# What Clergy and Pastoral Counselors Need to Know About Suicide Loss

## *How to Help After a Suicide*

**Tony Salvatore, MA**
**Survivors of Suicide, Inc.**
**PO Box 128**
**Morton, PA 19070**
**215-545-2245 (VM)**
**Sosphilly30@gmail,com**
**@phillysos**
**sosphilly.org**


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**About this booklet:**

Suicides are a daily occurrence in southeastern Pennsylvania. There are almost 500 completed suicides every year in the five-county area. That's close to 10 such tragic deaths every week. Suicides may not occur that often in your faith community, but you may be involved in the aftermath of one, if this has not already happened.

Suicides do not occur in a vacuum, they occur in families and support systems. For the individuals affected, a suicide is a traumatic loss. You will be in a position to help when your responsibilities:

- Put you at the scene of a recent suicide
- Require you to call on congregants who have experienced a suicide
- Call for you to notify a family about the loss of a loved one to suicide

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

What do you say? What do you do? How do you help those struggling with this tragedy? We are going to try to help you answer these questions and others.

This booklet is based on the SOS philosophy and 30 years of giving support to those who have suffered the worst loss of all. It also reflects the literature on suicide loss and postvention.



*In memory of PAS 1968-1996*

**Contents:**



## What is suicide postvention?

Postvention is post-trauma support. Here we use it in relation to attempting to reduce the negative consequences that may affect those close to the victim after a suicide has occurred. (Postvention should also occur after suicide attempts.)

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

These are the objectives of any postvention effort:

- Ease the trauma and related effects of the suicide loss
- Prevent the onset of adverse grief reactions and complications
- Minimize the risk of suicidal behavior on the part of survivors

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

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

Selected Readings on Helping After a Suicide:
C. Barlow and H. Morrison (2002) "Survivors of Suicide: Emerging Counseling Strategies" *Journal of Psychosocial Nursing* 40 28-39.
D. Clark (1993) *Clergy Response to Suicidal Persons and Their Family Members*
E. Dunne, J. McIntosh, and K. Dunne-Maxim (1987) *Suicide and Its Aftermath, Understanding and Counseling the Survivors*

## Why do suicides happen?

Every suicide is different and the circumstances leading up to it are always unique. Common underlying factors include intense psychological pain and extreme hopelessness. Psychological pain arises when there is some frustrating situation in an individual's life. It may be a real or perceived personal, financial, or legal problem, or something else.

Whatever the nature of this problem, coping and problem-solving skills do not work. Self-esteem and sense of control over his/her life diminish. Hopelessness may follow.

Hopelessness may lead to suicidal thinking. Without strong protective factors (e.g., social supports, religious values) and with serious risk factors (e.g., drinking, access to a gun), a suicide may occur. Death is the means not the end. The tragedy of suicide is that its victims were not able to see that their pain was only temporary.

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

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

Some suicides may be impulsive, but most are the outcome of a process of psychological debilitation that happens over days, weeks, or even months. Those at risk move along a track of increasing intent and rising capability to take their lives. They develop a plan, acquire the means, and, in the absence of a change of heart or outside intervention, they complete suicide.

While not every suicide can realistically be prevented, suicide is preventable. It never has to happen.

Selected Readings on Suicide:

S. Goldsmith (2002) *Reducing Suicide: A National Imperative*
K. Jamison (1999) *Night Falls Fast: Understanding Suicide*
T. Joiner (2006) *Why People Die by Suicide*
D. Lester (1992) *Why People Kill Themselves*

## Who are the victims of suicide?

There are almost 48,000 reported suicides in the US yearly. In Pennsylvania, there is an average of 1900 or more suicides annually. In each of the four suburban counties there are 60-100+ suicides yearly. In Philadelphia there are 150-160 suicides each year.

In the region, men in their 20s to mid-60s represent about 70% of suicide victims. There are few teen suicide deaths in southeastern PA. Older adults, those age 65 and older, account for about 13% of suicides. Men 80-84 have the highest suicide rate of any age group. Regardless of age, suicide is always a premature and unexpected death.

Women complete suicide less often than men because they tend to use less alcohol, they have less access to guns, and they more readily seek help. Older women rarely complete suicide. Females make more non-fatal suicide attempts than males.

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

Firearms, most commonly handguns, are the lethal means in most suicides. Guns are involved in about half of male suicides across all age groups and in about 40% of adult female suicides.

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

## Beliefs and misconceptions about suicide:

Religious beliefs regarding suicide are too complex to address here. Instead we will briefly consider secular myths and misperceptions about suicide. However, the stigma associated with suicide clearly has religious roots.

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

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

Some see suicide as "making sense" in cases of devastating illness, disability, legal, or financial problems. This makes suicide seem a rational decision. Saying someone "committed suicide" conveys the notion he or she was in control. It also equates it to sin or a crime. This isn't comforting to family members and other survivors.

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

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

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

## What is different about suicide loss?

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

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

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

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

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

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

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

## What are the immediate needs of suicide grievers?

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

- To see that what they are feeling is normal – Those bereaved by suicide often think that they are suffering a severe psychiatric breakdown. To understand what they are going through think about a mini-9/11 happening in your head.
- To get support – Most people have no personal experience with a sudden, unexpected, and possibly violent death. Whatever got them through any previous deaths will fail them now. Suicide loss is best endured with help. Different things will work for different people. Most suicide grievers find that one of the best sources of help is contact with others who have lost loved ones to suicide. This is available through suicide loss support groups (see pages 12-13).
- To understand they will need time to deal with their loss – The usual 1-3 days of funeral leave will not suffice. Most grievers will not have the energy or motivation to go to work or school and they will not really be there if they do. They need to take things slowly and take care of themselves and their families.
- To know what to say to any affected children – It is generally felt that kids should hear the truth. Their feelings won't be spared for long anyway.

Suicide grievers are the secondary victims of the suicide.

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

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

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

## Postvention "First Aid"

We all take our own path to recovering from loss. However, after a suicide loss there are some basic forms of help that seem to apply to everybody. Here's what you can do:

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

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

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

D. Share information on community services – Provide contact information on local grief support resources like Survivors of Suicide or other services, which the grievers may reach out to if necessary.

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

These actions can get the family started toward recovery. They involve something that you are very familiar with: Caring. They can manage with appropriate support.

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

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

Here are some expressions that don't help. Statements like these are often voiced after suicides. Such remarks may do more harm regardless of the speaker's intentions.

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

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

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

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

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

"You know, you have to let her/him go."
*(They really don't, but now's not the time to even think about it.)*

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

"Don't blame yourself, it wasn't your fault. It was his free choice."
*(This only gives the grievers something else to be upset about.)*

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

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

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

## Suicide grief support sources:

Mutual self-help groups create a sense of belonging, acceptance, and normalization. They are empowering and enhance coping ability. Suicide loss groups are "safe places" where grievers are with others who understand their their feelings. Survivors of Suicide (SOS) sponsors several self-help support groups for suicide grievers in SE PA and Camden County, NJ.[1]

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

All of our groups are "open-ended." There is no fixed agenda or timeframe and they can be joined at any time. Other groups may cover a preset agenda over a set period of time, usually 6 to 10 weeks.

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

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

Selected Web Sites:

American Association of Suicidology – www.suicidology.org

American Foundation for Suicide Prevention – afsp.org
Suicide Prevention Resource Center - www.sprc.org



[1] A listing of current SOS support groups is available at www.sosphilly.org. Information on groups elsewhere in PA and in other states is available at www.afsp.org.

## About Survivors of Suicide (SOS):

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

SOS is governed by a board of directors made up of individuals who have experienced a suicide loss. Individual donations, occasional small grants, and in-kind contributions support SOS's activities.

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

SOS works with other community organizations to increase community awareness of suicide and suicide loss. SOS volunteers helped organize and actively support suicide prevention task forces in three counties. We provide assistance to those seeking to form new support resources.

We sponsor an annual candle lighting memorial service in Delaware County. We work closely with the American Foundation for Suicide Prevention's Greater Philadelphia Chapter.

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