What Clergy Need to Know About Suicide Loss

How to Help After a Suicide

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Delaware County Suicide Prevention & Awareness Task Force
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About this booklet:

There are about 400 suicides every year in the five southeastern Pennsylvania counties. That's roughly one suicide every 22 hours. This mean that on average at least one suicide occurs somewhere in the metropolitan area every day!

Suicides may not occur that often 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
- Call for you to notify a family about the loss of a loved one to suicide

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.

What do you say? What can you say? What do you do? How do you help those struggling with this tragedy? How do your attitudes towards suicide affect your behavior? We are going to try to help you answer these questions and others like them.

This booklet is largely based on the SOS philosophy and 25 years of giving support to those who have suffered the worst loss of all. It also reflects the literature on suicide loss and postvention (see readings and resource list on last page).

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

Contents:

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. For example, postvention should occur after suicide attempts. Here we use it in relation all interventions that attempt to reduce the negative consequences that may affect those close to the victim after a suicide has occurred.

The purpose of suicide postvention is to facilitate the recovery from traumatic loss of individuals touched by a suicide. Suicide loss is emotionally devastating. "Healing" or "getting over it" or "closure" don't apply. Recovery means eventually rebuilding a normal life around the loss. Doing this often takes outside help and that's postvention.

There are three objectives to any postvention effort:

- Ease the trauma and related effects of the suicide 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 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 be contacted by or to reach out to those close to a recent suicide victim. The information in the following sections can help you get postvention and 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, common underlying factors include intense psychological pain and extreme hopelessness.

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

Whatever the nature of this loss or problem it is something that he/she finds devastating and something that cannot be resolved. Coping and problem-solving skills do not work. Self-esteem and sense of control over his/her life diminish. Hopelessness may follow.

Hopelessness may lead to suicidal thinking. In the absence of strong protective factors (e.g., social supports, religion) 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, much worst.

Recently, Joiner (2006) noted that two conditions must be present to overcome the instinct for self-preservation. The first is an intense desire to die caused by an extreme sense of not belonging and the belief that one is a burden. The second is the capacity for lethal self-harm acquired through abuse, pain, past suicidality, trauma, and other factors. Both must be present for a completed suicide.

Some suicides may be thought of as sudden and impulsive, but most seem to be the result of a process of psychological debilitation 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 risk.

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 30000-32000 reported suicides in the US yearly. In Bucks, Delaware, and Montgomery counties there are an average of 60-70 or more suicides annually. In Chester County there are just over 40 suicides yearly. In Philadelphia there are 150-160 suicides each year.

In the region, men in their 20s to mid-60s represent about 70% of suicide victims. There are few teen suicide deaths in southeastern PA. Elders, those age 65 and older, account for about 13% of suicides. 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 because they tend to use less alcohol, they have less access to guns, and they more readily seek help. Older women rarely complete suicide. Females attempt suicide more than males.

Most suicide victims are white. Suicides in the Afro-American community are increasing. Suicides remain uncommon among Asians and Latinos. The suicide rate among non-white women is very low. It is felt that strong social ties, spirituality, and cultural values act as protective factors to suicide in minority communities.

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. As noted, guns are part of the reason that more males die by suicide than females. More women use guns to complete suicide than in the past.

What do the numbers say? Most suicides involve a white male, usually an adult, who died violently in a location where he will most likely be found by someone who very close to him in life. He will be a son, brother, spouse, fiancé, partner, friend, or co-worker. He leave 6-8 or more people behind who will be have an especially hard time dealing with his loss. These are the people who may 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 the notion he or she was in control. Characterizing suicide as a rational or voluntary choice or a right isn't comforting to family members.

Mental illness, drugs, and alcohol 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. 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. Grievers feel responsible and guilty because they "didn't do anything." Parents, especially fathers, agonize that they let their child down when most needed. Blame for the loss may be directed at a third party (i.e., 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 grievers 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 are the immediate needs of suicide grievers?

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

- To see that what they are feeling is normal – Those bereaved by suicide often think that they are suffering 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 endured with help. Different things will work for different people. Most suicide grievers 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 (see pages 12-13).
- To understand they will need time to deal with their loss – The usual 1-3 days of funeral leave will not suffice. Most grievers 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 felt that kids should hear the truth. Their feelings won't be spared for long anyway.

Suicide grievers are the secondary victims of the suicide.

Those affected by a suicide loss must deal with police, EMTs, and the Coroner or Medical Examiner. 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.

The family may 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. Printed copies may be requested by calling 215-545-2242 or sending an e-mail to phillysos@hotmail.com.

Postvention "First Aid"

We all take our own path to recovering from loss. However, 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 with them.

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 those who may be resources, e.g., family physician, other 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.

E. Encourage their follow-through – Urge them to see their family physician as soon as possible. Grief isn't a medical problem but it 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 may manage adequately with appropriate support.

One thing appears quite certain – the intensity, complexity, and duration of the bereavement after a suicide is 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 don't help. Statements like these are often voiced after suicides. Such remarks may do more harm regardless of the speaker's intentions.

"It was his time."
(A suicide is always a premature death and never anybody's "time.")

"There was nothing anyone could have done."
(This is fatalistic, not reassuring, and often untrue.)

"Didn't you know that he was seriously mentally ill?"
(This may be wrong and it is stigmatizing in any case.)

"He must have been very *disturbed.*"
(This may disturb whoever hears it as mental illness may not be involved.)

"God wanted him more than you did."
(Saying "He's with God now" would be 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 grievers 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 with them.)

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 their feelings.

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

All of our 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 (see next page for our area groups), 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. (N.B.: There are TCF Chapters in Phoenixville, Pottstown, and West Grove.)

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 (TLA) provides mutual support to those who have lost spouses to any cause.

The Internet offers many on-line support groups and other resources. These have the advantage of 24/7 availability and some on-line support groups specifically welcome parents, siblings, or spouses. We recommend moderated groups that screen participants and monitor group concerns.

Some grief services for children: the Safe Harbor Program Abington Memorial Health Center, Willow Grove, PA, 215-481-5983; Peter's Place Center for Grieving Children & Families, Berwyn, PA, 610-889-7400; and the Center for Loss and Bereavement, Skippack, PA, 610-222-4110; The Center for Grieving Children, Teens, and Families, Philadelphia, PA, 215-744-4025.

Tri-state Area Support Groups:

Lower Bucks County, PA:
Frankford Hospital/Bucks County Campus
380 N. Oxford Valley Road, Langhorne, PA
Pat Lufkin (215) 545-2242
4th Tuesday 7:30Pm

Central Bucks County, PA (Doylestown Area):
St. Paul's United Methodist Church
2131 Palomino Drive, Warrington, PA 18976
Nancy Heacock (215)-545-2242
2nd Tuesday 7:30 PM

Chester County, PA (Western Main Line):
Paoli Memorial Hospital
Paoli Medical Building, Willistown Room
Route 30, Paoli, PA
Sue Kelleher (215) 545-2242
2nd Wednesday 7:30 PM

Delaware County, PA:
Crozer Chester Medical Center
15th Street & Upland Avenue, Upland, PA
(215) 545-2242
Call for information

Philadelphia County, PA (Center City):
3535 Market Street, Phila.- Room 2037
Gail Dohrn (215) 545-2242
1st Tuesday 7:30PM

Montgomery County, PA (Eastern Main Line):
Bryn Mawr Hospital, Clothier Auditorium
Bryn Mawr Avenue & County Line Road
Bryn Mawr, PA
Linda De Feo (215) 545-2242
1st Wednesday 7:30 PM

Philadelphia County, PA (NE Phila.):
Frankford Hospital, Torresdale Campus
Conference Rm. 1
Knights & Red Lion Roads, Philadelphia, PA
Pat Lufkin (215) 545-242
4th Monday at 7:30 PM

Montgomery County, PA
"Recovery from Suicide Loss Support Group"
Brooke Glen Behavioral Hospital
7170 Lafayette Ave, Ft. Washington PA
2nd Tuesday, 7:30
Facilitator: Rodica Mihalis (215) 545-2242

Upper Bucks County, PA:
"Survivors of Suicide"
328 Park Avenue, Quakertown, Pa 18951
Anne Landis/Craig Landis (215) 536-5143
Call for information

New Castle County, DE:
First Unitarian Church, 730 Halstead Rd., Sharpley, Wilmington, DE
DE Mental Health Assn. (302) 765-9740
Rev. Karen Covey-Moore
1st, 3rd, & 5th Mondays

Ocean County, NJ:
"Survivors of Suicide"
St. Mary's Church, 747 West Bay Avenue,
Barnegat, NJ 08005
(609) 698-5531 (Rectory)
Ettye Hurley
4th Wednesday 7:00 PM - 9:00 PM

Please call before attending any group to make sure that it is meeting as scheduled.

This listing is not exhaustive. SOS is very interested in learning of any other suicide loss support group resources in the tri-state area..

Updated 11/08

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 grievers. 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 and co-sponsor an annual candle lighting memorial service with the Delaware County Suicide Prevention Awareness Task Force. We work closely with the American Foundation for Suicide Prevention's Greater Philadelphia Chapter.

SOS appreciates the encouragement and comments that were received from clergy, church and faith-based organizations, pastoral counselors, and others during the preparation of this booklet. SOS is solely responsible for the content.

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*
E. Dunne, J. McIntosh, and K. Dunne-Maxim (1987*) Suicide and Its Aftermath, Understanding and Counseling the Survivors*
S. Goldsmith (2002) *Reducing Suicide: A National Imperative*
K. Jamison (1999) *Night Falls Fast: Understanding Suicide*
T. Joiner (2006) *Why People Die by Suicide*
D. Lester (1992) *Why People Kill Themselves*
J. Maltsberger and M. 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. Wrobleski (1991) *Suicide Survivors: A Guide for Those Left Behind*,

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 2005 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
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 listing of useful references and resources. SOS welcomes information on other helpful print and on-line sources.