

## **SUICIDE PREVENTION RESOURCES:**

### **A HANDBOOK**

### **FOR**

### **TEACHERS AND COUNSELORS**

This handbook was written by David L. Conroy, Ph.D., the Director of Suicide Prevention Resources, Box 7693, FDR Station, New York, NY 10150-1914. It should be used in conjunction with the handout "What can I do to help someone who may be suicidal?" and the specific guidelines of your organization or facility. New York City Board of Education employees should have a copy of the regulation of the Chancellor No. A-755. City Department of Health employees should have the Suicide Risk Protocol of the Bureau of School Children and Adolescent Health. The information provided here is not intended to be a substitute for professional treatment, which should always be sought in working with people who have suicidal feelings or ideation.

## **CONTENTS:**

SUICIDE PREVENTION RESOURCES:.....	1
A HANDBOOK .....	1
FOR .....	1
TEACHERS AND COUNSELORS .....	1
CONTENTS:.....	2
" LISTEN" .....	3
NO SECRETS .....	6
FEAR .....	7
A PREJUDICE ABOUT PAIN .....	8
THIRD PARTIES.....	9
ALCOHOL AND DRUG ABUSE .....	9
TEENAGE SUICIDE .....	10
THE ELDERLY .....	12
BEFRIENDING EMOTIONALLY DISTURBED PEOPLE.....	13
THE DEMORALIZING INCIDENT .....	14
THE SURVIVORS OF SUICIDE VICTIMS .....	15
ADDITIONAL BURDENS OF THE MOURNING PROCESS .....	15
GUILT .....	17
A MYTH ABOUT SUICIDE .....	17
TALKING ABOUT IT.....	18
SECRECY .....	19
DURATION OF GRIEF .....	19
CAREGIVERS AS SUICIDE SURVIVORS .....	20
COPYRIGHT INFORMATION .....	21

## ***"LISTEN"***

is the first thought that should occur to you in any situation related to suicide. It should be sympathetic, non-judgmental, patient and attentive to the needs of others.

Listeners to people in pain soon discover the truth of two time tested psychological facts:

A despairing person who unloads his troubles to a sympathetic listener usually does not feel as badly at the end of the conversation as he (or she) did at the beginning.

A person who has opportunities to verbally discharge hostile feelings toward himself or others is less likely to discharge his feelings by physical action.

Listening is the best initial course of action with suicidal people; with friends, relatives and counselors of suicidal people; and with relatives and friends of suicide victims. Listening is especially important with young people and with people in recovery programs. It shows them that talking and listening are positive coping skills that can be used in place of the negative coping mechanisms that they are at risk of using.

Be Yourself: Nearly all suicidal people suffer from loneliness. Simple contact with another human being is a step for the side of life. You do not have to be more than you are.

Validate the Behavior and the Feelings: Let the person know you are glad he sought help. Sympathize with his pain.

Take an Extra Step: to show that you are on the side of life. People with depression negatively interpret the experiences of ordinary life. Be clear and direct in showing that you care, that you value him, and that you accept him.

Reflect: The technique of "reflection" is invaluable in working with the suicidal. In its simplest form, you rephrase what the person has said and repeat it back to him. "I'm frightened of what my parents will say," can be reflected as "You're concerned about how your parents are going to react?" Reflection seems like nothing, in fact it shows attention, understanding and concern. These are three things the suicidal believe the world does not offer. Reflection is the method of choice in listening to people who are agitated and upset.

Try to Remain Calm: Even if the person is sobbing, hostile, agitated, confused, or delusional, remember that fundamentally he is issuing a cry for help. Although the content and manner of his verbal behavior may be entirely negative, what he is doing is a positive step.

Try to See and Feel Things from his Point of View: Avoid arguments. Avoid making the person feel that he has to justify his thoughts, feelings, or behavior. Saying "Snap out of it" or "Pull yourself together" is belittling and is usually

perceived as rejection. “You’ll feel better tomorrow” is usually said to make its speaker feel better today.

Understanding: The suicidal often feel that no one understands and that they are losing the ability to make themselves understood. You can help reduce this pain by listening in a way that is accepting and patient. However, “I know just how you feel”, when said to a suicidal person, is also belittling - and is rarely true.

Acceptance: A suicidal person can be very quick to assume that you are disapproving or that you don’t care about him. Be as accepting as you can. This may be difficult when the person discusses things that you feel are socially offensive. Try to find aspects of his frustration, fear or anger for which you can express understanding. Here, as elsewhere, simply listening is usually the best policy.

Patience: Generosity with our time is a sincere way to show our care and compassion.

Look for Strengths: After you have spent some time listening to the person, you will find things that you can honestly say are of value.

Steer Toward the Pain: Give the person opportunities to express his feelings about the private and painful things that others do not want to hear about.

Vicious Circles: Suicidal people often have problems that feed off each other. The variations are endless, but a simple example is someone who can’t get a job because of poor health, can’t get health treatment because he lacks money, and lacks money because he can’t get a job. Even if they find people who are willing to discuss individual difficulties, they rarely have opportunities to discuss the interaction of the problems. Vicious circle problems make other people feel uncomfortable and counselors often practice strong denial on them. This denial will be supported by claims that listening to this type of problem is unproductively dwelling on the negative and will heighten feelings of powerlessness and hopelessness.

Unfortunately, vicious circle problems are real and avoiding them will not make them go away. Suicidal people are often very grateful for the opportunity to unload these frustrations and it significantly increases feelings of understanding and acceptance. A willingness to explore these aspects of the person’s situation will leave you with a more accurate and cooperative basis on which to proceed.

Confidentiality: Inform the person of your organization’s policy. Policies that require you to access the greatest number of resources are the most difficult to manage in the initial interview. The best approach is to try to enlist the person’s cooperation and support: “Our policies require that I not keep this a secret. I need to consult with my co-workers and we need to take action to get support for you. How do you feel we ought to go about this? Who is the best person to contact?”

Avoid Belittlement: Minimizing the problem deters people from presenting additional problems, demeans their capacity for self-assessment, and shows that you don't understand the pain the person is in. Belittlement helps counselors reduce their own anxieties; but it increases the pain of the suicidal. The estrangement between you and the client leaves you with a poor basis on which to develop a recovery program.

Listening is not problem solving, advice giving, or a substitute for professional treatment. Intense suicidal feelings are usually short lived and simply showing care can help a person through a crisis. But it is very unlikely that you can solve the person's problems during the course of a brief interview. Attempting to do so usually involves an overestimation of your own capabilities and an underestimation of the depth of the person's difficulties.

Assess Suicide Risk: If you are with someone and the idea "suicide risk?" is crossing your mind, there is a good chance the person is doing things to cause you to have that thought. It is essential that you ask the question "Are you having thoughts of suicide?" If you get a "yes" answer, you need to ask a series of further questions concerning plan, acquisition of means, and whether a time has been set for the attempt. You should also ask about prior attempts. You are not giving the person ideas or abetting the progression of his ideation. You are establishing a closer and more accepting relationship, learning more about his specific risk and his general situation, and giving him greater opportunity to unload feelings he has not shared with anyone else. When he gets these ideas out in public space, they will look and sound a little different. This disparity creates a doubt, "Is this what I want?" The overwhelming majority of suicidal people will honestly say "no" at some point in the assessment of risk and this will be a relief for both of you.

Counselors sometimes ask about the problem of client sincerity in these assessments and the possibility of mood swings shortly after the interview. They may have had experience with someone who denied that he was suicidal when they had strong independent evidence that he was. (The person may have written a note or told a friend. This situation does happen and your questions are only one part of your assessment of risk.) There are cases of people who seemed fine one day and attempted or completed suicide the next. These are both very real problems, but they do not invalidate the usefulness of assessing suicide risk. Most suicidal people will honestly disclose the extent of their pain and assessing risk will help guide your response to their situations. People who are afraid that accurate answers will bring them more pain, as well as people who may soon suffer increased risk, will know that it is OK in the future to seek help. Assessing risk shows you are on the side of life, no matter what the response.

## **NO SECRETS**

Most public service organizations have policies that require employees who have been in contact with a suicidal person to report the situation to a co-worker or supervisor. Copies of your organization's guidelines should be appended to hard copies of this booklet. Compliance with the rule of no confidentiality will be increased if organization members know about it and if they see it as part of a broad support network for themselves and the person at risk. (See the "Organization Program" section for material on developing support networks.)

Fatal secrets have a different underlying psychology than ordinary secrets. When people become friends, whether it is socially, on the job, or even within families, they invariably share things with each other that they do not with people outside the relationship. This is how they show and receive trust and acceptance; how they identify themselves to each other as friends. This is a nice part of normal life. The dynamics of fatal secrets are not normal. It is the part of the person that is afraid of more pain that says "Keep this a secret." It is the part that wants help that indicates that the "this" is the pain of suicidal ideation and feelings. Respond by getting help, and by trying to do it in a way that avoids more pain for the person at risk. If the secret is kept a life may be lost and the burden and subsequent grief for the secret keeper will be terrible. If the secret is not kept, a half dozen or more people may be mobilized on the side of life.

The staff psychiatrist of a methadone clinic shared this experience during a suicide prevention workshop:

His teenage son had a friend who told the son that he was suicidal. The son told the father and the two of them discussed the situation for a good part of an evening. The psychiatrist knew the other boy's family and twice had his hand on the phone to call them. Each time his son talked him out of it. Two days later the boy jumped from a sixth floor window. He survived, but suffered major injuries.

The morals of this story are obvious: don't keep it a secret, don't keep other people's secrets a secret (ambivalence is communicable - each person wants help with his problem, and each is afraid of what will happen if he gets help), don't keep it a secret off the job as well as on, and take all indications of suicidality seriously.

The fatal secret dynamic repeats itself in many forms. Principals sometimes get calls from parents who say *"My daughter won't be school for a week. She attempted suicide. Please don't tell anyone."* It is the part that wants help that accurately reports the situation, the part that is afraid of more pain that says keep it a secret. The mobilization of support for the person is not incompatible with doing it in ways that do not make the person's situation worse. It is in fact done all the time, and done quite successfully.

Spending time empathetically listening to a suicidal person is a stressful and emotionally engaging event. All of us are liable toward two types of error:

- a. denial on the severity of the problems, leading to an underassessment of suicide risk.
- b. being deeply moved by the severity of the person's problems, absorbing his sense of hopelessness, and reaching an inaccurately low prognosis for recovery.

Consultations are an effective way of correcting these natural distortions. Suicide prevention should not be regarded as an individual activity. Distributing the responsibilities - and the anxieties - makes it easier and much more effective. There is a certain type of pride that says *"I should be able to solve my own problems; I should not admit to others that I have a problem."* This is not the best attitude for a suicidal person to have, or for a person who works with suicidal people.

## **FEAR**

In the encounter between the suicidal person and his potential helper, there are two people who are afraid.

Suicidal people are afraid that if they ask for help, they are going to get more pain on top of the pain they already have. In particular, they are afraid they will get:

- A. Verbal Abuse: selfish, foolish, stupid, manipulative, attention seeking, failure, loser, inadequate, sinful, weak character, immature, anti-social, narcissistic; being the subject of ridicule, teasing, belittlement, moral condescension, blame for the condition.
- B. Social Abuse: hostility, rejection, shunning, aversion, stigma, threats, pressure, being passed along from counselor to counselor and agency to agency, loss of confidence in judgement or character.
- C. Pain Causing Breaches of Confidentiality: social embarrassment and shame; people who may already be inflicting verbal, emotional or physical abuse will find out and then inflict more abuse; written records that will come back and haunt them with discrimination and stigma.
- D. Suspension from school or work, police custody, involuntary incarceration.
- E. Bringing shame and stigma upon the family, being a burden on people already under stress, causing fear and anguish in the people in whom they confide.

Individuals and organizations that do not cause these fears to become reality will enable more suicidal people to seek help sooner. The manner in which they

seek help will be less defensive and hostile and they will have greater receptivity to suggestions for recovery programs.

The great fear of the counselors of the suicidal is that the person may later attempt or commit suicide; and then we will suffer horribly from blame and guilt.

If you pick up on the warning signs and involve yourself in a constructive way, then the chances that the suicide attempt will occur are greatly reduced. If the attempt occurs, and it may, you will at least know you did what you could.

The alternative, having an awareness of the situation and not getting involved, will not insulate you from suffering and feelings of guilt. The feelings will be different, but they will still be bad. Helping suicidal people through a crisis is cause for anxiety and stress; but it does not diminish you as a human being. The idea that "I" am responsible for the prevention of the suicide needs to be abandoned from the outset. It is important to make suicide prevention a team effort in which your role will often be secondary and limited to a few specific actions.

A second fear of counselors is that the suicidal person is being manipulative or is playing a prank. If you make a prior decision to treat all suicidal situations seriously, sympathetically, and compassionately, you will not afterwards feel that you have been duped. The prior decision is determining your behavior, not the other person. By making the decision ahead of time you will have less anxiety and greater objectivity and effectiveness during and after the encounter. You will see that underneath the suggestion of suicidal intent there is nearly always a real problem that needs attention. There are other ways of manipulating people, getting attention, playing pranks, - why has this person chosen suicide? Remember, it is probable that this person has a positive attitude toward you. If a suicide attempt does occur later, you will not regret having underestimated the seriousness of the situation.

The fears of counselors will be reduced if they have policies, procedures and support systems in place ahead of time.

### ***A PREJUDICE ABOUT PAIN***

Human beings do not respond in a uniform manner to loss and trauma. Being victimized by sexual assault, losing a job or relationship, and a death in the family will affect different people differently. Some suffer longer and more intensely than others. Unfortunately people whose suffering is greater than average are often singled out in ordinary life and by professionals as "having something wrong with them." (This is an aspect of a more general prejudice: anyone in any kind of emotional pain or unhappiness, regardless of precipitating event, has some personal inadequacy.) This charge is usually inaccurate and always lacking in compassion. The basis is not evidence; there are no scientific studies supporting the claim that "greater than average sufferers" have higher

incidences of mental illness or moral inferiority than “less than average sufferers”. Its real source is usually the uncomfortable feelings that the other person’s suffering is arousing in the person making the charge. The prejudice reduces the discomfort of those who hold it; it increases the pain of those who are its victims.

The relatives and friends of a suicide victim usually suffer more pain than survivors of other types of death. This prejudice is particularly applied to individual suicide survivors whose suffering is longer, more intense, or more openly expressed. Counselors need not only to avoid this prejudice, they need to actively counter its malevolent effects with sympathy, acceptance and compassion.

### ***THIRD PARTIES***

Third parties are persons who are concerned about someone they know who may be suicidal.

If a third party turns to you, your first reaction should be to respond to his needs. Listen, sympathize with his stressful situation, and reassure him that has done the right thing by taking the situation seriously and seeking out help.

By listening you help the third party calm down and review the situation objectively. Many third parties are responsible individuals; with support they will help develop constructive courses of action. If the third party is really the person at risk, then befriending him will give you an opportunity to turn the conversation toward his own problems. The Question - *“Are you having thoughts of suicide?”* - can be asked of the third party: *“Have you ever been in a situation where you have had thoughts of suicide?”*

You and the third party can review the suicide prevention steps discussed earlier: the warning signs, listening to the suicidal person, assessing suicide risk, removing means, not leaving the person alone, seeking professional help, and getting further help for yourselves.

### ***ALCOHOL AND DRUG ABUSE***

Many studies have shown that alcohol abuse is involved in one third to one half of all completed suicides. The victim may have drunk to excess on a daily or periodic basis, may have mixed alcohol with barbituates as the means of suicide, or may have been intoxicated at the time of death. Some experts believe that deaths caused by cirrhosis of the liver or reckless behavior while intoxicated should be classified as “subintentioned suicides”.

A recent two year study in San Diego investigated 133 completed suicides of people under the age of 30 and found evidence of drug abuse in 88 cases. (66%) The same study examined 150 suicides of people over 30 and found evidence of drug abuse in 39 instances. (26%)

Alcohol and drug abuse often begin as a solution: a solution for anxiety in social situations, for stress at work, for insomnia, for disappointment, for physical pain. As the disease of substance abuse progresses, the person's capacity for implementing healthy coping mechanisms diminishes. Psychological dependence can then lead to physical addiction. Many substance abusers eventually find themselves with lifestyles or behavior that they regarded with disapproval at earlier points of their lives. An outstanding characteristic of substance abuse is denial: it is the disease that tells you that you don't have a disease. Alcohol and/or drugs are increasingly used to cope with the two common denominators of suicide - feelings of powerlessness and hopelessness. Three "warning sign" conditions shared by substance abusers and suicidal people are loss of interest in other activities, increasing social isolation, and loss of self-esteem. Like suicide, substance abuse affects people from all walks of life.

The person who is in the drying out period - the first weeks or months after he stops the abuse of alcohol and/or drugs - may be undergoing the most acute pain of his life. He is suffering physical and emotional withdrawal, feelings that have been suppressed for years may come flooding back, and he may be full of remorse and guilt.

Users of this material are encouraged to attend meetings of Alcoholics Anonymous or Narcotics Anonymous and to include materials on substance abuse in their organization's inservice training program. Self-help and inpatient substance abuse treatment programs are themselves highly effective suicide prevention measures. When a person has a number of problems, it is difficult to make progress on any of them until the substance abuse problem is addressed.

## ***TEENAGE SUICIDE***

There are several good reasons for giving special attention to suicidal behavior among young people:

1. The official rate for completed suicide for people under the age of 25 has increased significantly over the last several decades.
2. Young people have a higher than average rate for attempted suicide.
3. There is evidence of an increase in suicidal behavior among pre-adolescents.
4. Society has a special obligation to concern itself with the welfare of the young.

5. Schools and child care agencies are appropriate places to disseminate information about critical issues in public health.

There is also a not so good reason for focusing on teenage suicide. Teenagers, the 13 to 19 age group, have an incidence rate for completed suicide that is no greater than that for the general population and account for 7% to 8% of all suicides in The United States. More than 90% of the completed suicides in our country are adults. Yet teenage suicide is the part of the problem that commands most of the attention and interest of the general public. The underlying reason why a smaller part of the problem gets a larger share of the attention is that adults feel very uncomfortable talking about adult and geriatric suicide; they feel less uncomfortable talking about teenage suicide.

In school based suicide prevention programs, for example, this discrepancy between fact and feeling manifests itself in two ways. The school will have policies and procedures for responding to suicidal behavior among students, but none for responding to suicidal behavior among staff members. Suicide prevention education programs for staff members and students will assume that the person in jeopardy is a teenager, not an adult. Our programs need to reflect the fact that both young people and adults may encounter a suicidal person of any age.

The element of hypocrisy

- a. Suicide in our age group is a taboo subject.
- b. Suicide in your age group is not a taboo subject.

at some level does not go unnoticed and is bound to reduce the effectiveness of the suicide prevention program. The content of the suicide prevention talk, "It's OK to talk about issues related to suicide in your age group," is the opposite of the behavior that is being modeled. Education that we need for "everyone", rather than education that we need for "you", will find a more receptive audience.

Most users of this material, of course, are concerned about self-destructive behavior among young people. There are a number of special stress factors for this age group:

1. In a short period of time adolescents must cope with major physical, emotional, sexual, social and educational changes. Pressure from parents and peers, often conflicting, adds to the stress. The highest teen suicide rates are among older males of all ethnic groups. They are at the stage when the pressure of the major developmental task of adolescence - independence from the family - is at its peak.

2. Young people are liable to suffer at least as much pain as adults. They can become victims of trauma and loss of every sort. A general problem in suicide prevention, denial of the severity of the situation, is particularly common in dealing with young people. You cannot assume that other people suffer painful events in the same way you suffered them (or imagine that you would suffer

them.) Situations as diverse as a death in the family and acceptance by one's peers normally affect young people more strongly than they do adults. And a situation that has little effect on one person may cause another considerable anguish. All expressions of suicidal ideation in all age groups need to be taken seriously.

### 3. Young people have fewer resources with which to cope with life's difficulties:

- a. They do not have a life history in which they have experienced misfortune, lived through it, found ways of coping, and moved on to other things.
  - b. They have limited experience in coping with issues of sexuality and sexual identity.
  - c. They have little or no freedom to change family arrangements, residences, schools, or to obtain private counseling.
  - d. They are inexperienced in using their own efforts and the assistance of others to improve painful situations.
  - e. They have poorer vocabularies with which to articulate their problems to themselves and others.
  - f. They live in a society where instant gratification is the norm; they do not know that some problems take a long time to resolve.
4. As with many adults, teenagers do not have realistic conceptions of death. They may fantasize about being present at their own funerals, about being at peace, or about being reunited with a loved one. Their stronger levels of denial about their own mortality also manifests itself in their greater willingness to engage in reckless behavior.
  5. Counselors who deal with children under the age of 15 frequently mention two factors in discussing suicide attempts and expressions of suicidal ideation. The first is physical, sexual or emotional abuse in the home. The second is severe parental loss or dislocation due to death, terminal illness, divorce, separation, remarriage, substance abuse, mental illness, or institutionalization.
  6. Teenagers with disabilities have additional hardships in trying to achieve adolescent developmental goals. They have difficulties in learning to deal with social, sexual, and family issues. Young people with learning disabilities have a higher than average incidence of depression.
  7. A study at a Bronx hospital found that 50% of the teenagers admitted for attempting suicide had presented themselves to a medical provider within two weeks prior to the attempt. Often they were young women who in the initial presentation made indirect complaints: headaches, "a pain down here", sleeping problems, stress in the family.
  8. A high risk period for suicidal behavior (completions, attempts, presentations of feelings and ideation) is during a disciplinary crisis or shortly before a disciplinary crisis is expected.

## **THE ELDERLY**

1. Have the highest suicide rate of any age group.
2. Tend to use more lethal means in attempting suicide.
3. Have a lower ratio of attempts to completions.
4. Have an even greater risk for completed suicide if they have a previous attempt.

The warning signs that were listed earlier must always be taken seriously. Those that are particularly significant for this age group are:

- a. death of a loved one, especially a spouse.
- b. problems with physical or mental health.
- c. losses of economic status, social status, sense of self-esteem.
- d. threat of relocation, loss of mobility, loss of personal security.
- e. declining capacity for coping with problems.
- f. feelings of loneliness, of being a burden, of being unwanted.
- g. neglect of personal health.

Alcohol and drug abuse are a serious problem among the elderly. One or the other or both are involved in at least half of all suicides among older Americans. An older person may have discovered that mixing a small amount of alcohol with a small amount of prescription medication will produce a stronger effect than larger quantities of either substance taken alone. This may cost less money and require fewer trips to liquor stores and medication providers (and thereby contribute to increased social isolation). This behavior is medically very dangerous and needs to be strongly discouraged.

An issue in the prevention of geriatric suicide, which recurs in different forms in every area of suicide prevention, is that counselors and friends give themselves reasons for backing off. "This person is an adult; I should respect his right to privacy; I should respect his right to do what he likes." In many cases the real motive for backing off is fear. The counselor or friend misinterprets his own behavior as "I'm acting out of respect". The elderly person also misinterprets the behavior and sees it as "I'm not worth bothering about". Here, as elsewhere, the side of life requires that that you take a step beyond normal manifestations of care and concern.

"Masked depression" is a problem in both adolescent and geriatric suicide prevention. The high energy level of young people distorts and disguises the classic symptoms of depression. Symptoms of depression in the elderly may be mistakenly attributed to the effects of age or they may be the side effects of medications taken for physical conditions. It is essential to make a thorough assessment of all complaints that are associated with depression. This assessment should include asking "the next question": "Are you having thoughts of suicide?"

### ***BEFRIENDING EMOTIONALLY DISTURBED PEOPLE***

Some users of this material are asked to spend time with people who have delusional beliefs about reality. Often emotionally disturbed people do not respond to your presence and the things you say with the types of verbal and non-verbal feedback that non-delusional people do. They may rave uncontrollably about things that make little sense. We are often left feeling

inadequate and frustrated because we do not achieve a normal level of conversational interaction.

The majority of people with mental illnesses - schizophrenia, paranoia, depression, manic depression, agoraphobia - are not suicidal. But they are nearly always extraordinarily lonely human beings. Besides their illness, they suffer from the social stigmas associated both with mental illness in general and with their particular type of illness. Because of their illness, they alienate and withdraw from others and become more lonely. And because of the growing estrangement and loneliness, their disorder gets worse. Being in this Catch 22 situation for months or years produces a horrible loneliness that is beyond the imaginations of people who have never suffered from mental illness.

You are doing something positive for emotionally disturbed people simply by being with them in a way that is calm, patient, sympathetic, and non-judgmental. They are afraid of "going crazy", of losing control, and of losing their capacities for being understood by others. If you listen you will find aspects of their story - a concern for personal health or safety - that are connected with reality and to which you can sincerely respond. It is unfortunately a part of their illness that they may do little to indicate that they recognize and appreciate your attention. But in some sense they do know that another person is there and is listening to them.

Being with emotionally disturbed people is a stressful experience. You may not feel that this is the most effective use of your time on the job. But at the level of one human being to another, you are doing something positive. While you are with them, their loneliness is less terrible.

### ***THE DEMORALIZING INCIDENT***

The demoralizing incident occurs when

- a. A counselor, relative or friend makes a considerable effort to get assistance from a healthcare facility for a suicide attempter or an acutely suicidal person.
- and
- b. The healthcare facility either refuses to provide treatment or gives a level of assistance that is grossly inadequate for the severity of the situation.

This is very disheartening. During talks with school personnel, social workers and police officers it is almost the norm that one or two members of the audience will express frustrations and disappointments over such experiences.

In trying to cope with these experiences we need to realize that no organization - yours or theirs - is going to act in a perfectly appropriate manner in all situations involving suicide. Each of us has an understanding of suicide that is very

inadequate and each of us and our organizations are affected by the myths, stigmas, prejudices and taboos that surround the subject. Given the number of people affected by completed and attempted suicides and by the anguish of suicidal feelings and ideation, it is obvious that American society gives a disproportionately low share of public resources to suicide prevention education, research and treatment. Unenlightened attitudes about suicide, and great fear and defensiveness, are unfortunately quite normal obstacles in work with the suicidal.

Lapsing into cynicism does not help matters. We need to see difficult experiences as opportunities for improvement. Pushing ahead often brings some progress. A good strategy to use when problems arise is to have your supervisor or principal talk with the supervisor at the other facility. These difficulties do not occur because you are doing an inadequate job; they occur because of problems that are out of your power to manage. Developing higher level lines of communication is a good way to channel your frustration in a positive direction.

### ***THE SURVIVORS OF SUICIDE VICTIMS***

The “survivors” are the relatives, friends, and acquaintances of a suicide victim. This group has a suicide incidence rate that is higher than average.

Nearly all societies have mourning rituals. After a death, survivors need to go through a grief work process before they can return to normal functioning. When the deceased is a suicide victim, this process is much more difficult to complete. The grief reaction to death by illness or accident includes denial, shock, guilt, anger, and depression. Death by suicide intensifies all these and may also include feelings of shame, failure, and rejection.

### ***ADDITIONAL BURDENS OF THE MOURNING PROCESS***

1. **Stigma** - For centuries suicides, suicide attempters, and their families were badly treated by civil and religious authorities and by the general public. They were denied last rites, subjected to criminal penalties, and were the objects of social contempt of every sort. Some authors regard modern science as a fourth source of stigma: various psychological theories have held that suicide is caused by problems in parent/child relationships. Although the degree of stigma attached to suicides by these sources is diminishing, it is still very real.
2. **Pain and Anger** - Unexpected deaths usually produce the initial defense mechanisms of shock, numbness, and denial. All these are increased when death is by suicide. As they recede, reality sinks in. And this reality is more painful than other forms of grief. Survivors may experience great anger - at other people, at the victim, at God, at themselves.

3. **Saying Goodbye** - When someone dies by terminal illness, survivors often have a chance to say goodbye. This is of considerable value in the grief work process. Suicide survivors regret not having had this opportunity. What makes this especially difficult is that the suicide victim, without their knowing it, may have said goodbye to them. It is not uncommon for the suicide to tell a survivor, "I love you," within hours of taking his life.
4. **Health** - Health problems such as diabetes and high blood pressure may get markedly worse after the suicide of a relative or friend. Survivors may have lengthy periods of heightened anxiety over the welfare of themselves and other survivors.
5. **Anniversaries** - Holidays and the anniversaries of the birth and death of the victim can be very difficult.
6. **Less Support** - Historically, society denied the rituals of a funeral and a mourning period to the survivors of a suicide. Although this is no longer the case, the amount, quality and duration of social support that they receive is still much less than normal.
7. **Limited Assistance** - Until the last few years the special problems of the survivors of suicide have received little attention in the training of therapists and counselors. There is little publicly available literature. (see Bibliography) Because suicide is not talked about, counselors for every population underestimate the extent to which their caseloads include survivors.
8. **Trauma to the Family** - The family system of which the suicide was a member suffers a tremendous shock. 70% of the parents of teen suicides eventually divorce. The nature of the death increases the difficulty of resolving estate, insurance and child custody issues. Families frequently move after a suicide. They may be angry at the social stigma that has unfairly been placed upon them.
9. **The Mystery of Suicide** - In the cases of death by accident, illness, old age, alcoholism, and homicide, the survivors know what killed the deceased. They have something specific on which to focus their feelings of guilt and anger. Survivors of suicide, however, often become preoccupied with wondering why the person chose to take his life. Only about 10% of all suicides leave notes; and these are usually unsatisfactory as explanations. Even if one says that the underlying cause is severe depression; and the motive is relief from pain; these factors do not explain why a person put an end to his life at a specific time. The fact that the immediate cause of the suicide remains a mystery causes the mourning process to be more difficult and to last longer.
10. **Assault on Values** - The survivors usually come from the same social, economic, and educational background as the victim. They shared the same values and attitudes. The survivor may think to himself, "This person thinks life is not worth living; and he is a lot like me; so what should I think?"
11. **Loss of Faith and Trust in Oneself and Others** - Survivors may lose self-esteem and worry about suicidal feelings in themselves and others. Child and adolescent survivors may feel "You made me suicidal". Friendships become weakened or lost and survivors have difficulty making new ones.
12. **Delayed Grief** - It is not uncommon for the mourning process to be arrested for an indefinite period - sometimes decades - and then resume forcefully. This may be occasioned by some other crisis in the survivor's life and can be extremely distressing. "Waves of grief" are common for immediate survivors during the first year or longer.

Finally, survivors are burdened with deep and complex feelings of guilt.

## ***GUILT***

1. The most basic feeling of guilt is due to the facts that we are not perfect and that we make choices in how we deal with others. After suicide it is normal to have exaggerated feelings about one's ability to influence the life of another. The survivor may brood obsessively about things he wishes he could have done differently.
2. Guilt may help keep repressed feelings of anger towards the deceased; and keep conscious thoughts of anger from being expressed to others. (There is an adage that it is wrong to think or speak ill of the dead.) Not getting these feelings out may make the grieving process more difficult.
3. Sooner or later the survivors will have a few moments or hours in which they forget about the death and enjoy life as they previously did. When this interlude ends - with a jolt - they may have a surge of guilt.
4. Feelings of guilt often lead to self-punishment and denial. Survivors may refuse to participate in activities that normally bring them pleasure. They may fear that feeling pleasure may cause them to feel more guilt.
5. If the deceased was a burden to the family, they may have a feeling of relief. They may then feel guilty for feeling relieved.
6. Survivors may have disturbing dreams about the deceased. Some of these express ideas that cause the dreamer to feel guilty.
7. It is common for survivors to idealize both the victim and the relationship they had to him. This factor may increase the guilt feelings.
8. Feelings of guilt can be very persistent. They do not seem to fade and lose strength in the same way that other emotions do.

## ***A MYTH ABOUT SUICIDE***

The emerging field of suicide survivors literature is beginning to identify and attack a myth about suicide. The myth is a cluster of ideas that can be given both negative and positive formulations:

People who commit suicide have received inadequate love and understanding from those around them.

A normal (or even, a much greater than normal) amount of love and understanding will always prevent suicide.

It is true that some suicide victims have deprived or traumatic personal histories. Others, however, have received the same care and attention as non-suicidal siblings. Love and understanding are effective in preventing suicide. But sometimes, sadly, they are not enough.

## **TALKING ABOUT IT**

Writers on suicide bereavement are unanimous in saying that it is essential for the survivors to talk about it. They say that the word "suicide" should be used and encourage the survivors to talk about the death with each other. They feel that it is desirable for the conversations to take place in the home, that they begin as soon as possible, that they include children, and that each person share feelings and thoughts with as many other survivors as possible.

The growing number of self-help support groups for the survivors of suicide victims have much to teach the world about coping with pain. Members simply share their experiences and provide mutual support. Attendance at just a single meeting can help relieve the feeling of being alone with the tragedy, the feeling that no one understands, and the feeling that there is no process to suicide bereavement.

The groups help circulate literature, much of it is written by the survivors themselves. One handout contained

*"I wish you would not be afraid to speak my child's name. My child lived and was important and I need to hear his name.*

*If I cry or get emotional if we talk about my child, I wish you knew that it isn't because you have hurt me; the fact that my child died has caused my tears. You have allowed me to cry and I thank you. Crying and emotional outbursts are healing."*

Unfortunately, talking about it is not easy. For centuries suicide was one of those things that shouldn't be talked about. Even today many suicides are kept secret from family members as well as outsiders. People are afraid to talk because they are afraid of how the other person may react - and of how they may react. Simply by offering to listen we can do a great deal to help a survivor cope with the stigma and taboo and to come to terms with his grief.

## ***SECRECY***

Those who work with survivors feel that there are very few situations where secrecy about suicide is a good policy. Children, for example, will nearly always find out anyway, and often under less than desirable circumstances. Secrecy, partial secrecy, and delays in providing information usually create resentment and distrust. Resentments and distrust damage relationships among survivors; and survivors especially need strong and supportive relationships. Suspecting that you may not have all available information causes a feeling of insecurity - a permanent sense of waiting for the other shoe to drop. Information grounds the pain in reality, not in speculation. Children are profoundly affected by a suicide in the family. They very often, on their own, reach the conclusion that they are somehow to blame for the death. Not including them in bereavement activities and discussions does nothing to discourage these ideas. The people keeping the secret usually say they are doing so for the protection of others. In actuality benefits of secrecy for those being protected are unproven; and the secret keepers are spared an unpleasant task and have bolstered their own feelings by saying others cannot cope. Informing people in a timely and supportive manner is less bad than having them find out in other ways.

## ***DURATION OF GRIEF***

Something that is not widely appreciated is that the mourning process is greatly extended when death is by suicide. Unfortunately, we live in a culture in which faster is better, much better. The social stigma attached to this type of mourning means that both the survivors and the people around them may feel social pressure to have the mourning period come to an end. Survivors who do not perform (or pretend to perform) the impossible task of "snap out of it and get on with your life" may suffer further stigma and isolation. The fact that this type of mourning takes a long time, makes it take an even longer time. Survivors need all the patience and befriending that we can give them.

An effect of the stigma is that both the suicidal and the survivors of a suicide victim are reluctant to reach out for fear of rejection and negative judgement. Americans have strong senses of personal privacy. This may be good in many situations, but in our relationships with people in pain it often contributes to isolation and a weakening of support systems. We need to be willing to take an extra step to assure them of our concern.

## **CAREGIVERS AS SUICIDE SURVIVORS**

Healthcare workers, mental health professionals, counselors for at risk populations, and many others are likely to know and care about someone who dies by suicide. We experience versions of many of the emotional reactions that happen to immediate survivors. Unlike family and friends, caregivers have the grim advantage of knowing that sooner or later we are likely to suffer this kind of loss. As with survivors of someone who dies by terminal illness, we can to some extent prepare ourselves for the griefwork process.

A first step in this process is to commit ourselves to having postvention policies and training in place before it becomes necessary to use them. As with planning for other types of unhoped for crises, this practice will help reduce the chances that we will have need to use the procedures.

A second step is to recognize that for suicide prevention workers perfectionistic standards will do more harm than good. Many suicides are preventable, but the prevention of all suicides is an impossible goal. Suicide will happen, and it will happen in organizations that have the best available programs and procedures. If the caregivers were doing what they could in the circumstances, they cannot be faulted.

During the latter stages of the griefwork process it is helpful to remember that your relationship with the deceased had its positive aspects. You can make up a list of the things he brought to your life and you brought to his life. The support that you gave to the person may have reduced his loneliness and lengthened his lifespan and improved its quality. Even in the cases where what we have to give is not enough, what we do is still worthwhile.

In her book *On Death and Dying*, Elisabeth Kubler-Ross describes what it is like to befriend the terminally ill. She says that these people are glad to be interviewed by her seminar because of “...*the need of the dying person to leave something behind, to give a little gift, to create an illusion of immortality perhaps.*” Without knowing it, the people we lose do this: they come to occupy special places in our memories. Accepting these memories shows our care and concern; and it changes us as individuals. If taken properly, these changes can be positive.

## ***COPYRIGHT INFORMATION***

“Suicide Prevention Resources” is copyrighted © (1988) by David L. Conroy. Permission is granted to reproduce this handbook for use within your organization or facility. Permission is not granted to distribute this material with its text in an altered or retitled form. The only alterations permitted are those necessary for conversion of the text to other word-processing software formats. Public and private distributions of any portions of this material should acknowledge the publisher - Suicide Prevention Resources, Inc., FDR Station Box 7693, New York NY 10150-1914, the author - David L. Conroy, Ph.D., and the Spanish translator - Fanny Semiglia.