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POSTVENTION IN SUICIDE SURVIVOR SUPPORT: SOME ETHICAL CONSIDERATIONS

Postvention essentially deals with the aftermath in survivors of suicidal behaviour. Such bereavement support should consider the broader context in which it is offered, since a mixed picture can occur in respect of the impact of survivors' grief experiences on their mental and physical health. There are many different terms used to describe the reactions to this. These are often used interchangeably, but space does not allow for an in-depth discussion of it here. Suffice it to say that suicidal behaviour is a significant healthcare problem and thousands of people's lives annually are affected by it either directly or indirectly necessitating much needed postvention services. This article briefly addresses some ethical considerations that have implications for the implementation of postvention practices.

SURVIVOR RISK FACTORS

One should always to be alert to the possibility of depression (or other psychopathology) in suicide survivors. For example, severely depressed survivors following the suicide of a loved one may lack the ability to cope psychologically. The first option for help will often be their family physician because of a scarcity of mental health resources and limited access to postvention programmes. However, in developmental countries like South Africa, postvention programmes frequently have to be designed within a resource-limited context because of a shortage of adequately trained healthcare professionals. One way to overcome this is to rely on community-based efforts and trained volunteers. Specialiszed knowledge and skills, though, are required to educate health-care professionals and volunteers about postvention. Particular attention should be given to early detection and treatment of psychiatric/psychological conditions in survivors of suicide within primary health care settings.

The need for follow-up on survivor help both immediately after the suicide as well as long term cannot be over- emphasizsed. Those who run postvention programmes should also be aware of the role of the various cultural and religious aspects in this regard. Suicide in itself is not a diagnosis. It's a form of behaviour, the nature of which is a complex phenomenon. It usually involves intricate interactions between psychological, social, cultural and biological factors. Thus, it can not always be readily attributed to any single cause when dealing with survivor reactions to suicide. Many other survivor risk factors could impact on postvention efforts. Examples of these include the identification in survivors of:

- family psychopathology
- a history of family members' suicidal behaviour
- interpersonal problems (especially marital, partner-relationship and

family complications)
- suicidality in themselves
- substance abuse
- financial challenges and socio-economic difficulties
- high stress levels
- potentially life-threatening diseases that could impede their coping
- ambiguous emotions about the suicide that usually lead to an obsessive seeking for explanations and concerns about being left in the predicament of a survivor.

Although there can be an overlap of survivor risk factors between children and adults that need to be managed in postrevention efforts, children in particular can be badly affected and vulnerable young people may employ intense reactions to the suicide of a parent or family member. This can involve, amongst others:

- feelings of betrayal and abandonment
- academic problems
- guilt (especially when they feel self-blame that they are the cause of the suicide)
- fear of losing the other parent
- decreased coping/ behavioural patterns

Given the above, it is also important to bear in mind the negative effects of social media and the concepts of suicidal transmission and copycat suicides where the truth about the suicide often emerges in inappropriate circumstances, when there is little immediate postvention support. Not being truthful about the suicide can lead to other complications such as survivors having to go through secondary traumatisation and trying to deal with any related myths or second-guessing about the circumstances of the suicide. It is important, therefore, to create opportunities where they can express their feelings and the facts can be explained in a straightforward manner, to educate and support the family and to point out the value of trying to maintain a normal routine.

Understanding the process of their grief experience following their traumatic bereavement as well as any precipitating factors that could exacerbate the grief after the loss of the loved one through suicide can help survivors to deal with their subsequent varying emotions, which can be complicated and highly individualised. Such continued supportive understanding is vital, since in their quest for meaning, survivors find it difficult to comprehend the "why" behind the suicide and frequently report that initially they are offered compassion and support from people close to them, which tend to decrease as they try to re-focus on a sense of getting on with their lives.

SUPPORT GROUPS

Although help can be offered professionally, individually and through crisis centres, depending on individual needs and availability of resources, suicide survivor programmes and self-help support groups can be potent and inexpensive ways to enable survivors. This can be enhanced when survivors share their knowledge in order to support each other within group settings. However, group meetings should be conducted by experienced therapists who are skilled in suicide postvention and who is assisted by a moderator-survivor. In some culture-specific situations there can be a reluctance to openly discuss being a survivor of suicide, because of the risk that the stigma of suicide might lead to social isolation. Therefore, because suicide can affect an individual person as well as the whole family and/or community, support needs to reach beyond the family of the survivor especially where survivors feel rejected or are exposed to social or cultural disapproval.

Perceptions in a community about suicidal behaviour and the process of postvention can determine whether suicidal behaviour is disguised or not. Since this can be further influenced by the media, responsible media reporting on these issues should be encouraged. To assist with these and other obstacles, support groups should be augmented by information programmes to destigmatise the reasons for postvention.

The opportunity should be created to gather appropriate information from a mixed forum of resources that include personal experiences, research data, bereaved persons, health care professionals and volunteers in order to formulate improved postvention efforts. It is better to institute postvention sooner than later, for it to be offered as long as needed and not necessarily be time-limited. In this sense, postvention is not intended to be prescriptive but should aim to psychologically re-empower survivors so that they can rebuild a life without the loved one lost because of suicide. Authorities have pointed out that postvention can in fact be a form of suicide prevention among survivors who can be consumed by ruminations about missing their loved ones. Generally, most ethical approaches tend to overlap, but in essence in postvention it embodies decisions about what is right and appropriate for particular survivors and how to achieve the proper results for them. MHM

References available upon request