

After a Suicide

A Postvention Primer for Providers

There is, on average, at least one suicide every day in the five-county region of southeastern Pennsylvania. It is not known how many of these victims were in the care of behavioral health providers. It is known that the occurrence and co-occurrence of mental illness, and alcohol and substance use are major risk factors for suicide.

Many studies have reported that suicide rates for those with Major Depression, Bipolar Disorder, Schizophrenia, and Alcohol Dependence far exceed those for the general population. Behavioral health providers serve individuals who are at high risk of both completing suicide and experiencing the loss of someone they know to suicide.

A suicide loss is always an extremely traumatic loss. It is a crisis. It has severe emotional and psychological effects. It is always accompanied by a complicated and prolonged bereavement.

Suicide loss may bring on or worsen behavioral health problems. It may trigger recurrence among those in recovery and suicidal behavior among those in more active stages of an illness. Suicide loss not only impacts behavioral health recovery, it creates another distinct recovery track. Suicide loss only resolves through recovery.

Providers should stand ready to help those they serve deal with suicide loss. Providers already have the basic capabilities to help after a suicide. All that is needed is some grounding in the principles of suicide postvention. This issue provides some basic background in this area.

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“Addressing emergent psychological needs in the aftermath of a tragedy does not require an advanced degree in mental health. In fact, the best help is often rendered by people on the front lines – people who take the time to listen, and say the right things at the right time.”

M. Lerner (2005)

American Academy of Experts in Traumatic Stress

How does recovery relate to suicide loss?

Recovery means, “to regain,” “to get back,” or “to restore.” As such, recovery has a lot to do with suicide loss.

Terms like “healing” or “getting over it” or “closure” do not apply to what is experienced by someone who has lost a loved one to suicide. A suicide loss does not go away and it can not be left behind.

Suicide loss involves more than the loss of a family member or friend. It may take away a personal role or identity (i.e., being a spouse, parent, sibling, or friend). It always takes a part of one’s self. It also takes away normality. There is no getting get back lost loved ones or friends, but someone can get back, recover, that sense of things being normal, and functioning normally, that they had before their loss.

No one can get back to where he or she was before the loss. A suicide, to some degree, always changes those that it affects. However, they can get to a different normal, a “new normal.” They will always feel the loss, but they can move beyond its abnormal consequences. That is what recovery is all about.

In regard to suicide loss, a significant lessening of most of the stressful and hurtful emotions and feelings is what marks recovery. The anxiety, the sadness, the depression, the stress, and the pain gradually become manageable and eventually move into the background. Personal, social, and school or work-related activities become less of a strain and more routine.

Recovery from suicide loss is not passive. It will not happen by only letting things run their course. It is active, something that has to be worked at and worked towards. It is how one gets back his/her well-being and quality of life. Recovery is the goal of the journey through suicide grief. It is getting to the point of being able to live with grief rather than only grieving.

What about mental illness and suicide?

While suicide and mental illness are not synonymous, individuals with serious mental illness such as Major Depression, Bipolar Disorder, and Schizophrenia are at higher risk of suicide than those without these illnesses and constitute the largest at-risk group. Mental illness and alcohol and substance misuse are serious risk factors for suicide. Those with these problems often have other risk factors such as a history of suicidal behavior, exacerbations and recurrence of symptoms, and frequent psychiatric hospitalizations. The stigma attached to both suicide and mental illness, the impairment of help-seeking common to these illnesses, and disparities in service coverage demand that this group be given specific focus.

The incidence of suicide among those with serious mental illness is as follows¹:

- Overall about 5% of those with serious mental illness complete suicide.
- About 6% of those with schizophrenia complete suicide.
- About 2% of those treated as outpatients for a depressive disorder complete suicide.
- About 4% of those hospitalized for a depressive disorder complete suicide.
- About 9% of those hospitalized for a depressive disorder with suicidal ideation or an attempt complete suicide.

Individuals with serious mental illness not only have a higher risk of suicide, they have a far greater exposure to suicide loss among their peers as well as in their families and support systems.

Those with serious alcohol abuse problems have an even higher likelihood of experiencing the suicide of a peer. Up to 15% of alcohol-dependent individuals eventually complete suicide and alcoholics make up 25% of all suicides. Suicide is 120 times more prevalent among adult alcoholics than in the general population.

¹Bostwick, J. and Pankratz, V. (2000) “Affective Disorders and Suicide Risk: A Reexamination” *American Journal of Psychiatry* 157, 1925-1932; Palmer, B. et al. (2005) “The Lifetime Risk of Suicide in Schizophrenia: A Reexamination” *Archives of General Psychiatry* 62 247-253; Roy, A. (2001) “Consumers of Mental Health Services” *Suicide and Life Threatening Behavior* (31) (Supplement) 60-83.

What about suicide loss and mental illness?

Suicide loss is an acute response on the part of those close to the victim. It disrupts psychological and physical well-being, overrides coping mechanisms, and causes extreme stress and distress.

A suicide loss may invariably, and at least temporarily, affect the mental health or wellness of someone without mental illness. It can have a pronounced negative impact on the well-being of someone with a mental illness.

Children and adults who have experienced a significant interpersonal loss from any cause have been found to have an increased short-term and long-term vulnerability to mental illness. In adults, major depression, anxiety disorder, and other illnesses have been linked to traumatic loss. When the traumatic loss is caused by suicide the vulnerability is greater.

For some, any mental health consequences of the suicide may pass as they recover from their loss. For others, problems brought on by a suicide loss may persist or even worsen.

Individuals with a history of mental illness may be very seriously affected by the loss of a relative or friend (or therapist) to suicide. At the very least one's support system may be weakened or totally lost. This plus the emotional turbulence set off by the loss may make an existing illness worse or trigger a relapse in someone who had things under control.

Suicide loss influences attitude and motivation. It is hard to feel positive after a suicide and it's often hard to do anything but grieve. It is especially hard sometimes to care about oneself. Treatment routines and efforts to maintain sobriety may be casualties.

Suicide Grievers Help Preferences:

- First contact choice is a peer.
- Second choice is someone sensitive to family need.
- Majority open to offer of help or support.
- Contact by phone or in-person acceptable.
- Referral information from police, EMTs, Medical Examiner staff, ER, funeral director, seen as helpful.

*Survivors of Suicide, Inc. Annual Conference Survey
Upland, PA May 2005*

What is suicide postvention?

Postvention includes all interventions that attempt to reduce the negative consequences that may affect those close to the victim after a suicide has occurred.

Postvention is basically a special form of crisis intervention. Its purpose is to deliver acute psychological support, lessen the distress, and help restore coping ability.

Postvention is carried out to facilitate the recovery of individuals emotionally devastated by a suicide. "Healing" or "getting over it" or "closure" do not apply to such losses. Recovery involves eventually rebuilding a normal life around the loss. This may take help and that help is postvention.

There are four 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.
- Encourage resilience and coping.

Postvention involves (i) providing aid and support with the grieving process and (ii) assisting those who may be vulnerable to 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.

What is different about suicide loss?

Suicide loss is the most severe traumatic loss. It is sudden and unexpected. It is beyond the realm of "normal" grief and experience.

Remember your emotions in the hours, days, and weeks after September 11, 2001? Recall the disbelief, the anger, the anxiety, the vulnerability, the helplessness, the powerlessness, and the pain? Now multiply those feelings about 100 times. Suicide loss is a personal 9/11 of that magnitude. Most of us no longer feel the aftermath of 9/11 so acutely. However, those who lost someone to suicide in September 2001 are still trying to cope with intense feelings that may have eased little if at all.

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One way to understand suicide loss is to think of it in terms of the layers of grief that it involves. It is a much more severe and complicated form of the same grief that we all feel when we lose somebody that we loved or cared for a lot.

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 also be directed at a third party (i.e., a therapist, school, friends, etc.). Suicide is preventable but few grievors were aware of the risk. Also, in retrospect, many suicides appear predictable. In hindsight everything falls in place. This also may lead to self-blame by survivors or finger-pointing to those who should have seen the suicide coming, such as providers. However, suicides are not foreseeable in the near-term.

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, which generates anger, betrayal, abandonment, and rejection. Crisis centers and other providers may hear these feelings expressed.

The third layer relates to suicide’s unanticipated nature, which leads to a search for the “why.” Most family members and friends never saw it coming. Being blindsided by suicide generates anxiety, fear, and a sense of vulnerability. These feelings come early and come on very strong.

The fourth layer flows from the stigma and shame still attached to suicide. Churches and public attitudes are better than they used to be, but old beliefs die hard. Those close to the victim may even be blamed for the death by others.

Helplessness shapes the last layer. It opens the door for hopelessness, the 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 and interventions. It is available from the NY State Office of Mental Health at www.omh.state.ny.us/omhweb/grief.

Stressors at a Suicide Scene

Witnessing the suicide or finding the body is traumatizing enough, but either is often made worse by subsequent events. Here are some things that can cause problems in the minutes and hours immediately after the loss:

- Crime scene processing – “Treat all deaths as homicides at first, even suicides” or “Consider suicide notes as questionable documents.” Every police officer has heard something to this effect, but they were not told how upsetting this is to those struggling with the loss. The family needs to know that what is happening around them is procedural rather than personal.
- Official information gathering – The family may be interviewed in determining the cause of death. They may be sure that it is a suicide or that it is not a suicide. Often others at the scene take sides, or judge their motives, or try to get them to accept any apparent cause. Such death scene dissension is not conducive to initiating healthy grieving.
- Interference with the death scene – Sometimes the family cuts down the body, moves the gun, throws away the pill bottle, starts to cleanup, or hides any note. This usually leads to a stern lecture on death scene procedures that doesn’t help.
- Stigmatization – Neighbors, relatives, teachers, clergy, and others may have an understanding of suicide shaped by myths and misconceptions. They may add to the trauma through hurtful comments made to or within earshot of family members.
- Insensitivity – Families may be told of the death in a brusque manner or even by phone. This may happen when the death occurred far from home. Sometimes they learn of their loss from the media. They may be swarmed by reporters if the suicide was “public” or deemed “newsworthy.”

Postvention can avert or mitigate exposure to such experiences.

“Death by suicide is not a gentle deathbed gathering; it rips apart lives and beliefs, and it sets its survivors on a prolonged and devastating journey.”

Kay Redfield Jamison

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 know that what they are feeling is normal – Those bereaved by suicide, irrespective of any history of mental illness, often literally say that they think that they “are going crazy.” They need to know this is a normal reaction to an abnormal loss.
- Support – Most people have no personal experience with a sudden, unexpected, and possibly violent, death. Whatever got them through any previous deaths will often fail them now. Suicide loss is best endured with help. Most suicide griever benefit from contact with others who have lost loved ones to suicide. This is available through suicide loss support groups.
- Time to deal with their loss and grief – The usual 1-3 days of funeral leave was not set with suicide loss in mind. 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.

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

A booklet for suicide griever entitled “*Recovery from Suicide Loss*” is available on-line from Survivors of Suicide, Inc. at phillysos.tripod.com. A supply of printed copies will be provided free on request to crisis centers/hotlines in SE PA by calling 215-545-2242 or sending an e-mail to phillysos@hotmail.com.

Some Misconceptions About Suicide Loss

There are many misconceptions about the effect of suicide on those close to the victim. Some are related to a misunderstanding of grief in general, others are unique to the grief engendered by a suicide. Here are the most common.

- *In time those affected by the loss of someone to suicide will get over it*--“Coming to terms with the loss” is more likely in most cases than “getting over it.” Suicide loss can end in recovery, the ability to regroup and live normally despite the loss, which may always be felt to some degree.
- *Those who endure a suicide loss are made stronger by it*--Suicide loss shatters personal beliefs, depletes self-esteem, leads to depression, and sometimes to suicide. None of these are strengthening.
- *The young are spared the pain when a parent or sibling suicides*--Children grieve and may have serious problems if it is not acknowledged and supported. The very young may feel the effect years later when they learn what happened.
- *A suicide by an older person doesn't have the same effect as when the victim is young*--The griever of an elder victim may be told that he/she “was old and going to die anyway.” This marginalizes their grief and the victim's death.
- *Being around others who have had such a loss will just make you feel worse*--On the contrary, such contact is usually beneficial. It shows that one is not alone.
- *Those around someone who has had a suicide loss shouldn't talk about it*--Suicide loss should not be given “the silent treatment.” The bereaved are acutely aware of their loss. Acknowledging the loss, mentioning the victim, and recalling memories can help.
- *Learning about suicide after having a suicide loss will not do any good*--Most who suffer a suicide loss will seek to learn how it came to happen and to understand “why.” They may not get explicit answers but they may come to an understanding that works for them.

Demythologizing suicide loss is not part of postvention, but providers must be aware of such misconceptions and be able to address them if they arise.

Postvention “First Aid”

Suicide postvention requires being a good listener, being supportive, and being able to offer some sources of help and information. Mental health professionals already do these things every day. Here’s what they can do in the postvention mode:

Establish rapport with griever(s): Extend offer of help and caring by “being there.”

Initiate grief normalization: Let them discuss their feelings and concerns. Be ready for a lot of intense 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 acceptable given the abnormal nature of the loss.

Facilitate understanding of critical incident processing: If necessary, explain the investigative activities that occur with any unnatural death. Sometimes you may have to deal with frustration and perhaps anger regarding those at the scene. Tell them why and where the Medical Examiner/Coroner will take the body and how they can arrange pick-up by the funeral director. They may have many questions.

Assist in mobilizing the support system: Help grievers identify those who may be resources, e.g., family physician, clergy, other family members, or trusted friends. Don’t say they have to make these contacts, just note they may be helpful. “Is there anyone that I can call?”

Share information on community services: Offer contact information on local grief support resources like Survivors of Suicide or other services, which the grievers may reach out to if necessary. Don’t expect them to necessarily call right away.

Encourage their follow-through: Urge them to see their family physician as soon as possible. Grief impacts health and may aggravate pre-existing conditions. Insomnia, anxiety, and depression typically follow such losses.

These simple actions can get the individual or family started toward eventual recovery from the loss. Often one contact will be enough to help them, but a follow-up call would be appreciated by the family and will give you some sense of the postvention’s outcome.

What may complicate suicide loss?

Situations like these may worsen the suicide loss experience:

- Inability to express grief – Being in a setting (e.g., prison, the military) where open grieving is not possible or being around others who discourage grieving or deny the loss. If the circumstances cannot be controlled, the bereaved should be encouraged to try to grieve to the extent possible in private.
- Witnessing a suicide or discovering the body – Being present when the suicide took place or coming across the body may increase the trauma. There should be concern about possible Post-traumatic Stress Disorder (PTSD).
- Being away from the event or apart from those who share the loss – Not being in the area when the suicide occurred may intensify the sense of responsibility or guilt. Not being able to attend the funeral or memorial service may interfere with grieving. (In such cases, it may help if the bereaved holds a personal memorial.)
- Controversial suicide – Most suicides are relatively private and only known to a few people. Others may be “newsworthy” because of the method or public stature of the victim. Teen suicides are more likely to get press attention than those of the elderly. The media can be insensitive to the bereaved and their questions or the nature of the coverage may be hurtful to those close to the victim.
- Legal issues – The police, the medical examiner, or coroner are part of every suicide (which is, as noted elsewhere, customarily treated as a homicide until determined to be otherwise). Their investigations are necessary but may be painful to those at the scene or those contacted later if conducted with little sensitivity.
- Problematic relationship – Someone with serious behavioral health problems may find herself/himself estranged from the lost friend or loved one at the time of her/his death. This can generate guilt and anger.

These are all complex factors that can’t be fully considered here. Some may occur with deaths other than suicides.

Things Best NOT Said

Some phrases not to say after a suicide regardless of the speaker's intentions:

“It was his/her time.”

(A suicide is always a premature death and is never anybody's “time.”)

“God wanted her/him more than you did.”

(Saying “He's with God now” would be better.)

“All that anger will keep you from healing.”

(Anger is a normal reaction to a suicide.)

“He's in a much better place now.”

(This may have negative connotations and none that are positive)

Things that providers should particularly try to avoid:

Inappropriate “leveling”	“I really know how you feel.”
Unrealistic Expectations	“You have to let him go now.”
“Blaming the Victim”	“He should've been stronger.”
Being Judgmental	“See what using gets you.”
General Absolution	“No one could have stopped it.”

Telling someone who has experienced a suicide loss that you know what he or she is going through, when you don't, minimizes the loss. In the case of a suicide the first days, weeks, or even months after the death are too soon to bring up “letting go” or closure. It is acceptable to observe that suicide is often brought about by severe hopelessness or psychological pain and to leave it at that. Never rationalize or pass judgment on the suicide or what may have led up to it. “Survivor guilt” is almost inevitable after a suicide, and it will generally abate without any effort to minimize the feelings of responsibility on the part of the bereaved individual.

“How an individual copes with... a suicide is also determined by contacts with formal supports.

“Reactions by first responders, such as police, EMS, and Medical Examiner personnel have a lasting impact and can vastly influence the course of recovery.”

Assessing the Needs of Survivors of Suicide
Calgary Health Region (2005)

Questions That May Arise After a Suicide

- What happens to personal effects or other property of the victim removed by the police or the Coroner's/Medical Examiner's staff?
- Who gets suicide notes addressed to individuals who are not part of the victim's family or household?
- What happens to the gun (if one was involved)? Can disposal of the gun be arranged?
- Will an autopsy be performed on the victim? Why? Who sees the results of the autopsy?
- What about tissue or organ donations?
- How do you get copies of the death certificate?
- How can the scene be cleaned up?

A few phone calls or e-mails will get you the answers to these questions in your county. Any assistance that provider staff can give with queries of this nature would be of great help.

Remember that suicide loss brings on a sense of being powerless and helpless. Queries of this nature are best seen as efforts to reassert control and to do something for the victim and themselves.

Marginalized Suicide Loss

All who endure a suicide loss face many sad and painful challenges. Some must also face the hurtful and unnecessary experience of not being seen as bereaved because their relationship to the victim is denied, minimized, or unrecognized. These include:

- Common-law Spouses
- Gay or Lesbian Partners
- Estranged or Divorced Spouses
- Parents of Adult Victims
- Friends of Young Victims
- Roommates or Support System Members of Individuals with Mental Illness
- Prisoners

These individuals often endure what is known as “disenfranchised grief.” Their loss is amplified because it is unacknowledged. Such “left-out” grievors run greater risks of problems than those whose loss is accepted and supported.

Unmarried heterosexual partners, common-law spouses, and homosexual partners often suffer multiple losses when their loved one completes suicide. They may be kept from planning, participating in, or even attending funeral or memorial services. They may also find themselves cut off from homes and possessions to which they contributed. Families who deny such individuals their right to share in their grief may be separating themselves from important aspects of their loved one’s life.

Estranged, separated, and divorced spouses may also be similarly treated by their current or former in-laws and other relatives or friends of the victim. Some may not even be

told of the death or about the services. Sometimes they may find themselves the targets of the anger of the victim’s family who see them as responsible for their loss or who do not feel that they have any right to be bereaved. Some may even blame themselves.

Parents of adult victims may not be treated in the same way as the parents of younger victims. Because their child was an adult, he or she may not be seen as a “victim” but rather as someone who freely chose to die or who “knew what he was doing.” The parents of married victims may be denied a meaningful role in their child’s services or in the settling of their affairs. As they are no longer the “next of kin” they have no legal role.

The grief of close friends of teen and young adult victims is frequently overlooked. Yet young people may be more closely bonded to friends than to relatives and be even more bereaved than if the loss were that of a family member. The impact of the loss on the victim’s friends must be anticipated by their families, the victim’s family, and, in the case of students, schools. Teens and pre-teens are particularly vulnerable to the effects of suicide losses. They should receive immediate postvention and ongoing support. Like the other “left-out” grievors their grief and loss must be acknowledged and given opportunity for expression.

Inmate suicides occur with some frequency in the correctional system, particularly in county prisons. However, the formal organizational regimens and informal cultures of such facilities discourage or even disparage open grieving of a cellmate or friend lost to suicide.

Area Grief Support Sources	Phone	Web Site
Survivors of Suicide, Inc. (SOS)	215-545-2242	phillysos.tripod.com
Feeling Blue Suicide Prevention Council	610-715-0076	www.feelingblue.org
Compassionate Friends/Abington	215-643-8531	www.abingtontcf.org
Compassionate Friends/North Penn	215-884-6691	
Compassionate Friends/Pottstown		
Compassionate Friends/Delaware Co.	610-874-7712	www.geocities.com/tcfdelco

Grief services for children:

- 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.
- The Center for Loss and Bereavement, Skippack, PA, 610-222-4110.

Suicide Grief Support Sources

Grief self-help groups create a sense of belonging, acceptance, and normalization. Groups are “safe places.” Grievers are with others who understand their feelings.

Participants introduce themselves, say what they are comfortable in saying about their loss, and share thoughts and feelings. Suicide grievors lead many groups, and act as facilitators and try to assure that each meeting is meaningful for all in attendance. Materials may be shared for discussion. Information and education are key elements.

Some groups are “open-ended.” There is no fixed agenda and it can be joined at any time. Other groups may follow a set agenda over a period of 6-8 weeks.

Self-help support groups for suicide grievors are run by Survivors of Suicide, a resource specifically for suicide grievors, and The Compassionate Friends, a resource to those who have lost a child of any age to any cause. Grief centers may also have groups. To Live Again provides support to those who have lost spouses to any cause. Moderated on-line suicide loss support groups are also available on the Internet.

Grief support groups are not available in every community. In some areas crisis centers host groups. Some information on support group training is given further on.

Grief groups run by hospitals and hospices are basically designed for those coping with a “normal death” and may not meet the support needs of suicide grievors.

Crisis Centers and Suicide Postvention

In southeastern Pennsylvania and the surrounding tri-state area, those who have just experienced a suicide do not typically turn to a crisis center as a source of help with their loss.

This is not the case in other parts of the country. Crisis centers host suicide loss support groups and reach out to those left behind by a suicide, sometimes through in-home visits immediately after the death. These activities are part of what's known as suicide postvention.

Crisis centers and hotlines should help after a suicide because: (i) it relates to their mission; (ii) they are positioned to help; (iii) it is a serious unmet need in their service area; (iv) it is a standard for accreditation by the American Association for Suicidology; and (v) postvention is advocated in the National Strategy for Suicide Prevention.

Those recently bereaved by a suicide need information and support, and sometimes mental health services. Most never get the help they need. Many suffer unnecessarily before recovering. Others never truly recover. Crisis centers and hotlines already have the basic capabilities to help after a suicide. All they need is some grounding in the principles of suicide postvention.

There are two approaches to suicide postvention. The first can be called “reactive postvention” and is the most common. It puts the burden of reaching out for help on those bereaved by a suicide. Given the nature of a suicide loss this model leaves much to be desired in terms of timely intervention. The second approach does not wait for someone affected by a suicide to call for help. It can be called “proactive postvention” because it involves initiating a direct offer of post-suicide assistance to family members and others close to the victim. In this model a crisis center or other community resource partners with the Medical Examiner or County Coroner, which alerts them to a recent local suicide and provides family contact information. The family is contacted and offered postvention and related information. Ideally the call is made by a staff member or volunteer who has experienced a suicide loss also. Proactive postvention is especially appropriate for use with consumers who have experienced a suicide loss.

Postvention Program Assets

Program effectiveness is enhanced by the presence of: staff suicide loss experience, staff awareness of the nature of suicide loss, and a strong outreach effort to potential referrers.

Suicide loss experience: Program leadership by a staff member who can personally relate to those confronting a suicide loss is helpful, but not essential. Normalization is greatly facilitated by support from an individual who has endured a suicide loss.

Suicide loss education: Staff must be familiar with the nature of this type of loss, the support needs of those affected, and the basics of postvention. In-service education on suicide loss may be arranged by working with groups such as Survivors of Suicide, The Compassionate Friends, and grief centers or counselors, where present. Formal suicide loss support group training is offered by various sources. This training can supply a firm grounding to the needs of suicide griever.

Referrer development: Postvention starts with a call. Requests for postvention may come from medical examiner's or coroner's offices, police or EMTs, clergy, funeral directors, schools, employers, and those touched by a suicide loss. Crisis centers face a marketing challenge in creating demand for a service that has not been available for a need that few recognize. Centers must raise awareness to the needs of suicide griever among those that encounter them in the hours, days, and weeks after their loss.

The Impact of a Suicide Loss on the Provider

It is said that there are two kinds of psychiatrists – those who have lost a patient to suicide and those who have not yet had that experience². The same can be said about provider organizations that serve individuals with serious mental illness, those with dual diagnoses, and those with alcohol misuse problems. To a lesser degree, psychologists, psychotherapists, nurses, counselors, social workers, case managers, and other individual behavioral health staff are at high risk of losing a current or former patient or client to suicide.

Suicide loss only spares the indifferent and the uncaring. While most behavioral health professionals will not experience the same emotions with the loss of a client or patient as those

closer to the victim, such experiences are nonetheless traumatizing. Providers are typically no more prepared for the suicide of someone in their care than are families or friends of victims.

Both individual providers and provider organizations can benefit from postvention after losing a client or patient to suicide. The same approach outlined above for use with consumers or family members can be readily adapted for use with providers.

Over one-third of therapists who experience a patient's suicide may suffer severe distress according to interviews with the therapists of 34 patients who had completed suicide. Thirteen were found to be severely distressed. The researchers identified four factors as possible sources of this severe distress: failure to hospitalize a suicidal patient who then died; a treatment decision that the therapist felt contributed to the suicide, negative reactions from the therapist's institution, and fear of a lawsuit by the patient's relatives.

H. Hendin et al. (2004)
 "Factors Contributing to Therapists' Distress After
 the Suicide of a Patient"
 American Journal of Psychiatry 161:1442-1446

On-line Resources

American Association for Suicidology,
www.suicidology.org. The SOS Handbook

Griefwork Center, Inc: Suicide Postvention,
www.griefworkcenter.com.

American Foundation for Suicide Prevention,
www.afsp.org.

National Mental Health Association, www.nmha.org/infectr/factsheets/42.cfm

On line Postvention Education for Clinician,
www1.endingsuicide.com

Therapists as Survivors of Patients Suicides,
mypage.iusb.edu/~jmcintos/therapists_mainpg.htm

² It has been estimated that 50% of psychiatrists have lost patients to suicide and that 30% of other mental health professionals may have this experience.

Last Words: Screening for Unresolved Suicide-Related Grief

Providers may gather information about a family history of suicide loss when screening new admissions. This information may lead to some exploration of the presence of other suicide risk factors or the possibility of current suicide risk in the individual. However, it seldom generates any exploration of potential unresolved grief issues related to the suicide loss.

Unresolved grief usually refers to an atypical severity, intensity, or duration of the signs and symptoms of grief. These may include a prolonged bereavement or a preoccupation with the person lost to suicide. It may be accompanied by clinical complications such as anxiety, depression, or other emotional or physical morbidity.

It may not be enough to simply note the victim's relationship to the client or patient and when the loss occurred. The loss may have taken place in childhood but the individual has only recently become aware that it was a suicide. In such cases the individual may experience a belated reaction to the loss and can show many of the same emotions as those who more recently lost someone to suicide.

Here are some factors that providers should consider when they encounter a client or patient with a history of suicide loss:

- How has the loss affected the individual's mental health wellness and recovery?
- What coping strategy was used by the individual in dealing with the loss and was it effective?
- How much social support was available to the individual after the loss and how well was it used?
- How did the loss affect the family or the other members of the individual's support system?
- Was there interference from external sources, such as the media and the criminal justice system, in the individual's ability to grieve?
- How is the suicide loss impacting the individual at present?
- Is there a need for referrals to suicide loss support resources?

Readings

Suicide Loss Texts:

Chance, S. (1997) *Stronger Than Death: When Suicide Touches Your Life*.

Doka, K. (1996) *Living With Grief: After Sudden Loss Suicide, Homicide, Accident, Heart Attack, Stroke*.

Dunne, E., McIntosh, J., & Dunne-Maxim, K. (1987) *Suicide and its Aftermath: Understanding and counseling survivors*.

Hewett, J. (1980) *After Suicide*.

Mishara, B. (Ed) (1995) *The Impact of Suicide*.

Rubel, B. (2000) *But I Didn't Say Goodbye: For Parents and Professionals Helping Child Suicide Survivors*.

Wroblewski, A. (1991) *Suicide Survivors: A Guide for those Left Behind*.

Pertinent Grief Texts:

Boss, P. (1999) *Ambiguous Loss: Learning to Live with Unresolved Grief*

Doka, K., ed. (2002) *Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice*.

Kauffman, J. ed. (2002) *Loss of the Assumptive World: A Theory of Traumatic Loss*.

Rando, T. (1988) *How To Go On Living When Someone You Love Dies*.

Rando, T. (1993) *Treatment of Complicated Mourning*. Research Press.

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