A Review of Peer Support for Suicide Bereavement as a Postvention Alternative

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Abstract

Peer support is acknowledged as a cornerstone in recovery from mental illness and addictions; yet its applicability for survivors of suicide has not been explored. Most postvention programs consist of professionally led individual and group counseling services. Alternatives to traditional professional counseling interventions are reported in the mental health peer support literature. We examine the postvention literature and the related mental health literature on peer support programs to determine their relevance and applicability. This report considers peer support provided as a postvention option or supplied in tandem with conventional professional services. Finally, we examine this as an intervention that also needs to be documented by quantitative and qualitative methods so that the presumptions and hesitations about its efficaciousness with suicide survivors can be documented.

Introduction

The applicability of peer support, an acknowledged cornerstone in recovery from mental illness and addictions, has not been widely explored for survivors of suicide. Alternatively, long valued for its power to help recovery from alcohol abuse, peer-based Alcoholics Anonymous has become accepted by mental health services providers as an essential component in the continuum of care (Mead, Hilton, & Curtis, 2001; Mead & MacNeil, 2006; Soloman, 2004). Survivors of many different types of trauma and stressors have benefited from the unique perspectives and understandings that come from "having walked in those shoes." In contrast, mental health services concerned with post suicide intervention strategies have traditionally relied on professionally-led individual and group interventions. This paper examines the literature on peer support as utilized in a variety of mental health services and considers its applicability to adult survivors of suicide, a term used to refer to those grieving a death by suicide. Because there is an extensive separate body of literature on adolescent suicide bereavement and postvention activities that

are age-specific to this group, this discussion does not include postvention for adolescents bereaved by peer deaths.

Postvention and Survivors of Suicide

The impact of death by suicide is extensive. The World Health Organization (WHO, 2007) estimates that, globally, on an annual basis, there are one million people whose deaths are attributable to suicide. Furthermore, the number of individuals impacted by a single person's suicide is, according to conservative estimates, between six and ten (Beautrais, 2004; Clark, 2001). In the United States the annual death rate from suicide was 31,647 in 2004. Based on a conservative tally of 754,570 suicide deaths between 1980 and 2004 (National Centre for Health Statistics, 2007), there are at least 4.5 million survivors in the US (American Association of Suicidology, 2007). The UK reports 5,000 suicides yearly. New Zealand reports 10,500 such deaths, affecting 65,000 survivors over the past 25 years (Beautrais, 2004). In Canada, the number of persons impacted by suicide falls between 20,000 and 40,000 annually. Because bereavement is most often a multi-year process, the prevalence of those recently bereaved by suicide ,over a given five year span, the number of persons bereaved by the suicidal death of a loved one is staggering (Wilson & Clark, 2005). However, only a small fraction of them seek and receive support services.

Bereavement support, intervention and postvention (Schneidman, 1993), have evolved as terms frequently associated with services for survivors of suicide (Beautrais, 2004; Wilson & Clark, 2005), and are described in the literature as those services which assist the bereaved to manage the immediate crisis of the suicide and to cope with the long term personal and intrapersonal repercussions of the event. We use the term postvention to encompass post-suicide support services Wilson and Clark (2005) noted that postvention is a combination of humanitarian assistance for the bereaved, designed to ameliorate the impact of a death by suicide and an important suicide prevention strategy. It generally consists of early intervention close to or at the time of death by trained workers and includes individual and group therapy and support groups, frequently with an educational focus.

Postvention efforts specifically directed at survivors of suicide are based on the contested assumption that suicide bereavement differs from other types of bereavement. Those investigators who support this assumption (Beautrais, 2004; Clark, 2001; Davis & Hinger, 2005; Dyregrov, 2002; Jordan, 2001; Wilson & Clark, 2005) also maintain that such bereavement can be accompanied by intense guilt, complicated or traumatic grief, and related physical and psychological symptoms

(Dyregrov, 2002; Murphy, 2002; Wilson & Clark, 2005). Complicated grief is described as that which is marked by persistent and elevated distress, impairment in daily functioning and an inability to resume everyday functioning (Lichtenthal, Cruess, & Prigerson, 2004). But it is not clear that this is a specific disorder, or the extent to which it applies to suicide survivors (Hogan, Worden, & Schmidt, 2003). Brown and her colleagues (Brown, Sandler, Tein, Liu, & Haine, 2007) examined the grief reaction of children bereaved by the suicide or violent dearth of a parent and concluded that cause of parental death is only a modest indicator of the need for intervention services to improve adaptive outcomes. Evolving research in this area by Currier, Holland, and Neimeyer (2006), suggests an alternative conceptual framework. They contend that, while bereavement following violent loss increases complications in grieving, it is the failure to find meaning, the ability to find a way to understand and make sense of the loss experience, that is the crucial pathway to complicated grief symptomatology.

The Unsettled Question of Efficacy of Postvention Strategies

Despite the controversy related to the basic assumption that suicide survivors require specific interventions, programs have gained momentum. However, unsettling reservations have been raised about the efficacy of bereavement counseling for survivors of suicide, as well as for those bereaved by other causes of death. Upon examining general bereavement intervention literature, Jordan and Neimeyer (2003) concluded that the scientific basis for accepting the efficacy of grief counseling is weak. The extensive review conducted by Schut and his colleagues (Schut, Stroebe, van den Bout, & Terheggen, 2002) determined that positive outcomes are more likely for grief processes that are more complicated. Additionally, they found that studies using an outreach approach as opposed to examining the process of those who seek help, almost always showed less favorable results. They therefore concluded that intervention programs will be most effective for individuals who experience high distress because there is more room for improvement, and for individuals who ask for help.

Two major literature reviews, one from Australia and the other from the UK, (Beautrais, 2004; King, Khadjesari, Golder, Eichler, & Sowden, 2004) summarized research findings on postvention services specifically for suicide survivors. King and colleagues (2004) reported 13 studies that evaluated interventions for suicide survivors and 20 more that described interventions. The participants ranged in age from children through adults and included families, parents, and health care providers. Several studies

examined bereaved peers in school settings. Interventions examined included crisis counseling, professionally lead individual and group counseling, journal writing, and community meetings for bereaved adolescents. School-based interventions, described, but not evaluated, included crisis teams, crisis centers, crisis consultation, and community meetings. One study reported placing suicide survivors with a trained counselor in a bereavement support group (Brent, Moritz, Bridge, Perper, & Canobbio, 1996). None of the reports mentioned peer support other than the presence of a survivor as part of a co-leader's crisis team in a postvention group, and no peer support services were specifically examined. A review of more recent publications also failed to uncover reports on peer support as a postvention service.

As with the general bereavement interventions, meta-analytic reviews of studies that evaluate intervention efficacy with suicide survivors show weak outcomes (Jordan & McMenamy, 2004; Kato & Mann, 1999; Sakinofsky, 2007), or are methodologically flawed as to obscure the true reported outcome. Cited problems included failure in random assignment to treatment groups, small sample size, failure to use outcomes specific to bereavement, low adherence, and lack of a theoretical foundation for intervention (de Groot et al., 2007). Several exceptions to methodological flaws and lack of positive outcomes were noted (Pfeffer, 2002), including an interesting study by Constantino and her colleagues (Constantino, Sekula, & Rubinstein, 2001) that reported positive benefits in two group interventions for widowed suicide survivors . A comparison between a professionally led treatment group and a group that focused on socialization and leisure principles (Iso-Ahola, 1980) showed a reduction in depression, psychological distress, and grief, and an increase in social adjustment for both groups. Also, there was little variation in outcome between the two groups. The reviewers thus speculated that the very process of interacting with other survivors, regardless of the group's focus, may be beneficial. Such an explanation may in fact support the beneficial effects of peer support available to the comparison social group. The inconsistency in positive outcomes for interventions with survivors of suicide invites considerations of alternative models to traditional counseling interventions. A starting point for re-examining what help survivors require could be to consider systematically assessing survivor needs.

Assessment of Survivor Needs

While studies reveal that suicide prevention and postvention is strengthened by involving the survivor community (Goodman et al., 1998;

Lord & Farlow, 1990), survivors have, historically, not been invited to provide input on service provision. However, a number of mental health researchers in disparate regions (Canada, Australia, Norway, UK) reported on assessments to the postvention needs of survivors of suicide (Davis & Hinger, 2005; Dyregrov, 2002; Jordan & McMenamy, 2004; Wilson & Clark, 2005). Studies concerning bereavement experiences of survivors in Norway and Canada revealed similarities of expressed needs, especially for both formal professional and informal supports that included peer support activities. Several needs assessments of survivors suggested that peer support is an important component of the support system. Studies in Canada, the US, and Norway (Davis & Hinger, 2005; Dyregrov, 2002; Wilson & Clark, 2005) reported that, while support for survivors was usually delivered by professionals, there was an increasing demand and role for peer delivered services. Several investigators mentioned the desires of the bereaved to have the support of others with similar experiences (Beautrais, 2004; Wertheimer, 2001). Program assessments from Norway (Dyregrov, 2002), and Canada (Davis & Hinger, 2005) gave some "voice" to this intervention and the views of those involved in support.

Understanding survivors' experiences and felt needs was examined by Dyregrov (2002), using an open-ended questionnaire to assess perceived need for professional and community support, and semi-structured interviews requesting survivors to describe their preferences in terms of "ideal" support. Survivors noted the need for peer support because "they could learn much from the unique experiences of other bereaved persons concerning what to expect in the weeks to come and 'how to survive the pain'" (p. 657). In an assessment of bereavement needs, Davis and Hinger (2005) found that peer support was an important area of need for the respondents. Their recommendations included postvention strategies to "implement a coordinated, active program that will enable newly bereaved survivors to connect with trained and experienced survivors" (p. 23). Recently Cerel and colleagues (Cerel, Padgett, Conwell, & Reed, 2009) noted that support groups for survivors of suicide are now extensively available across the United States. However, research on their impact and effectiveness is lacking.

Individual, family, and group counseling are the postvention activities most often cited in the literature. They are also the focus of most research on postvention activities. Peer support is infrequently mentioned, but usually included in needs assessments that have a more general focus (Beautrais, 2004; Dyregrov, Dyregrov, Nordanger, Hall, & Epp, 1999). Because most postvention studies focus on a clinical sample, namely persons who have self-identified as in need of bereavement counseling

after the suicide of someone they knew well, the needs of the general population of suicide survivors is not well understood.

The opportunity to conduct such a needs assessment presents itself during the course of National Survivors of Suicide Day, which is sponsored by the American Foundation for Suicide Prevention. This annual international event, which includes a teleconferencing element, provides survivors with an opportunity to hear from experts, as well as a link with one another. Recently, a local venue to this event included in the program handouts, a short questionnaire that inquired about survivors' felt needs for and experiences with support services. Participants were asked to return completed handouts anonymously in designated collection boxes. The University of Calgary ethics board approval was obtained for this data collection.

Of 140 participants, 62% (N =87) returned the questionnaires. Their responses reflected a broad representation of those bereaved by suicide. For 23%, the loss had occurred within the past 6 months, but over 40% indicated that the loss had occurred more than 3 years ago. The ages of survivors at the time of their loss varied from 7 to 76, and their relationships to the deceased included spouse, child, sibling, and friend. The vast majority, 83%, indicated that they wanted support at the time of loss and 74% reported that this support came from multiple sources: family, friends and counselors. They also reported that they frequently (73% of the time) received peer support. With the exception of a postvention group jointly led by a survivor and a counselor, no formal peer support program existed in the area. Thus, the reported peer support is assumed to come from informal sources and represent a significant aspect of the support system. This reinforces the premise that peer support is wanted and valued, but has not been included in the usual array of postvention activities in research designs.

Peer Support

What is Peer Support?

Peer support can be described as the sharing of similar experiences, relating and offering advice, providing strategies for thinking and acting, and validating reactions and emotions (Mead & MacNeil, 2006; Soloman, 2004). Mead and colleagues (2001) described peer support as "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful" (p. 135). Additionally, they noted that peer support offers the context of a shared experience and connection, which "is a deep mutual experience where

people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships" (p. 135). Soloman (2004) elaborated on this concept, noting, "peer support is social and emotional support, frequently coupled with instrumental support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change" (p. 393). A more generalized description of peer support as the social, instrumental or emotional support that persons sharing similar life challenges or circumstances provide to each other in reciprocal fashion (Barlow, Waegemakers Schiff, Rawlinson, Hides, Leith & Chugh, in press), suggests that support is sufficient unto itself without any ultimate goal of change.

Peer support can occur in various contexts: between individuals or in groups, formally organized and agency sponsored or informal and without organizational auspices.

Historical Context

Peer support has a long tradition. In the 1920s, Harry Stack Sullivan first recommended using former mental patients to help others in psychiatric inpatient settings. Beginning in 1935, the AA movement advocated peer support and mentorship for those seeking abstinence from alcohol. Two years later, in 1937, Recovery, Inc., a mental health support organization based on peer helping principles, was founded. Since then, two main streams of peer support have evolved: those services that are part of mental health and other organizational efforts to provide help to specific populations, and those that are founded by grass-roots groups with a stated mission such as Alcoholic's Anonymous. In the 1970s, with the backing of the Community Support programs in the United States, which endorsed peer and consumer-led support services, peer support became a "mainstream" component of the mental health system (Davidson et al., 1999; Mead & MacNeil, 2006; Soloman, 2004). Within the mental health service system, peer support is usually found in one of three variations: mutual support groups that are naturally occurring; consumers of rehabilitative programs; and formal consumer operated programs.

A number of studies examined the peer support and consumer-survivor movements, particularly in the United States (Holter, Mowbray, Bellamy, MacFarlane, & Dukarski, 2004; Mead et al., 2001; Mead & MacNeil, 2006). Other countries, such as Australia, Canada, New Zealand, and the UK also contributed support for consumer-led services. These studies reported that the movement to include peer support in service delivery has been chiefly concentrated in programs for the seriously

mentally ill and found in the psychiatric patient, consumer, and survivor literature. Studies in the addictions field reveal that while some peer-operated support organizations such as Recovery, Inc. have been in existence for more than 50 years, they have not achieved the same proliferation as AA and its sister 12-step programs such as NA, NarcAnon, Alteen, and Gamblers Anonymous. Peer support has also been reported as instrumental in a program known as Compassionate Friends, which supports parents bereaved by the loss of a child (Klass, 1984). However, most of these support program do not appear to have been formally evaluated for efficacy or effectiveness. More recently, Mead and MacNeil (2006) noted that there is a "national trend towards integrating peer services within the traditional delivery system" (p. 8), and Soloman (2004) argued that they may be as effective or more effective than those of non-peer provision.

Further evidence of the increasing importance and popularity of peer support can also be found in institutionalized programs that are not part of traditional mental health services. Examples are numerous. The Canadian and American Cancer Societies (Canadian Cancer Society, 2007) offer peer support program for persons undergoing cancer treatment, and a peer support program in Nova Scotia targets persons with diabetes. The New York City Police Department established a peer support program for its members in the year 2000 and some school districts in Canada and the US have adopted peer support programs at the middle school level. Thus, the introduction of peer support for survivors of suicide as a formal program offering of those providing postvention services appears to be a natural evolution within this type of psychological intervention.

Although peer support under the auspices of mental health organizations is widely used by persons with psychiatric illness**,** it appears to have been overlooked as a means of helping those who encounter traumatic loss through suicide. A review of the suicide bereavement literature subsequent to those of Beautrais (2004) and King et al. (2004) indicates that programs in suicide bereavement continue to be confined to formal support groups that have survivors as co-leaders (Cerel et a., 2009).

Although, within the past 10 years, peer support groups for suicide survivors have emerged in the US as grassroots efforts outside of formal organizational sponsorship (American Foundation for Suicide Prevention, 2007), they are infrequently used by the service providers to suicide survivors. A possible explanation for the paucity of peer support groups for survivors of suicide may be that suicide bereavement is often complicated and prolonged, and it is often believed that survivor-led bereavement support may have a re-traumatizing effect (Beautrais, 2004). However, there is no empirical evidence to support this rationale. On the

other hand, research demonstrated that social support is a major influence on the reduction of psychological morbidity, which often takes the form of anxiety, depression, and social isolation (Kessler, Price, & Wortman, 1985). It is also noteworthy that the internet has produced a proliferation of various peer support movements, and suicide survivors are among those taking advantage of this opportunity. Survivors may thus be addressing their needs in newer communication channels. This strongly suggests the possibility that family and friends of survivors of suicide may uniquely benefit from a peer-modeled program: suicide bereavement peer support.

Peer Support as a Postvention Strategy

While this paper was not specifically intended to offer a model for peer support provision, the following section provides a starting point for developing a one-to-one peer support program for survivors of suicide. This model is restricted to an individual approach, which parallels individual intervention strategies for postvention widely reported in the literature. While a group approach, involving peers as survivor/leaders and group members may be an alternative, much literature suggests that persons recovering from traumatic experiences, of which suicide is one, need individual intervention before being willing and able to engage in a group process. (Herman, 1997). It begins with an overview of relevant research in the area of peer support and bereavement and concludes with general guidelines for program development.

Several studies addressed bereavement peer support as a postvention strategy. A New Zealand suicide postvention project (Beautrais, 2004) studied bereavement support services and recommended that families, whanau (extended family), and significant others be provided with "opportunities to talk about their experience of a suicide death with others who have been bereaved in this way" (pp. 39-40). In the South Australian Suicide Postvention Project, Wilson and Clark (2005) recommended that part of the postvention response should include a "trained volunteer as a 'been there' (one who has experienced similar trauma)...to be able to give on-going support to the newly bereaved" (p. 13). However, the peer support they mentioned usually consisted of interventions immediately following the death, and not those provided over an extended period of time. Campbell and colleagues (2004) reported on the development and implementation of a postvention initiative, Active Postvention Model (APM), which utilized trained suicide survivors who responded to the scene of a suicide as part of a LOSS (Local Outreach to Suicide Survivors) team. The research into the impact of this service on the peer provider and the possibility of traumatic responses indicates positive

psychological benefits, in part, because of the therapeutic bond that is established between the recent survivor and the peer supporter.

Most evaluations of peer support programs involve consumer-run services within the mental health sector, and tend to describe programs, participants, and the organizational context, as well as outline the perceived benefits (Davidson et al., 1999). Given the voluntary and consumer-driven nature of these programs, evaluation by randomized trials may not be viable (Davidson et al., 1999; Holter et al., 2004). An alternative approach used by Holter and colleagues (2004) examined the effectiveness of consumer-run peer support services in the United States by using a multi-site study involving a survey of "national experts on consumer-run services" (p. 53). They concluded that peer programs are at least as effective as professionally led programs and are certainly more cost effective. However, this study, within the mental health sector, looked at the providers and not the consumers of these programs.

The advantages of peer support are articulated in the mental health services literature (Soloman, 2004) and include benefits to the “provider” and the “recipient” of support. Soloman (2004) found that recipients of support have "improved social functioning, reduced substance abuse, and improved quality of life," while providers have "personal growth in terms of increased confidence in their capabilities, ability to cope with the illness, self-esteem, and sense of empowerment and hope" (p. 396). Also of note were advantages that extended to the mental health services system because the overall effectiveness and the cost-effectiveness of the delivery of mental health services could be improved through the utilization of peer support. Furthermore, it has been argued that peer support "has the opportunity to forge not just mental health system change but social change as well" (Mead et al., 2001).

Research on peer programs helped to identify the theoretical and practical components that account for their appeal and viability. These include the reduction of isolation, validation of experiences, increased feelings of acceptance, normalizing the experiences, and the opportunity to cognitively re-frame the experience. As they moved from “patient,” “client,” or “victim” roles toward becoming the “helper”, providers felt validated and were able to demonstrate new behaviors and re-examine their world views. This opportunity to explore and find meaning in their experiences may contribute to the prevention of complicated grief as reported by Currier, Holland, and Neimeyer (2006).

Insights into Australian peer support were provided by Meehan and colleagues (Meehan, Hergen, Coveney, & Thornton, 2002). The threefold aims of that study were to develop a training program in peer support for former consumers (of mental health services), evaluate the psychological

impact on their well being, and identify barriers to consumer participation. This qualitative study involved ten participants in a 16-week training program with follow–up questionnaires and focus group interviews. The findings demonstrated positive outcomes for the trained supporters of peer support programs. The study argued for the specialized training of peer supporters, as well as the "development of policies that consider and value consumer participation" (p. 38). Another study involved quantitative methods focused on the use of ”self-help” services and community mental health agencies (Segal, Hardiman, & Hodges, 2002). The investigators found that consumer-delivered peer support services "provided services aimed at fostering socialization, mutual support, empowerment, and autonomy" (p. 1145).

Hardiman (2004) followed up earlier quantitative research into consumer-delivered mental health services with a qualitative inquiry into the "lived experiences of the participants" (p. 431). Through the use of interviews, he was able to provide a forum for the participants to elucidate their experiences. This unique perspective gave that often missed “voice” to the issue of peer support programs and services. Participants identified peer support as “networks of caring” that were invaluable. Hardiman’s findings supported both theoretical and empirical perspectives on peer support as an alternative to traditional mental health services.

Guidelines for Developing a Peer Support Program

Crucial aspects of peer collaboration that were extrapolated from these evaluation studies can serve as guidelines for program development. Mead and MacNeil (2006) articulated the "critical ingredients of peer support" as "the peer principle, the helper principle, empowerment, and advocacy" (p. 2). Salzer and Shear (2002) suggest that the theoretical processes of peer support consist of "social support, experiential knowledge, helper-therapy principle, social learning theory, and social comparison theory"(p. 394). Given these principle, it is possible to develop a peer support program that addresses core needs.

Peer support is based on mutuality which implies that, in their interactions, participants simultaneously assume the role of helper and helpee in such a way that vulnerabilities are shared and strengths are valued. Barlow and Phelan (2007) noted that peers engage in an equal, nonhierarchical relationship that acknowledges equal status, but individual differences in terms of temperament, style, skills, and knowledge. Such reciprocity fosters personal responsibility, self-determination, mutual respect, and problem-solving abilities (Miller &

Stiver, 1997). Based on the overarching principle of mutuality, the peer support programs are guided by the following beliefs. First, people are healed by finding affiliation within an equal relationship with someone who has had a similar life experience. Second, helping someone can be self-healing. Lastly, through a process underscored by mutual sharing of their lived experience, people gain hope that change is possible.

Structurally and practically, a one-to-one peer support program initiative that is located within the context of a helping agency should screen participants, offer an ongoing support program to all participants, engage participants on a voluntary basis, be available for an extended period and not just immediately after the loss, offer informal settings for meetings, support flexibility, and be non-hierarchical. In supporter/helpee dyads, an existing suicide survivor peer supporter should be matched with a client according to gender, type of loss, age, and relationship to the deceased. Dyads should contract to meet regularly, face-to-face for a four month period. While this may be supplemented with telephone contact after an introductory phase, in-person contact should remain as the primary support vehicle. In order to assure that supporters have had adequate opportunity to deal with their own immediate grief responses, ideally they should have between one and two years of time lapse between their loss and beginning to take on a supporter role. In addition, they should have engaged in some sort of postvention counseling or peer support activity as a recipient, so that the role of receiving help is also familiar. Additionally, in an effort to buttress the peer supporters, a suicide services counselor should hold monthly debriefing and educational sessions for the supporters, and be available on an as-needed basis in the event of any untoward event, Given that this is a newly emerging model, program monitoring should occur so that modifications to these guideline can be made as necessary. In terms of the supportive function of peer support, this is best characterized by three critical attributes: emotional, informational, and affirmational support (Dennis, 2003). Emotional support generally includes the expressions of caring, encouragement, reflection, reassurance, and only minimal advice-giving. It does not include criticism (Helgenson & Gottlieb, 2000). Informational support includes the sharing of knowledge relevant to problem solving. Affirmational support entails encouragement, reassurance, and the communication of optimism (Wills & Shinar, 2000). Additionally, Dennis (2003) noted that peer support primarily occurs without the provision of instrumental support, so that critical components have a psycho-social dimension without a specific service delivery component.

Research Implications

Gaps in the research literature on suicide bereavement span topics of specific interventions as well as precise research methodologies, data collection strategies and ethical issues in data content and access to survivors. In a survey of Canadian-based research on suicide, White (2003) pointed out the lack of research on suicide bereavement and clinical responses. Literature reviews from the United Kingdom (King et al., 2004), New Zealand (Beautrais, 2004) and the United States (Cerel et al., 2009) noted the scarcity of information on suicide bereavement programs and the lack of research and evaluation about their efficacy. Peer support does not appear as a targeted service in any previous reviews or in any updated surveys conducted by current investigators. Nor has the use of peer-delivered services been rigorously studied with people who are bereaved from any loss. There is scant mention in the literature of this type of intervention with survivors of suicide ((Beautrais, 2004; White, 2003; Wilson & Clark, 2005) and studies on its impact and effectiveness are non-existent (Cerl et al., 200(). Wilson and Clarke (2005), in a sweeping review of post suicide intervention (postvention) literature, note that there is a gap in the knowledge base of the conditions and relationships of the people involved in suicide bereavement support. Although traditional empirical works have supplied much needed information on the needs, experiences, expectations, and concerns over the provision and delivery of services to the survivors of suicide, the voices of survivors have seldom been heard. Most of these studies have been either descriptive or quantitative (King et al., 2004). Hardiman (2004) argued for the use of qualitative research methods that would foreground survivors' expressed needs and foster a deeper understanding of their "lived experiences."

Because of the sensitive nature of the data collected, some investigators have noted that there are ethical issues regarding the extent of intrusiveness of some research questions (Dyregrov et al., 1999). Therefore, attention should be directed to research processes which counterbalance these concerns, with the aim of capturing survivors' stories. While there is an impetus toward evidence-based research, the experiential nature of qualitative inquiry would allow for the understanding and interpretation of survivors' experiences in a different manner. This, in turn, would inform the provision of appropriate postvention services. Several authors noted the importance of research in such areas of bereavement response as complicated grief, in such interventions as peer support, and in policy development (Cerel, et al,

2009; Clark, 2001; Dyregrov, Dyregrov, Hall, & Epp, 2005; Murphy, 2002). Studies by Dyregrov (Callahan, 2000; Callahan et al., 2000; Dyregrov, 2002) and Provini, Everett, and Pfeffer (2000a) discussed the use of research methodology that would include in-person interviews. The Provini team (2000a) noted that due to the sensitive nature of the subject matter, telephone interviews might be preferable; however, they additionally argued that "extensive efforts must also be made to achieve direct contact with this population, such as through in-person interviews" (p. 17) and were thus equivocal about which research approach is preferable. Dyregrov's (Callahan et al., 2000; Dyregrov, 2002) study, using face-to-face interviews, supported this conclusion. Data collection was also the concern of Provini and colleagues (Provini, Everett, & Pfeffer, 2000b) who assert that "content-analysis of semi-structured interview data, might provide valuable insight into participants' experiences" (p. 17). Finally, White (2003), in work on suicide-related research in Canada, stated that suicide bereavement has not been examined by many Canadian studies. Among the relevant research gaps identified were effective clinical responses in suicide bereavement, program evaluation (interventions), and suicide-related research with a social work perspective.

Summary

Surveys, comparison studies, pre- and post-intervention investigations, needs assessments, program evaluations, and impact assessments have contributed to the increasing literature on suicide bereavement and interventions (King et al., 2004; White, 2003; Wilson & Clark, 2005). In the matters of current service delivery and understanding of the phenomena of survivors' bereavement responses to a death by suicide, two avenues that can further our understanding of what works? for whom? and possibly, why? have been identified. One avenue is peer support; the other, qualitative examination of survivor postvention needs.

Peer support, an intervention that provides some training to survivors who are past the immediate impact of the death so that they can provide peer support to newly bereaved persons, is an important postvention strategy that has garnered little attention Yet, it has substantial merit. Peer support has a long and positive history in the provision of mental health services. Furthermore, there are no proven impediments to this approach, and it can be readily established within existing postvention programs for little, if any, additional costs.

The second avenue, the lived experiences of survivors in a helping capacity, has not been well documented. Although evidence-based

research helps with understanding the parameters of the issues confronting suicide survivors, there is also an important role for qualitative research that will allow the narratives of individuals to be expressed (Hardiman, 2004). Such an approach will provide a richer understanding of the services and supportive approaches that are most helpful to survivors, and it may well complement the peer support postvention approach. Subsequent to these qualitative studies, quantitative data can better address the efficacy and effectiveness of these programs.

This review indicates that there is no definitive information on the most efficacious means of providing postvention support services. However, a body of literature that supports the inclusion of peer support as part of the continuum of counseling services for a variety of issues does exist. This literature discuses both theoretical and instrumental issues related to peer support and recommends the increased utilization of peer support in delivery of mental health services (Mead et al., 2001; Mead & MacNeil, 2006). For suicide survivors, peer support could strengthen and supplement formal or professional support. This approach is supported by several studies into peer-delivered services, which articulated the processes, the critical ingredients, and the benefits accrued. The literature on bereavement indicates that suicide bereavement presents a "difference" (Beautrais, 2004; Clark, 2001), and this difference lies in suicide-specific bereavement interventions and services. Peer support, offered as an option or alternative to, or provided in tandem with professional services, has been articulated as a postvention strategy that must be considered (Campbell et al., 2004). Finally, it is an intervention that also needs to be evaluated by quantitative and qualitative methods so that the presumptions and hesitations about its efficaciousness with suicide survivors can be documented.

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