Suicide Loss:

What Schools Should Know

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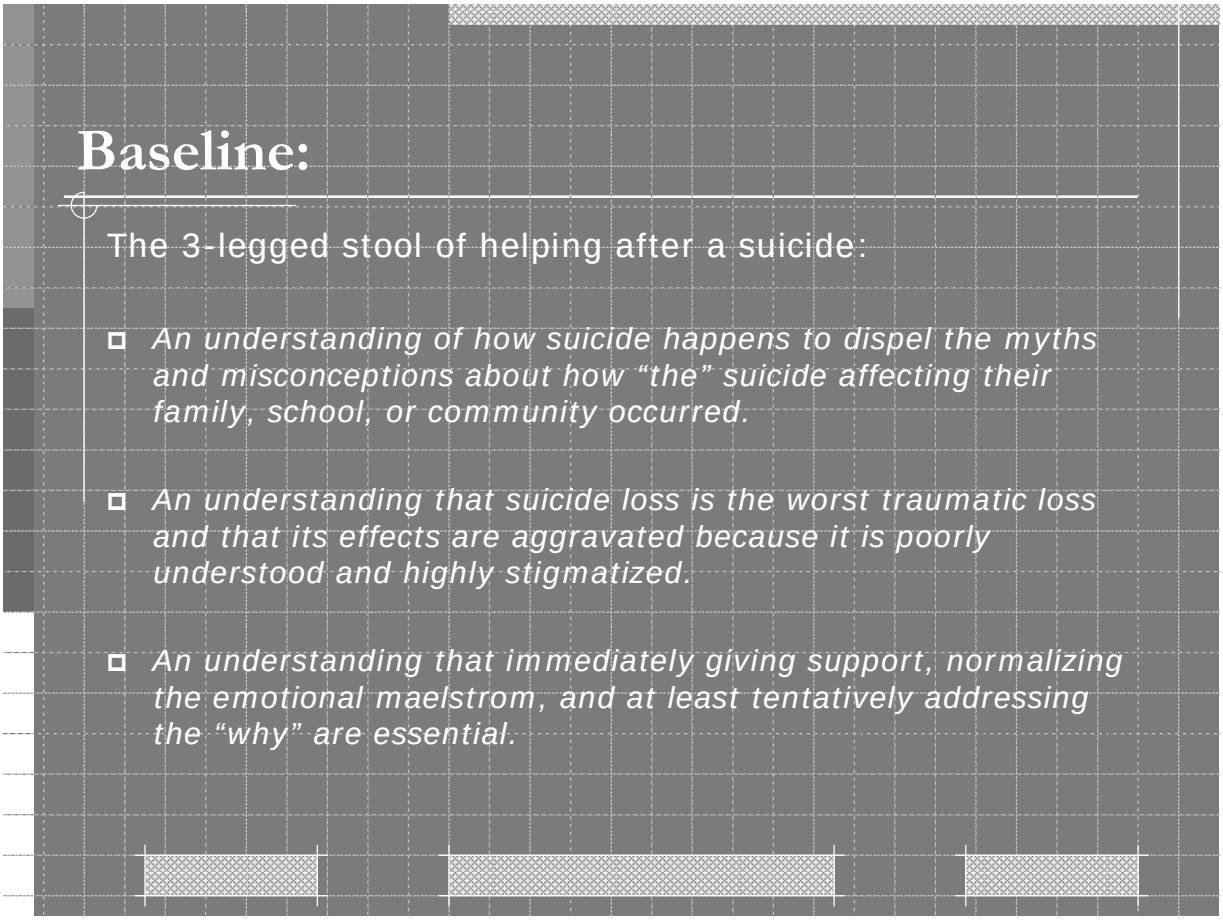
Purpose:

Most of us are not prepared for dealing with the people and the emotions that may be encountered after a suicide. What do we do? What do we say? What shouldn't we say? How do we help those struggling with this tragedy?

This presentation is an overview of the nature of suicide and suicide loss to help schools, parents, and the community to better understand the aftermath of a school-related suicide and how to respond to such an occurrence. It centers on the immediate circumstances and needs after the loss.

We draw on the professional literature and the experience of organizations such as Survivors of Suicide, which offer support to those bereaved by suicide, and it reflects the perspective of suicide prevention and suicide postvention. This is not meant to be a school suicide postvention manual.



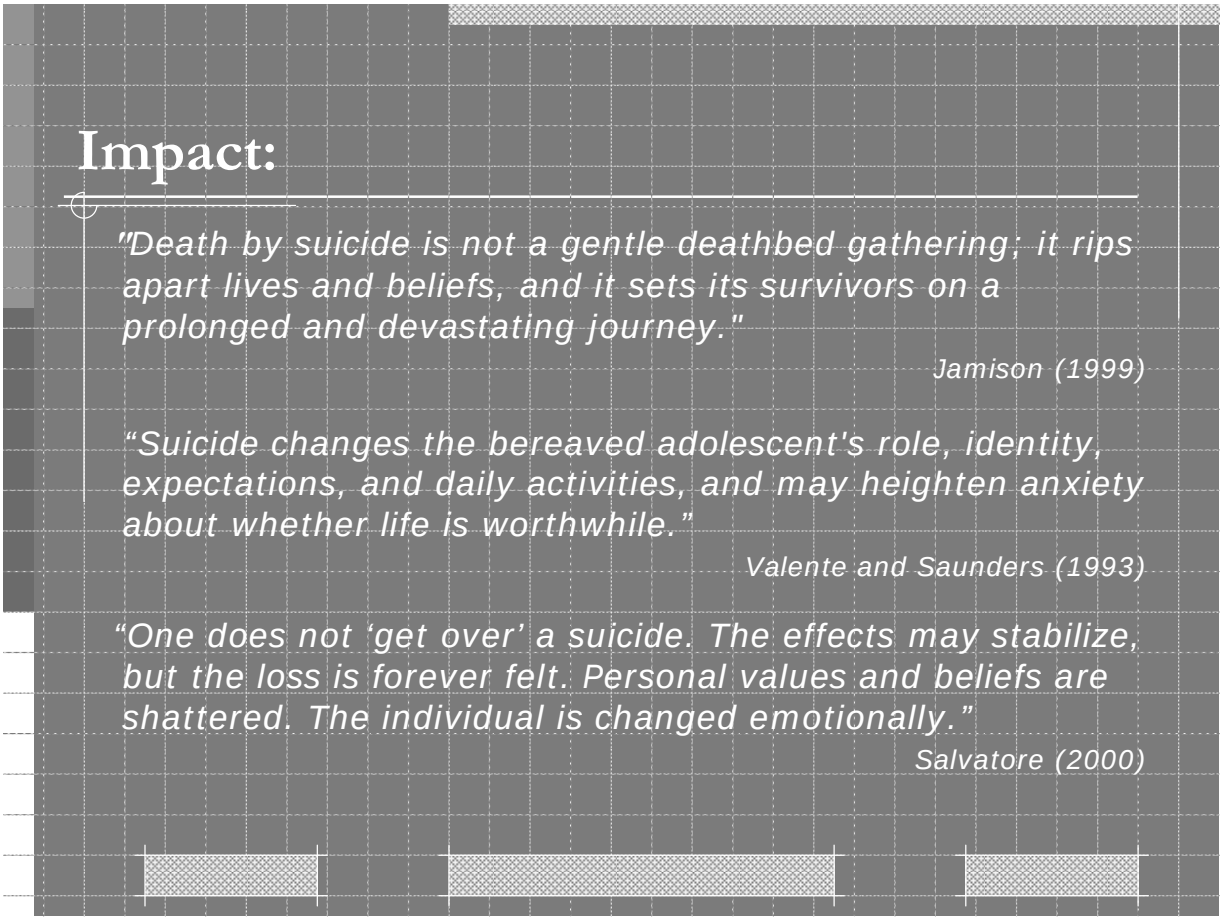
Core Competencies:

The pain of suicide loss is impelled by the features of suicide as a form of death. Suicide is poorly understood and colored by gross misconceptions and outright myths. Suicide is the most highly stigmatized human behavior. It is the most severe traumatic loss. Almost all who experience it need some measure of support and insight into what happened to the victim and what is happening to them.

Meaningfully helping after a suicide requires some objective understanding of suicide. Bad information about suicide will be of no help. Valid information will aid in dispelling the distorted perceptions of the bereaved and others that may impede recovery.

Suicide has been decriminalized and is not a sin in many religions, but it is still the subject of intensely negative sentiment. Survivors are very much caught up in a kind of "halo effect" with the victim. Caregivers must be able to counter the impact of stigma on the survivors.

Few in the school community will be spared the temporary trauma accompanying such a catastrophic loss and a few will be at high risk of long-term adverse grief reactions. Caregivers must be able to provide psychological first-aid as applied to suicide loss and plan for any ongoing support needs.



A Personal 9/11:

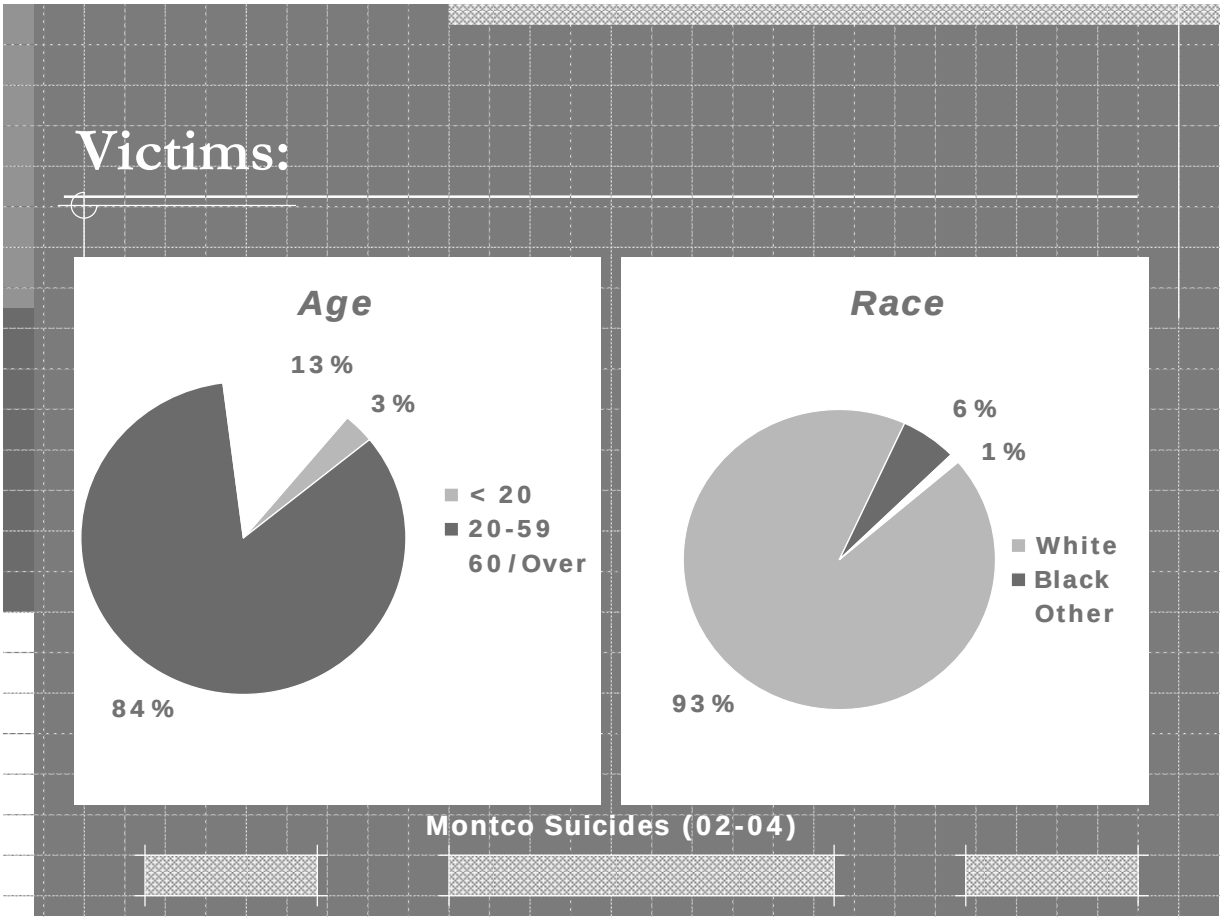
Suicide grievers are the secondary victims of the suicide. It is difficult to describe their experience. It has been likened to a "personal holocaust." A more timely reference may be a "personal 9/11." Try to recall how you felt on that day and the days after – the shock, helplessness, anxiety, fear, panic, anger, vulnerability, loss of control, disbelief, denial, grief, apprehension, incomprehension.

Throw in some "that only happens to others not to us" and a little of "why did this happen?" Try to imagine all of these emotions washing over you at an ever more intensifying level over succeeding days, weeks, and months. That's a partial approximation of what suicide loss is all about.

The effects of suicide loss set in when the reality of the death registers. The emotional trauma that follows cannot be averted, but it can be helped with support, understanding, and information. Aid given survivors as soon as possible after the suicide can limit the severity of the loss experience and facilitate their eventual recovery.

"Suicide is a mode of death that is mostly experienced as a brutal dissolution of life, and a violent disunion of existing relationships."

Cleiren and Diekstra (1995)



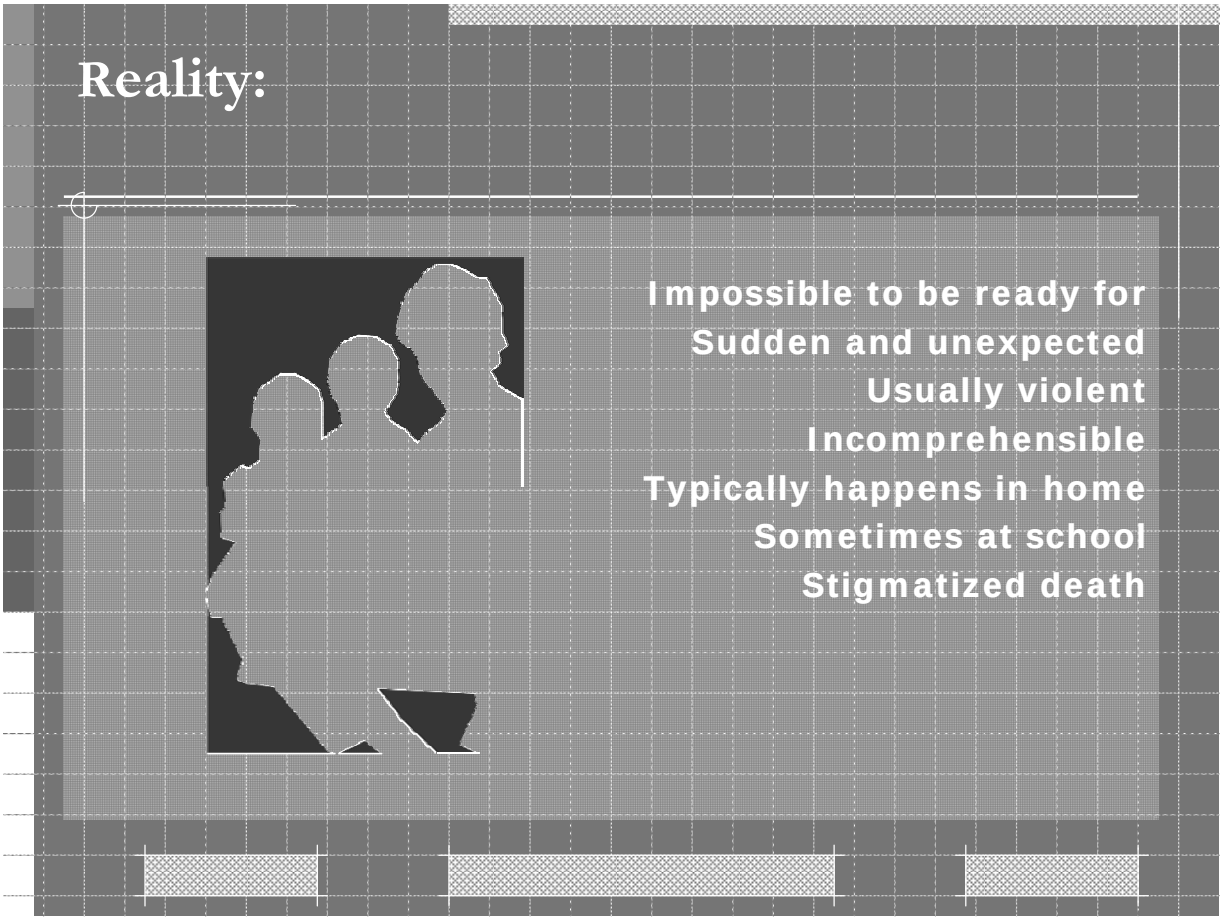
Who are the Victims of Suicide?

With little variances these charts characterize the demographics of suicide for the region and state. The young account for the fewest suicides. This is important to share with students and families who may have a far different impression as a result of the level of media attention paid to youth suicides. This doesn't lessen the enormity of the tragedy of any one suicide, but it helps put things in perspective.

The typical suicide victim is an adult white male. In any given school community, most members of the faculty, administration, and support staff are at far greater risk than the students. Keep this in mind because the loss of adults to suicide does occur in school communities and has the same devastating effects as the loss of a student.

"A conservative estimate is that at least one-third to one-half of the number of suicide deaths each year affects at least one child or adolescent. Thus 10,000 to 20,000 children and adolescents may be bereaved as a result of suicide each year."

Cynthia R. Pfeffer, MD



The Nature of Suicide Loss:

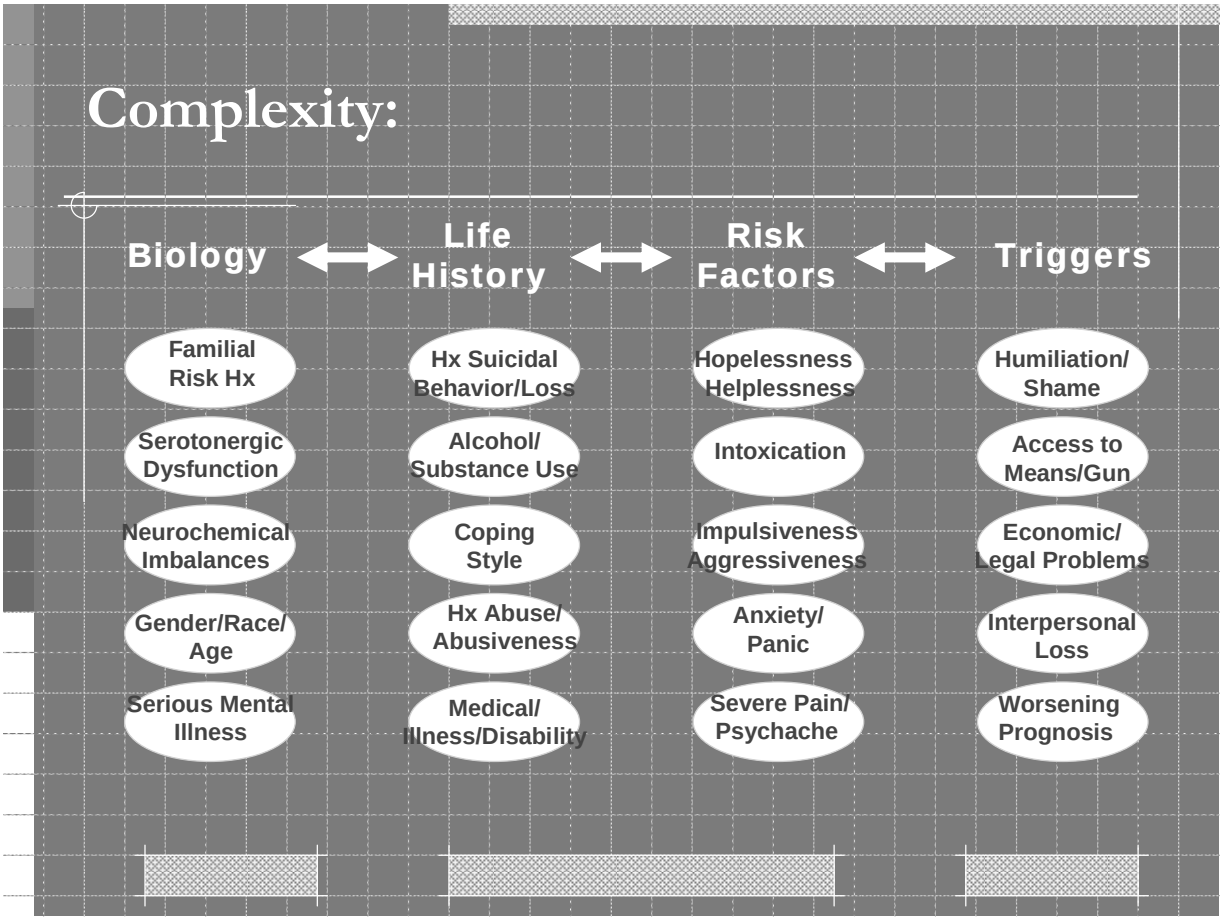
While some victims may have had a history of suicidal behavior or made past attempts, this in no way prepared anyone in their family, school, or community for a completed suicide. No one is ever ready for a suicide -- never.

The school may have a comprehensive crisis plan covering every foreseeable action to be taken in the event of a suicide. This will help, but no plan can fully provide for the reality of a suicide.

A suicide occurs with no warning and violently shatters the school's daily routine and the emotional stability of all it touches. Something that is beyond comprehension quickly reduces adults and adolescents alike to a state of shock, helplessness, and immobility.

The school becomes ground zero. The safety and security that it once symbolized are gone. The school is rocked as the psychological equivalent of an earthquake sends the institution into a near panic. It is a struggle to maintain control or even clarity in the face of fast spreading emotional chaos.

A suicide is more than a crisis. It is a disaster.



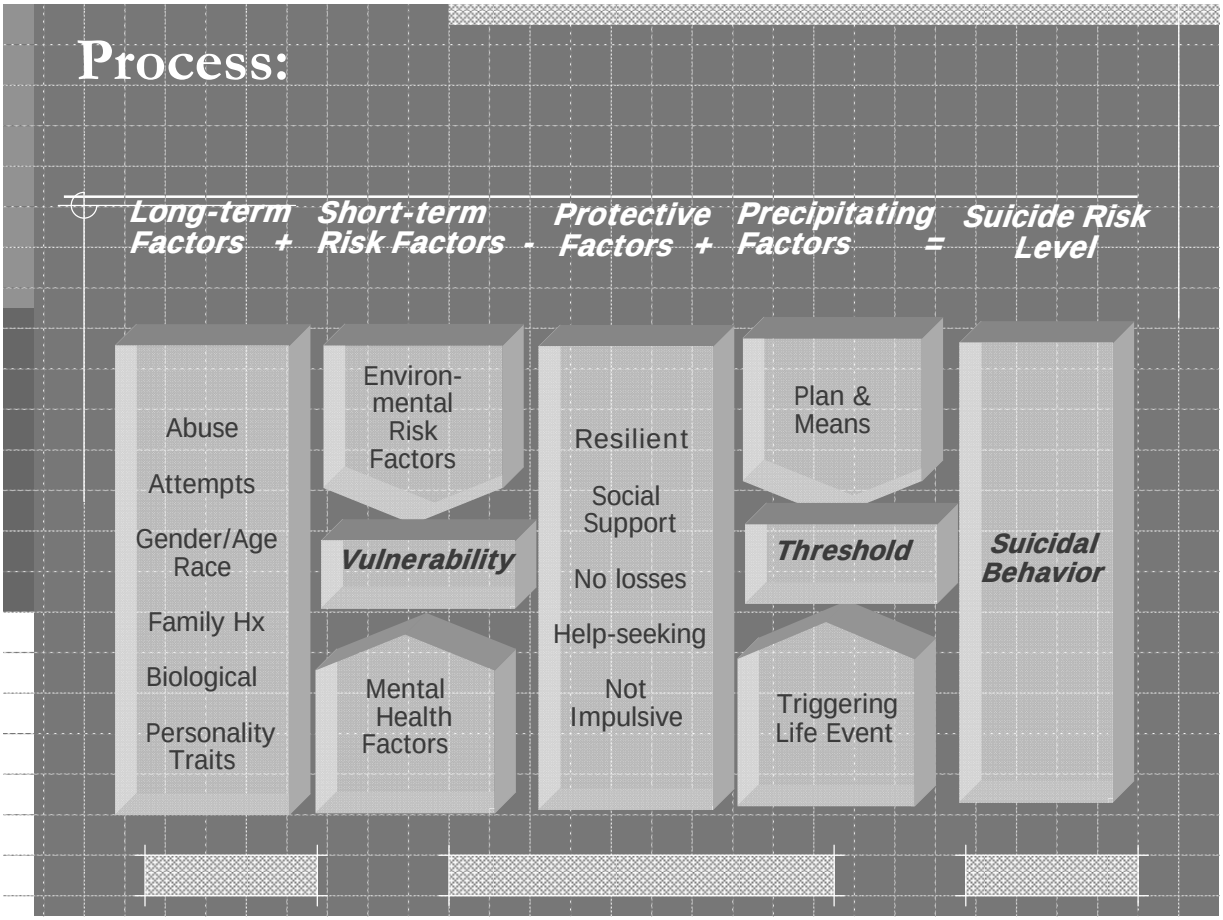
Multivariate Risk:

Some may take comfort in seeing the suicide as linearly linked to a single discernible variable in the victim's life. This may make for good news bites, but it won't hold up for the survivors who will conduct their own psychological autopsies for months after the death.

A wide range of demographic, psychological, social, cultural, interpersonal, and environmental risk factors are associated with suicide. These factors interact to increase the risk of suicide and they are different for each individual.

Some are fixed, long-term attributes acquired at birth or later that cannot be readily modified and create a lifelong risk situation. Others are dynamic and modifiable. These are produced by life experiences whose effects for most individuals can be changed. Then there are near-term factors which tend to "drive" a suicidal crisis when they are present.

Suicide risk factors vary across the life span and for different populations such as racial and ethnic groups or those with serious mental illness. Risk factors alone do not cause suicide. They can help survivors see that suicide is not amenable to a simple causal analysis.



Suicide is a Process[1]:

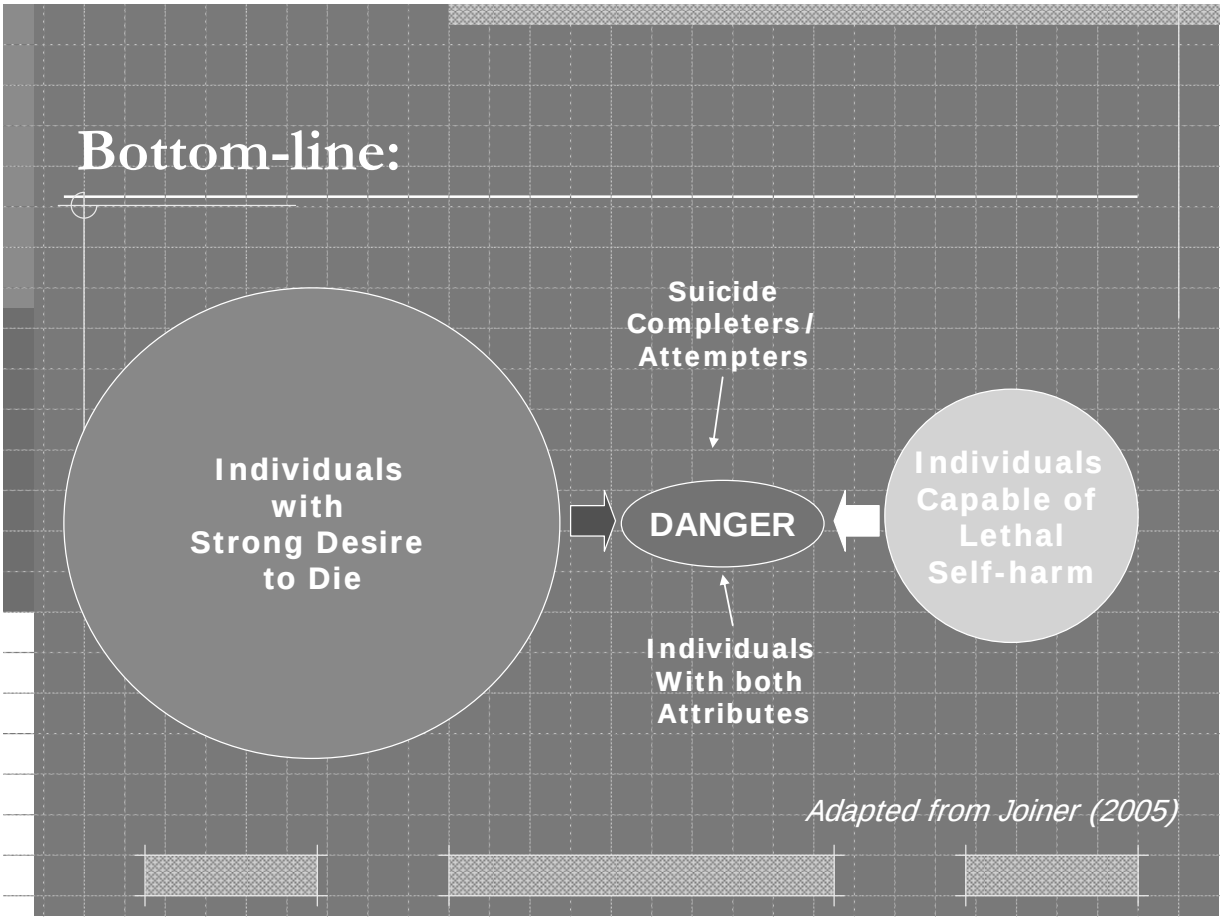
Suicide doesn't "just happen." It is the outcome of a complex intermingling of variables interacting over time in and around the victim. A suicide is, as noted by suicidologists Eric Caine, MD and Yates Conwell, MD, of the University of Rochester, "the punctuation mark at the end of the story." The "story" may be sometimes short but it will rarely have a simple plot.

The danger mounts as the process unfolds. The three main warning signs of suicide may be evident: (1) threatening to hurt or kill self; (ii) looking for ways to kill self; and (iii) talking or writing about death, dying, or suicide. These may be missed or seen only in retrospect.

More likely to be apparent are some of the key danger signs – hopelessness, feeling trapped, no way out, withdrawal from family or friends, anxiety, agitation, sleep problems, dramatic mood changes, no reason for living, and reckless or risk-taking behavior.

It is important that those affected by a suicide be given some insight into suicide as a multifactorial process. This enables them to see that while suicide is not predictable it offers many points for intervention and is not an inevitable outcome.

[1] The diagram is adapted from S. Matthews and R. Paxton (2001), ***Suicide Risk: A Guide for Primary Care and Mental Health Staff*** (see www.cofc.edu/betterthingstodo/Peer_Educator/**suicide**.pdf).



Why does Suicide Happen?

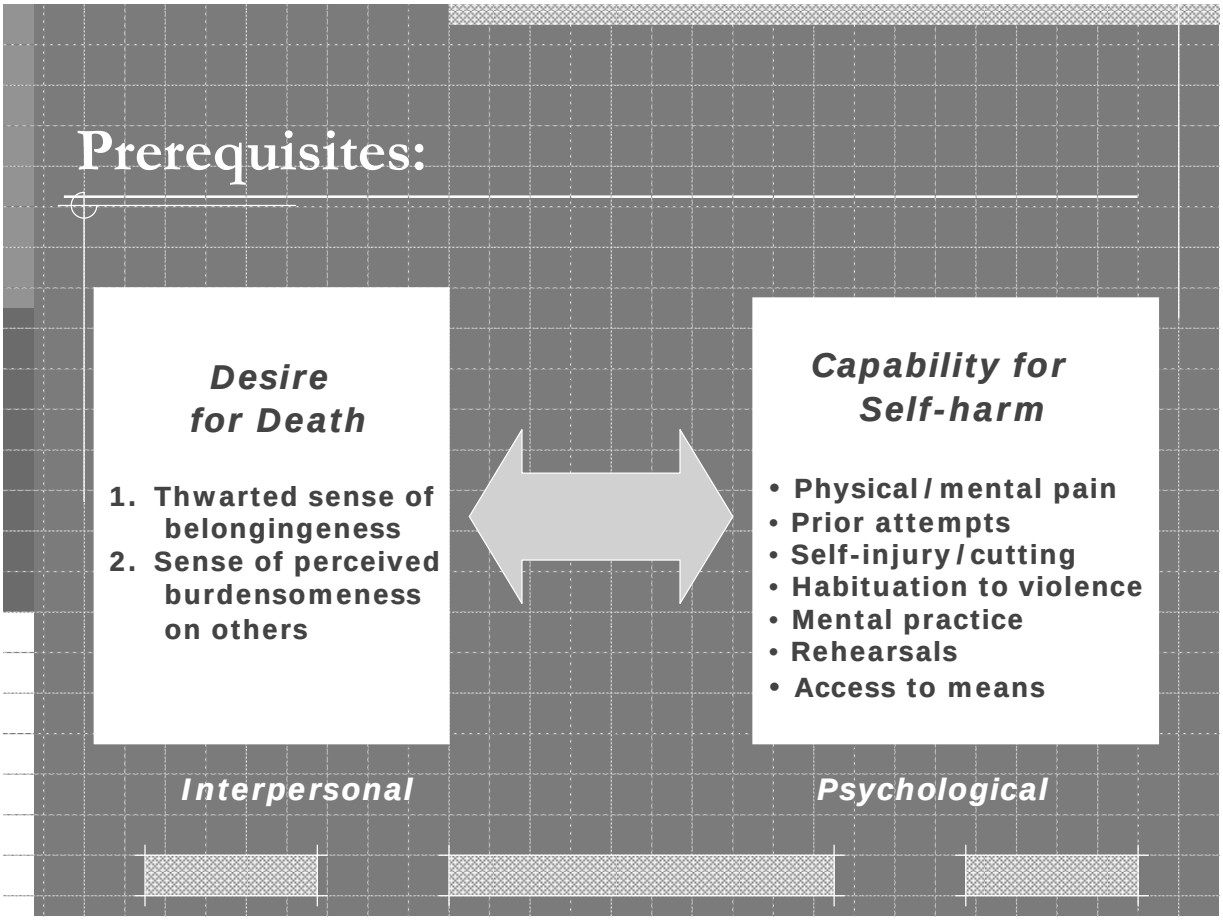
Every suicide is different and the circumstances leading to it are unique. A common underlying factor is intense psychological pain that arises when there is some irresolvable and totally frustrating situation in an individual's life.

Whatever the problem it is something that he/she finds devastating and something that seemingly cannot be resolved. Coping and problem-solving skills fail. Next self-esteem and sense of control over his/her life diminishes significantly. Then comes hopelessness.

Hopelessness may lead to suicidal thinking. In the absence of strong protective factors (e.g. family, religion, social supports) and in the presence of high risk factors (e.g., drinking, access to a gun), suicide may occur.

The risk is greatly increased by alcohol or drugs, which lessen inhibitions and increase impulsiveness. These substances heighten vulnerability and make things like depression and anxiety much worst.

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.



How does Suicide Happen?

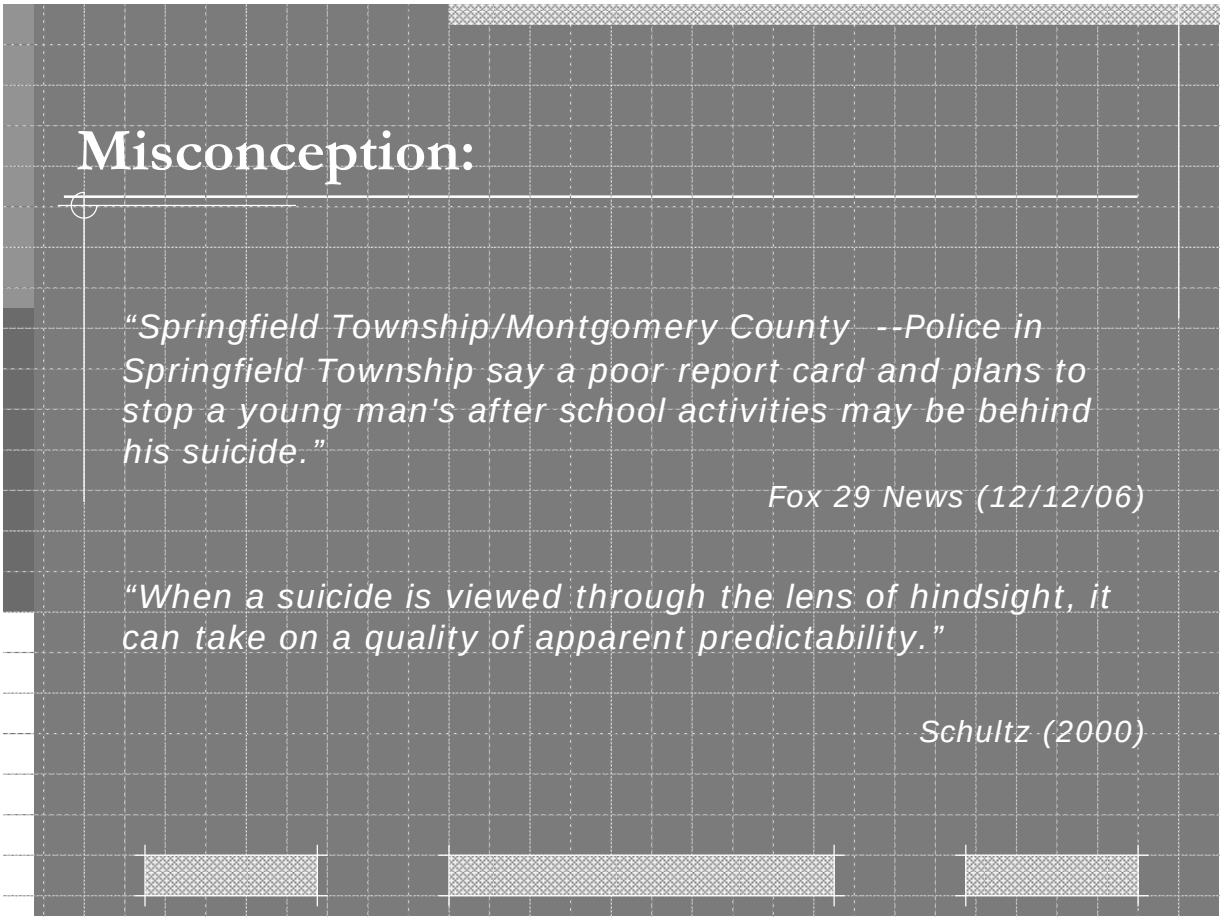
Psychologist Thomas Joiner notes that the completion of suicide requires both a desire for death and a capability for lethal self-harm[2]. These are the necessary and sufficient conditions for suicide. Without both a suicide will not occur.

A desire for death arises from perception of burdensomeness to others and low sense of belongingness. This occurs when someone experiences extreme hopelessness and helplessness and comes to feel that nothing or no one can help them.

A capability for lethal self-harm is brought about by "mental practice," self-injury, severe pain, or abuse. These behaviors and experiences can mitigate the innate inhibition against self-harm and make suicide possible.

Dr. Joiner's theory shows that there are reasons that a suicide happens just as there are reasons for other types of death

[2] See ***Why People Die of Suicide,*** Cambridge, MA: Harvard University Press, 2005**.**

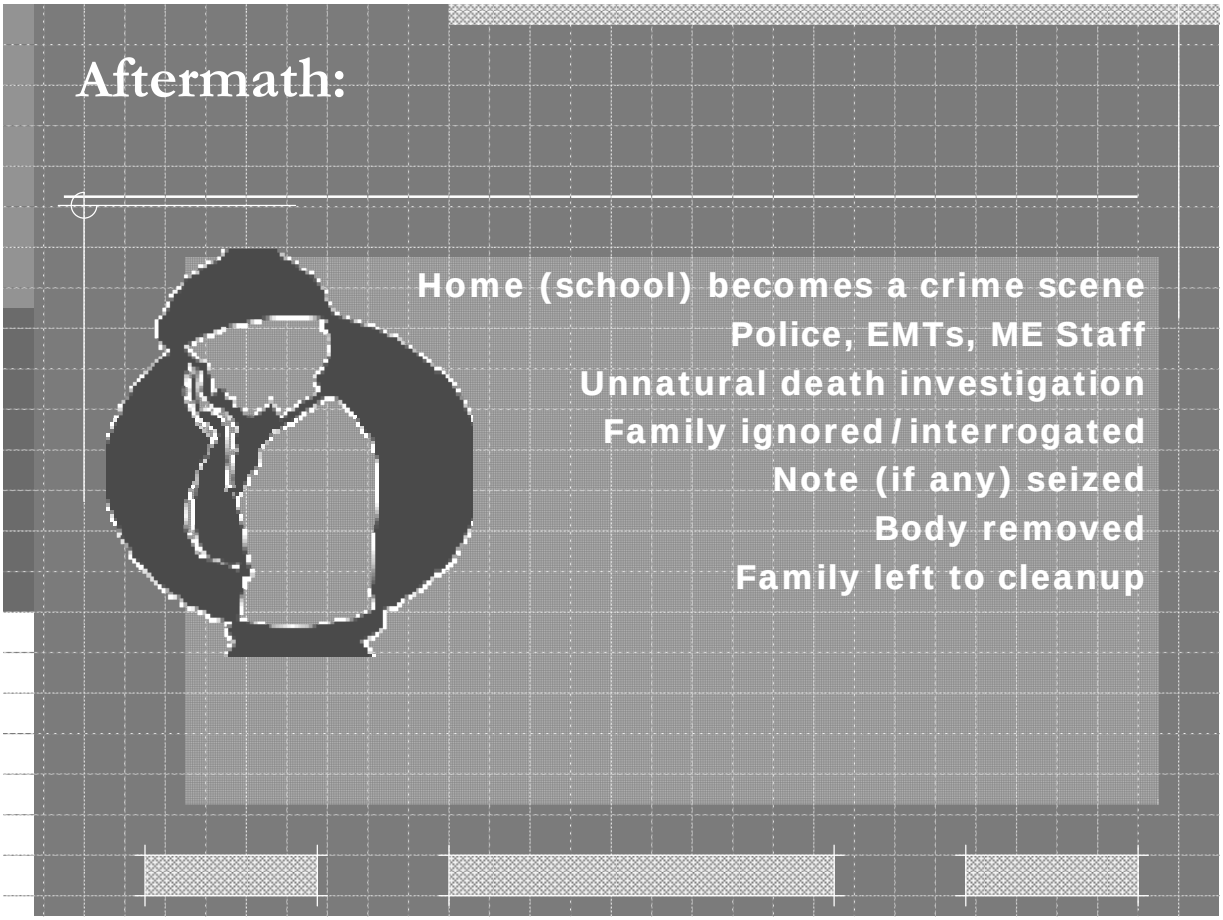


Non-benign misconceptions:

Most of what is said after a suicide is wrong and can be wretchedly hurtful. This can happen when a possible trigger is taken to be the cause. Worst yet is fixing on something that may have nothing to do with what happened, but may nonetheless leave someone second-guessing their last interaction with the victim for the rest of their life.

School or family problems may help push a suicidal individual across the threshold to suicide, but they are not necessarily what brought about the victim's vulnerability. As we have seen, suicide does not lend itself to facile explanations.

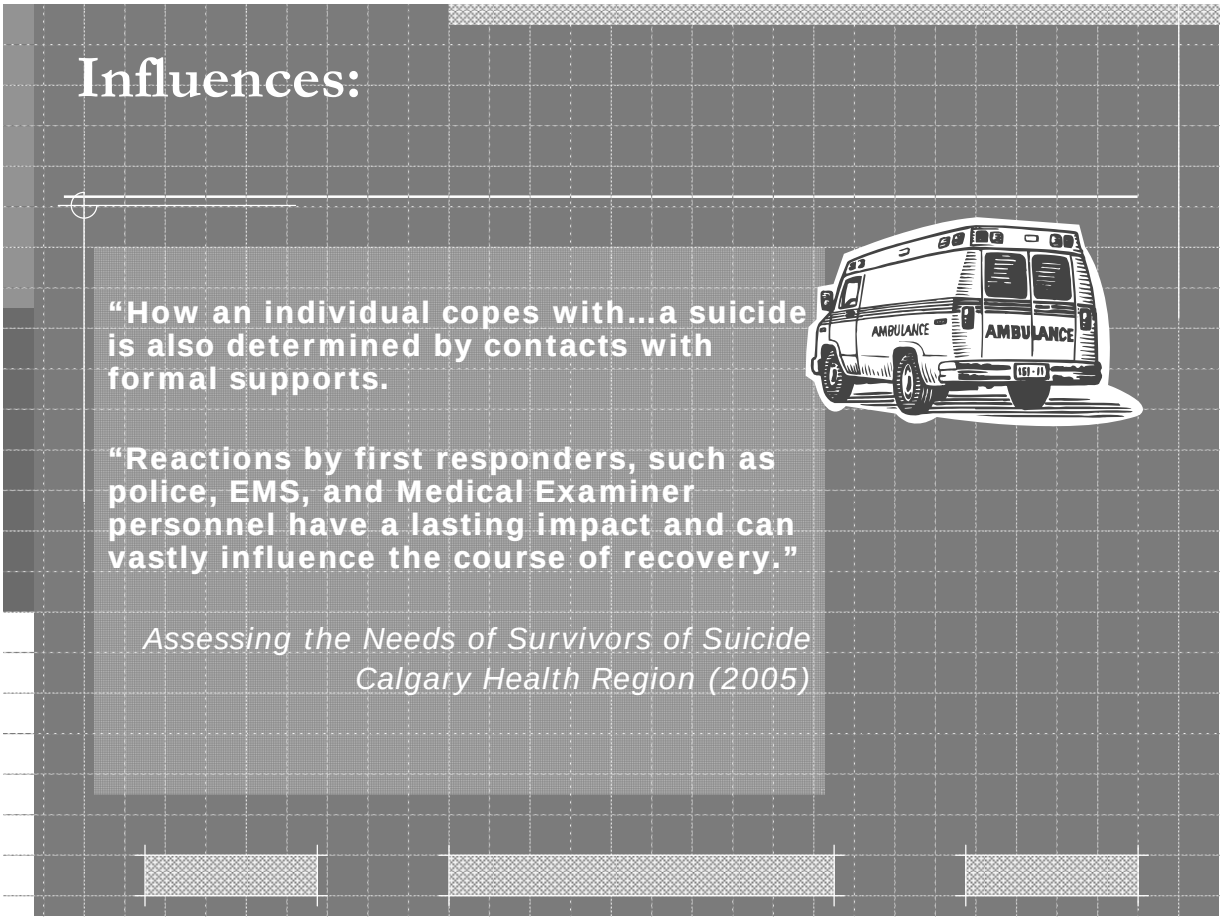
Similarly, implying that a suicide "made sense" in cases of disability, legal, or financial problems casts it as a rational decision. Saying someone "committed suicide" conveys control (as well as sinfulness or criminality). Characterizing suicide as a voluntary choice isn't comforting to family members.



The Post-suicide Scene:

Here are some things that can cause problems immediately after the loss:

- Unnatural death processing – "Treat all deaths as homicides at first, even suicides." Police officers are not told how upsetting this is to those struggling with the loss.
- Official information gathering – The family may be pained when questioned. Encourage them to provide the facts in a way that is as minimally disturbing as possible.
- Interference with the scene –The family may cut down the body, move the gun, throw away the pill bottle, start to cleanup, or hide any note. Getting a lecture on death scene procedures won't help.
- 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). Worst yet they may learn of it from the media.
- Officiousness – Suicide scenes may involve a struggle between a family that has lost any sense of control and responders who are trying to impose some measure of control to facilitate their job.



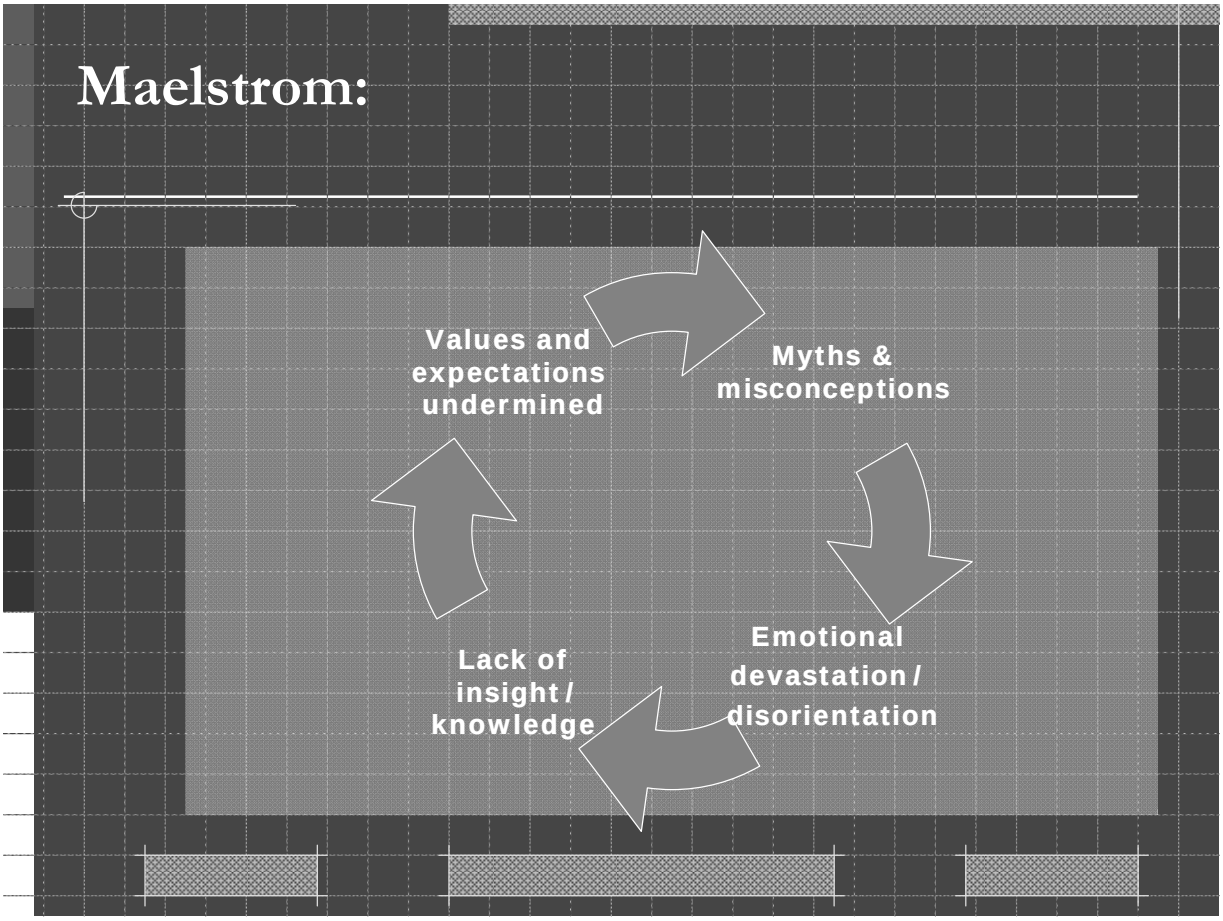
Support is Everybody's Job:

With suicide loss as in many other areas what is done is either part of the solution or part of the problem. Attention has already been given to the potentially negative effects of first responders who may stigmatize a suicide and add to the pain of the survivors' grief journey.

This can happen just as easily in a school setting. It is generally recognized that a school's educational mission yields temporarily to one of support after a suicide. It is less well understood that this expectation applies to the school as a whole and not just to designated personnel.

While specific staff may be formally trained to provide support, a student may turn to anyone they see as approachable. Coaches, moderators of activities, office staff, maintenance, housekeeping, security, and drivers may be sought out by students who see them everyday. These members of the school staff need do no more than listen, be supportive, and, as necessary, encourage students to take advantage of other school-based supports. If they are not supportive a student may not look for help elsewhere.

There's no such thing as "not my job" after a suicide.



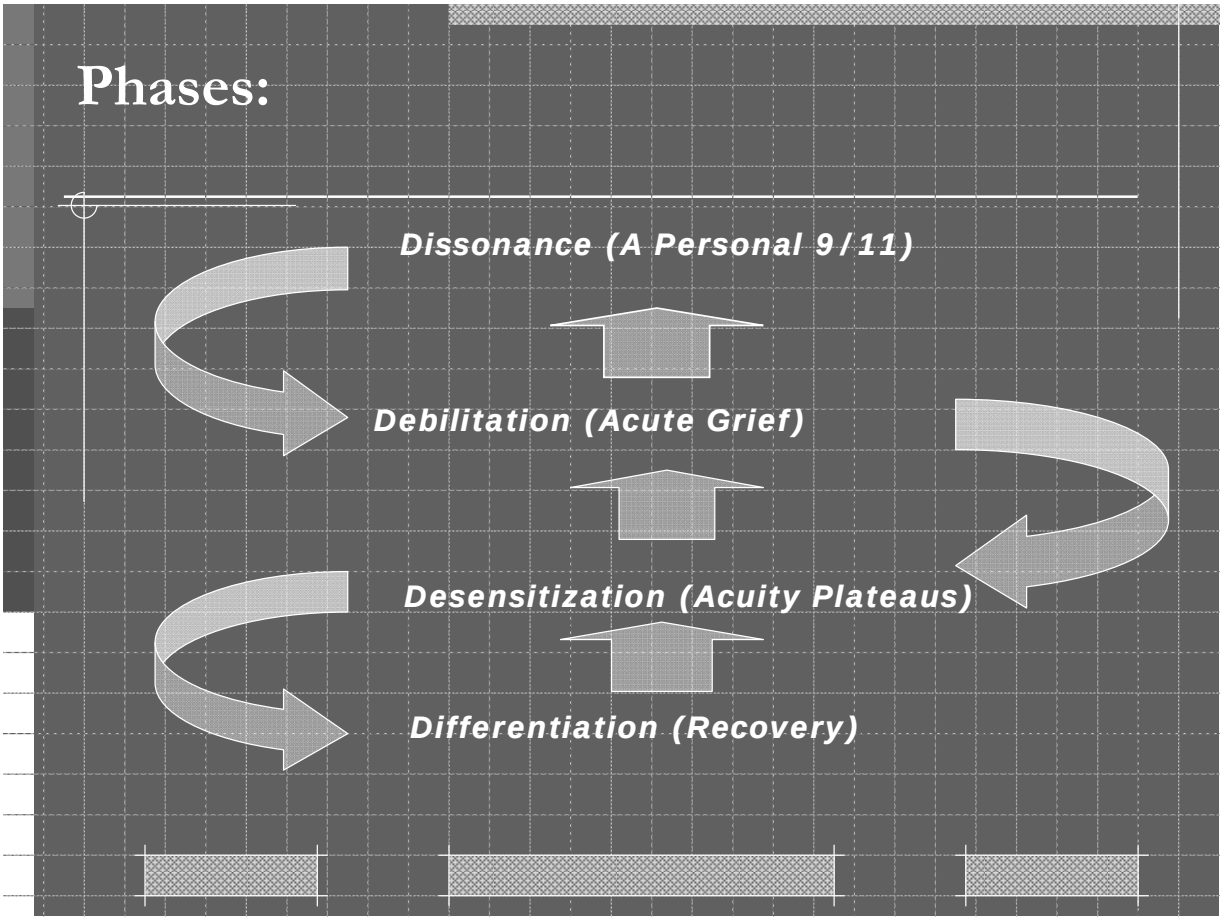
What is different about suicide grief?

A suicide loss involves a struggle with complex social, emotional and cultural issues that can make grief overwhelming and isolating. The experience challenges personal relationships, spiritual beliefs, concentration, and memory. Emotions become unsettled and fragile. All realms of life are affected

Because a suicide is the ultimate "unnatural" death many family members and others close to the victim may become consumed with causation. Some will search for "the" reason their loved one completed suicide. Others will lock on a particular event, conversation, or interaction. Help them to understand that the loss was the result of many factors, which may never be discernible.

Where the victims had been under the care of a counselor or therapist the search for "why" may center on these parties. Because of confidentiality and risk management most mental health providers will be of little help. Family members may respond very negatively to being denied "closure."

Communications from the victim may be found after the death. Some may be unsettling. The contents cannot be taken literally given the state of mind of the victim. Who receives messages may also be upsetting. Sometimes those closest are not recipients. This may be because the victim thought they would understand without being told.



Stages in the Suicide Loss Process:

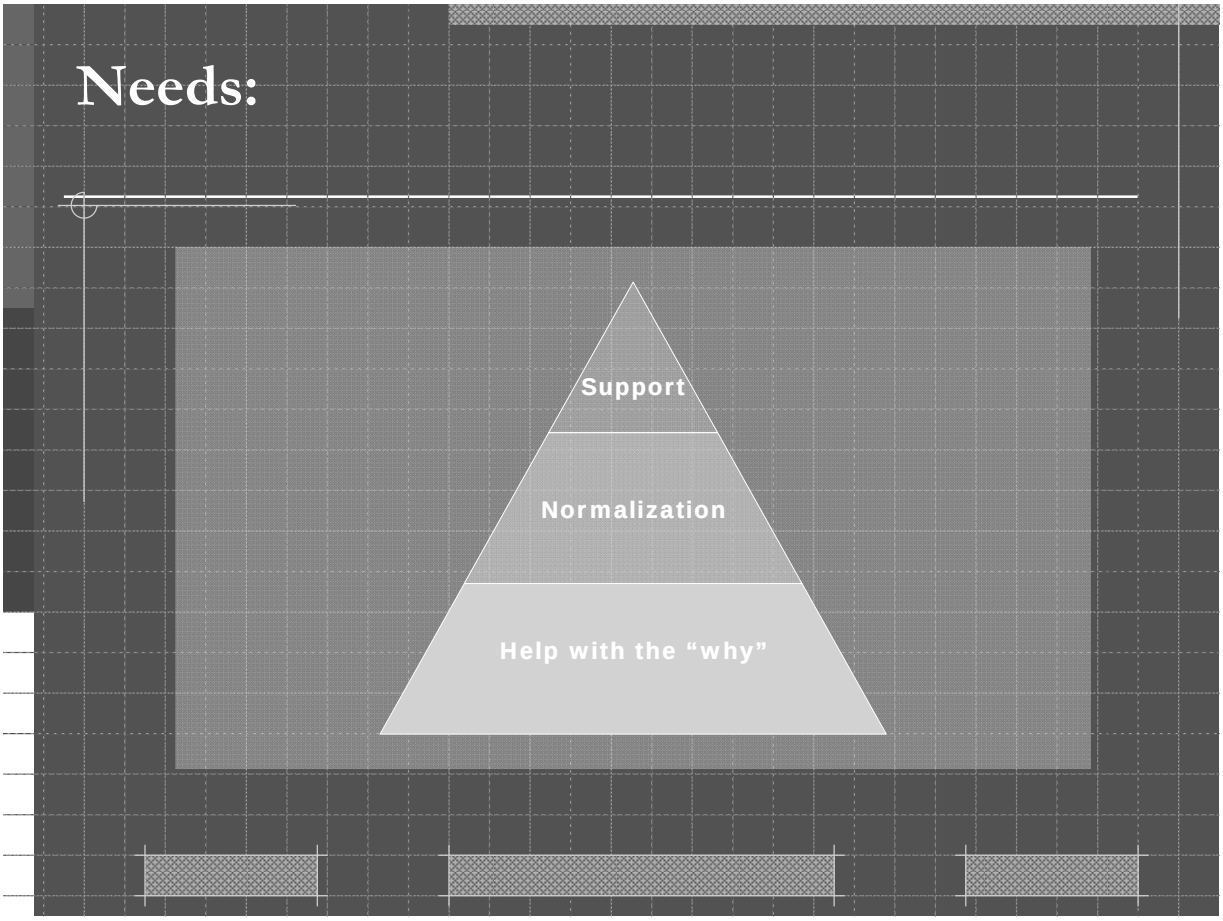
There seem to be phases to suicide loss that survivors pass through at their own pace.

The first is dissonance. This is the period after the loss when nothing literally fits. Devastation and anguish and sweep over the survivor. It can be a time of panic, blame, and incrimination. This is when survivors need the most support.

It is followed by debilitation, a time when survivors may feel that they are breaking down emotionally and psychologically. Acute emotional pain coupled with growing stress and depression brings this about. They feel disaffection from those who do not share their loss. They may also feel a loss of control over their lives and a pervasive sense of powerlessness. Many personal interests are abandoned.

Gradually, and often imperceptibly, rebound begins. The acute grief subsides. The emotional pain stops worsening. This is desensitization. Energy increases and some interests that were set aside may come back. Survivors are still vulnerable to relapses, but they are moving in the right direction.

The last is the differentiation. By the time survivors reach it they are truly different persons. They arrive at a changed sense of who they are as a result of their loss. Personal beliefs and values have been modified by what they e experienced. There is the emergence of a "new normal."



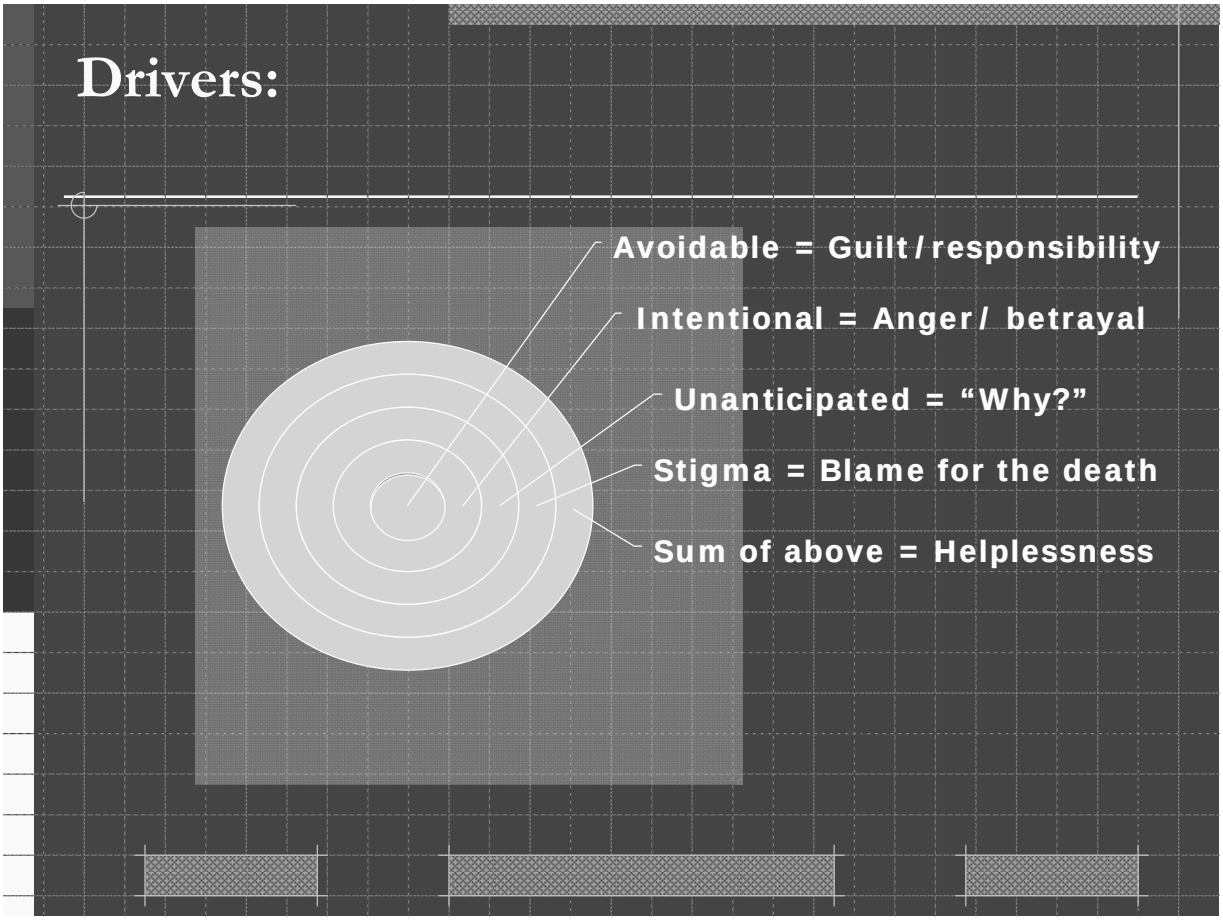
Immediate Needs:

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

- To understand that what they are feeling is normal – Those bereaved by suicide often think that they are having a severe psychiatric breakdown. To understand what they are going through think about our characterization of suicide loss as a personal 9/11.
- To get support – Most people have no personal experience with a sudden, unexpected, and possibly violent death. Whatever got them through any previous deaths will fail them now. Suicide loss is best managed with help.
- To achieve a tentative understanding of why their loss occurred – Most people know little about suicide and what they think they know is more myths and misconceptions than facts. It will take much time to work out a personal understanding of the loss.

An effective helping strategy for those bereaved by a suicide must provide:

- The opportunity for suicide grievers to talk about their loss as soon as possible
- The availability of staff led support and mutual self-help groups
- The access to information about suicide and the nature of suicide loss and grief.



What Drives Suicide Loss?

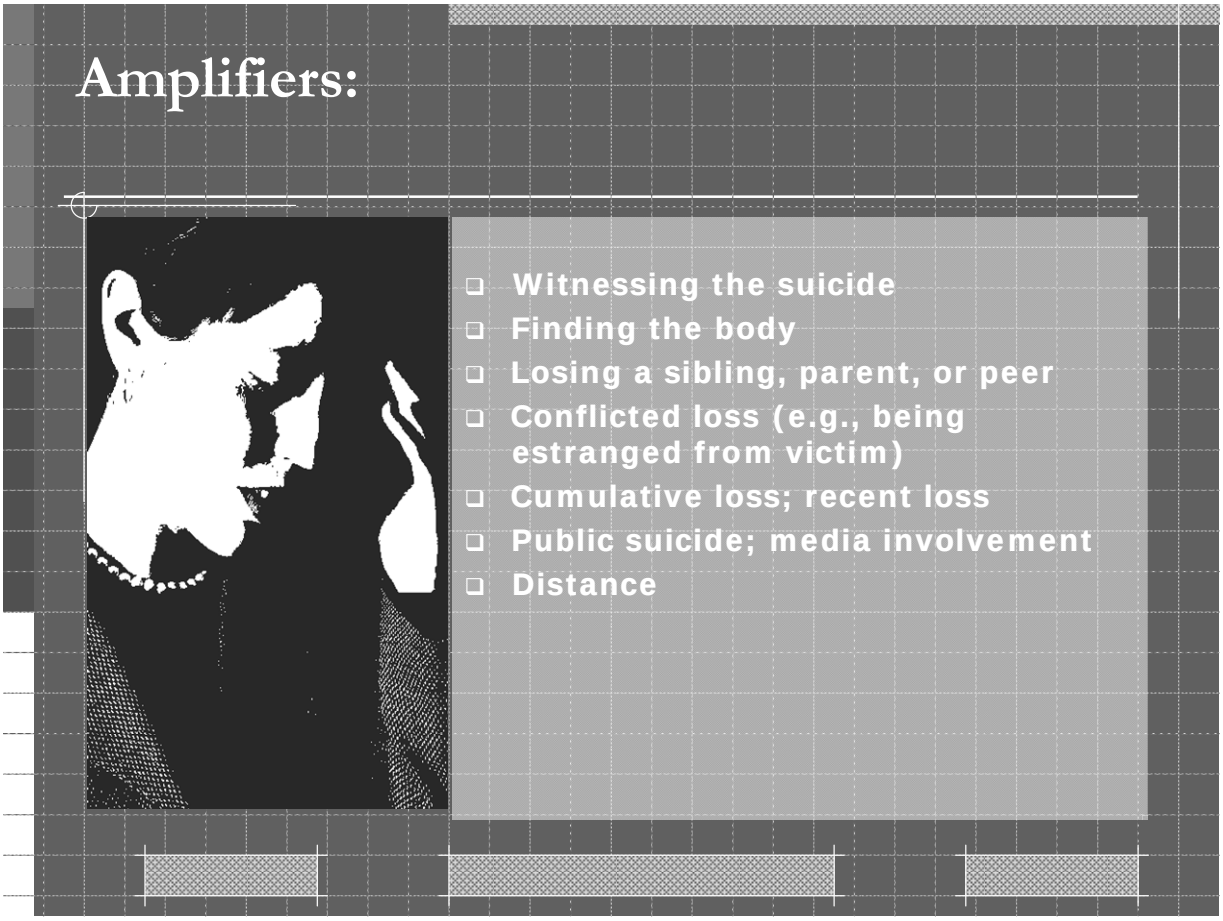
Suicide loss can be though of it in terms of layers. The first layer relates to suicides being avoidable. Grievers feel responsible because they "didn't do anything." Parents agonize that they let their child down. Blame for the loss may be directed at a counselor, the school, friends, etc. that knew of the risk, but didn't act.

The second layer relates to the seeming intentional nature of a suicide. Grievers may feel that the victim chose to leave them. This can generate a sense of abandonment, betrayal or rejection.

The third layer relates to the unanticipated nature of suicides, which leads to a 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 attached to suicide. Even when outsiders do not express such feelings (and they often do) the family may hold values about suicide. Those close to the victim may even be blamed for the death by others, including family and friends.

The last layer is shaped by utter helplessness which opens the door for hopelessness, the potentially deadly mindset behind the emotional pain that precipitated the victim's suicide.



What Makes Suicide Loss Worse?

Being present when the suicide takes place or finding the body can complicate the suicide loss. These experiences may precipitate Post-traumatic Stress Disorder (PTSD). Flashbacks may be triggered when the death scene was in the home or a location that the survivor routinely visits, such as school.

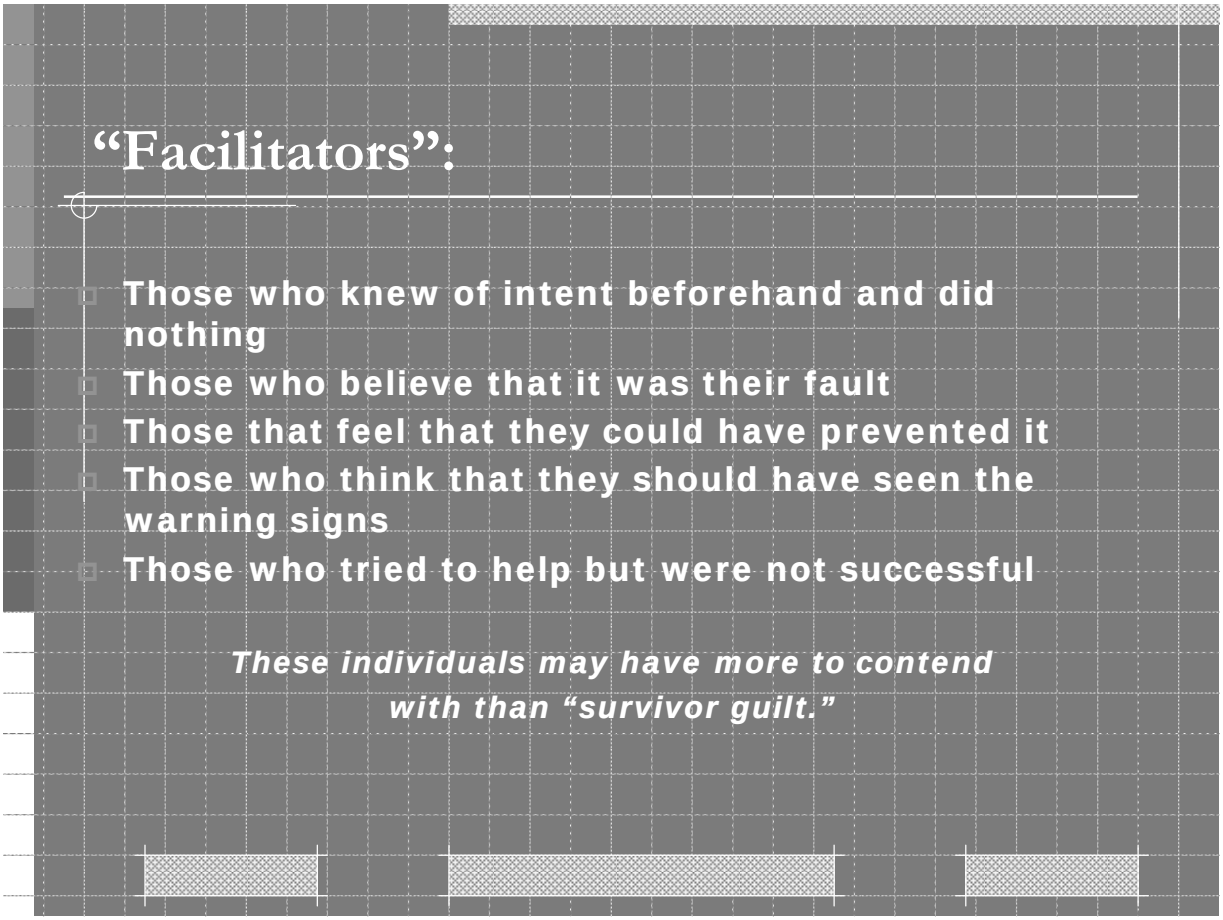
Those with a primary relationship to the victim may face a problematic bereavement. Loss of a child is commonly followed by a prolonged and intense grieving. Siblings and grandparents may be comparably affected. Less is known about peer responses to the loss overtime.

A troubled relationship with the victim can add even greater feelings of guilt, responsibility, and even liability to the survivor's burden. Divorced or separated parents may feel culpable.

Those who have endured a previous suicide loss or loss of a primary relative or close friend warrant special attention. Cumulative loss is a risk factor for suicide. Reach out to these students.

Most school-related suicide losses either occur in public or attract media attention. Survivors will find themselves grieving and mourning under close scrutiny.

Just "not being there" may raise the level of loss. Older sibs or close friends away at school or in the military need to know that they should not feel responsible.



Students Needing Additional Assistance:

Many close to the victim may feel responsibility or that they could have done more. Typically there is little opportunity to intervene. In a few cases, one or more individuals may have been more involved with the victim and feel the death resulted from a breach of duty on their part.

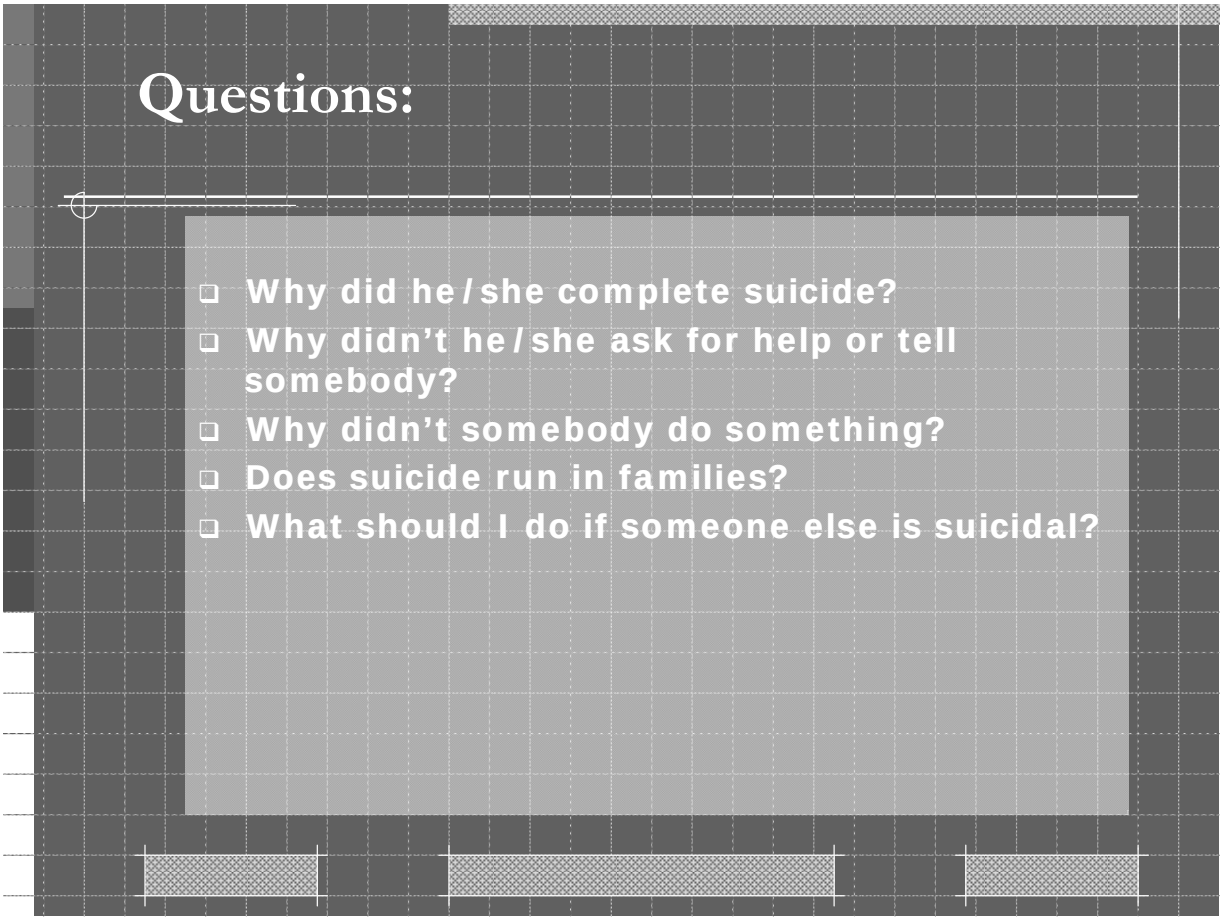
In school situations this is most likely to occur with friends or classmates sworn to secrecy by the victim who may have shared his/her ideation, intent, or plan. Sometimes these individuals will step forward and express their remorse; others may remain silent for fear of blame or even out of loyalty.

Also of concern are students who feel that they may have enabled the suicide. They feel guilty about things that he or she said or did to the victim before the death; students who did not take a suicide threat seriously, had been too busy to talk with the victim who asked for help, and/or observed events that they later learned were indicative of the victim's suicidal intent.

Others at high risk of complicated grieving:

- Any young person who is a sibling, other relative, or best friend of the deceased youth.
- Any young person with a history of suicidal threats and attempts himself or herself.
- Any young person who identified with the victim's situation.

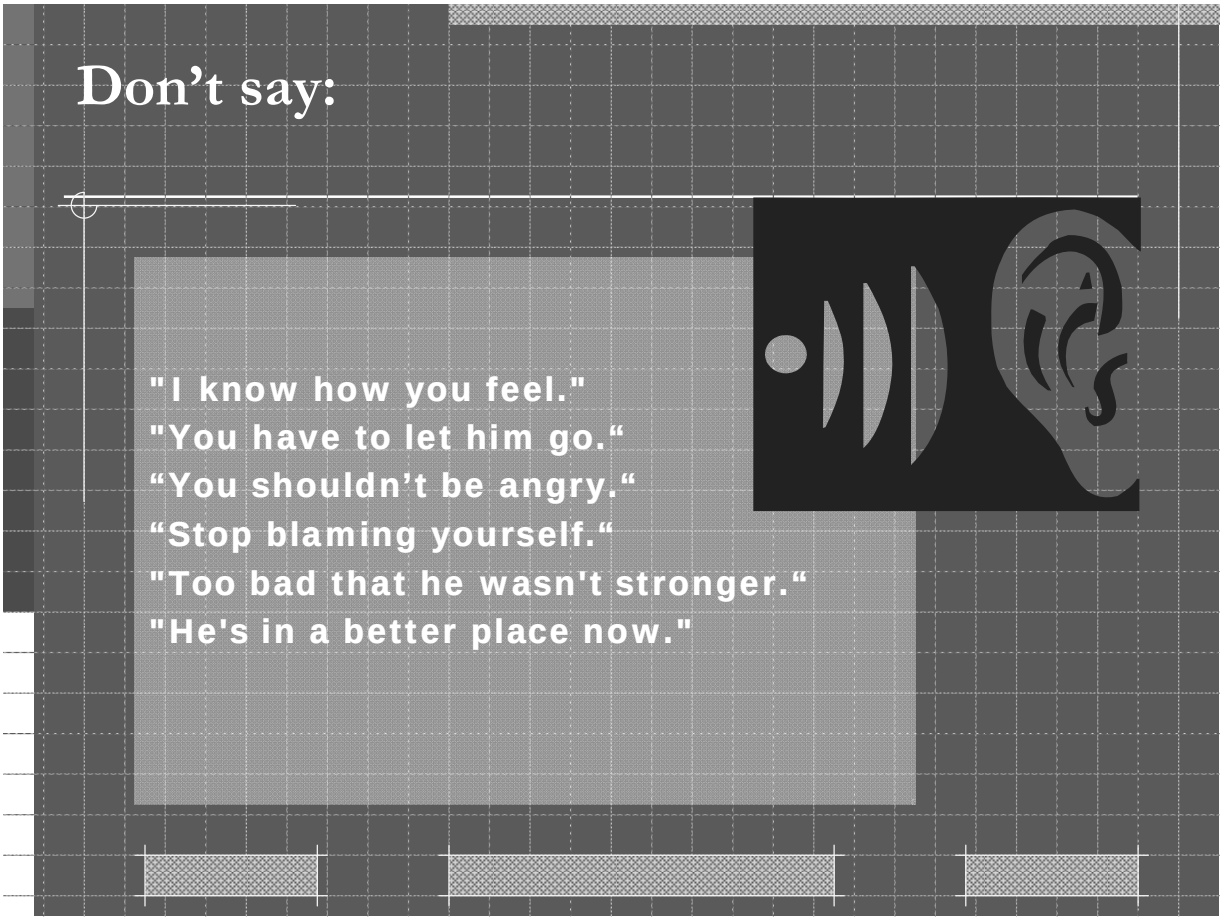
Sometimes there will be students who fall into more than one or even several of these categories.



Questions that may come from family and friends:

- 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)?
- Will an autopsy be performed on the victim? Why?
- What about tissue or organ donations?
- Is it possible to see the body at the Coroner's/ME's Office? Where is the county morgue located?

A few phone calls or e-mails beforehand will get you the answers to these questions in your county. Family members feel powerless and helpless in the aftermath of their loss. Queries of this nature are efforts to reassert control and to do something for the victim and themselves.



Some things best ***not* said:**

Remarks like these may do more harm than good regardless of the speaker’s intentions or their value with other deaths.

"It was his time."
(A suicide is never anybody’s “time” and is never predestined.)

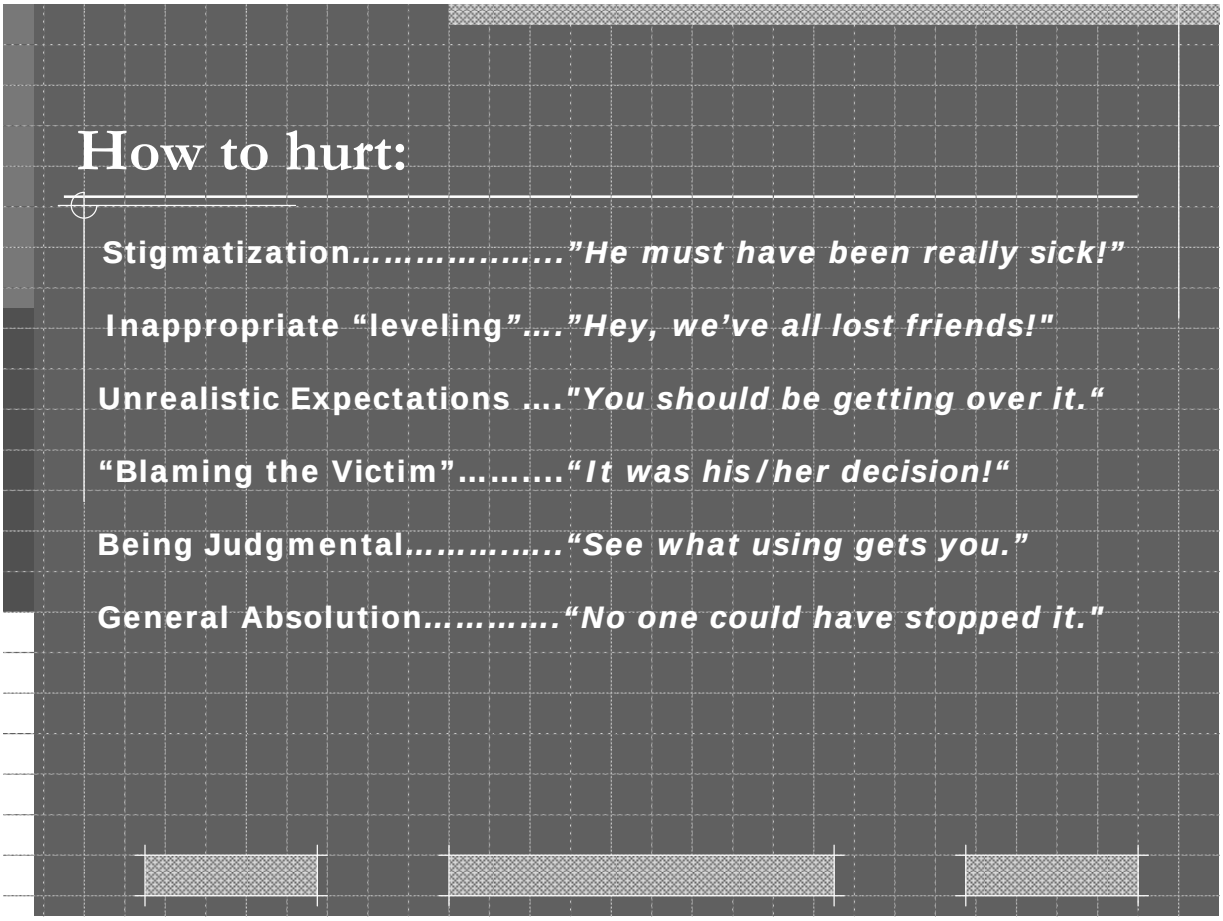
"All that anger will keep you from healing."
(Anger is a normal reaction and “healing” equates the loss to a cut or fracture.)

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

"He's in a much better place now."
(To those bereaved the place he/she should be is here.)

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

Those close to the victim should not be asked: “Why do you think he/she did it?” This question is already consuming them because they don’t know the reason.



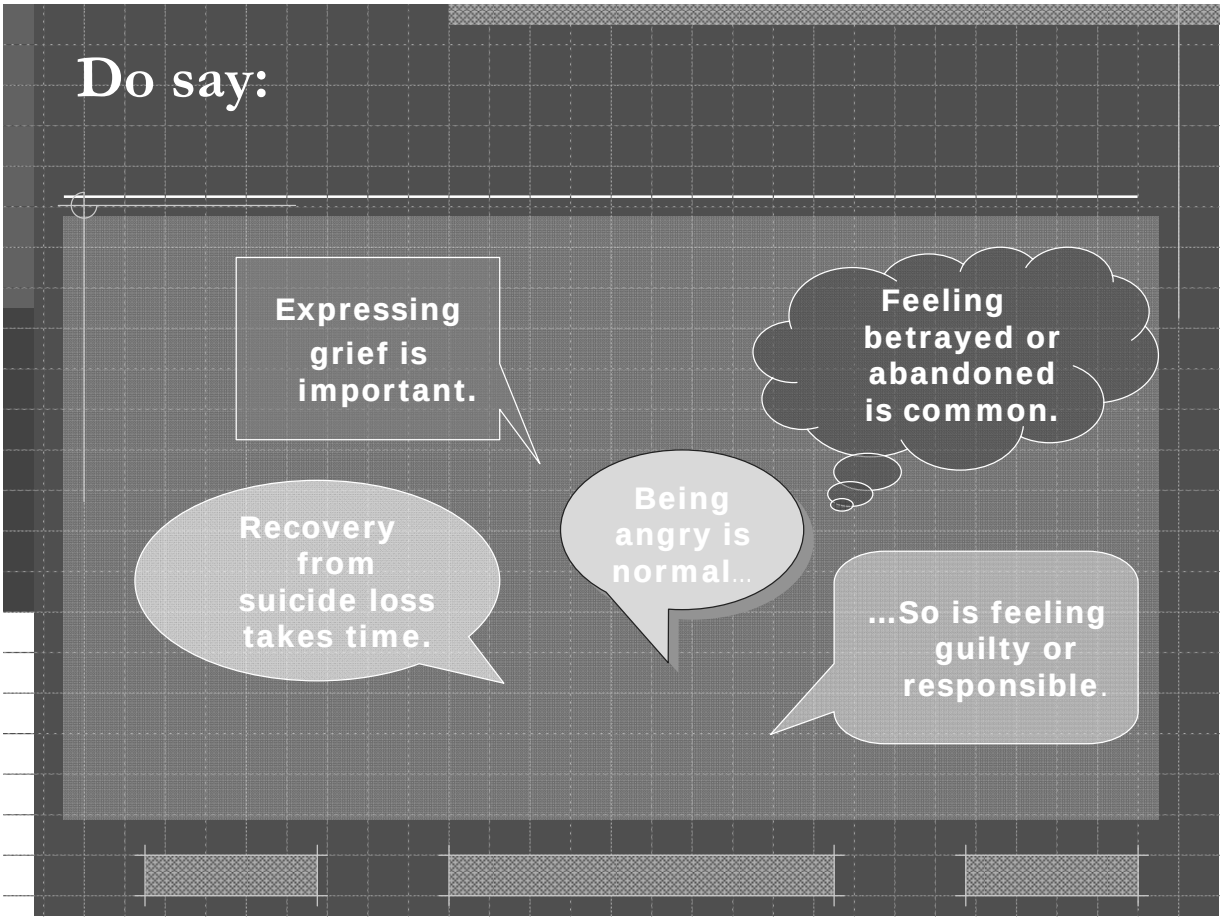
What's being heard:

There's no going too far to avoid stigmatizing or other value-ladened comments after a suicide. Given the capacity for immediate hurt and long-term harm, too much cannot be said about what should not be said after a suicide.

Must students and school staff will probably not even notice such comments, and some may even be the source. Affected students and family members are hypervigilant to any reference to the suicide and anything said anywhere in the school community will find its way to them.

Be wary of those who would micro-manage the survivors' grief. They'll want to let them know when its "time to move on" or to "start putting it behind" (often within 72 hours or less after the loss). Their sense of timing is usually just as bad in prematurely calling for "closure."

When these pronouncements are made by those that the survivors respect or trust the effect may to make them feel that they are grieving improperly or that their feelings for the victim are misplaced.



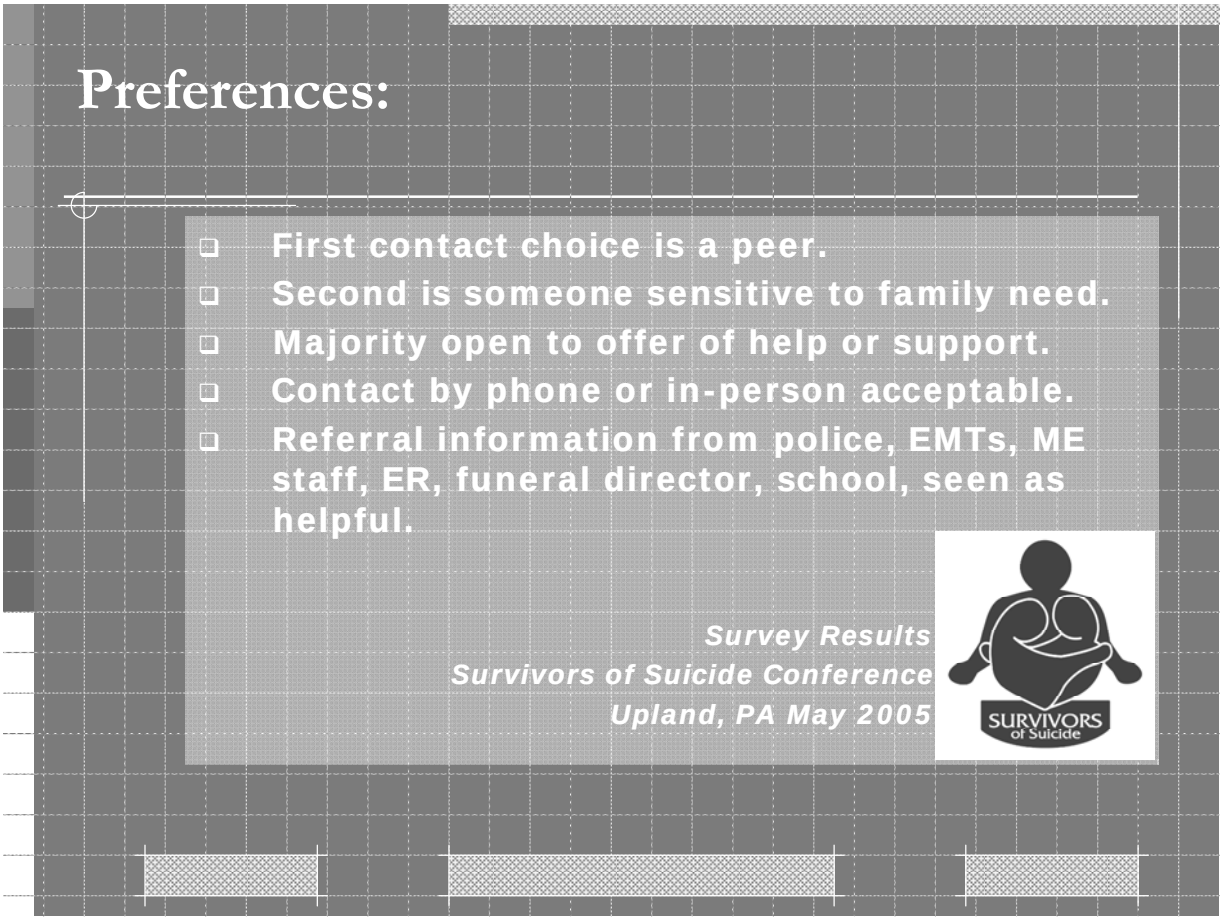
Okay Things to Say:

There's little that can be said right after a suicide that will make a family member or affected student feel better. There are things that can be said that will not make them feel worse. These include things that speak to concerns that may be troubling them.

Some survivors, particularly males, may literally need to be told that it is okay to grieve and even to cry. They may need to be given permission because they have been socialized to suppress such feelings. Remember saying its okay is enough; don't tell them to do so.

It is okay to mention the victim by name and to let the survivors talk about the victim's special or endearing attributes. Neither will bring on any additional pain or discomfort. There's no problem in speaking positively of the victim's qualities as a person. This is not idealizing her or his suicide.

You can say that you're sorry for their loss and their pain. You can also say: "I really don't know what to say."

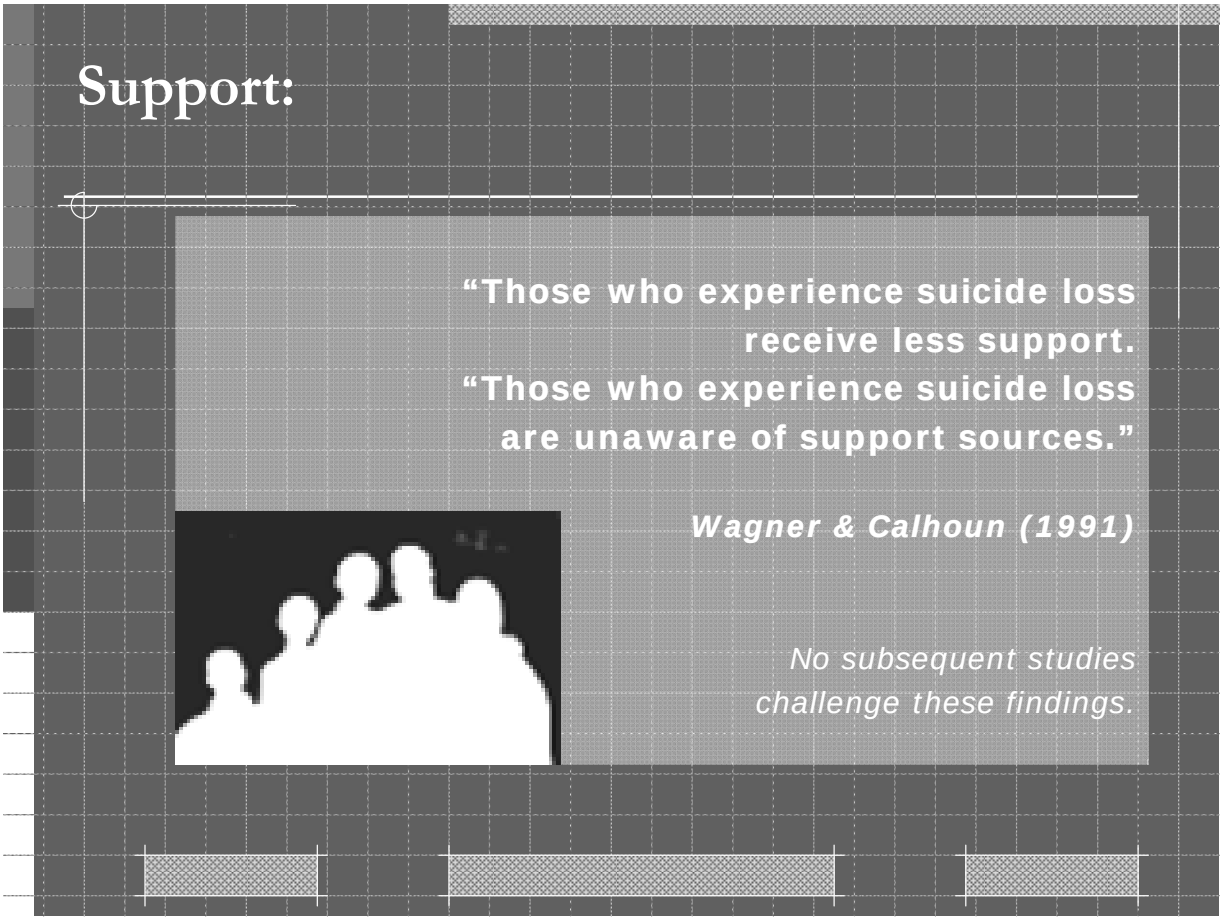


What Survivors Find Helpful:

There is not a great deal of research on the help preferences of those who have experienced a suicide and most of what we know concerns adults. Most of what has been reported on help preferences soon after the loss can be summarized as follows:

- Most affected by a suicide welcome expressions of help and support.
- Most are open to being contacted by someone who has also experienced a suicide loss and who can help them normalize their feelings.
- Most would accept information on available community resources from first responders at the scene or from others encountered immediately after the loss.
- Most would find it helpful to be contacted by phone or at home about possible sources of information, help, and support.

It should be kept in mind that this applies to the window opened by the devastating trauma of the suicide. As days and weeks go by this window for support will become smaller and eventually close.



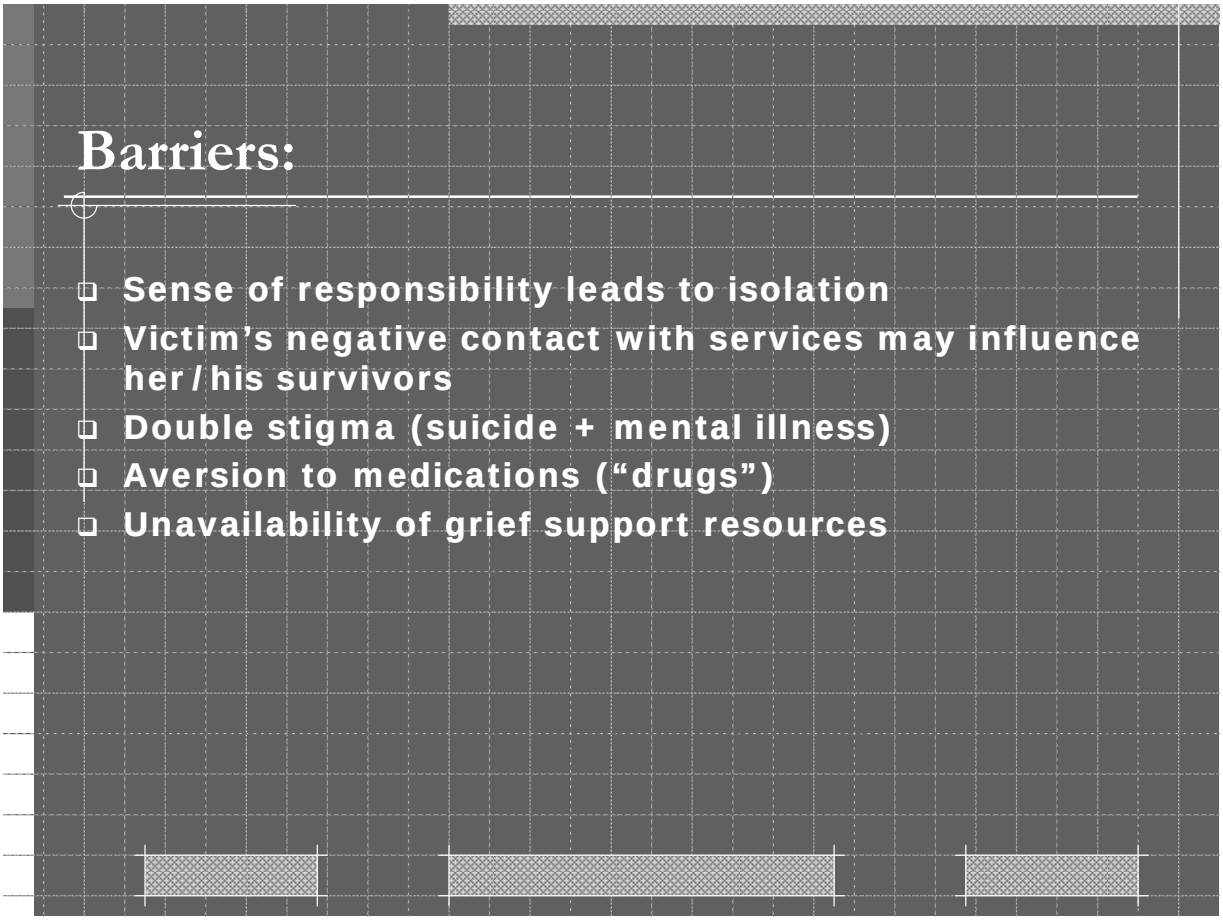
Suicide grief support sources:

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

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

Some Grief Support Sources	Phone	Web Site
Survivors of Suicide, Inc. (SOS)	215-545-2242	www.sosphilly.org
Compassionate Friends/Delaware Co.	610-874-7712	www.geocities.com/tcfdelco
Compassionate Friends/Abington	215-643-8531	www.abingtontcf.org
Feeling Blue Suicide Prevention Council	610-715-0067	www.feelingblue.org

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.



Obstacles to Seeking Support:

Students who feel involved with the loss may not be forthcoming about their needs or even seek help at all for fear of being blamed for the loss. When the victim was in counseling or other mental health treatment, some of those close to her or him may express an aversion to similar help with their grief because they feel that such interventions didn't help the victim.

The nature of the loss itself can impede help-seeking: "The trauma of the suicide of a peer and/or friend may make it difficult for child and adolescent survivors to reach out for support as they become overwhelmed by feelings of abandonment, rejection, social isolation, and confusion." (Mauk, 1999).

School-based supports are usually in place for the remainder of the school year. Some students may not feel the need for help or show signs of grieving problems until much later. Community-based supports for young people are scarce in most communities (as indicated on the previous page)..

What is suicide postvention?

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

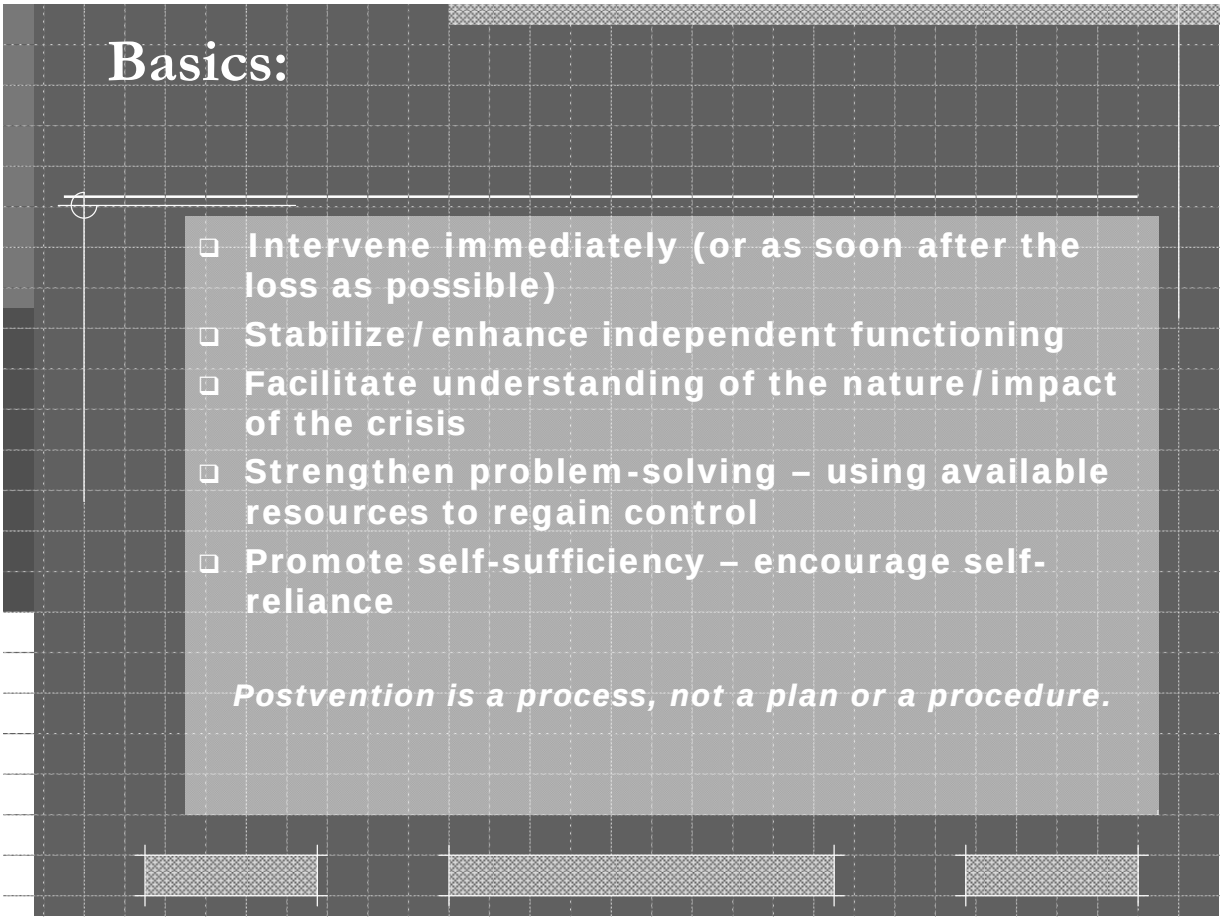
Postvention facilitates the recovery. Suicide loss is emotionally devastating. "Healing" or "getting over it" or "closure" don't apply. Recovery means eventually rebuilding a life around the loss. Doing this often requires outside support and that's postvention.

There are three objectives to any postvention effort:

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

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

Postvention should begin as soon as possible after the suicide loss. That's where you come in. You are likely to be among the first to reach out to those close to a recent suicide victim.



Postvention "First Aid"

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

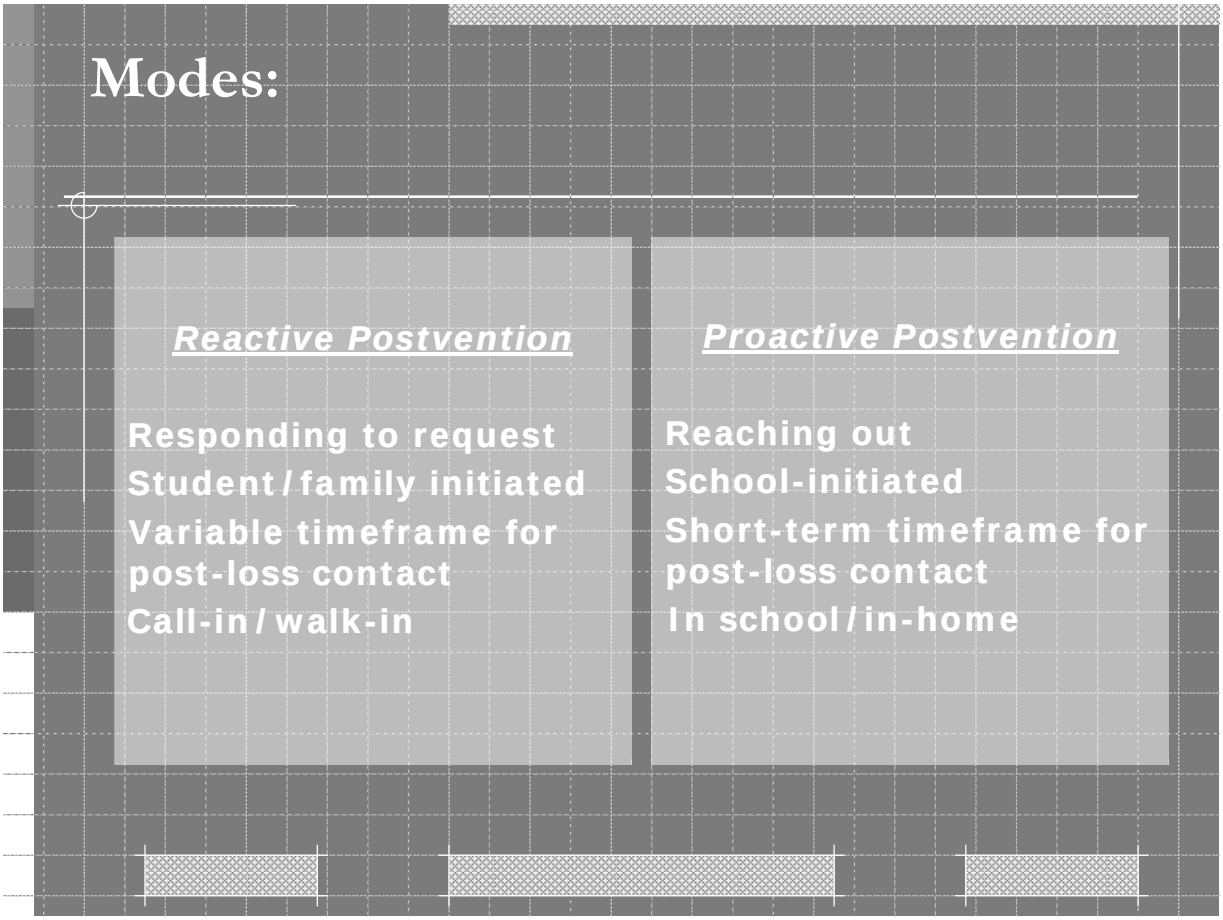
A. Establish rapport – Extend offer of help and caring by just "being there." If you feel that you are forcing things, just back off. If not, sit down and listen.

B. Initiate grief normalization – Let them discuss their feelings and concerns. Be ready for a lot of emotion and conflicting sentiments. Don't try to sort things out for them. They'll get to that later. Let them know that their emotional turmoil is okay given the abnormal nature of the loss.

C. Assist in mobilizing their support system – Help them identify or call those who may be resources, e.g., a physician, family members, or trusted friends. Don't say that they have to make these contacts, just note that they may be helpful.

D. Share information on community services – Provide information on local grief support resources, which the grievers may reach out to if necessary or when they are ready.

E. Encourage their follow-through – Urge them to see their family physician as soon as possible. Grief isn't a medical problem, but it impacts health and may aggravate pre-existing conditions.



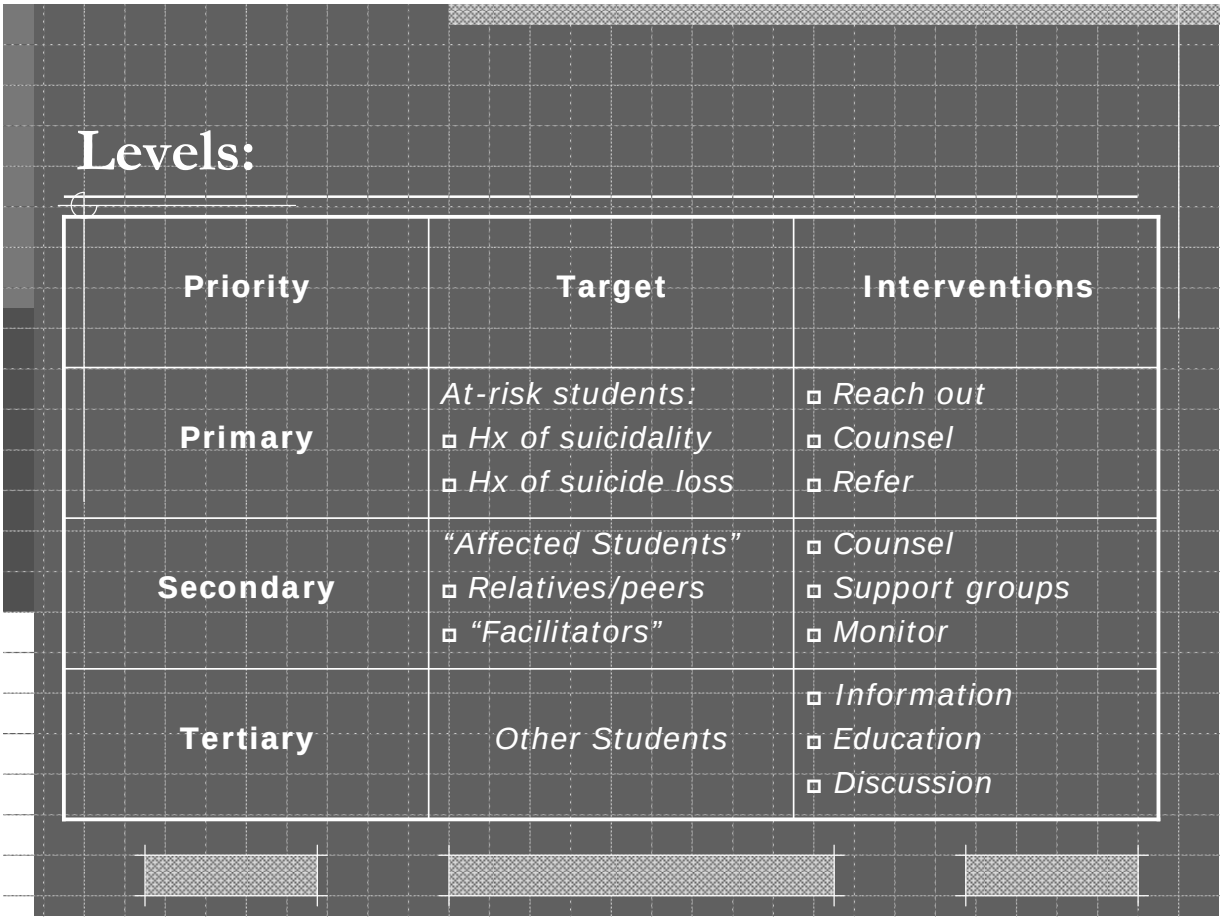
Postvention Approaches:

Ideally, those affected by a suicide should be offered appropriate help without having to ask for it. Such a proactive model is indeed followed in school settings, but it remains the exception outside the school in most communities.

Part of a school district's emergency plan should be to promote the organization of a community-based proactive suicide postvention program. As noted earlier, many of those affected by the suicide in the greater school community will be too immobilized to seek help, even if available.

Parents and siblings (unless students themselves) don't typically have access to the proactive supports provided by the school. The school district should support a proactive postvention program to offer help and orientation to the loss. Such a resource will benefit the school by allowing it to focus on needs in the student body while the family's needs are being addressed.

Publicizing existing support groups and issuing resource guides helps but is not enough because no one ever expects to need such services. What's needed is a basic outreach effort to those in the community felt to be affected by the suicide. This would best be done by a survivor volunteer who can provide resource and related information, and, as necessary, a compassionate and empathetic understanding of the loss, as well as serve as a contact as questions and concerns arise.

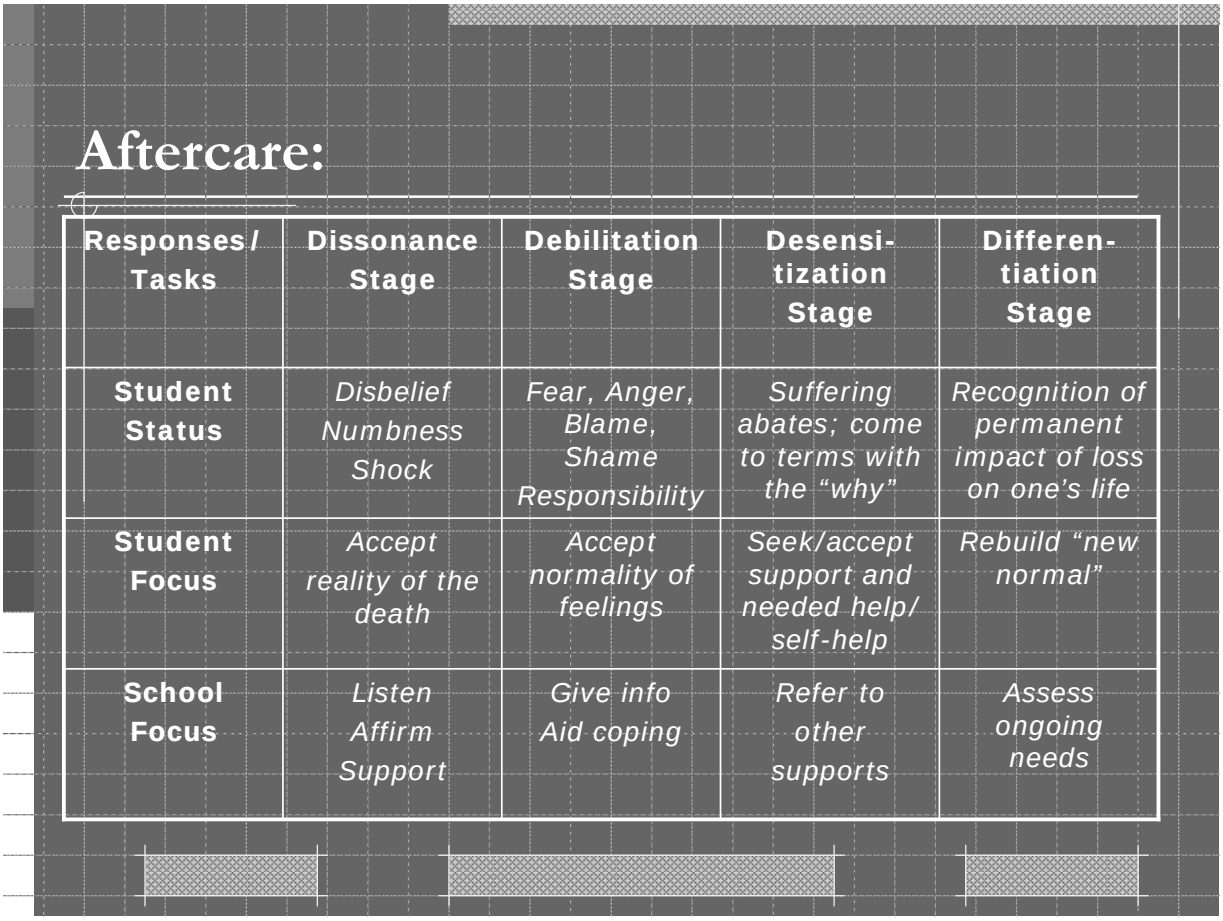


Postvention Priorities:

A school community that has experienced a suicide may be broken into three groups in terms of how the loss impacts suicide risk or compromises the ability to cope with the loss:

- Those "at-risk" with a high degree of emotional vulnerability because of a history of suicidal behavior or suicide loss.
- Those directly affected by the loss, which includes close relatives, friends, and students who feel involved with the occurrence of the loss (and those who closely identified with the victim).
- All others who are exposed to the loss by virtue of their membership in the school community, but who are not known to be at risk and not significantly affected by the loss.

Those known to be at-risk should be sought out by school counselors and given one-on-one support. Those significantly affected by the loss should be individually assessed and directed to help specific to their needs. Those who feel some involvement in the suicide may need to be relieved of this burden before participating in other group-based supports with other students. In-school groups or class discussions may be the most practical and effective supports. Those not at-risk or felt to be seriously affected by the loss may benefit by more global supports.



Staging Help:

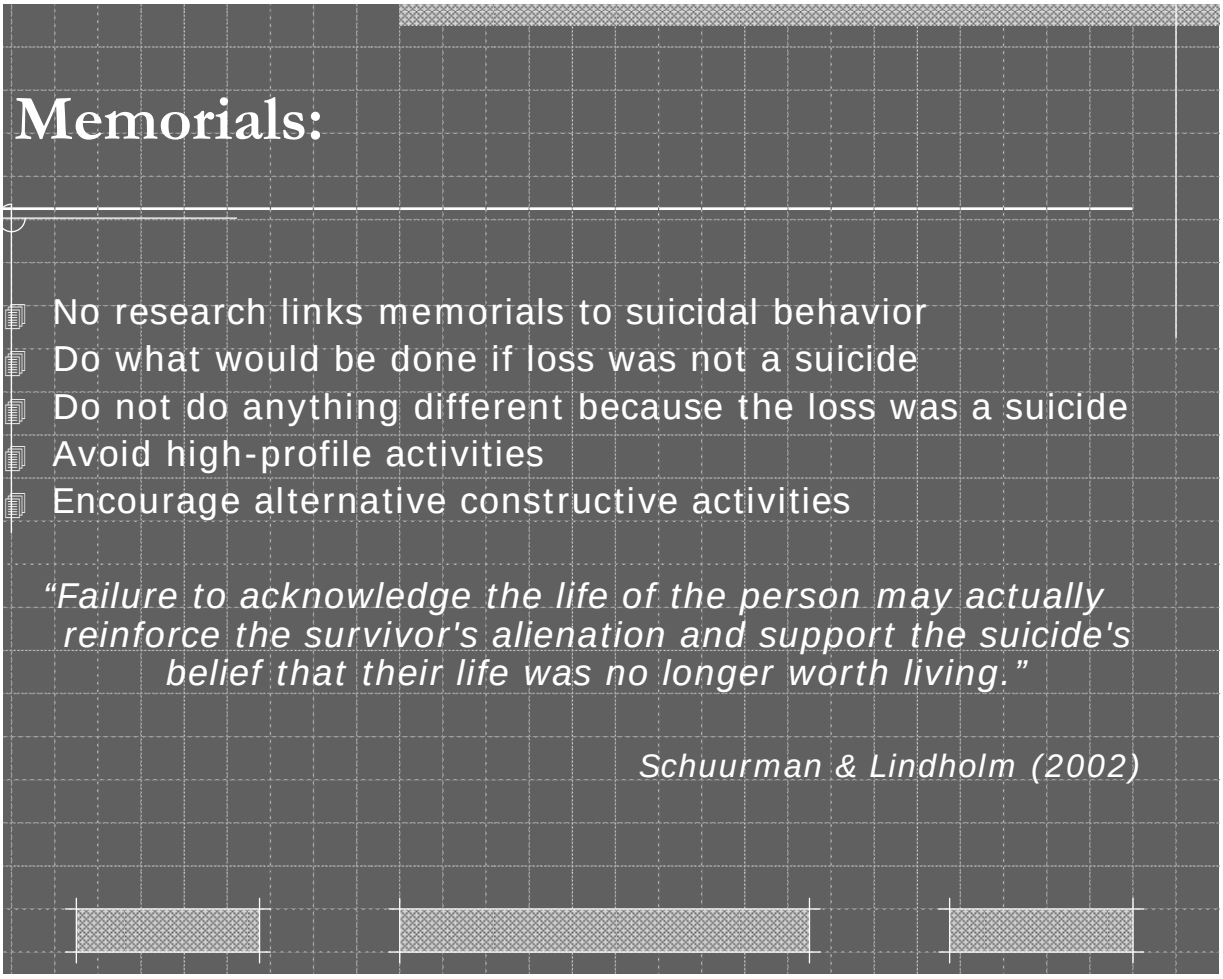
The nature of the help needed after a suicide will be determined by the needs of each individual and where he or she is at in the suicide loss process.

Initially most students and others in the school community will experience the dissonance phase of suicide loss. There will be widespread shock and difficulty in accepting the reality of the loss. The school's job here is enable feelings to be vented and to mobilize postvention first-aid.

Generally only those most seriously affected by the suicide will move on in the suicide loss process. They will need the school's help in understanding what they are going through and why others seem to be returning to normal while they remain bereaved.

Parents and teachers will need to know what to expect so that they can be appropriately supportive. Those students less affected by the loss will need to understand that grief is an individual matter and that neither they or their bereaved fellow students are grieving too little or too much.

Education, information, and building coping skills will help most students as they move through the suicide loss process. Some may need additional professional assistance. Provision should be made for support over school year breaks and the summer, if needed.



Doing Something:

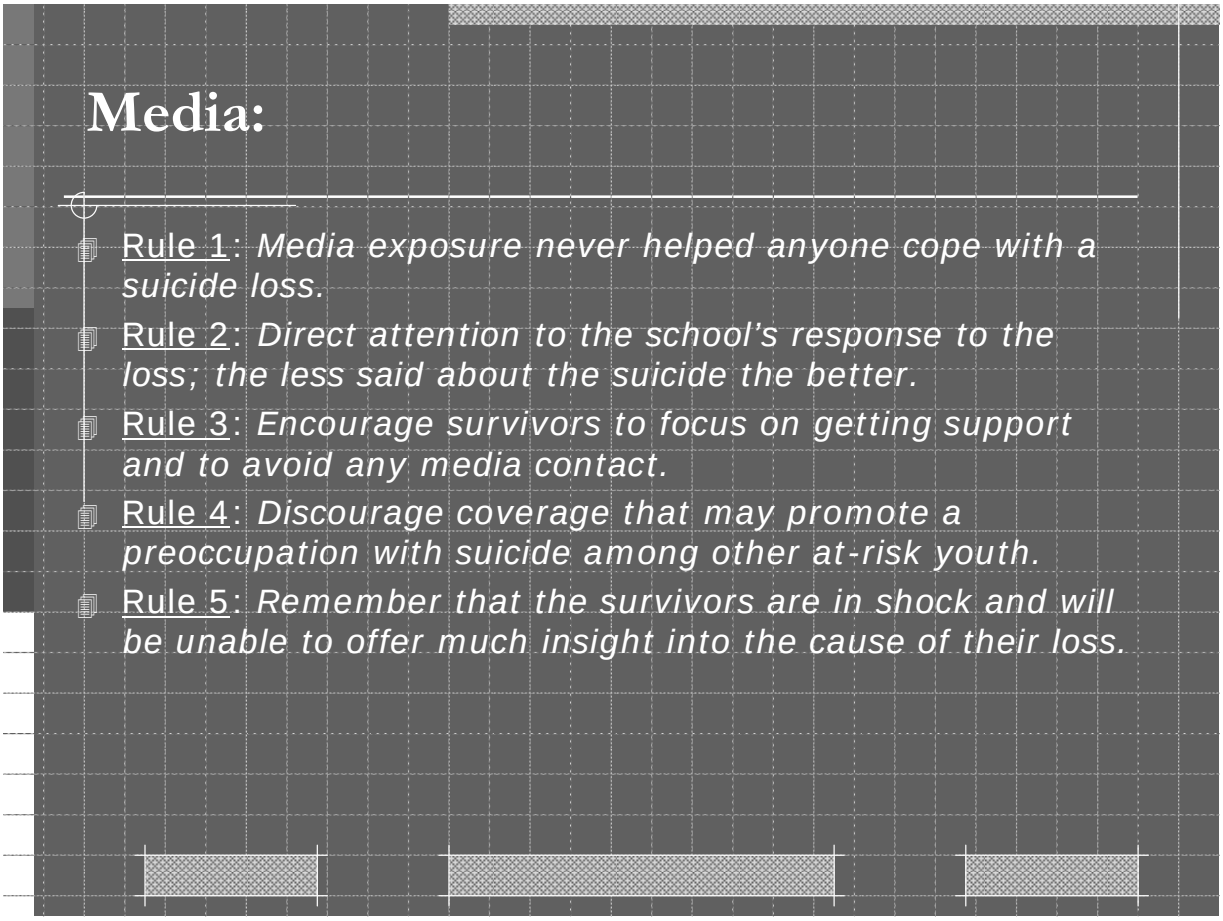
Most of the caveats on memorials seem to be based on anecdotal evidence. From a survivor perspective, much of the response to memorials sounds discriminatory and stigmatizing.

Survivors may wish to "do something" in memory of their lost loved one or friend. Some ideas may be inappropriate, though most of those originate in the early, very intense stages of their grief. The insensitivity and rigidity with which their requests are usually met does little to lessen their pain or lower their newly acquired life-long risk.

The antipathy towards memorials is related to the former romanticizing of suicide in the media. This now takes the form of an unnecessarily detailed write-up on the victim, the alleged motive, the means, the location, etc., and portrayal of the suicide as a seemingly rational act. None of this applies to a shrub or bench with a small plaque that says, e.g., "In Memory of..., 1968-1996."

It is true that some sites (usually bridges or buildings) have been the scene of multiple suicides but it is a stretch to extend this to any permanent memorial of any scale anywhere. It certainly does not serve as a justification for excluding a deceased youth's picture in a yearbook.

We should be more concerned with the vitriol that frequently greets the desperate and sometimes ill-advised efforts of families or students to remember someone they cared for deeply.



Dealing with the Media – Don't!

This may seem impractical advice, but it will grow on you after you see or hear how the loss in your school community is portrayed in the days after it occurred. The media are poorly informed about suicide and suicide loss and are likely be more hurtful than helpful.

The media has questions, here are some for them: What interest is served by details on the means used? Do we need simplistic speculations on causality? Why aren't parents, teachers, and students who are in shock getting support instead of contending with insensitive interviewers?

Why the persistent criminalization of suicide? "Shooting" equates it with terrorism, and "gunman" demeans the victim, the family, and friends. Sensational language conveys a sense of malevolence that may deter other students from disclosing suicidal thoughts and seeking help.

Thankfully most suicides receive no media attention. This raises the question of why any suicide should find its way into a newscast or newspaper. Suicides by well-known, young, or multiple victims, suicides by dramatic means, and highly visible suicides are all deemed newsworthy. Regrettably a school-related suicide will always become the center of a media feeding frenzy.

Questions:

Contact info:

610-279-6100

tsalvatore@mces.org

"School is where we equip children for life, and loss is part of life."

J. Turner (1996), Grief at School.

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*
S. Goldsmith (2002) *Reducing Suicide: A National Imperative*
E. Dunne, J. McIntosh, and K. Dunne-Maxim (1987*) Suicide and Its Aftermath, Understanding and Counseling the Survivors*
K. Jamison (1999) *Night Falls Fast: Understanding Suicide*
T. Joiner (2005) *Why People Die by Suicide*
M. Kerr (2003) *Postvention Standards Manual: A Guide for a School's Response in the Aftermath of a Sudden Death*
D. Lester (1992) *Why People Kill Themselves*
J.T. Maltsberger and M.J Goldblatt (Eds.) (1996) *Essential Papers on Suicide*
R. Maris, A. Berman, and M. Silverman (2000) *Comprehensive Textbook of Suicidology*
E. Shneidman (1996) *The Suicidal Mind*
A. Wrobleski (1991) *Suicide Survivors: A Guide for Those Left Behind*,
H. Wright (1993) *Crisis Counseling: What to Do and Say During the First 72 Hours*

Selected Articles

C. Barlow and H. Morrison (2002) "Survivors of Suicide: Emerging Counseling Strategies" *Journal of Psychosocial Nursing* 40 28-39.
J. Jordan (2001) "Is Suicide Bereavement Different? A Reassessment of the Literature" *Suicide and Life-Threatening Behavior* 31 91-101
G. Mauk (1999) "A Light unto the Darkness: The Psychoeducational Imperative of School-based Suicide Postvention" *Adolescent Psychiatry*
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
Suicide Prevention Action Network USA - www.spanusa.org
Suicide Prevention Resource Center - www.sprc.org

Selected On-line Resources

"Grief Counseling Resource Guide: A Field Manual" is available from the NY State Office of Mental Health at www.omh.state.ny.us/omhweb/grief.
"Recovering from Suicide Loss" is available from Survivors of Suicide, Inc. at phillysos.tripod.com or 215-545-2242 or by sending an e-mail to phillysos@hotmail.com.
"What Everyone Should Know about Suicide" available from Montgomery County Emergency Service (MCES) at www.mces.org or 610-279-6100.
"After a Suicide: A Postvention Primer for Providers" *MCES Quest* (5:2; Dec. 2006) available from Montgomery County Emergency Service (MCES) at www.mces.org or 610-279-6100.
"Preparing for and Responding to a Death By Suicide" Louis de la Parte Florida Mental Health Institute at www.fmhi.usf.edu/institute.pubs/bysubject.html.
"Teens & Grief" *The Prevention Researcher* at www.tpronline.org/teens_&_grief.
"School Memorials After Suicide: Helpful or Harmful?" Centre for Suicide Prevention *SIEC Alert* #54 (May 2004) www.suicideinfo.ca/csp/assets/alert54.pdf.