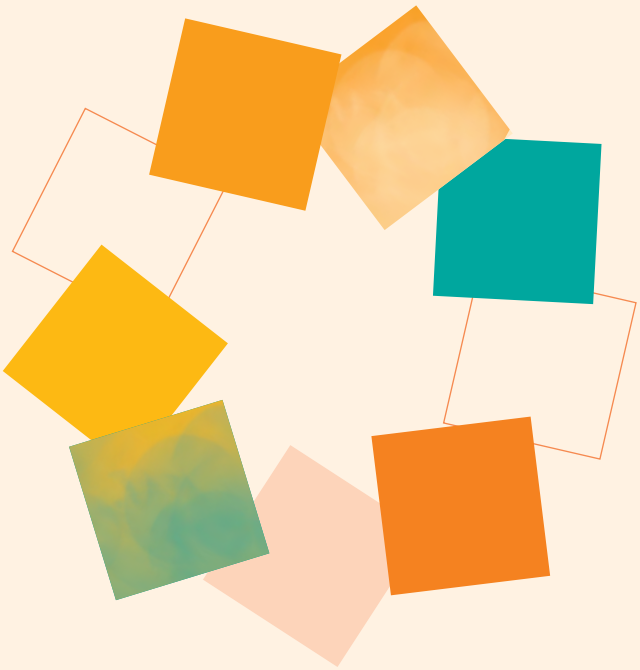
Suicide bereavement support groups

GUIDE

NAME

DATE



This is a joint initiative of the Canadian Association for Suicide Prevention (CASP) and Centre for Suicide Prevention (CSP).

ADVISORY TEAM/EXPERT PANEL

Yvonne Bergmans , PhD

Dammy Damstrom-Albach, RSW, MSW

Dena Moitoso, MSc

Rebecca Sanford, PhD

Peris Wasonga, MA

WORKING GROUP

Nancy Battaglia, BA, MBA, D.TATI

Kim Chicote, BSc

Pat Doyle, BA

Mara Grunau, BEd, MPA

Sean Krausert, BA, LL.B

Karin Lavoie, BMus, MLIS

Karen Letofsky, BA, CM

Robert Olson, BA, MLIS

Hannah Ratz, BA

Crystal Walker, BCS

CASP CANADIAN ASSOCIATION FOR SUICIDE PREVENTION
ACPS ASSOCIATION CANADIENNE POUR LA PRÉVENTION DU SUICIDE

centre *for* suicide prevention

Canadian Mental Health Association
Mental health for all

LAST UPDATED NOVEMBER 2023

Introduction

Suicide grief is unique: people who have lost someone to suicide experience grief that can be more complicated than the grief following other types of loss.

They may feel higher levels of guilt, shame, rejection, or abandonment and may experience suicidality themselves, as well as depression, PTSD, and complex grief (Andriessen & Krysinka, 2012; Groos & Shakespeare-Finch, 2013; Young et al., 2022). Support groups specifically designed for people impacted by suicide loss, rather than general grief groups, are optimal for people who have lost someone to suicide (Feigelman & Feigelman, 2008).

Participation in a suicide bereavement support group has been found to reduce depression, isolation, and symptoms of stress reactions, including PTSD, and enhance self-esteem, self-worth, connection and belonging (Knight, 2006). These groups may empower members to: discover and develop internal and external resources (including coping strategies), find meaning and purpose, and seek and offer help (Heart House Hospice, 2020). Members have the opportunity to work through questions of "why" the person died by suicide in a supportive setting. They may ultimately realize that they may never receive an answer (Sanford, 2016).

All of these outcomes can help members work through their grief. However, people are unique and bereavement groups may not be helpful to everyone (Sanford, 2016).

centre *for* suicide prevention

CASP CANADIAN ASSOCIATION FOR SUICIDE PREVENTION
ACPS ASSOCIATION CANADIENNE POUR LA PRÉVENTION DU SUICIDE

Table of contents

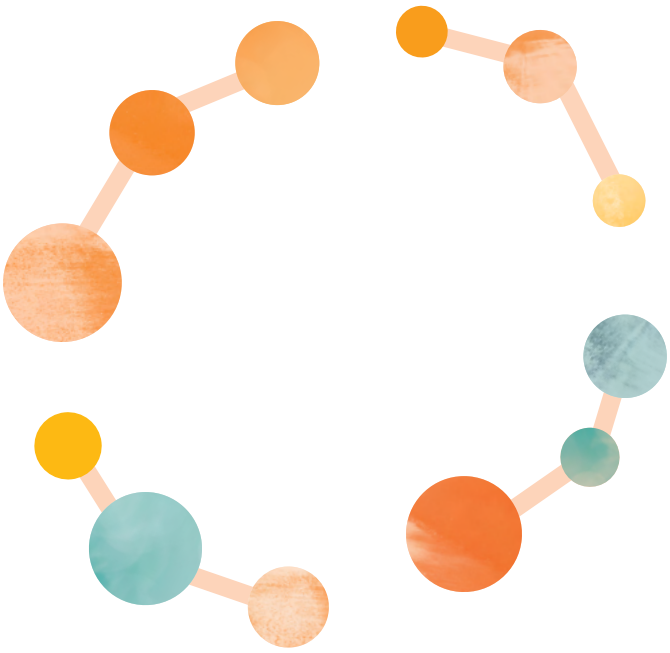
What to expect from this guide

This guide presents promising strategies and best practices for facilitating safe and effective suicide bereavement support groups.

It is intended for organizations and/or group facilitators that are currently operating or interested in starting a suicide bereavement support group. The focus of this guide is on closed groups. A separate, but complementary, guide will focus on open groups.

About closed groups

Closed groups tend to be more formal and structured since group members generally make a commitment to attend a pre-set number of sessions and membership stays the same throughout (Salvatore, 2010; Heart House Hospice, 2020). There are several advantages and disadvantages to closed groups.



ADVANTAGES TO CLOSED GROUPS:

- Bonding and trust between members can develop over time, leading to a greater likelihood of sharing, developing new friendships, and learning from each other's stories.
- Closed groups can be designed to meet the needs of their members more specifically. For example, if the group is made up of young adults who have lost a loved one, content can be directed to meet their needs.
- A more defined structure allows for the presentation and discussion of specific topics throughout the group cycle.
- Having a defined beginning and end point can help bring comfort to members and make it easier for members to "graduate" from the group.

(Sherman, 2012; Heart House Hospice, 2020; Salvatore, 2010).

DISADVANTAGES OF CLOSED GROUPS INCLUDE:

- People being unable to come and go as they please
- New members must wait until the next group cycle begins
- Having a defined end point may result in some members feeling the group ended too soon and that they need more support

(World Health Organization & International Association for Suicide Prevention, 2008; Heart House Hospice, 2020; Sherman, 2012)

Who should organize a group?

Many suicide bereavement support groups begin at a grassroots level and operate without an organization's guidance or support. However, it is recommended that suicide bereavement support groups be organized or guided by an organization.

Having an associated form of governance, a risk management strategy, and an accountability structure can help safeguard the group (Lifeline Australia, 2009). Group facilitators benefit from organizational support and supervision, especially peer facilitators (those with lived experience of suicide loss) who may lack formal training and experience personal challenges when facilitating a group (Sanford et al., 2018).

> Partnering with an established organization often means greater sustainability and credibility for the group (K. Letofsky, N. Battaglia & P. Doyle, personal communication, August 24, 2023).

Group principles and objectives

Group principles and objectives help members align their expectations with the purpose and direction of the group.

The following principles and objectives have been found to be effective for suicide bereavement groups:

- The group will strive to create a sense of community, belonging, and mutual support by promoting an environment of inclusivity, respect, and confidentiality.
- The group will encourage the process of coping and adaptation to loss, with a focus on reducing stress by using resources (D. Moitoso, personal communication, July 18, 2023).
- By participating in the group, members can hopefully regain a sense of stability in their lives.
- Group facilitators will have experience and expertise in suicide bereavement through their own lived experience and ongoing training.
- The group setting is a confidential, compassionate, and non-judgmental space where free expression of grief is accepted. Members are free to discuss fears and concerns.
- Through mutual support and sharing, members are encouraged to share and further develop coping strategies for dealing with daily life and important events.

(World Health Organization & International Association for Suicide Prevention, 2008; Lifeline Australia, 2009; Flatt, 2007)

Confidentiality

In support groups, there is usually a discussion with members about confidentiality.

Most often, members are expected not to share anything that is disclosed in meetings unless the person who shared explicitly states otherwise (Center for Peer Support, 2016; Self Help Alliance, 2013). Confidentiality is agreed upon among group members which fosters a sense of security and may encourage people to share more openly (Self Help Alliance, 2013).

There are some limits to confidentiality that will not remain confidential, including any disclosure of:

- Intent to self-harm
- Intent to harm others
- Illegal activities, including child abuse and elder abuse

(Self Help Alliance, 2013)

Establishing expectations

Before the support group begins, or in its first sessions, it can be helpful to clarify expectations for prospective and accepted group members, including:

- Membership criteria (e.g., age, type of loss, length of time after loss)
- Structure of group and sessions (e.g., what content will be presented when, how much time there will be for sharing, discussion, and content presentation)
- Member expectations (e.g., everyone is encouraged to share or contribute to the discussion)
- Members will not explicitly discuss the means or methods of a suicide death
- Confidentiality parameters (as previously mentioned)

(Heart House Hospice, 2020)

What are some ways that you can establish expectations before the group begins? During the group session?

ADD YOUR NOTES HERE:

Considerations for setting up a group

Membership criteria

Most support groups are designed to reach a specific population (Center for Peer Support, 2016). While diversity among group members can offer a variety of perspectives and insights, it can also pose a challenge to group cohesion. For example, characteristics such as age, type of loss, social class, education levels, and language can impact a group member's ability to relate to other members (Center for Peer Support, 2016). However, the size of the community may also dictate how specified the support group is. For example, there may not be capacity in the community to have groups differentiating between type of loss (general bereavement vs. suicide bereavement for the loss of a child, for example) (K. Letofsky, N. Battaglia & P. Doyle, personal communication, August 24, 2023).

LENGTH OF TIME AFTER LOSS

If people join a support group too early on in their grief journey, they may share details of their story in a way that could re-traumatize other group members, or they may not be ready to hear the stories of others. They may also be experiencing symptoms of bereavement which could make group participation difficult. Thorough intake and screening processes are critical to determine readiness of prospective members to participate in the group. Facilitators may also set criteria that those whose suicide loss happened within the past 3 to 6 months cannot join the group (Sanford, 2016).

It is extremely important that facilitators distribute Centre for Suicide Prevention's Guidelines for sharing experiences with suicide (*bit.ly/3QlYubO*) during the intake process and in the first meeting, and that these guidelines are upheld throughout the group. These guidelines help participants understand how to share their personal experiences with suicide. Facilitators are encouraged to remind participants of these guidelines at the start of each group session and in instances when participants do not share personal stories in a safe way.




Intake process

Having an intake process for prospective group members is common practice for bereavement groups to ensure applicants fit the group criteria and are likely to benefit from the group (Lifeline Australia, 2009). However, not everyone will be ready for or benefit from group support. The intake process can also help ensure that accepted members are not likely to re-traumatize other participants (Feigelman & Feigelman, 2011). If someone applies but may not fit the criteria or is otherwise found to be unsuitable, they should be referred to other resources (Center for Peer Support, 2016).

The intake process should be clearly outlined for applicants and may include an interview (in-person or virtual), a brief conversation, and/or a survey (Lifeline Australia, 2009; Sherman, 2012).

Typical information collected from applicants during the intake process includes:

- ☐ Name
- ☐ Age
- ☐ Gender
- ☐ Relationship to the deceased
- ☐ Date of loss/length of time since loss
- ☐ Emergency contacts
- ☐ Type of current treatment, if applicable, and any relevant health issues that may impact an individual's participation

(STAR Center, 2019; Lifeline Australia, 2009)

The intake process is also an opportunity to provide information on suicide, suicide loss, grief, and trauma to applicants (Lifeline Australia, 2009). A description of the group and its expectations will be made explicit at this time, as well as criteria for non-inclusion, to ensure the group is a right fit for applicants.

Click here (*bit.ly/3QJw37O*) to access a sample intake form.

Suggested information for distribution:

- Centre for Suicide Prevention's Guidelines for sharing experiences with suicide (*bit.ly/3QlYubO*)
- Canadian Association for Suicide Prevention's support services directory (*bit.ly/3Mew54Y*)

Number of participants

A group size of 12 to 14 people is recommended. Ideally, a group will have not a fewer than 5 people. The size of a group can impact its effectiveness: if there are too many participants, it can be challenging to ensure everyone has an opportunity to share their experiences without feeling rushed. Having a group of 12 to 14 people can also ensure a good number is maintained, even if some members drop out. However, groups with slightly fewer members (5 to 10) can be effective too.

(Heart House Hospice, 2020; Center for Peer Support, 2016; Sherman, 2012)

Scheduling

DAY AND TIME

Group sessions need to be offered at a day and time that best fits member schedules; it's important that organizers have the flexibility, resources, and capacity to make this happen. Where possible, consult members, during the intake process or after, about what day and time is best for them.

(Heart House Hospice, 2020; Sherman, 2012; D. Moitoso, personal communication, December 2, 2021; A. Shneidman, personal communication, December 15, 2021; P. Wasonga, personal communication, December 1, 2021)

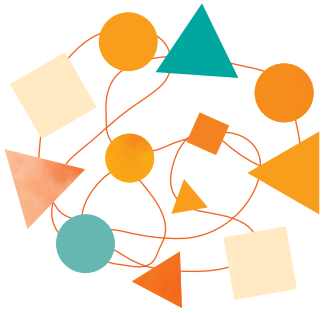
LENGTH AND FREQUENCY

Most groups meet bi-weekly or weekly and research suggests that meeting for 8 to 12 weeks is optimal. Meetings that are 1.5 to 2.5 hours allow space for members to share while not being overly tiring.

(Rubey & McIntosh, 1996; Flexhaug & Yazganoglu, 2009; Heart House Hospice, 2020; D. Moitoso, personal communication, December 2, 2021; A. Shneidman, personal communication, December 15, 2021; P. Wasonga, personal communication, December 1, 2021)

In-person or virtual

As with day and time considerations for the group, giving members the choice of attending in-person or virtual is best (O'Connell et al., 2023).



IN-PERSON

Research has found that in-person groups may create stronger connections among members. However, there are many logistical elements to be considered when hosting in-person groups (O'Connell et al., 2023).

VIRTUAL

People may prefer a virtual support group for many reasons, including: geographic location, transportation limitations, and scheduling/time limitations (Gibson et al., 2020). As with in-person groups, there are many logistical considerations for virtual groups. For example, with virtual groups, it is important to ensure the safety of members; this is more difficult to achieve in virtual spaces, but it is possible.

During the intake process, ask applicants about their comfort level with using technology and familiarity with the chosen virtual platform (Gibson et al., 2020). This can help facilitators know what level of technological support is needed for each participant.

- *What are some questions that you can ask to find out about someone's comfort level with technology?*
- *What are some ways that you can support someone with using technology?*

ADD YOUR NOTES HERE:

Facilitation

The facilitation of a suicide bereavement support group is key to the group's success and managing group dynamics ensure member needs are met (Sanford, 2016).

A minimum of two facilitators is recommended; two facilitators can better meet the needs of the group while balancing the demands of facilitating (Lifeline Australia, 2009). However, depending on group size, some groups do operate with one facilitator (K. Letofsky, N. Battaglia, & P. Doyle, personal communication, August 24, 2023).

Types of facilitation

There are three common types of facilitation: professional-led, peer-led, or mixed, with one of each (McIntosh, 2017).

MENTAL HEALTH PROFESSIONAL FACILITATOR

Professional-led suicide bereavement groups are intended to provide members with an opportunity to develop specific skills through psychoeducation and emotion-focused supportive discussion (Flexhaug & Yazganoglu, 2009).

The involvement of a mental health professional is considered critical in supporting people bereaved by suicide because of their complex grief experiences, their vulnerability to suicide, and the potential need for psychiatric intervention (Flexhaug & Yazganoglu, 2009).

PEER FACILITATOR

A peer facilitator is a facilitator who also has lived experience of suicide loss. Group members may more readily build trust with peer facilitators, and peer facilitators have the opportunity to model effective coping skills, which can offer group members hope for the future (Flexhaug & Yazganoglu, 2009). However, people bereaved by suicide may be more likely to experience a high level of trauma and may therefore require assistance from those with specialized training. Peer facilitators who have not received specialized training in mental health may not be fully aware of these needs and be unable to respond appropriately (Sanford, 2016). Research has found that, compared to professional facilitators, peer facilitators experience more difficulty managing group dynamics, maintaining appropriate boundaries, and recruiting participants (Sanford, 2016).

For more information on peer support, read the Centre for Suicide Prevention's briefing note (*bit.ly/3QwHjV1*) on the topic.

MIXED (COMBINATION OF PROFESSIONAL AND PEER FACILITATORS)

Mixed facilitation is optimal for a support group as it allows facilitators to share responsibilities and emphasize respective strengths and perspectives (Center for Peer Support, 2016; Mood Disorders Association of British Columbia, 2021; Flexhaug & Yazganoglu, 2009).

- Having a professional facilitator helps safeguard against group members' potential for complicated grief experiences, vulnerability to suicide, and the potential need for psychiatric intervention.
- Having a peer facilitator provides an opportunity for group members to speak to someone who has been in a similar experience, which can help develop trust and connection

(Flexhaug & Yazganoglu, 2009; Center for Peer Support, 2016; Mood Disorders Association of British Columbia, 2021).

Roles and responsibilities of facilitators

Facilitation must be done in a way that ensures the safety of group members and fosters a supportive, trustworthy, and friendly atmosphere (Mood Disorders Association of British Columbia, 2021). When group members feel safe, they are more likely to lower their guard, open up and be vulnerable with the confidence that they will be heard and accepted.

The facilitator's role is first and foremost to establish and maintain a safe and supportive environment for both physical and emotional safety. It's also vital that facilitators are experienced and skilled in managing group dynamics. They must ensure a supportive environment that promotes emotional well-being.

PROVIDING FEEDBACK

During a group session, facilitators may provide feedback that is respectful, factual, objective, non-judgmental, non-reactive, and with the intention of helping the receiver. They may also guide group members in providing helpful and appropriate feedback to other members, and guide receivers in accepting feedback (Mood Disorders Association of British Columbia, 2021).

Note: Facilitators must be skilled and have the ability to separate their personal interpretation of the situation, including inferences about what someone's intentions or feelings are, from what actually happened and only describe the reality of the situation (Mood Disorders Association of British Columbia, 2021).

Trauma-informed facilitation

Facilitators need to work within a trauma-informed framework and recognize the importance of ensuring the delicate balance of safety and empowerment in the group.

The goal is to reduce the likelihood that group members will be re-traumatized. Trauma-informed facilitation recognizes and responds to the possibility of past trauma and its potential impact on current difficulties (Baird & Alaggia, 2021). As previously mentioned, people who are bereaved by suicide are particularly vulnerable to re-traumatization (O'Connell et al., 2023).

Facilitators can reduce the risk of re-traumatization by:

- Assessing suitability for group participation during intake
- Reviewing Guidelines (*bit.ly/3QlYubO*) for sharing experiences with suicide regularly as a reminder of how to maintain safety
- Identifying and managing group member distress during group participation
- Regularly checking in with group members
- Ensuring support resources and services lists are readily available and accessible

(O'Connell et al., 2023)

Facilitators need to remind members of group guiding principles and objectives and remind members not to discuss the means or method of a suicide death. Group members may be provided with Centre for Suicide Prevention's Guidelines for sharing experiences with suicide (*bit.ly/3QlYubO*) (alternatively, this may be done during intake, as mentioned above).

AVOIDING TRAUMA TRIGGERS

A trauma "trigger" happens when a person hears, sees, smells, touches, or feels something that provokes them to recall a traumatic moment and feel intense emotions that they find difficult or unable to control in the moment (Mood Disorders Association of British Columbia, 2021). For example, if one group member discusses details about how the person they lost died by suicide, this can invoke upsetting memories or mental images for other group members and can even increase the risk of imitative behaviour in group members who are already vulnerable to suicidality (Mental Health Foundation of New Zealand, 2018).

IT IS HIGHLY RECOMMENDED THAT PEOPLE WHO WANT TO FACILITATE A SUICIDE BEREAVEMENT SUPPORT GROUP HAVE TRAINING IN:

- Mental illness, suicide, suicide prevention, suicide intervention skills and suicide bereavement
- Trauma-informed care
- Facilitating group dynamics and support groups, specifically
- Maintaining boundaries with group members
- Appropriately and effectively utilizing self-disclosure
- Responding to group attendees who are at different stages in their grief journey
- Identifying appropriate resources for group attendees
- Coordinating meeting space

(Flatt, 2007; Sanford, 2016)

Is there training available in your area that addresses the list of skills needed? If so, list the training below.

FACILITATOR TRAINING

People who would like to facilitate suicide bereavement support groups greatly benefit from training and education in suicide bereavement and understanding the needs of those bereaved by suicide. This training and education can help ensure they are adequately and appropriately meeting the needs group members (Sanford et al., 2018).

ADD YOUR NOTES HERE:

Content

Support groups usually follow one of three content formats: curriculum-based, topic-focused, and open-forum (Center for Peer Support, 2016).

- **Curriculum-based formats** are often psycho-educational groups which incorporate information relevant to group members' needs (including how to manage their current circumstances) by utilizing books, articles, or other resources as a focus of group discussion. Several topics are planned to be discussed over time.
- **Topic-focused formats** are similar to curriculum-based formats as group members are provided with written materials to guide discussion on a specific topic, but they are often less structured as topics can be rotated based on the interests and needs of the group.
- **Open-forum formats** have no pre-arranged agenda. They are often offered as a drop-in meeting and do not follow regular attendance rules. Frequently, they are utilized as follow-up support for those who have gone through a closed-meeting process (D. Moitoso, personal communication, December 2, 2021).

(Center for Peer Support, 2016)

DISCUSSION THEMES

Common topics of discussion include:

- The grieving process and traumatic loss
- Physical and emotional feelings
- Coping strategies
- Honouring a life
- Looking toward the future

(Groos & Shakespeare-Finch, 2013)

Topics should be sequenced to allow participants to build comfort and personal safety by first learning about grief, stress management, and coping strategies (D. Moitoso, personal communication, July 19, 2023).

PERSONAL SHARING

Content discussed in a suicide bereavement support group may involve group members sharing their experiences and stories. This can help people bereaved by suicide to reshape their identities and make meaning of loss (Sanford et al., 2018; Rubey & McIntosh, 1996; Cerel et al., 2009; Sanford, 2016). Personal sharing can cause emotional distress and/or re-traumatize both the person sharing and other group members. However, re-traumatization and emotional distress are less likely when group members have a safe space to share their feelings.

Group members who share their stories may feel an increased sense of self-efficacy, and sharing can also help them develop the skills necessary to regulate their emotions. Hearing the stories of others can promote understanding and acceptance - two critical components to the healing process. Facilitators must prepare the group for safe sharing by upholding safe sharing guidelines, being mentally and emotionally available to group members, and being able to manage the impacts of sharing (O'Connell et al., 2023; Knight, 2006).

Topics that lead discussions of personal sharing may include: how to handle important dates (e.g., holidays, anniversaries, birthdays) and how to deal with difficult and/or awkward questions related to a suicide loss (Cerel et al., 2008).

- *What are some ways that you can uphold safe sharing guidelines when facilitating personal sharing discussions?*
- *Are there any group activities that can accompany discussions of personal sharing?*

ADD YOUR NOTES HERE:

Conflict resolution

Constructive, well-managed conflict can help those involved release emotions and stress, resolve tension, and understand other perspectives as a means to move forward as a group following conflict.

Poorly managed conflict can harm a group's dynamic and cohesiveness and facilitators should be skilled in managing conflict in a constructive way (Center for Peer Support, 2016).

Reasons for leaving

There has been some research to suggest that facilitation issues are one of the main reasons that group members leave bereavement support groups before the group sessions are finished (Sanford, 2016).

Group members identified that they were affected by facilitators who:

- Had unresolved grief that impacted their ability to support others
- Had insufficient knowledge of group processes
- Had insufficient group management skills
- Allowed certain group members to monopolize the group
- Failed to engage all members
- Did not allow members to help each other

(Sanford, 2016)

Another common reason that group members left early was the sharing of inappropriate/triggering death stories (Sanford, 2016).

It is vital for facilitators to learn about suicide bereavement and have training in support group management to ensure members' needs are adequately and appropriately met and avoid participant turnover.

Assessment and evaluation

Assessment and evaluation will help to determine whether the group is meeting its members' needs and identify what's working well and what needs to be improved. It's recommended that facilitators collect feedback directly from group members as part of assessment and evaluation.

An evaluation survey can be distributed to group members at the second-to-last or last meeting, or a short and simple electronic evaluation can be sent out after the last meeting (Heart House Hospice, 2020; Sherman, 2012). An additional option is to ask for feedback half-way through the group, providing open-ended questions when participants are more familiar with group processes. Questions can include: "Are you feeling heard?" or "Are there topics you would like added to the agenda?" (D. Moitoso, personal communication, July18, 2023).

When assessing the success of the support group, facilitators may ask themselves the following:

(Self Help Alliance, 2013; Mental Health Foundation of New Zealand, 2018)

What are other measures (or outcomes) that can be used to determine the success of the support group?

ADD YOUR NOTES HERE:

Self-care

Participation in a suicide bereavement group, either as a facilitator or member, can be difficult. Self-care is fundamental and crucial for both the facilitator and the group (Center for Peer Support, 2016).

- *What are some resources in your community that can be useful for those bereaved by suicide?*
- *What are some online resources that can be useful for those bereaved by suicide?*

FOR GROUP FACILITATORS

Those in caregiving roles are at high risk for burnout if their own needs are being neglected (Heart House Hospice, 2020). Working with people who are bereaved by suicide can be emotionally challenging for facilitators, especially peer facilitators, as it's necessary for peers to separate group members' pain from their own (Flatt, 2007). Managing the well-being of the suicide bereavement support group begins with managing the well-being of its facilitators (Center for Peer Support, 2016).

FOR GROUP MEMBERS

Although group members are ultimately responsible for their own health and well-being, facilitators may want to refer them to self-care resources. As group member needs are unique, facilitators should ensure they have access to varied types of self-care resources. Facilitators can do this by:

- Ensuring referral protocols are in place to connect to other support services in the community
- Considering requirements for sources of support between meetings and providing information on ways to obtain support
- Having a list of relevant and up-to-date information on local community support services that are easily accessible

(Lifeline Australia, 2009)

ADD YOUR NOTES HERE:

REFERENCES

Andriessen, K. & Krysinska, K. (2012). *Essential questions on suicide bereavement and postvention. International Journal of Environmental Research and Public Health*, 9, 24-32. https://doi.org/10.3390/ijerph9010024

Baird, S. L., & Alaggia, R. (2021). *Trauma-informed groups: Recommendations for group work practice. Clinical Social Work,* 49, 10-19. https://doi.org/10.1007/s10615-019-00739-7

Center for Peer Support. (2016). *Support Group Facilitation Guide.* https://www.mhanational.org/sites/default/files/MHA%20Support%20Group%20Facilitation%20Guide%202016.pdf

Cerel, J., Padgett, J., Conwell, Y. & Reed, G. (2009). *A Call for Research: The Need to Better Understand the Impact of Support Groups for Suicide Survivors. Suicide and Life-Threatening Behavior*, 39(3), 269-281.

Cerel, J., Padgett, J. & Reed, G. (2008). *Support groups for suicide survivors: Results of a survey of group leaders. Suicide and Life-Threatening Behavior*, 39(6). https://doi.org/10.1521/suli.2009.39.6.588

Flatt, L. (2007). *The Basics: Facilitating a suicide survivors support group. Suicide Prevention Action Network USA*. https://www.mirecc.va.gov/visn19/postvention/docs/Support_Group_Facilitator_Guide.pdf

Feigelman, B. & Feigelman, W. (2008). *Surviving after suicide loss: The healing potential of survivor support groups. Illness, Crisis & Loss*, 16(4), 285–304. https://doi.org/10.2190/IL.16.4.b

Feigelman, B. & Feigelman, W. (2011). *Suicide survivor support groups: Comings and goings, part 1. Illness, Crisis & Loss*, 19(1), 57-71. https://doi.org/10.2190/IL.19.1.e

Flexhaug, M. & Yazganoglu, E. (2009). *Best and promising practices in suicide bereavement support services: A review of the literature*. https://albertahealthservices.ca/assets/healthinfo/ip/hi-mhw-b-and-p-practices-in-suicide-bereavement-support-serv.pdf

Gibson, A., Wladkowski, S. P., Wallace, C. L., & Anderson, K. A. (2020). *Considerations for developing online bereavement support groups. Journal of Social Work in End-of-Life & Palliative Care*, 16(2), 99-115. https://doi.org/10.1080/15524256.2020.1745727

Groos, A. & Shakespeare-Finch, J. (2013). *Positive experiences for participants in suicide bereavement groups: a grounded theory model. Death Studies*, 37, 1-24. https://doi.org/10.1080/07481187.2012.687898

Heart House Hospice. (2020). *How to facilitate a grief group*. https://hearthousehospice.com/wp-content/uploads/2020/06/RunningAGriefGroupToolkit.pdf

Knight, C. (2006). *Groups for Individuals with Traumatic Histories: Practice Considerations for Social Workers. Social Work*, 51, 20-30. https://doi.org/10.1093/sw/51.1.20

Lifeline Australia. (2009). *Towards good practice: Standards and guidelines for suicide bereavement support groups*. https://www.lifeline.org.au/media/uj5n4tl5/standards-and-guidelines-for-suicide-bereavement-support-groups-2009.pdf

McIntosh, J. L. (2017). *Characteristics and effectiveness of suicide survivor support groups. In K. Andriessen, K. Krysinska, & O. T. Grad (Eds.), Postvention in action: The international handbook of suicide bereavement support* (pp. 117–130). Hogrefe Publishing: New York.

Mental Health Foundation of New Zealand. (2018). *Support groups for suicide loss*: A handbook for Aotearoa New Zealand.

Mood Disorders Association of British Columbia. (2021). *Support group facilitators manual*. https://peerconnectbc.ca/wp-content/uploads/Facilitator-Manual-Revised-March-2021-incl-appendices.pdf

O'Connell, S., Troya, I.M., Arensman, E., and Griffin, E. (2023). *'That feeling of solidarity and not being alone is incredibly, incredibly healing': A qualitative study of participating in suicide bereavement peer support groups. Death Studies*, 1-11. https://doi.org/10.1080/07481187.2023.22019223

Rubey, C.T. & McIntosh, J. (1996). *Suicide survivors groups: Results of a survey. Suicide and Life-Threatening Behavior*, 26(4), 351-358. https://doi.org/10.1111/j.1943-278X.1996.tb00838.x

Salvatore, T. (2010). *SOS support group facilitator handbook: Creating a safe space for those dealing with suicide loss*. Morton, PA.: Survivors of Suicide, Inc. https://phillysos.tripod.com/sos/SOS_leader_handbook.pdf

Sanford, R.L. (2016). *An exploratory factor analysis of the survivor of suicide support group facilitator scale: Identifying meaningful factors for group facilitation and outcomes. Theses and Dissertations-Social Work*. https://uknowledge.uky.edu/cgi/viewcontent gi?referer=&httpsredir=1&article=1013&context=csw_etds

Sanford, R. L., Cerel, J., & Frey, L. M. (2018). *Survivor of suicide loss support group facilitators: Do peers and professionals differ? Social Work with Groups*, 41(4), 306-322. https://doi.org/10.1080/01609513.2017.1351414

Self Help Alliance. (2013). *Starting and Maintaining a Peer Support Group Manual*. https://cmhawwselfhelp.ca/wp-content/uploads/2016/10/Starting-and-Maintaining-Peer-Group-Manual-2013.pdf

Sherman, N. (2012). *Models of Adult Bereavement Support Groups*. https://cdn.ymaws.com/www.naswma.org/resource/resmgr/imported/FCE_2012.9_AdultBereavement.pdf

Services for Teens at Risk (STAR-Center). (2019). *Survivors of Suicide: A Support Group Leader's Handbook*. https://www.starcenter.pitt.edu/sites/default/files/survivors_of_suicide_-_final_-_1.9.19.pdf

World Health Organization & International Association for Suicide Prevention. (2008). *Preventing suicide: How to start a survivor's group*. Geneva, Switzerland. https://apps.who.int/iris/bitstream/handle/10665/44801/9789241597067_eng.pdf?sequence=1&isAllowed=y

Young, I.T., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M., & Zisook, S. (2022). *Suicide bereavement and complicated grief. Dialogues in Clinical Neuroscience*, 14(2), 177-186. https://doi.org/10.31887/DCNS.2012.14.2/iyoung

The Canadian Association for Suicide Prevention (CASP) envisions a Canada without suicide. The organization works towards the achievement of its mission by advocating, communicating, and educating for suicide prevention, intervention, postvention and life promotion in Canada.

CASP CANADIAN ASSOCIATION FOR SUICIDE PREVENTION
ACPS ASSOCIATION CANADIENNE POUR LA PRÉVENTION DU SUICIDE

Centre for Suicide Prevention is a branch of the Canadian Mental Health Association.
For over 40 years we have been equipping Canadians with knowledge and skills to respond to people considering suicide.

We educate for life.

Canadian Mental Health Association
Mental health for all

Canadian Association for Suicide Prevention

casp@suicideprevention.ca
suicideprevention.ca
@CASP_CA
@CanadianAssociationforSuicidePrevention

Centre for Suicide Prevention

T 403 245 3900
csp@suicideinfo.ca
suicideinfo.ca
@cspyyc