Clinical Social Work Intervention for People Bereaved through Suicide

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Abstract : *Suicide is an unexpected and violent death that brings unlimited sufferings for deceased family. Each suicide has the deleterious, devastating and far-reaching effects on the functioning of suicide loss survivors such as families, friends and communities left behind. The suicide survivors tend to have a serious form of bereavement. Statistics shows that as a minimum six beloved ones are directly affected by each suicidal death. Another statistics illustrates that about 48 million people every year are found to have experience of suicide bereavement globally. On the other hand, 11,000 people kill themselves every year in Bangladesh. But literature within suicide bereavement and its prevention is still limited because of paucity of methodologically vigorous studies involving the people bereaved due to suicide. Hence, the present paper is an attempt to confer an indication of suicide bereavement and the prospective role of the clinical social work for supporting the individuals bereaved through suicide. In doing so, literatures related to suicide bereavement were reviewed from the secondary sources of data and findings have been presented in this paper. This paper describes the affected people's reactions in bereavement and the needs for provision of effective post-intervention support system for the families of the deceased. However, this paper concludes with few recommendations to make stronger and potential postvention to assist the governments, policy makers and other stakeholders, and some actionable measures for countries according to their available resources and context along with mentioning necessity of effective and time-bound practical support to promote recovery of individuals affected by suicide bereavement.*

Keywords : *Suicide, Bereavement, Clinical Social Work, Postvention.*

Introduction

Suicide is being considered as a serious public as well as mental health crisis due to its far reaching and life altering impact and intergenerational consequences. It is estimated that every suicide affects 6 to 8 persons in their everyday lives while liberal estimate opines that about 28 nearest people can be placed in bereavement after suicide of a person (Bland, 1994). American Association for

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Suicidology (2004) stated that every death by suicide lefts at least six bereaved people. While estimation of World Health Organization (WHO, 2014) express that 800000 people pass away by suicide every year and 60 persons are now understood to be affected by every suicidal death (Berman, 2011). It indicates that worldwide suicide bereavement in every year stands at 48 million (Pitman et al, 2016).

Suicide creates layers of intricacies in bereavement experience that intensified by stigma. Bereavement by suicide often has the association with suicide attempt and very often acts as a hazardous issue for unresolved grief (Fhaili et al., 2016; Rando, 1993). The post-bereavement issues that include non-suicidal self-harm, profession drop-out, social dysfunction and depression could be the secondary clinical and occupational outcomes created by suicide bereavement (Pitman et. al., 2016). Since suicide bereavement that manifested by different types of symptoms has austere and prolonged impacts on family members, friends and community; widespread concern and increased effective interventions for suicide bereaved people are becoming well documented (Fhaili et al., 2016) for the survival of suicide bereaved people. But there is still scarcity of literature related to the role of clinical social work for the bereaved people by suicide. Therefore, this article aims at delineating the continuum model for identifying the suicide bereaved, look at the reactions to and coping strategies of suicide bereaved with a view to revealing the intervention techniques looking especially at the role of clinical social work.

Methodology

The present paper is qualitative in nature and based on secondary data. Document analysis has been followed as research method in this paper and relevant data have been collected from secondary sources such as research articles published in journals, books, research report and web materials to attain research objectives. Data have been presented in narrative way to explain the research issue.

Why Suicide Bereavement matters?

Studies (Andriessen et. al., 2017a, 2019; Fhaili et al. 2016; Jordan, 2001; Mitchell et al., 2004; Pitman et. al., 2014, 2016, 2017; Prigerson

et al., 1997) show that experiencing suicide bereavement could be the foremost stressors and suicidal bereaved people are at higher risk of suicidal ideation, suicidal thoughts, suicidal behaviors and attempting suicide. Crosby and Sacks (1994) mentioned that the people knew someone committed suicide in previous year were found 1.6 times more likely to think committing suicide, 2.9 times more likely to have suicidal plan and 3.7 times more attempted to suicide. Suicide is the reasons for the most awful bereavement experience (Storebe & Storebe, 1983) placing bereaved people at a serious risk for adverse physical, social as well as mental health problem like stigma, self-harm, rejection, traumatic and complicated grief, depression, post-traumatic stress disorder, social dysfunction etc. higher than that of bereaved individual because of other types of death (Osterweis et al., 1984). As mentioned by Jordan (2011) some specific features of suicide bereavement may lead to delays in survivors' healing and keep them away from seeking support. Therefore, suicide bereaved needs a proactive approach to the provision of support system or postvention strategies that ensures both suicide prevention as well as the wellbeing of bereaved people. Support for suicide bereaved people has already got a significant focus in international suicide prevention strategies (Pitman, et al., 2014). But in supporting the suicide bereaved people, it is necessary to understand how and why it differs from other kind of bereavements.

Understand the Meaning of Bereavement and Postvention

Bereavement

Bereavement is the mourning phase or state of severe grief associated with overwhelming and far-reaching feelings especially after expire of a beloved one. Bereavement refers to the situation having experience of loss which includes expire of life partner, off spring, other family members, or very nearest/dearest friends. It also refers the process of coping with the loss (Kalish, 1981; Zhang et. al., 2005; Pitman and et. al, 2014, 2016). In other word, bereavement is connected with accepting the loss, adjusting with the situation, and learning to survive with difficulty.

However, it is noted that 'bereavement', 'mourning', and 'grief' are used interchangeably and could not distinguish their internalize meanings.

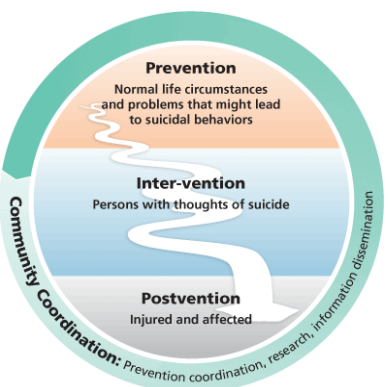
Zisook and Shear (2009) focus on complexities in conceptualizing these key concepts. They described the term 'grief' as "the emotional, cognitive, functional and behavioral responses to demise"; they state 'mourning' as the "behavioral expressions of grief, that are influenced by social and cultural and rite and rituals, such as funerals, visitations, or other customs" (Zisook & Shear, 2009, p.67).

However, bereavement is stated as 'the objective reality of a loss' by Klein and Alexander (2003). The latter one has been followed in present paper. Nonetheless, a lot of people might be exposed to suicide that include who were not familiar with deceased personally. Therefore, this paper primarily highlights the close personal connections with the deceased.

Postvention

Though postvention has been recognized as significant facet of suicide deterrence (WHO, 2014; Department of Health, 2017) and major form of suicide prevention (Postvention Australia, 2017), effective postvention is also considered as a prime community and mental health challenge (Andrissen et al., 2019). The following picture of PIP (the Suicide Prevention, Intervention and Postvention) developed by Canadian Association for Suicide Prevention will be helpful to understand the postvention initiative conceptually.

Figure 1: Suicide Prevention, Intervention and Postvention.



[Retrieved from https://suicidepipinitiative.wordpress.com/background/on October 11, 2021]

'Postvention' is also referred to efforts for providing support to families and communities after suicide. It includes those activities developed by with, or, for in the purpose of facilitating revival aftermath of suicide and to avert unpleasant outcomes including suicidal ideation (Andrissen, 2009). It also refers to provide support to suicidal bereaved family and other persons whose possibility of committing suicide might be augmented because of experience in any capacity to suicidal death of any other persons (Survivors of Suicide Loss Task Force, 2015).

It is allied with some measures taken after a suicide to decrease related shock for reinstating well-being. It works like future prevention as the persons affected by suicide may expose to suicidal ideation and behavior. It comprises the course of action to remove the distress, depression, prolonged grief and shock affected by suicide, alleviate the risk of succeeding suicide and uphold the hale and hearty revival of the affected community (Headspace, 2019). However, postvention could be defined as a systematic response to suicide bereavement to ease healing grief, trauma and distress resultant of suicide death, to diminish the negative effects and thwart the peril of exposure to future suicide, to help different organization respond more effectively (Grief after Suicide Blog, 2015).

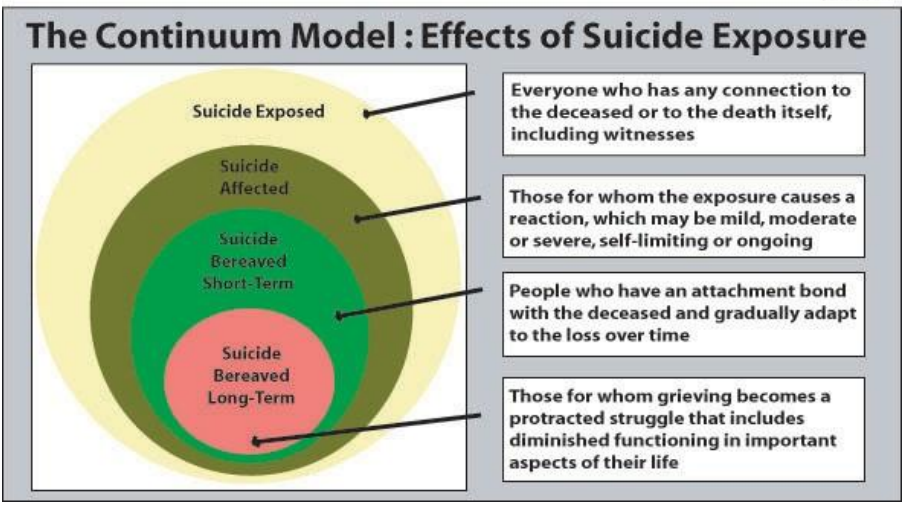
Nonetheless, needs of the suicide bereaved people are significant to know before taking any kind of intervention. Postvention services should respond to needs during crisis of the suicide bereaved individual. Owing to paucity of information regarding these needs, based on literature, the US Survivors of Suicide Loss Task Force identified few needs (Cited in Australia Postvention, 2017) such as useful information, comprehensive community response, support from social networks and communities, peer support, family support, compassionate assistance from first responders, help for electronically connected communities as well as assistance from efficient and experienced mental health professionals and other persons providing social service.

Who is suicide bereaved people?

Worldwide there are discussions regarding the appropriate terminologies for those who are bereaved by suicide. Despite America throughout the world prefer suicide bereaved instead of suicide survivors (Postvention Australia, 2017). Here it is noteworthy that for avoiding the terminological complexity regarding suicide survivors and suicide bereaved this article presents the continuum model (Cerel et al., 2014). This pictorial presentation shows four stages of effects of suicide exposure from 'exposed' category to suicide-bereaved long-term. The present paper denotes the suicide-bereaved people as the fourth category (suicide bereaved long term) of this model where they struggle with prolonged and complicated grief.

Figure 2: The Continuum Model.

Table 1



Source: Cerel et al., 2014.

What makes suicide bereavement different?

Conflicting findings exist regarding the differences of suicide bereaved and bereaved by other reasons (Gaffney & Hannigan, 2010). A few studies (Barett & Scott, 1990; Mullar & Thompson, 2003) indicated

no differences between two types of bereavement but few studies (Fieldon, 2003; Jordan, 2001; Knipper, 1999; Van , 1989) supports the qualitative differences between suicide bereaved and other bereavements mentioning as more complex process, contains unique theme, and take longer to move on. It is reasonable to assert that bereavement on the aftermath of suicide is unlike the bereavement of forms of loss in three significant ways according to Jordan (2001):

- **Thematic aspect of suicide bereavement**: Three themes make bereavement of suicide divergent from bereavement of other kinds that include guilty feelings, blame and responsibility for the suicide of the deceased, denial by the loved one, greater difficulty in making sense of the death (Bailley, Kral, & Dunham,1999; Reed and Greenwald,1991; Silverman, Range, & Overholser, 1994).
- **The social processes surrounding the suicide bereaved**: It is found that the social networks of suicide bereaved often make them isolated, stigmatized; they are viewed and judged more negatively due to suicide than other mourners (Jordan, 2001). Differential treatments towards them by the community create awkwardness and hesitation that corresponded to survivors and misconstrued as rejection (Range, 1998), and thus resulted into experience of self-stigmatization (Dunn & Morrish-Vidners, 1987), feeling of frustration, withdraw from their social network (Seguin, Lesage & Kiely 1995) and receive less emotional support (Bailley, Kral, & Dunham,1999).
- **The impact of suicide on family system**: Suicide exerts devastating effects on family interaction. In one hand, it contributes to suiciadiality in mourner's own (Blumenthal, 1990; Lester, 1994; Moscocki, 1995) as well as heightened the risk of suicidal behavior of the members of those families which have dysfunctional family environment, disturbed family interaction style, increased disruption of attachment (Adam, 1990; Brent, 1995; Jordan, 2011; Samy, 1995) early parental loss, disorganization and breakup, intra-family violence, and sexual abuse (Lonnqvist, 1993; Murphy, 1995). Depression is also found in families of normal functioning (Brent et.

al., 1996). Even children manifest guilt and communication distortion after parental suicide (MacIntosh, 1987). Moreover, since suicide is a traumatizing way to die, it traumatizes the bereaved too.

However, despite the bereavement experiences of suicide is not different from other bereavement experiences, like Jordan (2011) and Suicide Prevention Australia (2009), GPMHC (2016) also admitted that higher levels of few experiences such as thoughts of rejection and desertion; stigmatized and guilt feelings; propensity of blaming; self-destructiveness and suicidality; activism and obsession make suicide bereavement different from those of others (Andriessen et al., 2019; Lindemann & Greer, 1953; Mishra, 1995; Mitchell et al. 2004; Seguin et al., 1995).

Reactions to Suicide Bereavement

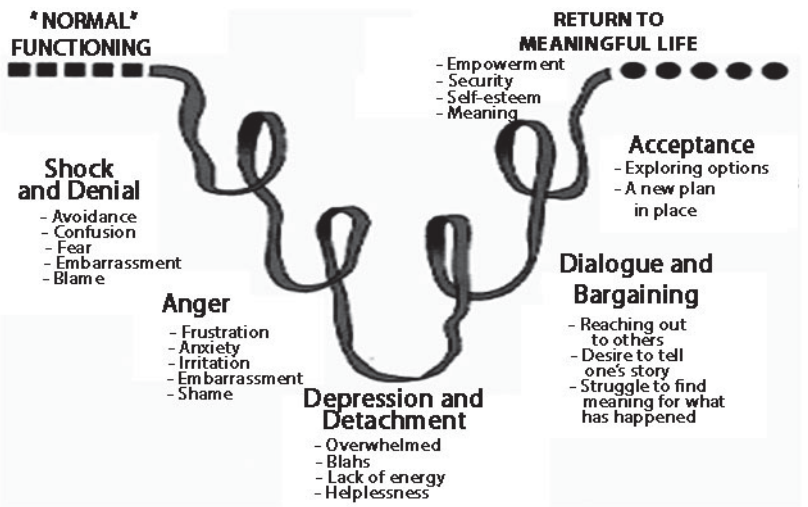
Despite in the different ways people might respond, there is some common reactions suicide bereavement. Along with the grief reaction, suicide bereaved people experience prolonged, recurrent and intense pangs of complicated grief that interfering with functioning (Mitchell *et al*., 2004; Young *et al*., 2012). The experiences reflected by suicide bereaved people often follow the five stages model of grief proposed by Kubbler-Ross (1969). This model shows that despite having unique experience of loss, people experience some regular patterns of emotion and mental processes in different stages. After completion of such grief, people reintegrate with their normal life and plan for futures again. However, who becomes unable and failure to adjust with significant loss, manifests different reactions. Factors that make bereavement different and challenging for the suicide loss bereaved people include:

Rejection and Anger**:** Sometimes bewildering clash of emotions is expressed by the bereaved people. They become uncomfortable and irresolute to act. They consider the deceased as perpetrator not as victim; at the same time act of suicide is considered as a mugging on, rebuff of those left behind. As a result feelings of both anger (Spillane et. al., 2018; Young et al., 2012) and rejection (Sveen and Walby, 2008) occur among the bereaved people. Bereaved people feel angry due to be failure to avert the death as well as not asking for assistance by

the victim to work through his difficulties. Simultaneously, they feel rejection since the relationship was not enough to keep the deceased one from dying by suicide (Cerel et al., 2008).

Stigma and Isolation: Suicide bereaved individuals are the victims of stigma at higher level (Pitman 2014). Suicide is condemned as sin from religious view as well as considered as offence. Due to such legal, religious and social sanctions against suicide (Cvinar, 2005; Pitman, 2016), bereaved people feel sore and deterrent to talk about it to others, try to conceal the incident and reluctant to divulge about the causes of death. Such decision of keeping secret of death from others creates loneliness, puzzlement and dishonor (Young et al., 2012). It keeps away the bereaved people from needed support and healing resources too (Pitman, 2016; Rusch, 2014). According to Jordan (2011; Cvinar, 2005) suicide related stigma creates obstacles and delay the healing of the victims. Uncaring and judgmental attitudes of the community people often could be the source of tension and conflict that triggers isolation, rifts and sense of hurt among the bereaved people (Cvinar, 2005, Jordan 2011).

Figure 3: The Five Stages Model of Grief.



Source: Kubbler-Ross (1969)

Need for Reason: Suicide bereaved people very often face some unanswered questions after committing suicide by beloved one such as: Why did the deceased follow the path of suicide? Could I prevent the suicide anyhow? If such self-punishing questions occupy the thought process of suicide bereaved people, it can damage their hope, self-esteem and confidence (Harvard Women Health Watch, 2020).

Mental and Physical Health Sequelae: Studies (Dyyregrov et al. 2003; Groot & Neeleman 2006; Miyabayashi et. al. 2007; Spillane, *et. al*. 2018) reveal that family members of the deceased have poorer general health and physical illness. Physical illnesses, losing appetite, severe abdominal pain, lack of energy and inability to sleep have been found as health reactions. Moreover, some unpleasant mental health difficulties among the bereaved people have been explored by the different studies. In many cases, psychosomatic disorders like nausea, pain in chest, problem in breathing are expressed by the suicide bereaved people (Spillane, 2018). Furthermore, elevated level of depression, hypertension, anxiety, stress, panic attacks, intrusive images, nightmares, memory loss, PTSD (Zishook *et al*., 1998) are the most common forms of emotional sequeale following suicide bereavement exposed by them (Azorina et al., 2019: Bolton, et al. 2013; Erlangsen et al., 2017; Spillane, 2018; Youn et. al., 2012).

Rumination/Recurring thought: Recovery of the suicide bereaved people is often hindered by rumination (Eisma & Storbe, 2017). Thinking repeatedly or persistently regarding reasons and impact of emotions is called Rumination (Nolen-Hoeksema, 2001; Michael, Halligan Clark & Ehlers, 2007). Such recurring loss related thinking lead bereaved people to weak adaptation. Consequently, higher level of adverse mental health outcome like distress, anxiety, unhappiness, PTSD, complex grief exposed by the bereaved people (Eisma et al, 2015a, 2014a, 2012; Ito et al,. 2003; Morina, 2011; Nolen-Hoeksema et al., 1994, 1997). Even study findings (Eisma et al., 2013) showed that involvement in social, occupational, recreational activities are reduced by cogitation that lead to depression to PTSD symptom.

A Risk for Survivors: Bereaved people experience the venomous impact of losing nearest one through suicide. Due to such emotional loneliness and thought of desperation (Krysinka, 2003; Runeson and

Asberg, 2003; Storbeet et al., 2005), bereaved people often compel to think, plan or attempting suicide. Studies (Guldin et al, 2017; Molina et. al., 2019; Storbe et al., 2005) show that bereavement is associated with suicidal ideation, attempt to suicide and committing suicide. Song et al., (2015) and Santosh et al., (2015) also found bereaved people endorsed suicidal ideation as killing him/herself is the only viable solution to get rid of pain (young et al., 2012). Therefore, such bereaved population need to be identified for intervention to plummet their risk of suicidal thought in bereavement.

Coping Strategies

Coping strategy for suicide bereavement is a intricate phenomenon. Suicide bereaved people face the challenge of coping with suicide loss as it a compound phenomenon. Though there exists a paucity in the literature on coping strategies taken by suicide bereaved people (Gaffney and Hannigan, 2010), different coping strategies has been mentioned in different researches that might be applied in this field. Lazarus and Folkman (1984) divided coping mechanisms into two categories that include problem focused and emotion focused based on cognitive stress theory (Storbie and Schut, 2010). Recently research on coping reveals meaning making strategy as emotional process of coping (Folkman and Moskwoitz, 2000). Schnider et al. (2007) mentioned three types of coping techniques such as a) problem focused which include active coping, preparation, direct support and religion, b) dynamic emotional coping that embraces optimistic reframing, pleasurable expression, fun, acceptance and emotional assistance, and c) avoidant emotional coping comprises self-disturbance, rejection, behavioral detachment and substance use.

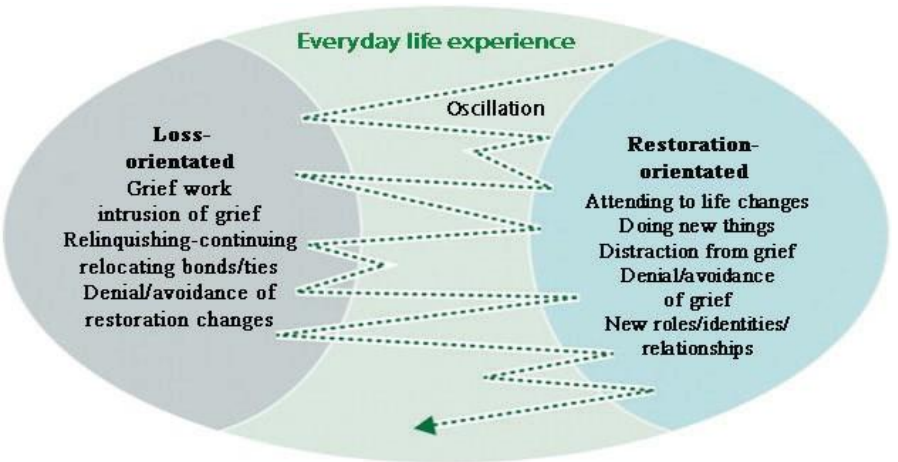
Strengthening problem-focused coping strategy is generally considered as an **adaptive mode** of adjustment that include planning or involving in explicit performance to address the problem creating distress (Folkman & Lazarus, 1985). Adaptive strategy indicates the decreased level of negative psychological and physical grief (Storebe and Schut, 2001). Adaptive coping skills could be beneficial for the suicide bereaved people having experiences of traumatic loss through protecting from PTSD reactions (Schinder et al., 2007); Foa, Davidson,

& Frances, 1999; Drapeu et al., 2019). The **Emotion-focused** coping strategy regulates one's emotions, and might be viewed as active or avoidant coping (Holahan & Moos, 1987; Schinder et al, 2007). **Active** emotional coping, like vent of person's emotional suffering or cognitively reframing a stressor's impact, is classically considered as an adaptive emotion-regulation strategy (Folkman & Lazarus, 1985) in one hand; **Avoidant o**r repressive emotion focused coping, in general, is considered as mal-adaptive (Ross et al., 2018) or less adaptive on the other. The initial aftermath of suicide is characterized by such coping style. The veracity of the suicide loss is so devastating in the beginning for the bereaved people that isolate them to survive and perturb the everyday functioning (Gaffney and Hannigan, 2007). Hence, bereaved people often follow **the avoidant** coping style by refusing to discuss about the loss to others, working excessively to avoid the pain of thinking of loss (Ross et al, 2018). It can lead to the worse mental health outcomes overtime (Coyne & Racioppo, 2000; Holaha & Moose, 1987). Avoidant coping is such an adjustment mechanisms that has wide and harmful impact on post-bereavement effect (Fisher et al., 2020).

In contrast, trying to maintain a positive attitude, taking care of own physical and mental health, keeping memories alive, writing in journal about the deceased, visiting the resting place, attending religious place, maintain psychological bonds (Neimeyer et al., 2006; Shields et al., 2017) through rituals maintaining routine through work for being occupied are the examples of **positive coping** strategies used by the bereaved. It is considered as adaptive coping strategies (Ross et al., 2018). It is relate to sense making phase of rumination which indicates the understanding and acceptance of occurrence of suicide by the suicide bereaved people (Genest et al., 2017).

It is noteworthy that effective coping impact on adaptation to bereavement. This is well described and explained by Stroebe and Schut (1999, 2010) who developed dual process model (DPM) of bereavement. They identified loss versus restoration related stressors associated with bereavement through the figure 4.

Figure 4: Dual Process Model (DPM) of Bereavement.



Source: Stroebe and Schut, 1999, 2010.

Loss oriented stressors include weeping, yearning, expressing rejection; living in the situation of death, keep away from reinstatement actions. Conversely, restoration-oriented measures and stressors are related to secondary level of losses. These measures reflect the rethinking and re-planning of new routine develop new ways of connecting with different relationships, and refining a fresh life pattern. Stroebe and Schut (2010) states many persons will return and onward between these loss-related and restoration-related behaviors in order to adjust and that is the principle of oscillation. The notion of oscillation makes DPM distinctive in feature. It could be also explained as a dynamic, regulatory coping process as people confront loss as well as avoid loss. Thus oscillation highlights the necessity of drawing attention towards two categories of stressors and consequently is necessary for adaptive coping.

Attending Support Group

Coping ability and recovery of bereaved people could be gained by the assistance of bereavement support groups (Gaffney and Hannigan, 2010; Ross et al, 2018) through helping to access counseling, showing

empathy, considering the need to take time off. Bereaved people get relief by having a sense of connectedness to and talking and sharing feeling with the people experienced the similar loss. Thus they become capable to reconstruct their life in a meaningful way (Deigleman et al., 2009; Shields et al., 2017). Researchers (Shield et al 2017; Andrissen et al., 2017) also show that less opportunity of social support indicate uncomfortable relationship with others, withdrawal from social interaction, isolation etc.

Clinical Social Work and Postvention

Prolonged sufferings, impaired functioning, adverse health outcomes, post traumatic growth, complicated grief and depression could occur if coping strategies fail, which lead major emotional loss, severe health problems even suicide. Studies (Hawton and Simkin, 2003; Wiston and Marshall, 2010) also explored that suicide bereaved people reported having a great need of professional help and clinical intervention (Andrissen and Krysinska, 2012; Postvention Australia, 2017; Survivors of Sucide Task Force, 2015) in coping with their loss. Therefore, postvention services are necessary for the well-being of the bereaved people from exhausting physical, emotional and psychological grief.

Though clinical social work has the opportunity to talk about the suicidal thought, educate the family members and community about the means of committing suicide, counseling regarding suicide risk factors, delivering therapies and evidence based individual prevention program, provide coping and support training, work for suicide prevention hotlines and crisis centers, there is a few studies that documented clinical social workers' role to intervene in suicide bereavement and their preparation to address the complexities of suicide bereaved (Nejad, 2016). Since it is an under-researched topic, this section of the paper try to make an outline on postvention services and management techniques that clinical social worker could provide for the suicide bereaved people:

Support group

Support services for responding to the the needs, preventing adverse outcomes of suicidal behavior and facilitating the recovery of suicide bereaved people are increasing (Andrissen and Krysinska, 2012). Suicide bereaved people often find the support group as only valuable place (Gaffane and Hannigan, 2010) where they obtain assurance of acceptance, mutual support and the ability to deal with life adjustments following a suicide loss and drawn a therapeutic environment by relating with those who experienced the same situation as they faced; thus get the sense that they are not alone in their journey. When family, friends, immediate community became unable to provide support due to stigma, support group provide bereaved people with their only means of catharsis (Feigeiman et al 2008; Jordan 2001). They learn to work through their own grief, break the sense of isolation (CAMH, 2011) taking responsibility of life through suggestion and try to move beyond the sadness of loss. Along with the support services proactive monitoring could be the effective way to minimize the risk of suiciadility of the bereaved people. Such postvention could work as the potential prevention of future suicide (Jordan, 2001).

Group Psychotherapy

Suicide bereaved people often feel loneliness and isolation, face interpersonal problem, deal with major role transition with fragmented network. In such situation, group psychotherapy could be helpful (Lieberman and Yalom, 1998) to share experiences, develop new social skills and build coping mechanisms. Studies (Farberow, 1992; Pfeffer et al., 2002, Andrissen et al,. 2019) show that such group therapy could reduce anxiety, depression, and feelings of anger towards self and deceased, grief, guilt and shame.

E-health interventions/Internet based support

E-health intervention techniques are getting popularity in the globalized civilization. Now a day such interventions are being applied to find out the people at-risk, proffer self-help by web mechanisms and

to provide practical support in reference to individual's post in social media (Christensen et al., 2014) which is available 24 hours. Bereaved people who face suicide stigmatization from their surroundings and do not get complete console and assistance from their own localities often obtain vital assistance from online assistance group (Feigelman et al., 2008). Research also shows (Schotanus-Dijkstra et al., 2014) that bereaved people get relief from their grief by sharing their experiences, providing advices, and showing empathy through writing messages.

Psycho-education

Psycho-education is an intervention with knowledge transfer regarding illness and its treatment to enable and empower patients and their relatives to cope with disorders. Bereaved people through psycho-education learn to reinvest in life, realize the nature of psychiatric suffering associated with suicide and their influence causing psychological pain that led to suicide and recognize its impact on family. Some methods such as oral presentations, physical exercises and reading materials (Beradelli et al., 2020) could be applied as endeavors to educate the bereaved people. It is noteworthy that the people affected by suicide having no indication of posttraumatic stress may get benefit from such educational approach (Cha et al., 2018) while those highly distressed take advantage from psychotherapy (Supiano et al., 2017; Zisook et al., 2018).

Cognitive Behavior Therapy

CBT could be applied by the clinical social workers for suicide bereaved people to alleviate psychological distress and dysfunction. It provides a useful framework to understand bereaved people's experiences, identify the barriers that they face, and offer strategies to increase their sense of control (Morris, 2011) can help facilitate adjustment and reduction in depression. Several techniques of CBT could be used for this purpose. Clinical social workers concentrate on bereaved people's views and beliefs about their life; replacing ways of living that do not work with ways of living that work, negative thoughts, feelings and behavior to positive thoughts, feelings, resulted in less self-blame (De

Groot et al, 2007) and behavior to enable them to control over their lives. Clinical social workers could teach bereaved people to apply adaptive view regarding their loss along with reorganize their lives and improve the ability to function through rational emotive therapy. Compartmentalizing the worries, preparing to face new difficult situations, challenging unhelpful thinking, and helping to deal difficult decisions could also be achieved through CBT.

Complicated Grief Therapy (CGT)

CGT refers to alteration of interpersonal psychotherapy. It operates along with the components of cognitive behavior therapy and motivational interviewing. The fundamental principle of CGT is that severe grief is transmitted spontaneously into integrated grief under condition of addressing difficulty of grief (Young et. al, 2012). This therapy comprise of 16-sessions (Shear, 2010), which assists the individuals to make out and triumph over reasons (such as devastating emotions, escaping tendency, thinking about deceased beloved one) intervening in recovery (Shear et al., 2016). Both loss oriented grief task and restoration oriented concentration have been followed in every session. Loss oriented grief task helps the bereaved, through imagery, exposure techniques and cognitive restructuring, in discussing the death and related facts, accepting the loss, beginning to feel happiness and console in memories of the beloved one and feeling a profound judgment of relationship with the victim (Young et. al, 2012). On the other hand, the restoration focused work enable the person create a sense of interest, personal fulfillment, and engage in meaningful relationships with others through personal goal and self care, involvement of significant others and relationship functioning.

Dialectical Behavior Therapy (DBT)

DBT refers to comprehensive, support oriented, collaborative, cognitive-behavior treatment that is effective to decrease suicidal and other destructive activities (Grohol, 2020; Psych Central, 2016). It tries to identify and modify negative thinking patterns and pushes for positive behavioral changes. It improves one's ability to regulate emotions and cognitions and helps individuals to make adjustment

with devastating and recurrently altering emotions, increases acceptance skills and coping skills that facilitate individuals to gain knowledge to produce and maintain significant relationships by keeping self-respect (Wane, n.d.), teaches crises survival strategies (Grohol, 2020). It also assists to move through from grief process rather than getting stuck in avoidance, maladaptive coping or other obstacles to healthy processing.

Bereavement Counseling

Bereavement counseling is a specialized type of counseling that engrosses supporting individuals who losses a loved one. This counseling, as a source of supporting, helps bereaved people to work through their painful emotion, manage their grief, learn coping mechanisms, regain sense of self, and achieve life skills as well (Storbie and Storbie, 2012; Cuncic, 2021). It could be applied for anyone, of any age, who is being overwhelmed or adversely affected by their grief.

SafeTALK

SafeTALK, developed in 2006 and used in near about 20 countries, is a kind of training program acts as a suicide alert helper (Livingworks, 2015). It boosts up the confidence of anyone to make a suicide safer community and connect people as first aid resources. Clinical social workers could arrange such training program to identify the people with suicide thought, surmount the barriers to talking regarding suicide, move beyond the tendency to avoid suicide and connect people with life affirming resources by applying the TALK steps (Tell, Ask, Listen and Keep safe).

Community Engagement

Community engagement approach raises awareness, provides support, and ensures the effective mental health wellbeing initiatives and suicide prevention. The community contribution has been proven as indispensable in adopting suicide prevention strategy since it could trim down the risk and strengthens protecting factors through extending societal support to bereaved people, involving in follow-

up service, increasing responsiveness and combating stigma (WHO, 2016). It is community which can give bereaved people a sense of belonging (WHO, 2018) rather the grief of stigmatization. Community members could take the role as gatekeepers to indicate natives in danger of suicidal behavior. Creating social bondage and enhancing the expertise for making adjustment with complexities of the bereaved people could be achieved through social support within community.

Challenges

It is needless to say that the statistics of bereaved people by suicide is still scarce. Though helping bereaved people could prevent suicidal risk (Shneidman, 1972), limitation of statistics related to impact of suicide on bereaved people act as significant barrier. Contemporary studies highlighted strengthening strong foundation of awareness to prevent suicide and decreasing the number of suicide cases. In spite of necessity of such endeavors suicide bereaved people still remain outside of this effort (Moore et al., 2013).

Lack of suicide bereaved studies also impact on identifying the efficiency of postvention care and utilize of their personal wealth to deal with suicide. Bereavement process needs to recognize the individual differences for determining, making design and executing successful preventive interference for the people at risk for better recovery. But very often, limitations in such identifying of differences make the services weak and poor.

Paucity of professional care and proper support groups have been identified as impediments for access to services for the suicide bereaved people. Healthcare professional also have paucity of efficiency and confidence to extend support to the bereaved persons because of inadequate knowledge to recognize the multiplicity as well as exclusivity of suicide experiences.

Poor availability of services in local level and absence of culturally appropriate postvention activities could act as the barrier to address the needs of culturally diverse group. Another cause of limited access to postvention support services is fear of bereaved persons to be stigmatized by healthcare professionals.

Ways Forward

Literature shows that suicide is one of the severe mental health problems. It is an unexpected and violent death that produces unlimited sufferings for deceased family. Each suicide leaves the suicide loss survivors such as families, friends and communities in venomous situation. Even, vulnerable condition of physical and mental health in terms of high risk of suicidality is evident among bereaved people. Therefore, the following measures are recommended to address the problems of bereavement.

- We should identify and prioritize the suicide bereaved persons as susceptible group for taking measures to address mental health problem through conducting study;
- Media can help in reducing suicide and negative attitudes to suicide as well by raising awareness;
- Communities could be involved for providing social support and resisting stigma to those bereaved by suicide;
- Training of the professional both in local and national level is essential so that they could address the risk of lethality and provide support to suicide bereaved people;
- Advocacy for national policy on suicide prevention having the clauses for suicide bereaved people too;
- Establishment of emotional support and suicide prevention helpline such as *Kan pete roi* or *moner bondhu;*
- Seminar, symposium, workshop should be arranged on suicide prevention as well as focusing on the affected people by suicide;
- The government should ensure one trained clinical social worker/psychological counselor in each educational institution to enable an environment where students can easily seek help;
- Public dialogue on stigma attached to suicide should be encouraged and decriminalized the suicide;
- Since suicide bereavement is still non-renowned and less prioritized field, more empirical studies should be conducted

to identify the suicide bereaved people and to facilitate their recovery in the purpose of averting unpleasant outcome of suicide including suicide ideation.

Conclusion

This paper aimed to focus on the devastating and lasting effects of suicide bereavement and the management of suicide bereavement by clinical social workers along with the conceptual analysis. It also drew attention to suicide bereavement research for more knowledge on suicide bereavement, its related consequences, risk assessment and its treatment. Though the evidences for the efficacy of suicide bereavement management techniques are lacking, above mentioned postvention strategies could be the care resources for the suicide bereaved people. Clinical social workers could facilitate the care for suicide bereaved people through aforementioned intervention techniques in everyday practice and could perform an effective role in postvention to prevent suicide in future.

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