DOCUMENT RESUME

ED 312 548 CG 022 045

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TITLE Nursing Postvention for Suicide Survivors.
PUB DATE Apr 89
NOTE 34p.; Paper presented at the Annual Association of Suicidology (22nd, San Diego, CA, April 12-16, 1989).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Cancer; *Counseling Effectiveness; *Counseling Services; Death; Depression (Psychology); Emotional Adjustment; Heart Disorders; Intervention; Nursing; *Research Needs; *Suicide; *Widowed
IDENTIFIERS *Bereavement; *Suicide Survivors

ABSTRACT

Survivors of suicide are invaded by an unhealthy complex of disturbing emotions resulting in depression, psychological distress, grief, social isolation, and even suicide. This study examined the bereavement patterns of widows whose husbands had died from various causes including cancer, heart disease, and suicide. Subjects (N=117) were randomly assigned to a Bereavement Crisis Intervention Group, Social Adjustment Group or Control Group. The results indicated that feelings of loneliness, depression, and guilt were common in all subjects, but two of the three suicide survivors wished for, as well as developed a fear of, death. The overwhelming feeling expressed by widows was loneliness which became intolerable at nighttime. In the area of socialization widows' reactions revolved around the family, children, friends, co-workers, and neighbors. The need for intimacy became unfulfilled. They also reported their children suddenly became indifferent to them and considered them useless. Material and economic issues also confronted the widows. The symptoms suffered by the three suicide survivors were more serious and overwhelming compared with non-suicide survivor widows. Widows of suicide victims may have special psychosocial needs best served in a homogeneous group in which all group members are suicide survivors. A second study is proposed which would evaluate the efficacy of therapeutic activity that would alleviate depression, psychological distress, grief, and social isolation in suicide survivors. (ABL)

NURSING POSTVENTION FOR SUICIDE SURVIVORS

By: Rose Eva Bana Constantino, Ph.D., J.D., R.N.

Introduction

The purpose of this chapter is to introduce the reader to the concept of postvention and to two postvention programs: the Group Bereavement Postvention (GBP) and the Social Group Postvention (SGP).

Shneidman[1] proposed three constructs by which help should be provided to suicidal persons and to those persons who survive the suicide of a family member or a significant other. He called these levels: (1) prevention (before the fact), (2) intervention (during the crisis period), and (3) postvention (after the fact). While much has been written about suicide prevention and intervention, little attention has been focused on postvention despite knowledge that postvention probably represents the largest problem area needing attention. When one commits suicide, that person puts his psychological skeleton in the survivor's emotional closet thus victimizing the survivor, referred by Shneidman as "survivor-victims"[2]

This chapter focuses on one of the three constructs proposed by Shneidman[1]. He believes that postvention - "those appropriate helpful acts that come after the dire event" (p. 349), provided to the suicide survivor is the largest area needing attention in suicidology. Survivors of suicide, immediately after the suicide, are invaded by an unhealthy complex of disturbing emotions resulting in depression, psychological distress, grief, social isolation, and even suicide[3]. They continuously, either actively or passively, seek reasons and cast blame on themselves for the suicide of their spouse. The number of survivor-victims of suicide is uncertain but it is likely that they number in the millions[2]. Such a significant number of people represents a major mental health at-risk population. However, few programs have been developed with survivors of suicide as the focal point[2]. Calhoun, Selby, and Selby[4] concluded that survivors of suicide (1) feel a need to understand the death, (2) may experience less social support than in other types of deaths and often experience social interaction difficulties, (3) may experience more of guilt than do survivors of other causes of death, and (4) need to be assessed regarding the effects the suicide had and perhaps continued to have upon them.

Review of Literature

In this chapter, postvention is used as the framework whereby two kinds of group postvention programs are offered to persons who survive the death of a spouse by suicide. The Group Bereavement Postvention (GBP) and the Social Group Postvention (SGP) consist of nursing actions and activities integrating Yalom's[5] therapeutic group principles and Iso-Ahola's[6] and Neulinger's[7] social, leisure and recreative principles. The GBP's and the SGP's goal is to alleviate depression, psychological distress, grief and social isolation in suicide survivors.

Shneidman believed that an important historical error of omission in suicidology has been committed by not rectifying the tragedies that continue after suicide.[8] The term "survivor", although accurate, is considered by Dunne-Maxim[9] to be misleading because "survivor" implies that the person has undergone a life-threatening ordeal and emerged from it more or less intact. Usually, following the ordeal, the survivor experiences a burst of life-affirming energy, a sense of being able to beat the odds. But the survivor of suicide does not feel that sense of relief, energy or that life is no longer in jeopardy. Instead, the survivor feels that death had touched him/her in a unique way and is constantly threatened with the thought that suicide is a readily available option whenever pressed by stressful situations.[9] However, since "survivor" is a term used in the United States, this term will also be used in this study.

Initially, some suicide survivors may feel anger and resentment at mental health professionals for failing to save the life of the deceased or fear of the stigma as a mentally ill person.[9] However, these explanations do not absolve mental health professionals from the responsibility for this outcome nor should these explanation be a shibboleth that mental health professionals need not do anything to change this outcome. When survivors do enter therapy, they are likely to encounter therapists who are ill-prepared to handle the special needs of the suicide survivor. It is likely that most therapists will be unfamiliar with the issues that distinguish suicide survivor grief from other kinds of grief and suicide survivor intervention and postvention techniques from other bereavement intervention techniques.[9] Given this information, focus should be placed on what happens and what can be done to help those who survive the suicide of a spouse.

Social stigma of suicide has deep historical roots. The early Greeks believed that those who committed suicide must have been greatly wronged to have wanted to die, considered their ghosts to be extremely revengeful, dangerous, and frightening and capable of tormenting those they left behind. In China, the bodies of suicide victims had to be buried outside the city boundaries or were pulled through the streets and stoned. Suicide has also been illegal in many places, including the United States. Most modern Western civilizations no longer adhere to such beliefs and practices, but suicide is still regarded by many to be a moral rather that a mental health issue. Roman Catholics, regarded suicide as a mortal sin, used to forbid memorial mass and the last sacraments for a Catholic who died in this way. Insurance companies continue to deny benefits to families of people who commit suicide within two years of buying life insurance.[10]

These social stigma compound the problems of suicide survivors. Whether from shame or anticipation of blame from others, suicide survivors are often sensitive and reluctant to discuss the event of suicide. Sources of support, such as family, friends, clergy, etc., may find they are unable to comfort to survivor of a suicide. Threatened by the idea of being powerless to prevent a suicide, they may join in the search for a cause and may even blame the survivor for the death. This failure of the informal support system leaves the survivor socially isolated to deal with their complex feelings and problems alone. Some find that they can escape feeling ostracized and condemned only by leaving the community, but then they face loneliness, insecurity, and emptiness in an unfamiliar neighborhood. New job(s) and new home(s) can prolong the bereavement process and make it more difficult.[11]

Reports of interventions for survivors of suicide are mostly descriptive in nature. Jughardt,[12] a mental health nurse, discussed the Suicide Survivor Follow-up Program in which a nurse made home visits to help resolve the families' difficult grieving process. Hatton and Valente[13] described a group of six adults (two couples and two mothers) who met to resolve the grief of their children's suicides. The families reported being isolated from friends and family, as well as not being able to mourn with anyone. They were thus unable to develop coping mechanisms. Solomon[14] described the individual improvements of some members of his Suicide

Bereavement Group as a decrease in suicide ideation and a better resolution of the grieving process. Osterweiss[10] reported mutual support groups for survivors of suicide have been developed to bring together survivors of suicide and provide insight into the loss thus helping survivors of suicide to find ways of coping with the trauma. However, no empirical evaluation of the effects of the mutual support groups nor evaluation of the levels of the effectiveness of the various support groups have been reported.

Reactions and risk factors of survivors of suicide have not been examined carefully, nor have programs to help them cope been evaluated. No studies were found that: (1) identified the level of depression and social adjustment in this group; or (2) evaluated the effectiveness of programs developed to help survivors after their family member successfully committed suicide. Assisting suicide survivors cope with depression, psychological distress, grief and social isolation has been described in the literature.[3, 10-15] None of these investigators, however, studied this specific group at risk, measured their levels of depression, psychological distress, grief and socialization, nor carried out an experimental postvention study, and evaluated the effectiveness of the treatment. A study of this type may prove useful in developing postvention programs for suicide survivors.

What is known about suicide survivors comes primarily from clinical case studies of small numbers of subjects in treatment. The studies have not been systematically examined and controlled for demographic heterogeneity of the sample or variations in the intensity, duration, and content of the grief reaction. This study may provide a basis for further inquiry into the emotional and physical disorders following suicide of a spouse.

Silverman[16] found that suicide survivors are initially wary of those who offer help. They are generally so isolated by the experience that they may need more formal opportunities to ventilate their feelings and more reassurance than other bereaved persons. Many studies have established the need for intervention. Freedman et al.[17] suggest professional psychotherapeutic intervention to alleviate the effects of stress on the "survivor-victims" of suicide to provide milieu for the expression of covert emotions. The degree and type of intervention needed by a survivor depends on the specific circumstance. Augenbraun and Neuringer[18] found that therapy is not

necessary when the relationship between the suicide survivor and the suicide victim was "positive, minimally ambivalent," and the suicide incident can be traced to circumstances outside the control of the survivor. These investigators added that when the survivor has been involved in a conflict-laden relationship with the suicide victim and the act of suicide can be traced back to the conflict, then therapy might be appropriate. They further suggest that "more clinical research needs to be done to determine the circumstances that make survivors vulnerable to pathologic outcomes, and to determine which particular interventions are most effective under these circumstances".[10]

Bonner and Rich[19] proposed a transactional, stress-vulnerability model for suicidal ideation and behavior. Suicidal ideation and behavior are hypothesized as a multidimensional process that evolves through ongoing transactions of social, emotional, cognitive, behavioral, and environmental variables. The model asserts that social-emotional alienation, cognitive distortions, and difficult adaptive resources serve as a predispositional base in suicidal behavior. These factors create a "coping vulnerability" rendering the person vulnerable to suicide ideation in stressful situations. In a follow-up study to test the concurrent validity of the stress-vulnerability model of suicide ideation and behavior, Rich and Bonner[19] studied 202 college students (139 females, 63 males). Subjects completed self-report measures of life stress, loneliness, depression, dysfunctional cognitions, reasons for living, hopelessness, current suicide ideation, and predictions of future suicide probability. The results of multiple-regression analysis indicated that 30% of the variation in suicide ideation scores could be accounted for by the linear combination of negative life stress, depression, loneliness, and few reasons for living. The linear combination of current suicide ideation, hopelessness, dysfunctional cognitions, and few reasons for living explained 56% of the variance in self-predicted future suicide probability. The results are interpreted as being supportive of the proposed model.

Clayton, Desmaris, and Winokur and a subsequent study of widows (whose husbands died of various causes) by Clayton, Halikas, and Maurice[20] described that in bereavement, depressed moods, sleep and eating disturbances and crying are typical. Difficulty in concentration, loss of interest in current events, weight loss, guilt over minor mistakes and omissions occur frequently.

Demi,[21] however, in a study of widows, found more guilt and resentment among suicide survivors than among a group comprised of survivors of accidental or natural deaths. Vargas[22] observed greater anger at the deceased among relatives and intimat friends who survived a suicide than among a comparable group of individuals surviving accidental or natural deaths. Williams[23] studied "primary survivors", i.e., spouses or parents; at one week, one month, and two months following the death and revealed few differences in physical and behavioral symptoms (sleep, appetite, activity levels, health) among suicide and nonsuicide survivors, suggesting that clinically observed differences may become more pronounced as the grieving period progresses. Suicide survivors, however, more often reported major stress and emotional problems in their families in the years preceding the death than did other survivors.

Responses by suicide survivors in a symptom check list were compared with normative data by Moore[24] and by Rogers et al.,[25] and revealed that suicide survivors showed more global distress, a greater number of clinical symptoms, and higher intensity levels in all their symptoms. Dunne et al.[9] surveyed individual reactions to family suicide and found that marked distortions in time, emotional estrangements from other family members, a pessimistic outlook on life, including the idea of an early death, suicidal ideas and selfdestructive behaviors were some of the factors mentioned by the suicide survivors. Some survivors develop a distrust of police, coroners, family physicians, and other professionals. Others became hostile, uncooperative, and depressed. In spite of these data, little has been done in the United States and for that matter, in the world, to help suicide survivors either individually or in groups.[9]

One of the earlier group treatments of suicide survivors was described by Johnson.[26] The therapist kept the group focused on problems related to the members' grief and mourning. Members of the group were found to have been helped in their mourning process.

Suicide survivors have long been thought to be at greater risk for physical and mental health problems than the bereaved from other causes of death. There is some evidence of increased mortality among the widowed whose spouses committed suicide and among children whose parent(s) committed suicide.[27] Windholz, Maramar, and Horowitz[28] also found that widows and widowers are at greater risk of physical illness and even possible reduced immunity

to certain diseases. Gallagher, et. al[29] found that the variable most consistently predictive of better adjustment among the bereaved is the perception of greater social support. Studies comparing suicide and nonsuicide surviving subjects have been done by Stone[30], Rudestam[31], Solomon,[14] and Wallace[32].

Stone[30] surveyed 35 suicide and 31 non-suicide surviving spouses to examine the differences in their responses to grief. Using a Likert scale, he found significant differences in the following areas in which the suicide survivors reported: more sickness since the death; stigma associated with the death; blaming by friends and relatives; anger at spouse; guilt about their actions before the death and the events of the death; and less quality in their marriages at the time of the death.

Rudestam[31] interviewed 39 families and concluded that they had suffered a great many physical and emotional symptoms since the suicide. Likewise, Solomon[14] found similar results from an interview of 90 family survivors, In addition, 83 said they benefitted from merely discussing the suicide during the interview, and 34 asked for a mental health referral. Wallace[32] conducted 124 interviews of 12 survivor widows of suicide and concluded they suffered also from a lack of social support and inability to talk about their grief because the loss was not socially acceptable.

Hatton and Valente[13] described a suicide survivors group comprised of six individuals who met ten times over fourteen weeks. Members were parents of a person who had committed suicide. The participants' ages ranged from late 30s to mid-60s, the age of the deceased ranged from 15 to 30 years of age, and time lapsed since the suicide ranged from 3 weeks to 7 years. Despite the heterogeneity of the group it was apparent that the group was effective in that a significant decline in symptoms of depression after the 3-month group treatment was observed among members as well as improved concentration and a reduction of emotional lability was observed. Saffer[33] reported on a three-session postvention group with the friends of an adolescent suicide. The group appeared to have relieved the members of some of their excessive guilt.

Depression, psychological distress, grief, and social isolation are the major behavior patterns found by Shneidman[3], Demi[21], Vargas[22], Williams[23], and Constantino[15] in survivors of suicide. Focusing on these major behavior patterns, it was deemed necessary to measure suicide survivors' levels of depression, psychological distress, grief, and social isolation before and after a group postvention program.

Preliminary Study

Constantino[34] became aware of the unique needs of the bereaved when the cause of the significant other's death was suicide. In 1979, in her doctoral dissertation[35], she developed and compared two group interventions for widows. Thirty (30) widowed subjects were assigned to three study groups: (1) Bereavement Crisis Intervention Group (BCI), (2) Social Adjustment Group (SAG), and (3) Control Group. Because the study was limited to widows whose husbands died of heart attacks or cancer, the widows whose husbands died of suicide or accident had to be excluded from the study. This "exclusion" did not mean that telephone calls for help of these victims were left unheeded. They were, however, excluded from attending the study group meetings and their responses to the questionnaires were not included in the final data analysis. Telephone contacts and personal visitations with the "excluded" widows continued. It was during these contacts that the feelings of shame, guilt, anger and devastation reported by the widows who survive the suicide of their husband, as reported in the literature by Augenbraum and Neuringer[18], Resnik[36], Shneidman[1], and Osterweiss et al.,[10], became apparent.

In a further study on "Widows' Reactions to Bereavement"[16], the sample size was expanded from 30 to 150 and randomly assigned the subjects to the three study groups: Bereavement Crisis Intervention (BCI), Social Adjustment Group (SAG), and Control Group. In this study, the cause of husband's death was not limited to heart attack or cancer. Table 1 (below) shows the cause of husbands' death among the sample of widows studied.

Table 1
Outcome of the Three Study Groups of Husband's Death

	Total N=117	Treatment Groups SAG N=36		BCI N=44		Control N=37		
Cause of Husbands' Death	N	%	N	%	N	&	N	%
Cancer	56	47.86	13	55.56	13	29 54	23	62.16
Heart Disease	20	17.09	6	16.67	12	27.30	2	5.41
Acute Ch. Iliness	31	26.50	8	22.22	13	29.54	10	27.02
Accident	7	5.99	2	5.55	3	6.81	2	5.41
Suicide	3	2.56	0	0.00	3	6.81	0	0.00
Total	100	100	36	100	44	100	37	100

Of the 117 widowed subjects who participated in the study, five (5) subjects at varying times during the intake portion of the study reported that the cause of their husbands' death as suicide. These widows requested that a separate intervention group be set up for them because of the "unique" and "different" nature of their needs. When this special request could not be granted due to the nature of the study, two suicide survivor widows discontinued attendance in group meetings and stopped answering and returning mailed questionnaires. The other three continued to return the mailed questionnaires at appropriate intervals and actively participated in group discussions. They sought individual attention from the group leader after the group sessions. They also formed a subgroup within the group, in that they came to the meeting site together and if one was absent, another invariably would also be absent. One of the three suicide survivor subjects called Constantino and asked whether the group meetings could be held at her house, in the evenings, so the "privacy of their plight" could be maintained. Again this request was not granted due to the design of the study. The individual scores of the three widowed suicide survivors on the three questionnaires were pulled out of the sample pool of 117 widowed subjects and then were compared to the mean scores of the sample pool. The three questionnaires used were the BDI, DACL Form E, and the RSAS. Tables 2-4 show these comparisons.

Tables 2, 3, and 4 (below) show that depression increased steadily and significantly and socialization decreased significantly in the SAG. These increases in depression and in socialization scores in the SAG were attributed to two subject outliers. The majority (84%) of

subjects in SAG decreased in the mean scores of depression (BDI and DACL Form E) and in socialization (RSAS).

Table 2
BDI Means for 3 Study Groups and Scores of 3* Suicide Survivor Subjects

		TESTING INTERVALS				
GROUP/SUBJECT	N	1	2	3	4	5
SAG	36	12.1	15.1	17.9	22.8	23.8
BCI	44	17.4	7.3	8.0	9.8	8.3
CONTROL	37	13.4	14.0	13.2	10.7	10.9
3 subjects whose)	1	22	16	12	19	17
husbands died)	1	22	16	12	19	17
of suicide)	1	22	16	12	19	17

Table 2 shows that the 3 suicide survivor subjects' scores on the BDI were higher at intake than the mean scores of the SAG, BCI, and Control Groups. In the BDI scoring scale 0-21 indicated mild depression and 22-36 indicated moderate depression. All 3 subjects coincidentally were randomly assigned to the BCI group. In the DACL Form E, Table 3 shows a similar phenomenon.

Table 3
DACL Form E Means for 3 Study Groups and Scores of 3* Suicide Survivor Subjects

		TESTING INTERVALS				
GROUP/SUBJECT	N	1	2	3	4	5
SAG	36	13.6	15.7	15.8	14.7	14.8
BCI	44	12.4	7.0	9.4	10.6	10.0
CONTROL	37	12.8	13.2	13.4	11.9	10.9
3 subjects whose)	1	15	18	10	12	11
husbands died)	1	18	20	12	16	12
of suicide)	1	16	18	16	19	18

A similar higher score on the DACL Form E is observable in the three suicide survivor subjects. The subjects' scores increased or indicate increased depression even after six weeks of group intervention. Table 4 shows the RSAS comparison.

Table 4

RSAS Means for 3 Study Groups and Scores of 3* Suicide Survivor Subjects

		TESTING INTERVALS				
GROUP/SUBJECT	N	1	2	3	4	5
SAG	36	2.40	2.57	2.54	2.52	2.53
BCI	44	2.55	1.90	2.10	2.20	2.28
CONTROL	37	2.33	2.33	2.30	2.30	2.21
3 subjects whose)	1	3.60	3.40	2.70	2.80	3.50
husbands died)	1	4.80	3.60	2.62	3.60	3.60
if suicide)	1	3.40	2.20	2.60	3.60	3.50

*Drawn from the BCI group.

Table 4 shows that all three suicide survivors scored higher on the RSAS at intake and invariably after six weeks of group intervention continued to remain higher during the third, fourth, and fifth testing intervals. RSAS scores range from 1-5 with 1 indicating the highest level of socialization and adjustment and 5 indicating the lowest level of socialization and social adjustment. Although the numbers (3) were too small for statistical testing, these results suggest that the widows of suicide victims may be more psycho-logically and socially distressed than widows whose spouse died of natural causes.

Because the suicide survivors' scores stood out as different and indicated a higher level of depression and lower level of socialization from the mean scores of the main sample pool, qualitative data were obtained from group leader interactions with members and subjects' diaries were examined. The following are examples of interactions gathered from the general subject pool and where indicated, specific interactions with the three suicide survivor subjects.

Feelings of loneliness, depression, and guilt were common in all subjects, but two of the three suicide survivors wished for, as well as developed a fear of, death. One suicide survivor widow experienced physical symptoms of her husband's illness (blindness) prior to suicide. The overwhelming feeling expressed by widows was loneliness. Loneliness became intolerable at nighttime. They felt that the outside world was insensitive and uncaring. The latter was often magnified by their own hypersensitivity and low self-esteem. One of the three suicide survivor subjects described herself as "incapable of feeling, numb all over, my heart has turned to plastic".

In the area of socialization, widow's reaction revolved around the family, children, friends, co-workers, and neighbors. The need for intimacy, being close to someone and to share feelings

with someone became unfilled. Widows confided that "no one cared" whether they "live or die". They also reported that their children suddenly became "indifferent" toward them and considered them "useless". One subject shared her critical need to find an apartment of her own because her "daughter no longer needed a babysitter" since the grandchildren had all reached schoolage and therefore she "no longer was welcome to live with them". Some children were seen by widows as "not allowing" them to grieve because of their (children's) inability to cope with their own confusion, loss, and grief. Some widows complained that children refused to help with chores their father used to perform for fear of being "tied down". Some children reacted acutely to their father's death by acting out interpersonal problems in school, community, and work environments.

Material and economic issues also confronted the widows. Financial problems such as lost credit ratings, reduced income, social security benefit problems, wills or intestacies, insurance or no-insurance, unpaid debts and taxes, were some of the issues discussed during the BCI sessions by two of the three suicide survivor subjects. Entry into the job force became a stressful experience for several subjects. One suicide survivor subject interviewed for a job, a position for which she had training, education, and experience 15 years before. The interview went smoothly until the interviewer asked her a seeming insignificant question: "Do you own a car?" She suddenly became tearful and unable to talk, broke down in sobs, and was unable to continue with the interview. She then excused herself but never returned to reschedule the interview. Daily responsibilities of maintaining a home, balancing a checkbook, and meal-planning became burdensome tasks for the widow. Others reported "having fights with" in-laws and relatives. It was apparent in this study that the symptoms suffered by the three suicide survivors were more serious and overwhelming compared with non-suicide-survivor widows.

This study suggested that widows of suicide victims may have special psychosocial needs following the suicide of their spouses best served in a homogenous group e.g. all group members are suicide survivors. Further, these particular widows, as has been reported in other studies, showed both higher levels of depression and less socialization than others. The survivors experience both grief and withdrawal while recognizing the need to be close to others. It is not

clear whether a psychotherapy group focusing on the alleviation of depression or a structured socialization group with a homogenous group of suicide survivors would be the more effective approach to the resolution of post-suicide grief, loneliness and social withdrawal.

Two Group Postvention Programs

The two group postvention programs (GBP and SGP) are results of linking several theoretical formulations on therapeutic group programs with the suicide survivor's need for alleviating depression and psychological distress, resolution of grief and increasing socialization. The framework on which both GBP and SGP are based is Shneidman's[1] postvention construct. From this construct, tandem with the investigator's past research experience using group therapy and social activity with widows, the GBP and SGP were developed. The GBP and SGP consist of nursing actions and activities integrating Yalom's[5] therapeutic group curative factors and Iso-Ahola's[6] and Neulinger's[7] social, leisure and recreation principles. The focus, and framework, and the role of leader and of members for the GBP and SGP are presented below.

FOCUS AND FRAMEWORK GBP	SGP
1. Focus is on alleviating depression and psychological distress, and resolution of grief through therapeutic group interaction.	1. Focus is on alleviating social isolation and increasing social interaction through social, leisure and recreational group activity.
2. Framework is Yalom's[5] theory and practice of group psychotherapy and points to his formulation of 12 curative factors of group psychotherapy: altruism, group cohesiveness, universality, input of interpersonal learning, output of interpersonal learning, guidance, catharsis, identification, family re-enactment, insight, instillation of hope and existential factors.	2. Framework is Iso-Ahola's[6] and Neulinger's[7] principles of social, leisure and recreation as the sources of perceived freedom and intrinsic motivation. Participating in social and recreational activities just for the fun and pleasure of it are the most important factor in their formulation. Such activities provide pleasure, self-satisfaction, creative expression and expansion, a sense of personal identity and feelings of competence and mastery.
3. Sessions are planned, structured, and phase-specific.	3. Social and recreational activities are planned.
ROLE OF LEADER **GBP**	**SGP**
4. The group leader takes an active role in defining, setting, and helping members reach realistic goals. The leader imparts accurate information on suicide, suicide survivorship, grief, depression, etc. He/she uses empathy, listening, non-verbal communication and a supportive attitude in building a therapeutic alliance mong members.	4. The group leader takes an active role in planning social activities that are developmentally and physically appropriate for members. He/she is responsible in creating an environment that is conducive to social interaction. Respectful association, such as addressing each member by their full names, or using appropriate titles during all social activities are maintained. The group leader is responsible for seeing to it that planned activities provide pleasure, safety, self-satisfaction, creative expression and expansion and a sense of personal identity, learning and mastery.
ROLE OF MEMBERS **GBP**	**SGP**
5. With the objective of learning ways of coping with the stresses of being a suicide survivor, the group member participates in developing and evaluating a social microcosm, by giving an receiving feedback, by becoming a helper as well as helpee, by confronting feelings of alienation, by consensually validating multiple perspectives on existential issues and by sharing information, experiences, and hints on problem solving.	5. With the objective of reducing feelings of social isolation and loneliness, developing new friends and regaining control over feelings of anger, guilt, and shame, the group member participates in planning and performing social activities.
6. Practice interpersonal skills designed to enhance coping and remodeling of family and social relationships.	6. Practice social skills designed to enhance coping and rekindling of family and social relationships

The rationale for content sequencing and theme specification of the GBP are based on Shneidman's[3], Yalom's[37], Aguilera and Messick's[38], Parad's[39], Lopata's[40], Silverman's[16], and Constantino's[41] suggestions that for postvention to be effective, it must provide order and organization as well as detailed, open disclosure of events and reactions before, during, and after the event. Theme specification and content sequencing enhances organization, goal-directedness and growth. As each session's task increases in intensity and complexity, it is expected that members will achieve a feeling of accomplishment, catharsis, and change. An example of content sequencing and theme specification of the GBP is shown below.

Session	Curative Factor	Responsibilities, Roles and Actions
Session 1	Altruism and Universality	Introduction. Introduces members to each other, to the leader, and to the task at hand, and to the group norm and structure.
Session 2	Group Cohesiveness and Input & Output	Members begin to share and review the commonality of their feelings, plight, and problems, thus encouraging cohesion. Themes that may be identified during this session are the need to search for both physical and psychological clues as to the reasons for the suicide and the legacy of inexorable guilt.
Session 3	Catharsis & Insight	Members are assigned a reading and begin to keep a diary or a log. Members continue to share ideas and skills in understanding the complexity, but manageability of the situation. Themes that might arise during this session are alterations in one's interpersonal relationships due to real or imagined stigma and the complexity and incompleteness of grief.
Session 4	Guidance and Insight	Explore interpersonal skills, share thoughts about the assigned readings and ideas about coping. The idea that suicide is not a solution to a problem might be a theme during this session.
Session 5	Input & Output of Interpersonal Learning and Insight	Reach out and utilize external and internal support systems in organizing one's life. The erosion of the capacity to trust others may arise as a theme during this session.
Session 6	Insight & Family Re-enactment	Review feelings, both positive and negative, towards self, and surviving family members and the suicide victim. Recurring themes should be identified, discussed and evaluated. Family themes such as scapegoating, isolation, estrangement or cut-offs may also surface during this session.
Session 7	Instillation of Hope Insight	Begin to synthesize knowledge, acknowledge self and others' needs for company, help, and comfort. Various defenses and coping techniques should be discussed. Members and the leader could encourage others in replacing less adaptive coping skills with adaptive ones.
Session 8	Existential Factors	Continue synthesis and summarize learning and internalize own uniqueness. Groups go through several stages of development, such as orientation, conflict, conflict-resolution, and harmony and cohesiveness. Group members should come to understand and accept each other. Members must be prepared during each session that the group must come to closure and outstanding themes, issues and tasks have to come to an end.

The focus of SGP is in providing members an opportunity to plan and carry out social activities led by a group leader who is non-directive and guides group conversation on "here and now" events. Although SGP's weekly schedule will be planned from week to week by group members, a typical SGP session is shown below. Session topics and activities are adapted from Rogers, et al.[25], Constantino[16], Osgood[42] and Kelley[43].

Session	Social Principles	Responsibilities, Roles and Actions
Session 1	Identity, Social Affiliation and Integration	Introduction. The topic during this session is "getting acquainted". Introduces members to each other, to the leader, and to the social nature of the group. The leader may allow a 10-minute period of time for warm-up (head, shoulder, hand and feet) movements or exercises. Then, activities for the next meeting(s) will be discussed, including the nature of the activity, date, time and meeting place.
Session 2	Enjoying, Learning and Interacting	"Understanding ourselves" and "accepting feelings of loss and stress" may be the topic(s) for this session. This may be accomplished by listening to a musical arrangement or a reading of a poem. A discussion following the experience should follow.
Session 3	Enjoying, Learning and Interacting	A trip to a flower show or to a play may be planned for this session. This experience will allow members to focus attention to the "outside environment" instead of self, see beauty and feel pleasure, self-satisfaction and creative expression and appreciation.
Session 4	Reviewing, Reminiscing, Relaxing and Letting Go	"Facts of the loss: Role-playing, role changes,and coping skills" may be the topic of this session. The session could begin with a relaxation exercise. Then discussion and role-playing about certain situations should follow.
Session 5	Reviewing and Reminiscing	"Reliving and family renewal" might be the topic for this session. A discussion about nutritional needs and other health needs should open the session. Then a preparation of a meal or serving a ready-made meal family-style could take place during the session.
Session 6	Positive Self-concept, Self-esteem and Fulfillment	"Support systems: Recognizing and using them" could be a topic during this session. The discussion could start by answering the question: What am I good at? This should contribute to a positive self-concept and self-esteem and fulfillment. A job interview could be role-played.
Session 7	Creative Expression	"Summing it up and going on" may be the topic for this session. Each member could write his/her own brief resume or autobiography. Discuss each others strengths and wishes, and set up short and long term goals.
Session 8	Self-satisfaction and Feeling of Competence and Mastery	The SGP also goes through several stages of development. This process can be called forming, storming, norming, and conforming. Group members must come to understand, accept, and let go of each other. If social alliances and friendships are formed among members, this must be encouraged. Although the SGP must come to a close and outstanding activities must be completed, members may continue to associate or interact with each other on their own.

A Research Proposal

Clinical postvention programs must be tested through research. This chapter will not be complete unless a presentation of a research proposal is included.

Constantino[15] found that bereaved widows whose husband died from a variety of causes including suicide experienced depression, psychological distress, grief and social isolation. When two forms of group interventions (group therapy and social group activity) were offered to the widows, the widows' levels of depression and socialization from pre-intervention to postintervention differed or changed. Also it was found that the widows whose husbands died of suicide verbalized more psychological distress in a form of blame, anger and guilt.

The purpose of this research is to evaluate postvention during the bereavement process of widows and widowers whose spouse died of suicide. The specific aims are to: (1) evaluate the efficacy of two nursing postvention programs: the Group Bereavement Postvention (GBP) in contrast with the Social Group Postvention (SGP) on level of depression, psychological distress, resolution of grief, and social readjustment as measured by the Beck Depression Inventory (BDI), the Grief Experience Inventory (GEI), the Symptom Check List (SCL-90), and the Revised Social Adjustment Scale (RSAS); (2) describe the early (1-6 months after spouse's suicide) psychological status of widows and widowers age 50 and older (who volunteer for postvention) as measured by the BDI, the GEI, the SCL-90, and the RSAS; and (3) describe the sociodemographic status of widows and widowers age 50 and older whose spouse died of suicide (who volunteer for postvention) including age, sex, race, religion, education, income, and duration of marriage.

Levels of depression will be measured by the BDI, levels of psychological distress, grief, and grief resolution will be measured by the GEI and the SCL-90 and levels of social adjustment will be measured by the RSAS.

The following hypotheses will be tested:

1. There will be a statistically significant difference between the effects of GBP and SGP on levels of depression, psychological distress, resolution of grief and social adjustment immediately post treatment, six months post treatment, or 12 months post treatment.

2. The change in levels of depression, psychological distress, resolution of grief and social adjustment will be maintained over one year from the post treatment period in the GBP subjects as contrasted with the SGP subjects.

If, post treatment, the GBP and SGP differ in the decrease in levels of depression, psychological distress, grief resolution, and in the increase in levels of social adjustment or that the GBP is found to be more effective than the SGP, this suggests that a psychotherapeutic treatment group focused on coping may be planned for survivors of suicide. If, however, both groups do not differ, then survivors of suicide may be able to select the type of group intervention favorable and therapeutic to them. Those survivors of suicide who may have negative attitudes about group intervention or group therapy because of the label, may elect for a Social Group Postvention. SGP could be included into the general services for elderly widows and widowers who survive the suicide of a spouse.

In light of the literature and the preliminary study, an outcome study on the efficacy of therapeutic activity that would alleviate depression, psychological distress, grief and social isolation in suicide survivors is proposed.

I. Design

This five-year outcome study uses a randomized two-group comparison design with 100 widows/widowers randomly assigned to one of two postvention groups (the GBP and the SGP) to evaluate the efficacy of GBP in contrast with SGP. All subjects who volunteer will be given baseline assessments to describe sociodemographic and psychological profiles. Subjects meeting study criteria will be randomly assigned to groups and will receive 8 weeks of postvention with assessment of levels of depression, psychological distress, grief, and grief resolution and social adjustment at baseline, post-postvention and at 6 and 12 months follow-up.

This comparison study does not utilize a non intervention control group due to the potential level of risk of depression, psychological and social changes and even suicide associated with the population of suicide survivors. Individuals who suffer the loss of a spouse through suicide experience some, albeit in varying levels, depression, psychological stress, grief, and social isolation. It was deemed necessary to offer some form of therapeutic postvention to a comparison

group instead of a no-treatment control group. Consequently, the focus of this study is on comparing the efficacy of the GBP in contrast with the SGP.

2. Sample

Using formulas provided by Lachin[44] as shown in equation number 6, the minimum required sample size for the study would be 90 individuals needed to test the difference between means of two independent groups. This sample size would provide a power of 0.9 to detect statistically significant difference in the BDI, GEI, SCL-90, and RSAS tests with an alpha error of 0.05. Allowing for a 10% dropout rate, and based on this estimate, 100 suicide survivors will be accepted to the study.

The population from which the sample will be drawn will be widows and widowers aged 50 and older whose spouse died of suicide within the last 1-6 months, and who are able to complete questionnaires. Subjects will be obtained by newspaper advertisement or through referrals by religious, social, and health agencies. Although consideration was made to seek referrals from the coroner's office, it was decided not to pursue this source of referral due to the following reasons: The principal investigator who worked with widowed subjects in a previous study had the opportunity to have among her study sample 5 widows who had lost their husband through suicide. During the study period, 3 widows did not report the cause of their husbands death to the coroner's office as suicide, yet during the group intervention meetings these widows verbally sought in confidence the trust of the members and confided in them that the cause of their husband's death was suicide. They also confided that the coroner's office still is "undecided" as to the cause of the husband's death. Another reason for not pursuing the coroner's office as a source of referral is the social stigma attached to suicide. Suicide survivors fear that insurance monies due them will not be paid if it was found that their spouse died of suicide. A study conducted in California[45] wherein coroner's office files were searched weekly for elders who both commit suicide and have a surviving spouse, resulted only in 10% participation of the persons contacted through the coroners's office. From the 10% who agreed to participate in the study, one-half canceled out and declined the interview. The most common reason given is fear of invasion of privacy. Farberow et al.[45] added that many of the postvention subjects were involved in legal

matters, some deny that a suicide occurred, and others say that they are simply too distraught to talk to anyone about their feelings. For these reasons, it was decided to seek only referrals from media advertisement and from religious, social, and health agencies, instead of going through the coroner's office. It was also decided that because immediately after suicide of a spouse, the survivor spouse is still in a state of shock, denial, and confusion, subjects will be recruited only within 1-6 months of the suicide of a spouse. Also, since referrals will be accepted from other agencies, it is anticipated that those referred to the study would have already acknowledged the suicide event.

Interested respondents to advertising will be excluded from the study if they are: (1) disoriented, (2) psychotic, (3) homicidal, (4) suicidal, (5) unable to read or speak English, or (6) are physically unable to come to the assigned meeting site. Disorientation, psychoses, homicidal and/or suicidal tendencies, inability to read or speak English and physical impediments to come to the assigned meeting site, will be assessed during an individual intake interview. Subjects who attend any given meeting and are found to be psychotic, homicidal, suicidal, or disoriented, will be thanked for their time spent in coming to the meeting, will be excused from the meeting and will be referred to a Diagnostic and Evaluation Center (DEC) of a University psychiatric hospital.

To ascertain the availability of subjects for the study, published records on suicide rates by the County Coroners's Office and by the National Center for Health Statistics were searched. The distribution curves for the United States indicate that suicide increases with advancing age, while the distribution curves for the County indicate that the suicide increases for the 25-34 age group, decreases between the 35-44 and 65-74 age groups, and then increases again for the 75-84 age group. For the year 1985 especially, suicide rate for the 75-84 age group was 22.0, equal to that of the 25-34 age group for 1981 and 1982. The year-by-year changes in suicide rates in the young adult and the elderly illustrate the trend toward convergence of these two rates on both the County and in the United States[46]. Why have elderly suicides increased since the early 1980s up to the present time? No one knows for certain, but an informed observer would have to consider the impending losses that confront the elderly at this stage of their life: loss of health, loss of a spouse and other family members through death or separation, and most importantly for the tri-

state area where Allegheny County is located, the closing of steel mills and other factories and industries resulting to loss of jobs and virtually economic depression. For these reasons, this study is being proposed to focus on those persons aged 50 and older, who have lost a spouse to suicide.

To determine the eligibility of subjects, the BDI . be scored immediately while other forms are being explained or are still being completed. Those subjects who achieve a score of 30 or greater on the BDI will be excluded from the study. All subjects will be informed that they can request individual assistance or therapy at any time. With the use of a list of random numbers, the subjects will be randomly assigned to the two study groups: GBP and SGP. Thereafter the 8-week group sessions for the GBP and SGP will be scheduled. Each group member will be required to complete the BDI before each session begins. This will allow a weekly (for 8 weeks) assessment on the BDI. Again, for those subjects who achieve a score or 30 or greater at any time during the eight sessions and during the 6- and 12-month follow-up sessions, will be referred to the previously mentioned psychiatric emergency room.

To minimize dropouts, cards and telephone calls will be used to remind subjects of each scheduled group session and for the remaining follow-up testing intervals. The second testing interval for the GBP and SGP will be done during the latter part of the last or 8th group session. The 6- and 12-month follow-up testing intervals will be done at the research site. The same mode of reminding the subjects of the follow-up sessions (mailed cards and telephone calls) will be utilized to minimize dropouts. It is anticipated that in having each group come together, rather than having them respond to the questionnaires by mail, the processes of group cohesion and alliance will be maintained among the group members. The follow-up group sessions will also serve as a renewal of a support system among members.

After an explanation of the study, consent will be obtained and an identification number will be assigned to each subject to insure anonymity. The subjects will be tested according to the following schedule: at intake; 8 weeks later; then at 6- and 12-month intervals. The timing among the intervals was based upon studies of repeated measures over time using these instrument by Beck[47] and Weissman[48]. The investigators report the elapsed time between tests (two months

minimum) to be sufficient to prevent skewing of the results by familiarity or memory. Consultation with Weissman for RSAS, and Beck's research assistant for the BDI confirms the appropriateness of these meeting. During this meeting, the nature of the study will be explained to those in attendance. During this same meeting all subjects will be required to read and sign the consent form and complete the demographic data questionnaire, the BDI, the RSAS, the SCL-90, and GEI.

The conservative estimate of 10 subjects per Intake and Random Subject Assignment (IRSA) meeting is based only on County Coroner's Office report of an annual suicide rate of 170-180 persons in 1986. These numbers would provide a monthly suicide rate of 15-18 persons who are aged 50 and older. Past recruitment experience by the principal investigator of widowed subjects has suggested that 6-10 of the 10-12 suicide victims will have a surviving spouse and will volunteer for the study.

Based on the principal investigator's research experience, it is estimated with some degree of certainty that the waiting period from the time a volunteer or a referral indicates interest in participating in the study to the time when ten subjects can be randomized to the two group of 5 persons who are free to meet at the same time is 1-4 weeks. In general, volunteers will wait no more than one month. Group size of larger than 5 can be initiated. If there are fewer than 5 volunteers such that waiting will exceed 4 weeks, volunteers will be contacted by phone and will be offered a choice between waiting 4 weeks or withdrawing. Those who choose to withdraw will be offered referrals for treatment if they choose.

3. Measurements

The four scales that will be used are:

Beck Depression Inventory (BDI): This inventory helps to establish the existence of depression and to provide a guide to its severity. The BDI is composed of 22 self administered items. Average completion time is 3 to 5 minutes. The BDI is scored by adding the total score of all categories. The total may range from 0 to 66. The scores are then matched with established degrees of depression: minimal 0-9; mild 10-15; mild to moderate 16-19; moderate to severe 30-66.

Symptom Check List (SCL-90): The SCL-90 is a self-report clinical scale directed toward emotional and physical symptom ratings. It is a 90-item rating scale with 9 major symptom constructs: somatization, obsessive, compulsive, hostility, phobic anxiety, paranoid ideation and psychoticism. It is self-administering and can be completed by most persons within 20-25 minutes.[49]

Grief Experience Inventory (GEI): This inventory consists of 135 true or false items covering somatic and emotional content frequently associated with the process of bereavement. The items yield validity and symptom scales. The GEI is self-administering and can be completed by most persons within 20-30 minutes.[50]

Revised Social Adjustment Scale (RSAS): The RSAS assesses the performance of persons in work, social, and leisure activities, relationships with extended family, role as a parent, and economic independence. Each role includes assessments of performance at tasks, interpersonal relations, friction, and satisfaction of role. The lowest possible score for the RSAS is 1.00, indicating a maximum or highest level of social adjustment. The highest score for RSAS is 5.00, indicating non-socialization or social mal-adjustment. It is self-administering and can be completed in 35-40 minutes.[48]

4. Procedure

The death of a spouse by suicide is a stressor of unparalleled magnitude to the surviving spouse. Even the most psychologically mature and emotionally stable individual may encounter some difficulty in responding to it.[9] Careful and thoughtful deliberation have been made to insure in every way that the rights, needs, and dignity of subjects who volunteer to participate in this study are respected, met, and maintained.

Ten Intake and Random Subject Assignment (hereafter, IRSA) meetings will be scheduled during the study period. To insure equal numbers in each of the 2 study groups, IRSA will be done in groups of 10. For example, as soon as 10 subjects indicate their interest in participating in the study, have been assessed during an individual intake interview and have met sampling criteria, all 10 subjects will be invited to attend the IRSA meeting. During this meeting, the nature of the study will be explained to those in attendance. During this same meeting all

subjects will be required to read and sign the consent form and complete the demographic data questionnaire, the BDI, the RSAS, the SCL-90, and GEI.

The first 2 months of the study will be spent in recruitment, training and orientation of a project director, group therapist, secretarial staff member, and a graduate student assistant. Research advertisement and recruitment of subjects will start on the first months and will continue until the desired number of eligible subjects (100) is reached, which is anticipated to be 18-20 months. The first GBP and SGP group sessions will start as soon as 10 eligible subjects can be randomized to the two groups of 5 persons who are all free to meet at the same tie. The estimated waiting period from the time 10 eligible subjects volunteer to the start of the GBP or SGP is 1-4 weeks. Each group of 10 randomly assigned to the two groups (GBP = 5 and SGP = 5) by the use of a list of random numbers. It is anticipated that the GBP will have 10 different groups (19 x 5 subjects = 50) running concurrently with SGP's 10 groups (19 x 5 subjects = 50). Since each group has 8 sessions, once a week for eight weeks, it is anticipated that if the first group session for the GBP and SGP start on the third month of the first year of the study, the last group session of the last 10 GBP and SGP groups will run up to the 10th month of the second year of the study. This estimate includes the possibility of dropouts and reduction of volunteer subjects during the winter months. Follow-up testing for each group will take place as scheduled at 8 weeks, 6 months and 12 months. Scoring input will be done in batches. Data analysis will start after the completion of the last GBP and SGP sessions. At this time, a final report will then be written and submitted to the funding source.

5. Group Leaders

Six group leaders (3 for GBP and 3 for SGP) will be recruited from a pool of doctoral students from a University graduate department of Psychiatric-Mental Health Nursing. Although only four group leaders will be necessary, training six group leaders at the start of the study will provide back-up group leaders in the event a trained group leader will drop out of the study due to unforeseen circumstances. Master's level will be the minimum degree held by each group leader. They will be given a 3-day, 16-hour training program. Each potential group leader will be tested after completion of the training program using a 20-item true-or-false written test.

Ninety percent (90%) achievement on the test will be required to qualify for group leadership. Each group therapist's performance will be monitored closely by the principal investigator. At least three unannounced in vivo observations by the principal investigator will be made out of eight sessions to insure and to serve as a reliability check in assessing the implementation of the GBP and SGP protocols. By the use of a self-evaluation procedure, the group therapist will be required to evaluate his/her performance during each session. Each group leader will also be required to complete group progress notes for each group member after each session. Each group leader will also hold a one-hour supervisory session with the principal investigator after each session. This supervisory hour will be spent in critiquing the group progress, group structure, and evaluation of goals and critiquing of group themes and activities. Data gathered from the unannounced in vivo observations, self-evaluation form, group progress notes and from the supervisory sessions will be used as a basis for both formative and summative evaluation of each leader's performance and her continued participation as a group leader in the research project. Group progress notes will be used to determine the content focus and activity.

6. Analysis of Data

Data will be analyzed using a repeated measures multivariate analysis of variance to determine whether the two treatment groups (Group Bereavement Postvention of GBP, and Social Group Postvention or SGP) differ over time (from intake or pretreatment, the 8 weeks or post-treatment, and then at 6- and 12-month intervals) on levels of depression, psychological distress, resolution of grief and social readjustment as measured by the BDI, the GEI, the SCL-90, and RSAS. This measure is particularly useful as it would account for some degree of correlation which would be expected between these measures. That is, the participant who is grieving is also likely to have some degree of depression, psychological distress, and social isolation, as noted by Schneidman. Scheffe techniques for post hoc comparison will also be performed. Descriptive statistics, such as means, standard deviations, and percentages will be used to describe the demographic characteristics of the sample of suicide survivors and their scores on the five scales.

Data on dropouts will be handled by excluding the subjects from the study. Specifically, the score(s) of a subject who drops out at any time during the eight-week treatment period or who

misses any testing time post treatment, at 6-month or at 12-month follow-up will be excluded from the data analysis. However, differential rate of dropouts between the two study groups and between testing periods will be treated as an end point and characteristics of those who dropped out will be analyzed and reported. Analysis of dropout rates will serve as a useful measure of the relative appeal of the two group approaches. Scores for those subjects who receive 1:1 or other forms of treatment during the study period will be included in the data analysis, however, post hoc comparisons will be made between subjects who did not receive and subjects who receive 1:1 or other forms of therapy.

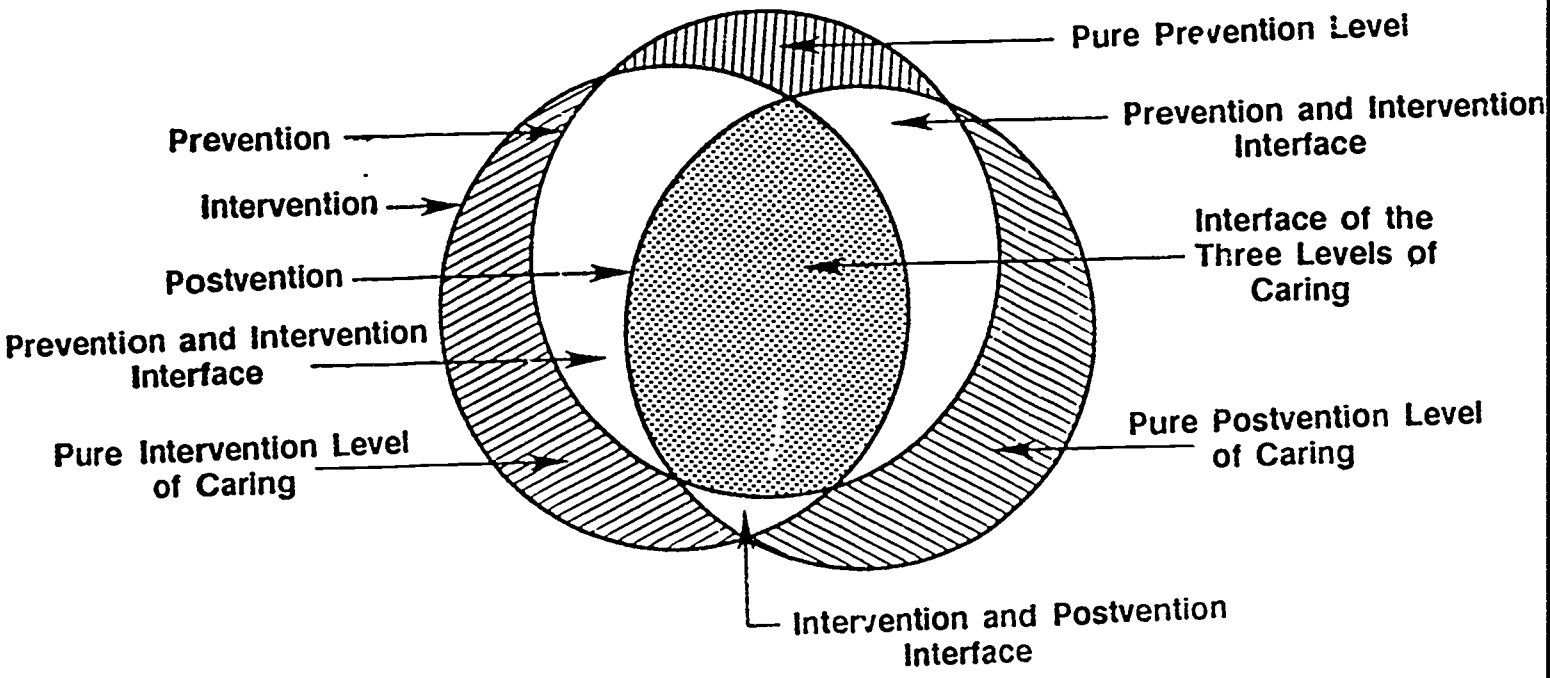
7. Limitations

A major limitation of this study lies in the possible forms of self-referrals which may shape the findings. The sample is restricted to volunteers in a group which is known to have some difficulty in disclosing suicide as the cause of death to public agencies such as insurance companies and coroner's offices. Therefore, the sample may not be representative of all older survivors of suicide in sociodemographic or psychological characteristics. While this is recognized, the need for efficacious interventions for suicide survivors is sufficient and sampling sufficiently sensitive that the most feasible course at this time is to utilize self-referred volunteers, fully recognizing this limitation. It is further recognized that subjects are not being matched on baseline assessment scores, with the expectation that randomization process will create equivalent groups. However, ANCOVA will be utilized to control for baseline characteristics in the outcome analysis.

Conclusion

Postvention is the reduction of the depression and suicide ideation of the suicide survivor after the suicide of a spouse. Postvention seeks to reduce the rate of residual effects, the depression, suicidal ideation and attempts and even for some; suicide, as a result of the experience. Emphasis in postvention is on maintaining a reasonable degree of adaptation and coping in suicide survivors. Below is Figure 1 depicting the circularity of the three levels of caring in suicidology.

Figure 1. The Three Levels of Caring in Suicidology



Postvention is akin to tertiary prevention wherein reconstruction is seen as a dynamic state of adaptation to stressors impinging on the suicide survivor, coming from within and from without.[51] In this scheme, postvention tends to lead back in a circular fashion toward prevention and intervention.

References

1. Shneidman ES: Foreword. In: Survivors of Suicide. (Cain A. ed.). Springfield, IL: Charles C. Thomas, 1972.
2. McIntosh J: Survivors of suicide: A comprehensive bibliography. Omega 1986; 16:355-370.
3. Scheidman ES: Postvention. The care of the bereaved. Suicide and Life Threatening Behaviors 1981; 11:349-359.
4. Calhoun LG, Selby JW, Selby LE: The psychological aftermath of suicide. Clinical Psychology Review 1982; 2:409-420.
5. Yalom S: Inpatient Group Psychotherapy. New York: Basic Books Inc., 1983.
6. Iso-Ahola S: The Social Psychology of Leisure and Recreation. Dubuque IA: William C. Brown, 1980.
7. Neulinger J: To leisure: An introduction. Boston: Allyn & Bacon, 1981.
8. Cain A: Survivors of Suicide. Springfield IL: Charles C. Thomas, 1972.
9. Dunne E, McIntosh J, Dunne-Maxim K: Suicide and Its Aftermath. New York: W.W. Norton and Co., 1987.
10. Osterweiss M, Solomon F, Green M (Eds): Bereavement Reaction Consequences and Care. National Academy Press, 1984.
11. Cain A, Fast L: The legacy of suicide: Observations on the pathogenic impact of suicide upon marital partners. Psychiatry 1966; 29:406-411.
12. Junghardt DZ: A program in postvention. In C.L. Hatton S.M. Valente & A. Rink (eds.). Suicide: Assessment and Intervention p. 124-132. New York: Appleton-Century-Crofts, 1977.
13. Hatton CL, Valente SM: Bereavement group for parents who suffered a suicidal loss of a child. Suicide and Life Threatening Behavior 1981; 11:141-150.
14. Solomon M: Bereavement from suicide. Canadian Psychiatric Nursing 1981.
15. Constantino RE: A comparison of two group interventions for the bereaved. Image 1988; 20:83-87.

16. Silverman PR: Intervention with the widow of a suicide. In: Survivors of Suicide (Cain A. ed.). Springfield IL: Charles C. Thomas, 1972.

17. Freedman A, Kaplan H, Sadock B: Psychiatric emergencies. Chapter 28 in: Modern Synopsis of Comprehensive Textbook of Psychiatry II (2nd Edition). Baltimore: William & Wilkins, 1976.

18. Augenbraun B, Neuringer C: Helping survivors with the impact of suicide. In: Survivors of Suicide (Cain A ed.). Springfield IL: Charles C. Thomas, 1972.

19. Rich A, Bonner R: Concurrent validity of a stress-vulnerability model of suicidal ideation and behavior: A follow-up study. Suicide and Life Threatening Behavior 1987, 17:225-230.

20. Clayton PJ, Halikas JA, Maurice WL: The depression of widowhood. British Journal of Psychiatry 1972; 120:71-78.

21. Demi A: Social adjustment of widows after a sudden death: Suicide and non-suicide survivors compared. Death Education 1984, 8:91-111.

22. Vargas L: Bereavement in the four modes of death in whites blacks and Hispanics. Unpublished doctoral dissertation University of Nebraska, 1982.

23. Williams M: Comparing responses of sudden death survivors. Paper presented at the annual meeting of the American Association of Suicidology Atlanta GA, 1986.

24. Moore S: After suicide: Clinical symptoms and experiences of those left behind. Dissertation Abstracts International 46:2817B. (University Microfilms No. DA 852 2983), 1986.

25. Rogers J, Sheldon A, Barebich C, et al: (1982). Help for families of suicide: Survivors support program. Canadian Journal of Psychiatry 1982; 27:444-448.

26. Johnson B: Psychological services for relatives of suicide victims. In N. Speyer R. Diekstra & K Van de Loo (Eds.) Proceedings of the 7th International Conference for Suicide Prevention (pp. 372-375). Amsterdam: Surets & Feilinger, 1974.

27. Shepard DM, Barraclough BM: (1976). The aftermath of parental suicide for children British Journal of Psychiatry 1976; 129:267-276.

28. Windholz M, Maramar C, Horowitz J: (1985). A review of the research on conjugal bereavement: Impact on health and efficacy of intervention. Comprehensive Psychiatry 1985; 26:433-447.

29. Gallagher D, Breckenridge N, Thompson L, et al: Effects of bereavement on indicators of mental health in elderly widows and widowers. Journal of Gerontology 1983; 38:565-571.

30. Stone HW: Suicide and Grief. Philadelphia: Fortress Press, 1972.

31. Rudestam KE: Physical and psychological responses to suicide in the family. Journal of Consulting and Clinical Psychology 1977; 45:162-170.

32. Wallace S: On the atypicality of suicide and bereavement. In B.L. Danto & A.H. Kutscher (eds.). Suicide and Bereavement pp.44-53. New York: Arno Press, 1977.

33. Saffer J: Group therapy with friends of an adolescent suicide. Adolescence 1986; 21:734-745.

34. Constantino RE: Nursing Care of Widows in Grief and Mourning Through Bereavement Crisis Intervention. Doctoral Dissertation University of Pittsburgh, 1979.

35. Constantino RE: Bereavement crisis intervention for widows in grief and mourning Nursing Research 1981; 30:351-353.

36. Resnick HLP: Psychological resynthesis: Clinical approach to the survivors of a death by suicide. In: Aspects of Depression (Shneidman E.S. & Ortega M. eds.). Boston: Little Brown and Co, 1969.

37. Yalom S: The Theory and Practice of Group Psychotherapy. New York: Basic Books, 1985.

38. Aguilera DC, Messick JM: Crisis Intervention. St. Louis: The C.V. Mosby Book Company, 1982.

39. Parad HJ: Crisis Intervention. Encyclopedia of Social Work. 16th ed. Vol. I. New York: National Association of Social Workers, 1971.

40. Lopata HF: Widowhood: Societal Factors in Life-Span Disruptions and Alternatives. In Life-Span Developmental Psychology: Normative Life Crisis. Data N. & Ginzberg L.H. (eds.). New York: Academic Press, 1975.

41. Constantino RE: Nursing Care of Widows Through BCI. In: Nursing and Thanatology Arno Press, 1982, p. 146-157.

42. Osgood N: Suicide in the Elderly. Rockville MD: Aspen Publications. 1985.

43. Kelly J: Socialization toward leisure: A developmental approach. Journal of Leisure Research 1978, 6:181-193

44. Lachin JM: Introduction to sample size determination and power analysis for clinical trials. Controlled Clinical Trials 1981; 2:93-113.

45. Farberow N, Gallagher D: The bereavement process in spouses of elderly suicides. The Gerontologist 1987; 5:592-600.

46. US Department of Commerce Bureau of Census: Current Population Reports: Marital Status of Family Status. Series P - 20 no 212, 1986.

47. Beck AT, Ward CH, Mendelson M Mode J & Erbaugh J: (1961). An inventory for measuring depression. Archives of General Psychiatry 1961;4:561-571.

48. Weissman M: The Assessment of Social Adjustment. Archives of General Psychiatry 1975; 32:357.

49. Derogatis L Lipman R & Covi L: SCL: An outpatient psychiatric rating scale-preliminary report. Psychopharmacology1977; 1:13-27.

50. Sanders C Mauger P & Strong P: A Manual for the Grief Experience Inventory. Tampa FL: University of Southern Florida, 1979.

51. Caplan G: Principles of Preventive Psychiatry. New York: Basic Books Inc., 1964.