

What Clergy Need to Know About Suicide Loss

How to Help After a Suicide

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April 2006

About this booklet:

There are about 400 suicides every year in the five southeastern Pennsylvania counties. That's roughly one suicide every 22 hours -- one suicide occurs somewhere in the metropolitan area every day. These suicides were "completed" not "committed." Suicide is the outcome of psychological debilitation that can happen to anybody.

Suicides may not occur every day in your community, but you may be involved in the aftermath of one, if this has not already happened. Your responsibilities may:

- Put you at the scene of a recent suicide
- Require you to call on congregants who have experienced a suicide loss
- Call for you to notify a family about the loss of a loved one to suicide or
- Have you accompany a congregant to identify the body of a family member

Like most other helping professionals and everyone else, you may not really be prepared for dealing with the people and the emotions that may be encountered after a suicide.

How prepared are you for this? What do you do? What do you say? What shouldn't you say? How do you help those struggling with this tragedy? How do your attitudes towards suicide affect your behavior or your beliefs? We are going to try to help you answer these questions and others like them.

This booklet is largely based on the SOS (Survivor of Suicide, Inc.) philosophy and almost 25 years of providing support to those who have suffered the worst loss of all, suicide of a loved one. It also reflects the limited literature on suicide loss and postvention (see readings and resource list on last page).

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This booklet was written in loving memory of Paul A. Salvatore 1968-1996

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Objective 7.5: By 2005, increase the proportion of those who provide key services to suicide survivors) who have received training that addresses...the unique need of suicide survivors.

"[Those who have early contact with suicide survivors] have the opportunity to set the tone for being respectful and sensitive to the needs of survivors and the need to be prepared themselves for the impact such events may have on their own thoughts and emotions."

National Strategy for Suicide Prevention: Goals and Objectives for Action
US Department of Health and Human Services (2001)
www.mentalhealth.org/suicideprevention

What is suicide postvention?

Postvention describes any form of post-trauma support. Postvention should occur after a suicide. It is the attempt to reduce the negative consequences that may affect those close to the victim after a suicide has occurred.

Postvention facilitates the recovery. Suicide loss is emotionally devastating. "Healing" or "getting over it" or "closure" don't apply. Recovery means eventually rebuilding a life around the loss. Doing this often requires outside support and that's postvention.

There are three objectives to any postvention effort:

- Give support and information to ease the trauma and other effects of the loss
- Prevent the onset of adverse grief reactions and complications
- Minimize the risk of suicidal behavior on the part of survivors

Suicide postvention involves (i) providing practical aid and support with the grieving process and (ii) identifying and assisting those who may be vulnerable to conditions such as anxiety and depressive disorders, suicidal ideation, self-medicating, and other harmful outcomes of severe grief reactions.

Postvention should begin as soon as possible after the suicide loss. That's where you come in. You are likely to be among the first to reach out to those close to a recent suicide victim. The information in the following sections can help you provide postvention and get the post-suicide grief process started in the right direction.

Why do suicides happen?

Every suicide is different and the circumstances leading up to it are always unique to the individual involved. However, the common underlying factor is intense psychological pain and extreme hopelessness on the part of the individual taking his or her life.

Psychological pain arises when there is some seemingly irresolvable and totally frustrating situation in an individual's life. This may be a compelling personal, interpersonal, financial loss and/or problem, or something else.

Whatever the problem it is something that he/she finds devastating and something that seemingly cannot be resolved. Coping and problem-solving skills do not work. Self-esteem and sense of control over his/her life diminish significantly. This brings about hopelessness.

Hopelessness may lead to suicidal thinking. In the absence of strong protective factors (e.g. family, religion, social supports) and in the presence of high risk factors (e.g., drinking, access to a gun), suicide may occur. Death is the means not the end. The tragedy of suicide is that its victims were not able to see that their pain was only temporary.

The risk of suicide is greatly increased by drinking or using drugs, which lessen inhibitions and increase impulsiveness. These substances heighten vulnerability to thoughts of suicide and make things, like depression and anxiety much worse.

Some suicides may be thought of as sudden and impulsive, but most seem to be the result of a process that happens over many weeks, months, or even years. It unfolds over time and offers many points for getting help. While not every suicide can realistically be prevented, suicide is preventable.

Suicide also has a neurological dimension. Researchers have found that chemical imbalances in the body and faulty neural processes in the brain play a role in suicide.

For more information about suicide download a copy of "What Everyone Should Know About Suicide" at www.mces.org or call Montgomery County Emergency Service (MCES) at 610-279-6100 for a copy.

Who are the victims of suicide?

There are 29000-30000 reported suicides in the US yearly.

Men from their 20s to mid-80s represent about 80% of suicide victims. There are few teen suicide deaths in southeastern PA. Elders, those age 65 and older, account for about 13% of all suicides in the region. Men 80-84 have the highest suicide rate of any age group. Regardless of age, suicide is always a premature and unexpected death.

Women complete suicide less often than men do because they tend to be less involved with alcohol, they do not use guns, and they more readily seek help. Older women rarely complete suicide. Females attempt suicide more than males.

Firearms, most commonly handguns, are the lethal means in most suicides. Guns are involved in 65%-70% of male suicides across all age groups and in 40%-45% of adult female suicides. Guns are part of the reason that more males die by suicide than females. More women are now using guns to complete suicide than in the past.

What do the numbers say? Most suicides involve a male, usually an adult, who died violently in a location where he will most likely be found by someone who was very close to him in life. He will be a son, brother, spouse, fiancé, partner, friend, or co-worker. He leaves 6-8 or more people behind who will have an especially hard time dealing with his loss. These are the people who will need postvention and your help.

For more statistical information about suicide in your county or municipality call the county health department or go to www.dsf.health.state.pa.us/health/site/default.asp (PA Dept. of Health).

Some misconceptions about suicide:

Attitudes about suicide affect how you behave towards those close to the victim. You may unknowingly share many popular myths about suicide or be influenced by beliefs about suicide that are part of your religious training and professional cultures.

Many in the general public still see suicide as the result of personal weakness. This and other misconceptions may lead to judging the victim and to marginalizing her or him as a "loser." This may come across to those close to the victim even if nothing is said.

Some see suicide as "making sense" in some cases of devastating illness, disability, legal, or financial problems. This makes suicide seem a rational decision. Saying someone "committed suicide" conveys control, sinfulness or criminality. Characterizing suicide as a rational or voluntary choice or a right isn't comforting to family members.

The belief that mental illness, drugs, and alcohol *cause* suicide is incorrect. They increase the risk of suicide but they don't cause it. People with serious mental illness do take their lives, but their deaths are usually the result of a combination of factors.* Depression is found among most suicidal individuals. Drugs and alcohol increase depression, reduce inhibitions, and increase impulsivity. They can be lethal when mixed with suicidal ideation.

Another myth is that "suicidal individuals really want to die" and there's nothing that you can do because they'll "do it" sooner or later. This implies that helping a suicidal individual is pointless. Those who are suicidal don't necessarily want to die, they just want to put an end to unbearable emotional pain. Most suicidal people are ambivalent about dying. Being acutely suicidal is not a permanent condition. With help it can pass within several hours to a few days.

* *Suicide loss is especially detrimental to those with a serious mental illness such as depression, bipolar disorder, or schizophrenia. It may rapidly trigger relapse or reoccurrence, crisis, or even suicidality. Such individuals should be referred to a crisis center or to their mental health provider ASAP. They will need more specialized help than is outlined here.*

What is different about suicide loss?

The best way to understand suicide loss is to think of it in terms of multiple layers of grief. It starts with the same grief that we all feel when we lose somebody that we loved or cared for a lot. However, it quickly worsens and is unlike any other loss.

The first layer relates to suicides being avoidable. Grievors feel responsible and guilty because they "didn't do anything." Parents agonize that they let their child down when most needed. Blame for the loss may be directed at a third party (i.e. a psychiatrist, a therapist, counselor, school, friends, etc.) that knew of the risk, but didn't act.

It is also not uncommon for anger to be expressed toward God even by those with strong faith. A suicide loss undermines even the most deep-seated beliefs and values of those that it touches. Some may reject your help. Anger may also be generated by how the family is treated by police and others at the scene or afterward.

The second layer relates to the seeming intentional nature of a suicide. Those left to grieve may feel that the victim chose to leave them. This can generate a great deal of anger and a deep sense of abandonment, betrayal or rejection. These feelings may arise very early on and may be witnessed by clergy who call on family members.

The third layer relates to the unanticipated nature of most suicides, which leads to an obsessive search for the "why." Family members and friends are literally shocked because they never saw it coming. Being blindsided by suicide generates anxiety, fear, and a sense of vulnerability.

The fourth layer relates to the stigma and shame that are still attached to suicide. Even when outsiders do not express such feelings (and they often do) the family may hold entrenched values that are in conflict with suicide. Those close to the victim may even be overtly blamed for the death by others, including family and friends.

The last layer is shaped by utter helplessness and worthlessness coupled with a loss of self-esteem. These open the door for hopelessness, the potentially deadly mindset behind the emotional pain that precipitated the victim's suicide. Suicide grievors are at high risk of suicidal behavior. Many victims had family histories of suicide.

"Grief Counseling Resource Guide: A Field Manual" is a good overview of basic grief issues. It is available from the NY State Office of Mental Health at www.omh.state.ny.us/omhweb/grief

What is different about suicide grief?

The grief after a suicide is significantly different than the grief felt after other kinds of losses. Losing someone to suicide has a much more intense and long lasting impact. It involves a struggle with complex social, emotional and cultural issues that can make grief overwhelming and isolating. The experience changes and challenges personal relationships, spiritual beliefs, concentration, and memory. Emotions and general health may become unsettled and fragile. All realms of life are affected

Because a suicide is the ultimate "unnatural" death many family members and others close to the victim may immediately become consumed with causation. Some will search desperately, ceaselessly, and fruitlessly for "the" reason why their loved one came to complete suicide. Others will quickly identify and lock on a particular event, conversation, or interaction as the "why." You can help them to understand that the loss was the result of many factors, which may never be discernible after the fact.

Where the victims had been under the care of psychiatrist or therapist or had a recent hospitalization the search for "why" may center on these parties. Because of confidentiality and risk management most mental health providers will be of little help. Family members may respond very negatively and even litigiously to what they regard as being denied "closure." Whatever their course, in the postvention phase you can help them best by aiding them in recognizing that they need to move towards learning to live with the loss more than a possibly futile search for causality.

Suicide communications, when present, are often troubling to the bereaved. Notes, e-mails, voice messages maybe delivered or found soon after the death. Some may be comforting, others unsettling. In the latter case, you may note that the contents cannot be taken literally given the state of mind of the victim. Who receives messages may also be upsetting. Sometimes those closest are not recipients. This may be because the victim was in fact close to them and thought they would understand without being told.

What are the immediate needs of suicide griever?

In the first hours and days, suicide griever may need any or all of the following:

- To understand that what they are feeling is normal - Those bereaved by suicide often think that they are having a severe psychiatric breakdown. To understand what they are going through think about a mini-9/11 happening in your head.
- To get support - Most people have no personal experience with a sudden, unexpected, and possibly violent death. Whatever got them through any previous deaths will fail them now. Suicide loss is best managed with help. Different things will work for different people. Most suicide griever find that one of the best sources of help is contact with others who have lost loved ones to suicide. This is available through suicide loss support groups.
- To understand they will need time to deal with their loss - The usual 1-3 days of funeral leave will not suffice. Most griever will not have the energy or motivation to go to work or school and they will not really be there if they do. They need to take things slowly and take care of themselves and their families.
- To know what to say to any affected children - It is generally thought that kids should be told the truth. Their feelings won't be spared for long anyway.

Suicide griever are the secondary victims of the suicide. They manifest many of the physical and behavioral signs of victims of disasters or trauma.

Those affected by a suicide loss must deal with police, EMTs, the Coroner or Medical Examiner, or, worst of all, the media. The police typically initially treat unnatural deaths as homicides irrespective of suicide notes or other indications to the contrary.

Witnessing the suicide or finding the body are both disturbing enough without the subsequent death scene processing. Few first responders are prepared to help the family members after a suicide. So you may find a doubly traumatized household (shocked by the loss and put out by the "official" response) when you arrive.

Wherever the suicide occurred the family may first need some help getting answers to claiming the body, recovering personal effects, and possibly arranging clean-up of the scene. You may have to help them sort through these concerns.

Our booklet "Recovering from Suicide Loss" is available at phillysos.tripod.com. A supply of printed copies will be provided free on request by calling 215-545-2242 or sending an e-mail to phillysos@hotmail.com.

Postvention "First Aid"

We all grieve differently and may take our own path to recovering from loss. However, in the near-term after a suicide loss there are some basic forms of help that seem to apply to everybody. Here's what you can do:

- A. Establish rapport - Extend offer of help and caring by just "being there." If you feel that you are forcing things, just back off. If not, sit down and listen.
- B. Initiate grief normalization - Let them discuss their feelings and concerns. Be ready for a lot of emotion and conflicting sentiments. Don't try to sort things out for them. They'll get to that later. Let them know that their emotional turmoil is okay given the abnormal nature of the loss.
- C. Assist in mobilizing their support system - Help them identify or call those who may be resources, e.g., a physician, family members, or trusted friends. Don't say that they have to make these contacts, just note that they may be helpful.
- D. Share information on community services - Provide contact information on local grief support resources like Survivors of Suicide or other services, which the grievers may reach out to if necessary or when they are ready.
- E. Encourage their follow-through - Urge them to see their family physician as soon as possible. Grief isn't a medical problem, but it directly impacts health and may aggravate pre-existing conditions.

These simple actions can get the family started toward recovery from their loss. They involve something that you are very familiar with: Caring. They aren't ready for formal grief counseling and may manage adequately with appropriate support.

One thing appears quite certain - the intensity, complexity, and duration of the bereavement after a suicide is significantly shaped by how those affected are treated by those they encounter or look to for help.

We know that being involved with a suicide is not easy for you either so after you've helped the family please take care of yourself. Suicides can be intense and may produce critical incident stress.

Some things best not said:

Here are some expressions that really don't help. While most may not apply to you, statements like these are often voiced after suicides. Remarks like these may do more harm than good regardless of the speaker's intentions or their value with other deaths.

"It was his time."

(A suicide is never anybody's "time" and is never predestined.)

"There was nothing anyone could have done."

(This is fatalistic and is not convincing or reassuring.)

"Didn't you know that he was seriously mentally ill?"

(This may be wrong and it is stigmatizing in any case.)

"He/she is at peace now."

(Perhaps, but this won't lessen the emotional turmoil of those left behind.)

"God wanted him more than you did."

(Saying "He's with God now" would be much more comforting.)

"I know exactly how you feel."

(You may "understand" how they feel, but hopefully you don't really "know.")

"You know, you have to let her/him go."

(They really don't, but now's not the time to even think about it.)

"All that anger will keep you from healing."

(Anger is a normal reaction and "healing" equates the loss to a cut or fracture.)

"Don't blame yourself, it wasn't your fault. It was his free choice."

(This only gives the grievors something else to be upset about.)

"It's too bad that he wasn't stronger."

(No, it's too bad that he/she didn't get the help that was needed.)

"He's in a much better place now."

(To those bereaved the place he/she should be is here.)

Suicide is an *abnormal* death; things said after a *normal* death do not apply.

Suicide grief support sources:

Mutual self-help groups create a sense of belonging, acceptance, and normalization. They are empowering and enhance coping ability. Suicide loss groups are "safe places" where grievers are with others who understand their feelings.

At meetings participants introduce themselves, say what they are comfortable in saying about their loss, and share thoughts and feelings. Facilitators may share copies of materials for discussion. Information and education are key elements.

Some groups are "open-ended." There is no fixed agenda or time frame and it can be joined at any time. Other groups may cover a preset agenda over a set period of time, usually 8 to 10 weeks.

Suicide grievers lead many groups. Group leaders act as facilitators and try to assure that each meeting is meaningful for all in attendance.

Sponsors of self-help support groups for suicide grievers include Survivors of Suicide (SOS), a resource specifically for suicide grievers, and The Compassionate Friends (TCF), a grief resource to those who have lost a child of any age to any cause, which welcomes parents, grandparents, and siblings.

Grief counselors, hospitals and hospices also have groups (Sadly those bereaved by suicide may not "fit" into general grief support groups geared to deaths by natural causes), To Live Again provides mutual support to those who have lost spouses to any cause.

Toward a proactive postvention model:

Some communities have specialized postvention resources to deliver short-term on-site support and referrals to other community services.

These resources remain few and far in between because there is little public awareness of a need for them. Here are some strategies for meeting this need:

- **Victim Services Model:** This approach basically extends the mission of a victim services unit or agency, which are available in many areas, to include suicide postvention. Such entities serve those affected by very traumatic events. With additional training they could readily assist those traumatized by suicide.
- **Medical Examiner's Office-based Model:** Postvention is offered by some ME's Offices (e.g., Philadelphia, PA). The ME staff are involved with all suicides and are often in contact with the next-of-kin or others close to the victim.
- **Crisis Center Model:** The American Association of Suicidology, which accredits crisis centers, promotes their involvement in suicide postvention. These services offer a natural "fit" with their roles in crisis intervention, linkages to mobile crisis services, and working relationships with police and EMTs.
- **Agency/Church Model:** In some areas social service and mental health agencies and faith-based groups have developed postvention capabilities. These entities may offer support on a long-term basis.
- **Trauma Response Model:** Postvention may also be offered by community or faith-based groups that help after sudden deaths or disasters. The Tragedy Response Unit Support Team (T.R.U.S.T.) in Blue, Bell, PA is an example.

Each approach has advantages and disadvantages. However, any of these approaches could go far in meeting a critical unmet need in the community.

About Survivors of Suicide (SOS):

SOS is an all volunteer nonprofit organization that helps individuals and families who have lost a relative, other loved one, or friend to suicide. SOS works to provide a "safe" place for suicide griever. We believe that the sharing of grief experiences and feelings is the best form of help. We feel that all who have suffered a suicide loss can help others comprehend the incomprehensible. SOS is built upon mutual self-help.

SOS is governed by a volunteer board of directors made up of individuals who have personally experienced a suicide loss and who serve SOS as support group facilitators or in other volunteer capacities. SOS has no paid staff. Individual donations, occasional small grants, and in-kind contributions support SOS's activities.

SOS was formed in 1983 in Philadelphia. Our founders had experienced a suicide in each of their families and each was independently looking for other people who had suffered this tragedy. They "connected" through the Self-Help Clearinghouse and decided to start a support group. In the following years groups were started in Chester, Delaware, Bucks, and Montgomery Counties, and in southern New Jersey.

SOS works with other community organizations to increase community awareness of suicide and suicide loss. SOS volunteers helped organize and actively support suicide prevention task forces in three counties. We provide assistance to those seeking to form new support resources. We hold annual regional support-oriented conferences for those bereaved by suicide in the tri-state area.

While SOS groups are present in many communities across the country SOS is not a single national organization. The majority of SOS organizations are autonomous and freestanding, but some function under the auspice of other entities. All came about to meet the same need and have similar support missions.

NB: Survivors of Suicide can best be thought of as a national movement made up of autonomous local chapters, some free-standing, some hosted by other entities.

SOS acknowledges the assistance of the many clergypersons, pastoral counselors, and others in the tri-state area who gave generously of their time in reviewing various drafts of this booklet. Their suggestions greatly increased the usefulness and readability of the booklet. Any errors are solely the responsibility of SOS.

Some Resources on Suicide and Suicide Loss:

Selected Books

- I. Bolton (1983) *My Son, My Son: A Guide to Healing After a Suicide in the Family*,
S. Chance (1997) *Stronger than Death: When Suicide Touches Your Life*
D. Clark (1993) *Clergy Response to Suicidal Persons and Their Family Members*
S.K. Goldsmith (2002) *Reducing Suicide: A National Imperative*
E. Dunne, J. McIntosh, and K. Dunne-Maxim (1987) *Suicide and Its Aftermath, Understanding and Counseling the Survivors*
K. Jamison (1999) *Night Falls Fast: Understanding Suicide*
D. Lester (1992) *Why People Kill Themselves*
J.T. Maltzberger and M.J Goldblatt (Eds.) (1996) *Essential Papers on Suicide*
R. Maris, A. Berman, and M. Silverman (2000) *Comprehensive Textbook of Suicidology*
E. Shneidman (1996) *The Suicidal Mind*
A. Wroblewski (1991) *Suicide Survivors: A Guide for Those Left Behind*,
H. Wright (1993) *Crisis Counseling: What to do and say during the first 72 hours*

Selected Articles

- C. Barlow and H. Morrison (2002) "Survivors of Suicide: Emerging Counseling Strategies" *Journal of Psychosocial Nursing* 40 28-39.
J. Jordan (2001) "Is Suicide Bereavement Different? A Reassessment of the Literature" *Suicide and Life-Threatening Behavior* 31 91-101
M. Willis (2005) "My Father's Sweater: A Daughter Works to Unravel Her Family's Tangled Past" *Reader's Digest* December, 61-66.
C. Van Dongen (1991) "Experiences of Family Members after a Suicide" *Journal of Family Practice* 33(4) 375-380

Selected Web Sites

- American Association of Suicidology - www.suicidology.org
American Foundation for Suicide Prevention - www.afsp.org
National Organization of People of Color Against Suicide - www.nopcas.com
Organization for Attempters and Survivors of Suicide in Interfaith Services - www.oassis.org
Pathways to Promises - www.pathways2promise.org/crisis/suicidethreat.htm
Suicide Prevention Action Network USA - www.spanusa.org
Suicide Prevention Resource Center - www.sprc.org

The above is offered as a partial and non-exhaustive listing of useful references and resources. SOS welcomes information on other helpful print and on-line sources.