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BK-SAGE-STEFFEN_ET_AL-220166-Chp00_Prelims.indd 3 02/11/22 7:35 PM

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London EC1Y 1SP

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Cover Design: Naomi Robinson
Typeset by KnowledgeWorks Global Ltd
Printed in the UK

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Library of Congress Control Number: 2022938970

British Library Cataloguing in Publication data

A catalogue record for this book is available from the British Library

ISBN 978-1-5297-6144-3
ISBN 978-1-5297-5920-4 (pbk)

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Navigating the Complications of Suicide Loss

Katherine Supiano

Kerry and Paul are the 60-year-old married parents of 35-year-old daughter Cami, who died by overdose. Cami had a history of depression dating from early adulthood, which worsened markedly in her marriage to a violent husband. The couple had a young son, and Cami divorced her husband after he broke her jaw in a violent altercation. She was prescribed opioid painkillers and antidepressant medication. She received counselling intermittently but became addicted to her prescribed opioids. When prescribing restrictions limited her access to this medication from her provider, she began using illicit opioids. During this time, her parents assumed her son's legal custodial care, financially supported her mental health treatment and remained engaged throughout multiple treatment–relapse–treatment cycles. Despite these struggles, and with sustained substance use disorder treatment, Cami had been in recovery for two years. Her depression, however, remained refractory to medication treatment, and she refused further counselling. She grew increasingly despondent and resentful about her dependence on her parents, despaired that she was a 'bad mother' in her impatience with her son and was eventually terminated from the last of a series of low-paying food service jobs. She was found dead by Paul when she failed to pick up her son from her parents' home. When police responded, they cordoned off the area and did not let Kerry or Paul remain in Cami's apartment. Cami's parents answered extensive questions from the death investigation officer on the scene, observed their daughter's body removed from the apartment in a body bag and received some supportive attention from the police chaplain. Her death was determined to be a suicide death by the medical examiner, as she had ingested a lethal amount of 'street' opioids and all of her prescribed antidepressant and antianxiety medications. While no suicide note was found on the scene, some months later, her parents found a note in her diary that conveyed her despair but also some hopefulness in what was to be her last job.

(*Continued*)

Kerry and Paul had very different grief responses to Cami's death. Paul reported vivid nightmares with images of Cami's body and frequently woke in distress as he considered Cami's thinking at the time of her death. These thoughts were punctuated by anger that she would 'do this' to them and to her son. Kerry maintained that her daughter did not take her life, but died by accidental overdose, a perception buoyed by her time in sobriety. These varying responses led to arguments and distancing between this couple, who had previously been united in years of caring for their daughter. Cami's parents' grief narratives reflect some of the common complexities of clinically attending to the bereavement of suicide loss survivors.

BACKGROUND

In 2019, the most recent year with substantiated statistics, 47,511 persons died by suicide in the US (Centers for Disease Control and Prevention, National Center for Health Statistics: Underlying Cause of Death 1999–2019). Over this same interval, Great Britain reported nearly 7,000 suicide deaths (Samaritans Enterprise, 2021). The World Health Organization reports over 800,000 annual suicide deaths and, notably, suicide deaths are increasing globally (World Health Organization, 2021). Current research by Cerel et al. (2019) has suggested that 135 persons are 'exposed' with each suicide death, exposure defined as being relationally connected in some way to the person who died. This reflects 5.5 million individuals per year exposed to suicide within their social networks. Cerel and colleagues describe a continuum of suicide exposure, ranging from some persons *affected* by suicide to other persons *afflicted* and best described as 'bereaved by suicide' (Cerel et al., 2014). Within this continuum of suicide exposure, approximately half of suicide loss survivors report that the death was disrupting; of this subset, about half report a major disruption and a quarter (10–15 persons per suicide death) report devasting disruption in their lives. These numbers suggest a larger magnitude of impact than had previously been considered and that the real and perceived relationship of the person who died to those in their social network necessitates precise assessment of any particular griever's distress. Further, Cerel et al. (2014) distinguishes those exposed to suicide, those affected by suicide, those experiencing short-term bereavement that proceeds to grief integration and those experiencing long-term bereavement that may have prolonged or complicated grief.

A word about terminology: we refer to those grieving the death of a person to suicide as *suicide loss survivors*, in contrast to the term *suicide survivor*, which refers to a person who attempts but does not complete a suicide. Also, the term *victim of suicide death* has become disfavoured, as many persons bereaved by suicide perceive it as disempowering. Of course, it is for the client to claim the terminology that serves their emerging identity as a grieving person (Pascoe et al., 2009).

IS SUICIDE BEREAVEMENT DIFFERENT FROM OTHER FORMS OF GRIEF?

As is true in all forms of grief, the common features that characterize grief following suicide loss do not necessarily describe each individual's unique grief experience, which must be thoroughly assessed before initiating a particular clinical approach. Nevertheless, any distinguishing features of suicide grief as a whole would suggest specialized considerations and necessitate distinct forms of treatment. Jordan and McGann (2017) have summarized the limited research literature in this area. Because many suicide loss survivors experience suicide death as traumatic – due to the actual circumstances of the death (objective trauma), their personal construction of the event (subjective trauma), or both – Jordan and McGann (2017) note that suicide grief has most of the common elements of sudden or traumatic death. However, they also detail unique clinical features which, if present, must be taken into account by clinicians in assessment and treatment.

Trauma features of suicide loss

Even in well-supported death from predictable, natural causes, the initial human response to death is shock. In expected death, this state readily resolves in most grieving persons as they recapture their awareness of the dying process and the psychological preparedness they bring to the moment of death. In suicide death, as is also the case following traumatic losses more generally, shock may be initiated and sustained by the unsettling or horrific nature of the death and may present as immobilization or as profound expressions of emotional distress. Shock is experienced even in grievers who are not 'surprised' by the death – for example, in cases of known serious mental illness or prior suicide attempts by the deceased. The experience for such grievers may include a sense of 'shock that they are not surprised' and resultant guilt. Shock may serve as a 'psychological anesthesia' in the initial aftermath of the death and be protective from psychological overwhelm. The care implications of shock in the early minutes to days after the death include careful attention to immediate sensory exposure that the individual may not be able to withdraw from on their own, moderation of information overload in persons unable to process 'facts' at this moment and consideration of immediate physical and safety needs.

While still in a state of shock, many of those bereaved by suicide experience profound guilt, blame, anger and fear (Jordan & McGann, 2017). These emotional responses are commonly accompanied by shame, as suicide death remains highly stigmatized in many societies, cultures and religions (Feigelman et al., 2009). Likewise, shame can feature prominently in grief following other stigmatized forms of traumatic loss, such as death due to homicide. Considerable effort has been given to reducing suicide-related stigma by advocacy organizations such as the American Foundation for Suicide Prevention, and several religions and cultures are softening

their judgement of suicide death. Nevertheless, many suicide loss survivors continue to experience disenfranchised grief and resultant social isolation. Doka (2002), who first conceptualized this phenomenon, describes disenfranchised grief as 'the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported' (Doka, 1989, p. 4; see also Chapter 17). This lack of social endorsement constricts available support to those bereaved by suicide and may contribute to prolonged grief disorder or PGD (PGD has been formerly referred to as complicated grief; see Chapter 2 for more information; Bellini et al., 2018; Scocco et al., 2019).

Given that the suicide act is often experienced as traumatic, grief following suicide loss can also be characterized by symptoms of post-traumatic stress, particularly intrusive re-experiencing of the death itself in the form of nightmares, disturbing thoughts and imagery related to the suicide. Such re-experiencing can be prominent even if the bereaved did not witness the suicide act, the scene of the suicide, or the body of the deceased; indeed, these symptoms feature prominently in Paul's experience of Cami's death. The clinical implications of intrusive re-experiencing are detailed in Chapter 20.

Clinically unique features of suicide

Making sense of the unexplainable

Unique to the experience of suicide loss is the struggle to make sense of the act of suicide itself (Jordan & McGann, 2017). Suicide defies a widely held fundamental human assumption that individuals invariably want to live. In so doing, suicide loss is intrinsically conducive of anguished attempts to explain the unexplainable by assigning responsibility and blame for the suicide. As a result, initial and continuing cognitive processing of the experience of suicide loss may include a sense of personal responsibility for the death, a sense of abandonment or rejection by the deceased and, in some, a sense of relief that the person who died is no longer suffering, potentially accompanied by guilt at experiencing such relief (Aguirre & Slater, 2010; Jordan & McGann, 2017). Grievers who cannot process and relinquish such self-defeating explanations for the death circumstance will struggle to achieve integrated grief – that is, grief that permits meaningful remembrance and healthy life function (see also Chapter 5). What is more, the circumstances of suicide loss lend themselves to the possibility of unfinished business between the bereaved and the deceased in the form of unexpressed or unresolved wishes, conflicts, questions and other relational concerns that linger in the aftermath of suicide or, indeed, are created as a result of it (Holland, Klingspon et al., 2020). For example, grievers may feel that they have lost the opportunity to address the suffering that may have contributed to the deceased's suicide or may find themselves disturbed by their lack of awareness that any such suffering existed (e.g., Maple et al., 2007). In fact, Holland, Plant et al. (2020) found a higher rate of unfinished business was endorsed following suicide bereavement (70%)

than in any other form of loss (e.g., 64.5% for loss due to accident, 37.5% for loss due to homicide). While the details of such unfinished business are diverse, the presence of unfinished business can become the focus of clinical work because the struggle to navigate relational strife left unresolved by the nature of the suicide can contribute to poor mental health outcomes (Holland, Klingspon et al., 2020; Holland, Plant et al., 2020). Indeed, Paul's grief experience was marked by such unfinished business as he struggled with bewilderment and anger towards Cami for her suicide act and its impact on Cami's young son.

An additional aspect of suicide loss is the phenomenon of ambiguous loss. Boss (2006) defines ambiguous loss as 'a loss that remains unclear and thus has no closure. A loss that has no official verification; can't be clarified, cured, or fixed', and notes that 'the loss can be physical or psychological but with incongruence between absence/presence [of the deceased]' (p. 2). The conceptualization of ambiguous loss has application to the experience of suicide death, even when the certainty of suicide is unequivocal (e.g., suicide by firearm); the ambiguity, much like the experience of trauma, lies in the interpretation of the death within the mind of the griever. The ambiguity of suicide loss arises from the uncertainty of the intention to take one's life (e.g., in cases of overdose), what the deceased was experiencing and, often, in the implications for the relationship between the griever and the deceased. This uncertainty is perceived as turmoil in the grief experience and, when present, requires clinical attention. As detailed below, for Kerry the destructive presence of ambiguity regarding Cami's suicide presented a vital starting point for clinical intervention.

Risks of suicide in those bereaved by suicide

Research and clinical experience demonstrate the known adverse mental health and social outcomes of those exposed to a suicide death, including new or worsening mental health, substance abuse, post-traumatic stress disorder and risk of suicide (Pittman et al., 2014). Pittman et al. (2014) report:

> an increased risk of suicide in partners bereaved by suicide, increased risk of required admission to psychiatric care for parents bereaved by the suicide of an offspring, increased risk of suicide in mothers bereaved by an adult child's suicide, and increased risk of depression in offspring bereaved by the suicide of a parent. (p. 86)

Thus, as Jordan and McGann (2017, p. 614) argue, 'all suicide prevention programs need to include postvention services as a direct form of suicide prevention with a population of people known to be at heightened risk for suicide themselves: suicide loss survivors'. Supportive care for those professionally exposed to suicide (e.g., police, first responders, emergency medicine personnel) likewise is essential. Those exposed to suicide at all levels of impact should be assessed and re-evaluated for suicide risk as supportive care, or mental health treatment, is initiated and progresses.

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CLINICAL ASSESSMENT OF PERSONS BEREAVED BY SUICIDE

Prior to arranging referral to care or to initiating support, counselling, or psychotherapy, a careful assessment that includes both a clinical interview and use of grief assessment measures is vital. A guiding principle of client-centred clinical assessment is allowing the client to tell their story as they are able and willing. In this unfolding narrative, the clinician weaves in interview questions and appropriate assessment instruments. This approach not only elicits accurate detail but simultaneously fosters relationship formation between client and clinician. The clinical interview should minimally include: the history and detail of the loss and circumstances of the death (assess understanding, autopsy report, trauma exposure), relationship kind (parent, spouse, child), quality and status at the time of death, availability and quality of social supports and the cultural context of suicide loss. In all grief narratives, but perhaps more so in suicide death, it is important to allow the client to tell the story, not only of the death but of the life of the person who died.

The comprehensive clinical grief interview also includes taking a loss history. In this part of the interview, the clinician may enquire, 'up until this moment, when [name] died by suicide, what was the most challenging loss you experienced?' In listening to this narrative, the clinician can assess the client's grief *mastery* or *sense of diminishment* in this loss story – a valuable indication of present coping abilities. The clinical interview is also improved by the use of reliable and validated assessment instruments. Those with particular value in suicide grief assessment include the Prolonged Grief Disorder-13R (PG-13R; Prigerson et al., 2021), which assesses PGD, and the Grief and Meaning Reconstruction Inventory (GMRI; Gillies et al., 2015). As assessed by the GMRI, meaning-making includes five domains: continuing bonds, personal growth, sense of peace, emptiness and meaninglessness, and valuing life. Meaning-making is theoretically and clinically considered a later element of growth in grief. Because 'making sense' of the suicide is salient for so many, particular attention to this dimension of the experience is beneficial. These two tools are useful in measuring clinical change over time. It is also essential to assess suicide risk, and there are several tools available and to assess the client's history of trauma and trauma exposure to this death.

The timing of the clinician's assessment must also be factored into the clinical formulation. One anticipates higher levels of client distress in the immediate aftermath of the death. It is essential to distinguish between the severity of acute grief and that of grief from a death weeks or months or years earlier (Shear et al., 2017).

The Assessment of Kerry and Paul

Kerry and Paul were referred for bereavement care by the psychologist who had last seen Cami in substance use disorder treatment and remained in touch with Cami to urge continued therapy. They were initially assessed seven

(*Continued*)

months after Cami's death. The clinician first met with the couple together as they shared their stories. As highlighted in the couple's introduction, their narratives were consistent in factual details but divergent in causal attribution. There was no evidence of suicide ideation in either Paul or Kerry, and they each had excellent work support, as their colleagues had accommodated their need to intervene on Cami's behalf through the years. They were concerned about obtaining care for their grandson and recognized that each family member had different needs. Their grandson was promptly referred to a children's grief programme and recommendations for their communication with his teachers were provided. In Paul's individual assessment, he demonstrated profound trauma symptoms and had not slept through the night since the death. He stated that he was still 'in shock' and only felt numb or angry. He was referred to an individual grief therapist who specialized in EMDR (see Chapter 11). Kerry evocatively described her despair, felt physically ill, cried all the time and 'could not believe' that her daughter 'meant to do this'. She had benefitted from the perspective Cami's therapist had shared about Cami's multiple suicide risks. Kerry agreed to begin individual therapy with the clinician. An additional component for this couple's care was arrangements for a pathologist from the Office of the Medical Examiner (OME) to provide a 'chaperoned' autopsy interview to explain the determination of suicide vs accidental overdose in Cami's death. Autopsy reports are medical documents and not written to convey clear information to families; for example, under certain circumstances, our OME in Utah offers this service to families, a practice that is becoming more widespread, along with the provision of resources and information to families (Utah Office of the Medical Examiner, n.d.). This very clear explanation was helpful to Kerry and reinforced the conversation provided by Cami's former therapist.

APPROACHES TO CARE

The specific approach and scope of care are based on assessment, available resources and client preferences. Those more distally affected may have their needs met by a single support session and employer accommodation and services (e.g., police, school-teachers impacted by suicide death). Appropriate care of family and close friends of the person who died by suicide varies by the severity of symptoms, pre-existing mental health issues, loss history and the relationship between the griever and the deceased. Treatment formats include peer support models, supportive counselling and psychotherapy, and these may be in an individual, family, or group approach. The overall purpose of care is to facilitate a process where the individual griever comes to terms with the finality of the loss, creates a working memory of the deceased that accepts but does not focus on the circumstances of the death as the defining feature of the relationship and integrates this loss into a purposeful present and future life (Shear, 2012).

Peer support

Most suicide loss survivors welcome acknowledgement of their loss's unique circumstances and benefit from contact with others who share this experience (Feigelman et al., 2012). Peer-to-peer support can occur through informal connections such as blogs and Facebook groups, informal peer support programmes with trained peer facilitators, or clinician-facilitated support groups that are commonly time-limited with a topic-based, incremental curriculum. Many suicide loss group support programmes have readily adapted to distance delivery due to the pandemic and such telehealth services have replicated face-to-face groups' outcomes (Supiano et al., 2020).

Individual counselling

Individual counselling for suicide loss survivors tends to place emphasis on addressing previously described clinical features that characterize grief following suicide. In particular, the trauma-related sequalae of such loss and the increased risk for suicide might be addressed with psychoeducation about suicide, fostering engagement with supportive others, guidance in self-care and emotion regulation, and exposure-based work targeting post-traumatic re-experiencing symptoms. At the same time, grief severity in suicide loss survivors is highly associated with self-blame and protracted difficulty making sense of the death. Accordingly, the presence of ambiguity or problematic causal attributions regarding the suicide act itself as well as unfinished business with the deceased might entail clinical work revisiting the relationship between client and the deceased with particular attention to perceived causality, support for meaning-making and navigating the social stigma of suicide loss. The cause of suicide death is almost always multifactorial. Addressing cause, self-attribution of cause, guilt and shame must be done in a compassionate yet forthright manner that challenges false assumptions and fosters acceptance of uncertainty, mystery and a willingness to live without having 'all the answers'.

Complicated grief in suicide loss survivors: psychotherapeutic treatment

Recent research by Bellini and colleagues (2018) reports that 63% of those bereaved by suicide experience PGD. In suicide loss survivors, this grief severity is functionally and socially disabling and associated with intrusive/avoidant cognitions, depression, post-traumatic stress, hopelessness and suicidality. PGD requires specialized psychotherapy, as the grief does not resolve with time, having social supports or self-resolving relationship issues with the deceased (Bellini et al., 2018; Scocco et al., 2019).

Three individual psychotherapeutic approaches for treating complicated grief have been validated in the research literature: Prolonged Grief Disorder Therapy

(formally known as Complicated Grief Therapy, Shear et al., 2005, Iglewicz et al., 2020), cognitive behaviour therapy (Boelen et al., 2007), and meaning reconstruction therapy (Neimeyer et al., 2010). Any of these approaches can be applied with suicide loss survivors who are experiencing PGD, although they have not been specifically tested with this population of grievers. Alternatively, prolonged grief group therapy (PGGT), formerly referred to as complicated grief group therapy (CGGT), is a group psychotherapy approach based on Shear's PGDT for individuals (Supiano & Luptak, 2014) and has been found effective specifically in suicide loss (Supiano et al., 2017; Supiano et al., 2021). PGGT is 12 weeks in duration with 120-minute sessions. Intervention elements focus on the relationship between the client and the deceased, how memories of life together and illness are interpreted and strategies for creating a life without the person who died. PGGT treatment techniques used to accomplish this work are drawn from motivational interviewing, cognitive-behavioural therapy, prolonged exposure, memory work and the meaning reconstruction paradigm – all these techniques are endorsed as essential in the work of Shear et al. (2011) described above. PGGT has the advantages of group work, including shared experiences, provision of support for isolated and stigmatized grievers and cost-effectiveness (Yalom & Leszcz, 2005).

Treatment for Kerry and Paul

Paul's therapy yielded an immediate and sustained change in his visual flashbacks and, with self-care skills, he resumed healthy sleep. His therapist encouraged his attendance at a grief support group, and his compassion for the suffering of others was reinforced and reflected by the group as evidence of his love for Cami. Kerry entered Prolonged Grief Disorder Therapy (PGGT). She was challenged yet supported in the re-telling of the death story – and noticed her transformation in the attribution of cause (suicide vs accidental overdose) and of blame ('she was suffering, but not because of me'). This shift in self-attribution readied her for the next step in therapy. She shared a very moving imaginal conversation with 'her daughter' in which each 'voiced' the giving and receiving of forgiveness. For Kerry, forgiveness included releasing distress at the means of death – no longer blaming Cami and also acknowledging and receiving forgiveness for whatever part she had in Cami's sadness. For 'Cami', as voiced by Kerry, forgiveness meant releasing Kerry from blame and endorsing her as a 'good' mother. This was a milestone in confronting the unspoken part of unfinished business in the mother–daughter relationship and was felt by Kerry as consolation. Paul joined the group as Kerry's supportive other, a role that strengthened the deep love they shared. Kerry and Paul requested an additional few sessions with the clinician to plan for their grandson's needs and their future and proceeded from distressing grief to a constructive journey to integrated grief. Paul and Kerry attend our spring remembrance events, and Paul has been active in legislative activism for suicide prevention efforts.

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A KIND WORD TO THE SUICIDE POSTVENTION THERAPIST

Care of those bereaved by suicide, coupled with an awareness of the prevalence of complicated grief and elevated suicide risk in these clients, can be a challenging professional and personal endeavour. Scrupulous self-care, attention to boundaries and access to peer supervision are vital to remaining compassionate and effective in practice. Over the course of a clinical career, one is likely to lose a client to suicide. This practice is not unlike that of an oncologist who cares for patients with complex disease with significant mortality and morbidity risk. Consultation, self-care, collegial support and use of therapy are all beneficial (Castelli Dransart et al., 2017). New care models for clinicians who lose a client to suicide are underway, including the SUPPORT-S trial, which incorporates emotional first aid, team-debriefing and both immediate and long-term support (Leaune et al., 2020). For the clinician, care of those bereaved by suicide represents a high-risk/high-reward practice and one that is becoming increasingly necessary and must be reinforced by best clinical practices.

KEY POINTS

- The grief of suicide loss impacts 135 persons per death, varying from those affected to those afflicted by suicide loss.
- 63% of persons bereaved by suicide loss experience complicated grief and benefit from specialized evidence-based care, either in individual, family, or group therapy, to effectively address this.
- Suicide grief care requires psychoeducation about suicide, attention to the traumatic experience of the death, revisiting the relationship between client and the deceased with particular attention to perceived causality, fostering engagement with supportive others, guidance in self-care and emotion regulation, support for meaning-making and navigating the social stigma of suicide loss.
- With respect to suicide grief, persons attaining integrated grief demonstrate acceptance of the mystery surrounding the death by suicide, an ability to remain with and also step away from their grief, and can consolidate both pleasant and unpleasant memories of the person who died into a constructive memory that is not forever tethered to the nature of the death.

RECOMMENDED READINGS

Jordan, J. R., & McGann, V. (2017). Clinical work with suicide loss survivors: Implications of the US postvention guidelines. *Death Studies*, *41*(10), 659–672. https://doi.org/10.1080/07481187.2017.1335553

National Action Alliance for Suicide Prevention (2015). *Responding to grief, trauma, and distress after a suicide.* US National Guidelines. https://theactionalliance.org/resource/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines

REFERENCES

Aguirre, R. T., & Slater, H. (2010). Suicide postvention as suicide prevention: Improvement and expansion in the United States. *Death Studies*, *34*(6), 529–540. https://doi.org/10.1080/07481181003761336

Bellini, S., Erbuto, D., Andriessen, K., Milelli, M., Innamorati, M., Lester, D., Sampogna, G., Fiorillo, A., & Pompili, M. (2018). Depression, hopelessness, and complicated grief in survivors of suicide. *Frontiers in Psychology*, *9*, 198. https://doi.org/10.3389/fpsyg.2018.00198

Boelen, P. A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2007). Treatment of complicated grief: A comparison between cognitive-behavioral therapy and supportive counseling. *Journal of Consulting Clinical Psychology*, *75*(2), 277–284. https://doi.org/10.1037/0022-006X.75.2.277

Boss, P. (2006). *Loss, trauma, and resilience: Therapeutic work with ambiguous loss*. W. W. Norton.

Castelli Dransart, D. A., Treven, M., Grad, O. T., & Andriessen, K. (2017). Impact of client suicide on health and mental health professionals. In K. Andriessen, K. Krysinska & O. T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 245–254). Hogrefe.

Centers for Disease Control and Prevention, National Center for Health Statistics: Underlying Cause of Death (1999–2019). Accessed at http://wonder.cdc.gov/ucd-icd10.html

Cerel, J., Brown, M. M., Maple, M., Singleton, M., van de Venne, J., Moore, M., & Flaherty, C. (2019). How many people are exposed to suicide? Not six. *Suicide Life-Threatening Behavior*, *49*(2), 529–534. https://doi.org/10.1111/sltb.12450

Cerel, J., Mcintosh, J., Neimeyer, R., Maple, M., & Marshall, D. (2014). The continuum of 'survivorship': Definitional issues in the aftermath of suicide. *Suicide and Life-Threatening Behavior*, *44*, 591–600. https://doi.org/10.1111/ sltb.12093

Doka, K. J. (1989). Disenfranchised grief. In K. J. Doka (Ed.), *Disenfranchised grief: Recognizing hidden sorrow* (pp. 3–11). Lexington.

Doka, K. J. (2002). Introduction. In K. J. Doka (Ed.), *Disenfranchised grief: New directions, challenges, and strategies for practice* (pp. 5–22). Research Press.

Feigelman, W., Gorman, B. S., & Jordan, J. R. (2009). Stigmatization and suicide bereavement. *Death Studies*, *33*(7), 591–608. https://doi.org/10.1080/07481180902979973

Feigelman, W., Jordan, J. R., McIntosh, J. L., & Feigelman, B. (2012). *Devastating losses: How parents cope with the death of a child to suicide or drugs*. Springer.

Gillies, J. M., Neimeyer, R. A., & Milman, E. (2015). The Grief and Meaning Reconstruction Inventory (GMRI): Initial validation of a new measure. *Death Studies*, *39*(1–5), 61–74. https://doi.org/10.1080/07481187.2014.907089

Holland, J. M., Klingspon, K. L., Lichtenthal, W. G., & Neimeyer, R. A. (2020). The Unfinished Business in Bereavement Scale (UBBS): Development and psychometric evaluation. *Death Studies*, *44*(2), 65–77.

Holland, J. M., Plant, C. P., Klingspon, K. L., & Neimeyer, R. A. (2020). Bereavement-related regrets and unfinished business with the deceased. *Death Studies*, *44*(1), 42–47.

Iglewicz, A., Shear, M. K., Reynolds, C. F., 3rd, Simon, N., Lebowitz, B., & Zisook, S. (2020). Complicated grief therapy for clinicians: An evidence-based protocol for mental health practice. *Depression & Anxiety*, *37*(1), 90–98. https://doi.org/10.1002/da.22965

Jordan, J. R., & McGann, V. (2017). Clinical work with suicide loss survivors: Implications of the US postvention guidelines. *Death Studies*, *41*(10), 659–672. https://doi.org/10.1080/07481187.2017.1335553

Leaune, E., Cuvillier, B., Vieux, M., Pacaut-Troncin, M., Chalancon, B., Perez, A. F., Haesebaert, J., Chauliac, N., Poulet, E., & Durif-Bruckert, C. (2020). The SUPPORT-S protocol study: A postvention program for professionals after patient or user suicide. *Frontiers of Psychology*, *11*, 805. https://doi.org/10.3389/fpsyg.2020.00805

Maple, M., Plummer, D., Edwards, H., & Minichiello, V. (2007). The effects of preparedness for suicide following the death of a young adult child. *Suicide and Life-Threatening Behavior*, *37*(2), 127–134.

Neimeyer, R. A., Burke, L. A., Mackay, M. M., & Stringer, J. G. van D. (2010). Grief therapy and the reconstruction of meaning: From principles to practice. *Journal of Contemporary Psychotherapy*, *40*(2), 73–83. https://doi.org/10.1007/s10879-009-9135-3

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin*, *135*(4), 531–554. https://doi.org/10.1037/a0016059

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

Prigerson, H. G., Boelen, P. A., Xu, J., Smith, K.V., & Maciejewski, P. K. (2021). Validation of the new DSM-5-TR criteria for prolonged grief disorder and the PG-13-Revised (PG-13-R) scale. *World Psychiatry*, *20*(1), 96–106. https://doi.org/10.1002/wps.20823

Samaritans Enterprise (Republic of Ireland) (2021). *Suicide statistics and trends for the UK and Republic of Ireland*. https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/. Accessed 30 March 2021.

Scocco, P., Preti, A., Totaro, S., Corrigan, P. W., Castriotta, C., & SOPROXI Team (2019). Stigma, grief and depressive symptoms in help-seeking people bereaved through suicide. *Journal of Affective Disorders*, *244*, 223–230. https://doi.org/10.1016/j.jad.2018.10.098

Shear, M. K. (2012). Getting straight about grief. *Depression & Anxiety*, *29*(6), 461–464. https://doi.org/10.1002/da.21963

Shear, M. K., Boelen, P. A. & Neimeyer, R. A. (2011). Treating complicated grief: Converging approaches. In R. A. Neimeyer, D. L. Harris, H. R. Winokuer & G. F. Thornton (Eds.), *Grief and bereavement in contemporary society: Bridging research and practice* (pp. 139–162). Routledge.

Shear, K., Frank, E., Houck, P. R., & Reynolds, C. F. (2005). Treatment of complicated grief: A randomized controlled trial. *Journal of the American Medical Association*, *293*(21), 2601–2608. https://doi.org/10.1001/jama.293.21.2601

Shear, M. K., Muldberg, S., & Periyakoil, V. (2017). Supporting patients who are bereaved. *BMJ*, *358*, j2854. https://doi.org/10.1136/bmj.j2854

Supiano, K. P., Haynes, L. B., & Pond, V. (2017). The transformation of meaning in complicated grief group therapy for suicide survivors: Treatment process analysis using the Meaning of Loss Codebook. *Death Studies*, *41*(9), 553–561. https://doi.org/ 10.1080/07481187.2017.1320339

Supiano, K. P., Koric, A., & Iacob, E. (2020). Extending our reach: Tele-health delivered grief support groups for rural hospice. *Journal of Social Work with Groups*. https://doi.org/10.1080/01609513.2020.18251

Supiano, K. P., Larsen, P., Riley, C., Hutton, A., Iacob, E., Walker, A. M., Morrison, S. J. (2021). Complicated Grief Group Therapy for community-residing persons diagnosed with serious mental illness. *Social Work in Mental Health*, *19*(5), 381–402. doi: 10.1080/15332985.2021.1940419.

Supiano, K. P., & Luptak, M. (2014). Complicated grief in older adults: A randomized controlled trial of complicated grief group therapy. *Gerontologist*, *54*(5), 840–856. https://doi.org/10.1093/geront/gnt076

Utah Office of the Medical Examiner (n.d.). https://ome.utah.gov/category/our-services. Accessed 30 March 2021.

World Health Organization (2021). *Mental health and substance abuse-suicide data*. www.who.int/teams/mental-health-and-substance-use/suicide-data. Accessed 30 March 2021.

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). Basic Books.