit samples of sufficient size to ensure adequate statistical power in quantitative studies, and identify appropriate participants using purposive or theoretical sampling strategies in qualitative research designs (e.g., focus group or grounded theory studies) that are methodologically appropriate to the research design.
- Observe established criteria (e.g., memoing, member checking) for the conduct of qualitative studies (e.g., using grounded theory, narrative, phenomenological or focus group methods) to ensure trustworthiness of conclusions.
- Rely on psychometrically valid and reliable instrumentation to assess quantitative variables of interest when those measures are available. Focus on the development of measures where they have not been previously created, and ensure these are validated over time.
- Distinguish research participants based on kinship (e.g., parent, child, spouse) and nonkinship (e.g., friend, coworker, emergency responder, therapist) relation to the deceased rather than combining them in a single category. When a larger grouping is justified, compare significant subgroups within the overall sample.
- Promote bridging of research and practice by soliciting engagement of relevant stakeholders in scientific studies of suicide loss and intervention. For example, ensure representation of the voices of survivors in the design and interpretation of relevant studies, in keeping with the principles of community-based participatory research, as has been done, for example, in the field of homicide bereavement (Neimeyer, Burke, & Lawson, 2013).

Objective 11.2: Employ relevant control and/or comparison groups to justify descriptive and causal inferences regarding suicide loss and its treatment. Compare suicide loss survivors to other relevant groups, such as people exposed to other forms of traumatic stress or bereaved by other modes of death, and include nonbereaved controls.

Comments:

- Compare and contrast survivors of suicide to other traumatized but nonbereaved populations to evaluate distinctive factors associated with traumatic death, *per se*, as well as to those bereaved by other modes of death (e.g., natural anticipated, natural sudden, and violent deaths, as through accident and homicide) to determine what is unique to suicide.
- Match suicide survivors with relevant comparison groups on other factors plausibly related to the independent variables of interest (e.g., demographic background, kinship and/or closeness to the deceased, ethnicity, and gender).

Objective 11.3: Explore novel recruitment strategies for suicide loss research, such as peer nomination and "snowball" sampling. Also, establish a national registry of people bereaved by suicide who are willing to be contacted to participate in research.

Comments:

- Many suicide survivors are motivated by altruism to collaborate with researchers and offer their experience in the hope of increasing understanding of this anguishing form of loss. Establishing a confidential registry of volunteers (perhaps under the auspices of a national or international organization) who are willing to be contacted by investigators and offered participation in quantitative and qualitative studies could do much to advance this goal.

Objective 11.4: Pursue mixed methods research, using both quantitative and qualitative methods.

Comments:

- The majority of research studies in suicide bereavement are quantitative in methodology, yielding objective descriptions of general trends and averages for participants as a group. A minority of studies adopts focus group, grounded theory, narrative, and other qualitative methods that yield a thick description of subjective experiences and meanings of suicide loss for survivors. Combining both methods in the same study can enhance the value of the research by drawing on the complementary strengths of both.

Goal 12: Establish valid and reliable estimates of the number of people exposed to suicide and the immediate and longer term impact of exposure. This includes people (a) exposed to and (b) affected by a given suicide as well as those who suffer (c) short-term and (d) long-term bereavement complications.

Objective 12.1: Clearly explain the criteria used to define who is a survivor of suicide loss in a given study.

Comments:

- Clearly define for purposes of both participant recruitment and reporting of results what constitutes "suicide survivorship" in a given study, giving consideration to recently advanced definitions for distinguishable subgroups of this overall category. One such promising categorization is the "continuum of survivorship" advanced by Cerel et al. (2014). Standard nomenclature should be promoted.
- Report subjective "closeness" to the deceased, insofar as level of intimacy can vary greatly within any given descriptive category of survivors (e.g., family, coworkers) and may prove to be more predictive of impact than kinship, *per se*. Recent research by Cerel and her colleagues (in submission) exemplifies this method.

Objective 12.2: Use epidemiological, prospective, and longitudinal methods to estimate the prevalence of suicide exposure and the subset of those exposed who suffer short-term and prolonged psychological distress. Trace the longer term responses of survivors to identify the typical course(s) of adaptation to suicide loss, including longer term negative and positive (posttraumatic growth) effects.

Comments:

- Use surveys of randomly or representatively sampled catchment areas to estimate the prevalence of suicide exposure and its impact (e.g., posttraumatic symptomatology from witnessing a completed suicide), inasmuch as recent research places the number of affected persons as significantly larger than the six survivors per suicide commonly quoted. For example, Feigleman and colleagues are collecting data utilizing the 2016 General Social Survey in which data on exposure to suicide are being collected in person from 1,500 adult householders from across USA. This in-person, door-to-door survey will offer a unique look at exposure to suicide and will finally begin to answer this question.
- Conduct studies permitting genuine prospective prediction of the impact of suicide through collecting data at two or more time points longitudinally (e.g., health data before and following suicide bereavement, coping responses early in loss as potential predictors of later psychosocial outcomes).

Objective 12.3: Expand the assessment of relevant variables beyond those concerned with grief and psychiatric symptomatology to evaluate the broader impact of suicide on the personal, interpersonal, and spiritual functioning of SOSL.

Comments:

- While evaluating symptom burden in relevant domains, include assessments of possible positive outcomes associated with survivorship (e.g., altruistic outreach to other survivors, posttraumatic growth). Note that resilience may not be simply the inverse of psychiatric symptomatology. Further, exploration of within-group differences that distinguish across the spectrum of outcomes from suicide exposure rather than a sole focus on bereavement is required. This area is of importance. Recent work on posttraumatic growth in SOSL (Moore, Cerel, & Jobes, 2015) is a beginning, but there needs to be more research to fully understand the broader impacts of suicide loss.
- Study how those who are bereaved by suicide actively cope with its impact psychologically and socially rather than treating them only as passive victims of a traumatic event. For example, sophisticated qualitative research by Silvén Hagström (2016) documents how young people mourning the loss of a parent to suicide contend against discourses of blame and stigmatization in their communication with others, both in face-to-face and online interactions.

Goal 13: Identify common and unique impacts of suicide bereavement as well as individual difference variables that function as risk factors for or buffers to such effects.

Objective 13.1: Using appropriate comparison groups, determine what features of response to suicide loss are shared with survivors of other types of losses, whether natural or violent, and what factors may be unique to bereavement after suicide.

Comments:

- In establishing what features of suicide loss might distinguish it from other forms of bereavement, consider qualitative differences (e.g., characterized by emotional themes such as shock, guilt, and anger as well as broader social impacts) that go beyond quantitative differences between groups (e.g., in overall levels of grief or depression) (Jordan & McIntosh, 2011).

Objective 13.2: Investigate factors from general bereavement research that may mediate the response to suicide (e.g., kinship relationship, psychological closeness, attachment security, coping style, meaning making, gender, social support).

Comments:

- Because much of research on the impact of suicide loss draws on large databases archived in public health records, preference is often given to readily available demographic factors that mediate or moderate its effect. Although this is valuable, more attention should be given to psychological processes that could dampen, amplify, or account for outcome, such as inability to find meaning or sense in the death (Currier, Holland, & Neimeyer, 2006). Likewise,

perceived closeness to the deceased has been shown to be the most salient variable in outcome for people exposed to suicide even when factoring in length of time since the death and exposure to multiple suicides (Cerel, Frey, Maple, van de Venne, & Sanford, 2016; (Maple et al., 2016)).

Objective 13.3: Consider the impact of developmental factors on adaptation to suicide loss, with special attention to such populations as children, adolescents, and older adults. Also included in this should be prior exposure to suicidal behavior and fatalities in the individual's history.

Comments:

- Solicit information from research participants about family history of suicide (death and attempt) and other potential risk factors that could predispose to adverse outcomes (e.g., mental illnesses such as depression or bipolar disorder as well as socioeconomic adversity) and analyze their relation to response to suicide loss. The research literature on children's responses following suicide is still germinal, as it is difficult to access samples of suicide-bereaved children and adolescents and to follow them over time to examine developmental trajectories. Future research should strive to better understand how suicide bereavement influences over time any individual exposed as a child.

Objective 13.4: Examine the role of gender, culture, and ethnicity, both within and beyond the U.S. context, in predicting the impact of suicide loss.

Comments:

- As a highly value-laden form of dying, suicide may carry quite different meanings for survivors who vary in culture and ethnicity, just as gender and role of the survivor and deceased in the family, community and economic system could predispose to different outcomes in the case of any given loss.

Objective 13.5: Analyze the role of circumstantial factors concerning the death (e.g., expectedness of the death, duration of the period of prior psychiatric disorder in the deceased, direct witnessing of the death, discovering the body, level of violence of the death, and ambiguity in the "intentionality" of the death (i.e., whether it is perceived unambiguously as a suicide by the survivor or not) in mediating the impact of exposure on SOSL.

- Much research on suicide loss suffers from a uniformity myth, tacitly presuming that those who have suffered it can be distinguished as a group from those who have not. Too few studies, however, concentrate on risk factors for worse outcome within the category of those bereaved by suicide. Recent reviews of predictors of complicated grief across different modes of death offer some direction for this effort (Burke & Neimeyer, 2013).

Objective 13.6: Investigate the role of social response to suicide as a mediating factor in the healing process of survivors. This includes the response of family systems, social networks (friends, work colleagues, etc.), and institutions and organizations (schools, churches, workplaces, etc.). Particular attention should be paid to the impact of stigmatization of suicide on loss survivors.

Comments:

- Situate studies of individual impact of and coping with suicide in the context of family processes of mutual grieving, meaning-making, and emotion regulation.
- Study the role of spontaneous face-to-face social support in the accommodation of suicide loss, including such factors as social network size, composition, and type of response to the loss (e.g., compassionate, avoidant, or intrusive).
- Describe and evaluate the impact of computer-based social networking and web-based dissemination of information on suicide loss in meeting the emotional and instrumental needs of users.
- Conduct research on the social stigmatization of suicide bereavement, both as reported by the bereaved themselves and as demonstrated in the attitudes of relevant others who vary in gender, race, ethnicity, culture, and relation to the bereaved. For example, Silvén Hagström's (2016) analysis of intensive interviews, theatrical performance and participation in internet chat groups by suicide-bereaved youth demonstrates how their communication with others both reproduces and resists dominant stigmatizing discourses regarding this form of loss.

Goal 14: Study the utilization and efficacy of interventions and services designed to assist people bereaved by suicide.

Objective 14.1: Establish a national database of approved institutional review board (IRB) protocols to provide guidance for future investigators and IRB bodies in balancing the delicate issues of protection of human subjects and adequate informed consent procedures in studies with suicide loss survivors.

Comments:

- As a potentially vulnerable but not clearly identified group requiring special safeguards as participants in research (such as children or prisoners), persons who have lost significant others to suicide are at risk of both underprotection and overprotection by ethical decision makers unfamiliar with this population (Moore, Maple, Mitchell, & Cerel, 2013). Archiving successful proposals and IRB responses can therefore

be of great value in providing guidance to boards and investigators alike.

Objective 14.2: Describe utilization of and satisfaction with different forms of support and intervention (e.g., peer support groups, spiritual counseling, pharmacotherapy, grief therapy) sought out by SOSL.

Comments:

- Although satisfaction cannot be considered a surrogate for demonstrated efficacy of various modalities of support as determined by controlled trials, it is one factor likely to determine willingness to seek help and continue to avail oneself of relevant resources. At present, relatively few support services for suicide loss receive even this level of evaluation. In a recent examination of loss survivors seeking help from therapists, most survivors felt that individual therapy was helpful (Sanford, Cerel, McGann, & Maple, 2016) but that post traumatic stress disorder (PTSD) was not identified as often as it should be. Research is beginning to examine experiences with survivors of suicide support groups (SOS) groups (Sanford & Cerel, in progress) and physicians (Foggin et al., 2016; Feigelman, W., Cerel, J., & Sanford, R. (in submission)).

- It is likely that many help-seeking SOSL avail themselves of more than a single source of support, for example, by attending both occasional mutual support groups and consulting a professional therapist. To date, however, the perceived contributions of each to the survivor's adaptation have received very little attention.

Objective 14.3: Investigate effectiveness of peer support groups for suicide loss. Include variables such as training and experience level of group leadership, group format, frequency and duration of group meetings, participant attrition, and frequency of participation. Study group interventions both in the research laboratory and in naturalistic settings where most support groups operate.

Comments:

- Evaluate safety and acceptability of peer-led support groups following suicide loss, with a particular focus on possible adverse effects of repeated exposure to the traumatic accounts and suffering of others and its role in contributing to group dropout (Feigelman & Feigelman, 2011a, 2011b). Ongoing research by Sanford (in preparation) is examining meaning-making in support groups as well as caregiver burnout by volunteers who lead groups.

Objective 14.4: As opposed to generic studies of unspecified therapies, conduct-randomized controlled trials of specific professional interventions that show promise of efficacy in the treatment of suicide bereavement (e.g., Eye Movement Desensitization and Reprocessing or EMDR, Active Postvention Model, complicated grief therapy, prolonged exposure interventions for PTSD, behavioral activation, and narrative and meaning-oriented interventions).

Comments:

- Because suicide bereavement stands at the intersection of bereavement and traumatic stress, relevant interventions to be evaluated could draw upon evidence-informed approaches from both fields of study. Examples might include attachment-focused therapy for complicated grief (Shear, Frank, Houch, & Reynolds, 2005), exposure therapies (Bryant et al., 2014), contextual behavioral activation (Papa, Sewell, Garrison-Diehn, & Rummel, 2013), and meaning reconstruction strategies (Neimeyer, 2016) as well as those arising within suicidology *per se* (Cerel & Campbell, 2008).

Objective 14.5: Investigate the role of clinician variables as a factor in outcome. This includes level of training, level of experience in working with loss survivors, and clinician history of exposure to suicide in personal or professional contexts.

Comments:

- In addition to passively measuring effects of clinician or facilitator background, document and disseminate evidence-based training for peer support and professional assessment and intervention following suicide loss. Evaluate learning outcomes, achievement of basic competencies and changes in actual treatment practices following training programs for facilitators of mutual support groups, first responders, allied medical professionals, and others who offer specialized services to suicide survivors at any point following the death.

- Construct evidence-based workshops and curricula, both face-to-face and online, for graduate-level training and continuing professional education in suicidology and in collaboration with other relevant professional groups (e.g., Association for Death Education and Counseling, International Society for Traumatic Stress Studies, American Association of Suicidology), and evaluate their success in meeting learning objectives.

Goal 15: Promote bridging of research and practice by soliciting engagement of relevant stakeholders in scientific studies of suicide loss and intervention.

Objective 15.1: Ensure representation of SOSL in the design and interpretation of relevant studies.

Comments:

- Potential users of proposed psychological treatments are in an optimal position to evaluate their credibility, safety and perceived relevance, potentially circumventing costly redesign of unrealistic or unattractive interventions. Likewise, when treatments

proved to be less acceptable or efficacious than desired, focus groups of users can offer invaluable insights for their improvement. The principles and practices of community-based participatory research (CBPR) can go some distance in cultivating these town and gown partnerships (Neimeyer et al., 2013).

Objective 15.2: Involve clinical practitioners in the construction, implementation, and evaluation of support and treatment programs for loss survivors, including the naturalistic study of best practices currently implemented in the field.

Comments:

- If evidence-based practices are to survive the translation from the laboratory to field settings, they need to attract the enthusiasm of the practitioners who will use them. This will best be achieved in a climate of mutual respect for the strengths of both clinicians and researchers, something that is too rarely achieved—or even attempted—in reality (Neimeyer, Harris, Winokuer, & Thornton, 2011).
- Evidence-based practice can be supplemented by practice-based evidence, when the therapies conducted by skilled clinicians who achieve demonstrably good outcomes are studied to detect relevant process–outcome links, which can then inform the design of future intervention programs (Piazza-Bonin, Neimeyer, Alves, Smigelsky, & Crunk, 2016).

Objective 15.3: Secure the buy-in of relevant institutions (e.g., agencies, services, funders) in the design and evaluation of treatment programs to ensure their sustainability beyond the period of initial study.

Comments:

- Conducting studies in the field settings in which they could be adopted, with adequate funding to underwrite clinic expenses from participating, can smooth the way for ongoing implementation, when coupled with the collaborative attitude toward treatment providers discussed above. Inattention to these contextual and institutional factors fates many research-based intervention programs to having an impact merely on the literature rather than the field.

Conclusion

In recognition of the universality of suicide loss globally, the Action Alliance Task Force has developed specific goals and objectives to guide future scientific research, in keeping with the charge given it by the U.S. Department of Health and Human Services. The present paper revisits these guidelines and offers a more elaborated commentary on their rationale and implications to extend these objectives. Along with others who served on the Task Force and contributed to this Special Issue

of *Death Studies*, we invite dialogue with colleagues pursuing similar initiatives in other nations who are striving to reduce the impact of this form of traumatic loss on communities, families, and individuals. We hope that future research contributes to these efforts and provides a clearer focus for primary and secondary prevention programs in USA and abroad as well as sharper implications for professional intervention when such efforts are warranted.

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