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Suicide bereavement and complicated grief

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Abstract

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Losing a loved to suicide is one of life's most painful experiences. The feelings of loss, sadness, and loneliness experienced after any death of a loved one are often magnified in suicide survivors by feelings of guilt, confusion, rejection, shame, anger, and the effects of stigma and trauma. Furthermore, survivors of suicide loss are at higher risk of developing major depression, post-traumatic stress disorder, and suicidal behaviors, as well as a prolonged form of grief called complicated grief. Added to the burden is the substantial stigma, which can keep survivors away from much needed support and healing resources. Thus, survivors may require unique supportive measures and targeted treatment to cope with their loss. After a brief description of the epidemiology and circumstances of suicide, we review the current state of research on suicide bereavement, complicated grief in suicide survivors, and grief treatment for survivors of suicide.

Keywords: *suicide bereavement, complicated grief, grief, bereavement, suicide*

Introduction

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Nearly 1 million people die by suicide globally each year.¹ Suicide is one of the top ten leading causes of death across all age groups. Worldwide, suicide ranks among the three leading causes of death among adolescents and young adults. During 2008-2009, 8.3 million people over age 18 in the United States (3.7% of the adult US population) reported having suicidal thoughts in the last year, and approximately 1 million people (0.5% of the adult US population) reported having made a suicide attempt in the last year. There were just under 37 000 reported deaths by suicide (completed suicides) during the same time period, and almost 20 times that number of emergency room visits after nonfatal suicide attempts.² Rates of suicidal thoughts and behaviors vary by age, gender, occupation, region, ethnicity, and time of year. According to a 2011 report² released by the CDC, in 2008, the highest prevalence of suicidal thoughts, plans, and attempts among those surveyed in the US was reported by adults aged 18 to 29 years, non-Hispanic white males, people who were unemployed, and people with less than a high school education. There were no reported differences in the rates of suicide attempts by geographical region, though people living in the Midwest region of the US were most likely to have made a suicide plan in the last year, and those in the Midwest and Western region of the US reported the highest prevalence of suicidal ideation. While rates of completed suicides tend to be higher among men than women and higher among middle aged or older adults than among younger people, rates of nonfatal suicidal behavior are higher among females and adolescents and young adults.¹

The most commonly employed methods of suicide are by gunshot, hanging, drug overdose or other poisoning, jumping, asphyxiation, vehicular impact, drowning, exsanguination, and electrocution. There are other indirect methods some attempters may employ, such as behaving recklessly or not taking vitally required medications. Many suicides go unreported, as it can be difficult to identify indirect suicide attempts as suicide, and even some of the more direct methods of suicide may not be clearly identifiable attempts. For example, drug overdoses or vehicular impact attempts are more passive methods, and it may be difficult to determine whether an event was an attempt or accident. Conversely, accidental drug overdoses can often be confused with suicide attempts. If the deceased left behind a note or told someone about their plans or intent to take their own life, this can help those left behind, the suicide survivors, to distinguish between an attempt and an accident, but often no such explanation exists.

Nearly 90% of all suicides are associated with a diagnosable mental health or substance-abuse disorder.³ The underlying vulnerability of suicidal behavior is the subject of intense research scrutiny, and includes biological, social, and psychological underpinnings.⁴⁻⁸ While depression and bipolar disorder are the most common disorders among people who attempt suicide, suicide attempters may also suffer from substance abuse disorders, other psychiatric disorders such as schizophrenia, and may feel that suicide is the only way to end an unbearable pain they may be feeling as the result of their mental illness, trauma, or a significant loss, rejection, or disappointment. Additionally, a past history of suicide attempts is the best predictor for future attempts.⁹ Common themes among suicide attempters are feelings of hopelessness, despair, and isolation from family and friends. Despite loved ones' and professionals' best efforts to support them in their suffering, suicide attempters are often unable to think clearly and rationally through their pain.

It is estimated that 85% of people in the United States will know someone personally who has completed suicide.³ For each suicide completed, at least 6 loved ones are directly affected by the death.¹⁰ While not everyone exposed to a suicide will be acutely affected by the death,¹¹ this is likely an underestimation as reported figures may not account for the emergency responders, health care providers, coworkers, and acquaintances also affected by the suicide. That said, individuals most closely related to the deceased are usually those most adversely affected by the death.^{7,12}

Grief reactions and characteristics

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Grief is the universal, instinctual and adaptive reaction to the loss of a loved one. It can be subcategorized as *acute grief*, which is the initial painful response, *integrated grief*, which is the ongoing, attenuated adaptation to the death of a loved one, and finally *complicated grief* (CG), which is sometimes labeled as prolonged, unresolved, or traumatic grief. CG references acute grief that remains persistent and intense and does not transition into integrated grief.

Acute grief

After the death of a loved one, regardless of the cause of death, bereaved individuals may experience intense and distressing emotions. Immediately following the death, bereaved individuals often experience feelings of numbness, shock, and denial. For some, this denial is adaptive as it provides a brief respite from the pain, allowing time and energy to accept the death and to deal with practical implications: interacting with the coroner's office, planning a funeral, doing what is necessary for children or others affected by the loss and settling the estate of the deceased. But, for most, the pain cannot be put off indefinitely. It may not be until days, weeks, or even months following the death that the reality is fully comprehended, both cognitively and emotionally, and the intense feelings of sadness, longing, and emptiness may not peak until after that recognition sets in. Indeed, grief has been described as one of the most painful experiences an individual ever faces. Shock, anguish, loss, anger, guilt, regret, anxiety, fear, intrusive images, depersonalization, feeling overwhelmed, loneliness, unhappiness, and depression are just some of the feeling states often described.

Feelings of anguish and despair may initially seem everpresent but soon they occur predominantly in waves or bursts—the so-called pangs of grief—brought on by concrete reminders of or discussions about the deceased. Once the reality of the loss begins to sink in, over time, the waves become less intense and less frequent. For most bereaved persons, these feelings gradually diminish in intensity, allowing the individual to accept the loss and re-establish emotional balance. The person knows what the loss has meant to them but they begin to shift attention to the world around them.

Integrated grief

Under most circumstances, acute grief instinctively transitions to integrated grief within several months. However, as described later, this period may be substantially extended for those who have lost a loved one to suicide. The hallmarks of “healing” from the death of a loved one are the ability of the bereaved to recognize that they have grieved, to be able to think of the deceased with equanimity, to return to work, to re-experience pleasure, and to be able to seek the companionship and love of others.¹³⁻¹⁵ For many, new capacities, wisdom, unrecognized strengths, new and meaningful relationships, and broader perspectives emerge in the aftermath of loss. However, a small percentage of individuals are not able to come to such a resolution and go on to develop a “complicated grief” reaction.¹⁶

Complicated grief

CG is a bereavement reaction in which acute grief is prolonged, causing distress and interfering with functioning. The bereaved may feel longing and yearning that does not substantially abate with time and may experience difficulty re-establishing a meaningful life without the person who died. The pain of the loss stays fresh and healing does not occur. The bereaved person feels stuck; time moves forward but the intense grief remains. Symptoms include recurrent and intense pangs of grief and a preoccupation with the person who died mixed with avoidance of reminders of the loss. The bereaved may have recurrent intrusive images of the death, while positive memories may be blocked or interpreted as sad, or experienced in prolonged states of reverie that interfere with daily activities. Life might feel so empty and the yearning may be so strong that the bereaved may also feel a strong desire to join their loved one, leading to suicidal thoughts and behaviors. Alternatively, the pain from the loss may be so intense that their own death may feel like the only possible outlet of relief.

Some reports suggest that as many as 10% to 20% of bereaved individuals develop CG.^{17,18} Notably, survivors of suicide loss are at higher risk of developing CG.^{11,19} CG is associated with poor functional, psychological, and physical outcomes. Individuals with CG often have impairments in their daily functioning, occupational functioning, and social functioning.²⁰⁻²³ They have increased rates of psychiatric comorbidity,^{19,24-26} including higher rates of comorbid major depression and posttraumatic stress disorder (PTSD). Furthermore, individuals with CG are at higher risk for suicidal ideation and behavior.²⁷⁻³² Additionally, CG is associated with poor physical health outcomes.^{33,34} Overall, untreated CG results in suffering, impairment, and poor health outcomes, and will persist indefinitely without treatment.

Bereavement after suicide

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Suicide survivors often face unique challenges that differ from those who have been bereaved by other types of death. In addition to the inevitable grief, sadness, and disbelief typical of all grief, overwhelming guilt, confusion, rejection, shame, and anger are also often prominent.^{11,35} These painful experiences may be further complicated by the effects of stigma^{36,37} and trauma.³⁸ For these reasons, grief experienced by suicide survivors may be qualitatively different than grief after other causes of death. Thus, while Sveen and Walby³⁹ found no significant differences in rates of comorbid psychiatric disorders and suicidality among suicide bereaved individuals compared with other bereaved individuals across 41 studies, they did find higher incidences of rejection, blaming, shame, stigma, and the need to conceal the cause of death among those bereaved by suicide as compared with other causes of death.

As outlined by Jordan,¹¹ certain characteristics of suicide bereavement that are qualitatively different from other forms of bereavement may lead to delays in survivors' healing.

Need to understand, guilt, and responsibility

Most suicide survivors are plagued by the need to make sense of the death and to understand why the suicide completers made the decision to end their life. A message left by the deceased might help the survivors understand why their loved one decided to take his or her own life. Even with such explanations there are often still unanswered questions survivors feel they are left to untangle, including their own role in the sequence of events.

Another common response to a loved one's suicide is an overestimation of one's own responsibility, as well as guilt for not having been able to do more to prevent such an outcome. Survivors are often unaware of the many factors that contributed to the suicide, and in retrospect see things they may have not been aware of before the event. Survivors will often replay events up to the last moments of their loved ones' lives, digging for clues and warnings that they blame themselves for not noticing or taking seriously enough. They might recall past disagreements or arguments, plans not fulfilled, calls not returned, words not said, and ruminate on how if only they had done or said something differently, maybe the outcome would have been different.

Parents who have lost a child to suicide can be especially afflicted with feelings of guilt and responsibility.⁴⁰ Parents who have lost a child to suicide report more guilt, shame, and shock than spouses and children.⁴¹ They often think "If only I had not lost my temper" or "If only I had been around more." The death of child is arguably the most difficult type of loss a person can experience,¹⁷ particularly when the death is by suicide. Parents feel responsible for their children, especially when the deceased child is young. Indeed, age of the suicide deceased has been found to be one of the most important factors predicting intensity of grief.⁴²

While guilt is not a grief response specific to death by suicide, it is not uncommon for a survivor to view the suicide as an event that can be prevented. Therefore, it is easy for survivors to get caught up in self-blame.³⁷ Understanding that most suicide completers were battling a psychiatric illness when they died helps some survivors make sense of the death and can decrease self-blame.

Rejection, perceived abandonment, and anger

Survivors of suicide may feel rejected or abandoned by the deceased because they see the deceased as choosing to give up and leave their loved ones behind. They are often left feeling bewildered, wondering why their relationship with the person was not enough to keep them from taking their lives.⁴³ One survivor told us that when she had shared her own suicidal ideation with her sister, her sister made her promise to never act upon her suicidal thoughts. When her sister took her own life, this survivor not only felt abandoned, but she also felt deceived. She felt angry about this perceived deception, she felt angry for being left behind to deal with life's stresses without her sister, and she felt angry that her sister put her and her family through the pain of dealing with her death by suicide. She was now alone.

Suicide bereaved spouses often struggle because the marriage may be the most intimate relationship an individual ever experiences, and to be left by a self-inflicted death can feel like the ultimate form of rejection.⁴⁴ Children who lose their parents to suicide are left to feel that the person whom they count on the most for the most basic needs has abandoned

them.^{45,46} Results of one study suggest that children whose parents completed suicide and had an alcohol-use disorder were less likely to feel guilty or abandoned, and suicide bereaved spouses whose partners had an alcohol-use disorder were more likely to react with anger than other suicide bereaved spouses.⁴⁷

Anger is a common emotion among many survivors of suicide. It can be experienced as anger at the person who died, at themselves, at other family members or acquaintances, at providers, at God, or at the world in general. Often survivors feel angry at themselves for feeling angry, as they also recognize that the deceased was suffering greatly when deciding to die. Survivors may also feel angry towards other family members or mental health providers for not doing more to prevent the death and angry towards the deceased for not seeking help. A few survivors told us that their loved ones took their lives after a shameful behavior was revealed and/or in the midst of strained relationships. Survivors under these circumstances often feel anger at the deceased for depriving them of the opportunity to work through the difficult time or for not taking responsibility for their behavior.

Stigma

Unlike other modes of death, suicide is stigmatized, despite recent valiant strides to destigmatize mental illness and suicide. Many bereaved individuals report that it can be difficult to talk to others about their loss because others often feel uncomfortable talking about the suicide. This can leave the bereaved feeling isolated.⁴⁸ The feeling of being unable to talk about the death is often compounded by the perceived need to conceal the cause of death. At times, other people's belief systems, including that of the survivors themselves, can be a barrier to accepting the death and a deterrent to talking about it. When coping with a loss, people often turn to religion for comfort and guidance. A challenge for some survivors is that several religions impose shameful restrictions on the grief rituals for those who have been bereaved by suicide. Suicide survivors face additional logistical barriers when handling the deceased's business after a suicide, as most insurance policies even have clauses with built-in stigma.⁴⁹ Despite alarmingly high rates of suicides in the United States military, it was only until very recently (July 6, 2011) that the United States Government began to honorably acknowledge the bereaved after a military suicide, as is done for other deaths that occur in combat zones. For many people, talking about their loved ones is vital for their recovery from their loss. The stigma of suicide poses a barrier to the healing process.³⁷

Trauma

Survivors of suicide are more likely than other bereaved individuals to develop symptoms of PTSD.⁵⁰ The majority of suicide methods involve considerable bodily damage. Occasionally, survivors are witnesses to the final act, or the first to discover the dead body. Those left to find the deceased's body struggle to get the gruesome images of out of their minds.⁵¹ In such circumstances, traumatic distress, marked by fear, horror, vulnerability, and disintegration of cognitive assumptions ensues. One survivor told us the poignant story of her boyfriend, who immediately after a breakup, climbed to a nearby bridge and leaped to his death while she looked on in horror. Not unexpectedly, her grief was replete with such trauma symptoms as preoccupation with reminders, terror-filled recollections, avoidance of high places, and other reminders. After a death by suicide, themes of violence, victimization, and volition (ie, the choice of death over life, as in the case of suicide) are common and may be intermixed with other aspects of grief. Disbelief, despair, anxiety symptoms, preoccupation with the deceased and the circumstances of the death, withdrawal, hyper arousal, and dysphoria are more intense and more prolonged than they are under nontraumatic circumstances.⁵²

Suicide risk in survivors

Suicide and mental illness runs in families, likely a result of both heritability and environmental factors.^{7,8} Survivors of suicide may be left to struggle with their own suicidal ideation, while seeing that the deceased escaped the anguish and put an end to their suffering. Despite the fact that the suicide bereaved intimately understand the intense pain and suffering experienced by all those who survive a suicide loss, survivors are at higher risk themselves for suicidal ideation and behavior than are other bereaved individuals.^{53,54} Crosby and Sacks⁵⁵ reported that people who had known someone who died by suicide in the last year were 1.6 times more likely to have suicidal thoughts, 2.9 times more likely to have a

plan for suicide, and 3.7 times more likely to have made a suicide attempt themselves. The pain of dealing with the loss of a loved one by suicide coupled with shame, rejection, anger, perceived responsibility, and other risk factors, can be too much to bear, and to some, suicide seems like the only way to end the pain. Some may feel closer to their loved one by taking their life in the same way. Indeed, a survivor told us of how her mother's death by suicide was so difficult to bear for her sister who, like her father, also struggled with bipolar disorder, that her sister completed suicide in the exact same way the following year, on the same date, at the same time. Finally, as with other types of losses, yearning for a loved one can be so intense, that the desire to join the loved one in death can be overwhelming.

Complicated grief in survivors of suicide

While research results are mixed regarding whether grief differs by mode of death,⁴³ data suggest that the incidence of CG is high among survivors of suicide, as survivors of suicide loss are at higher risk of developing CG.^{11,19} Specifically, Mitchell and colleagues⁵⁷ reported that the rate of CG was 43% among their pilot study population of 60 Caucasian, Christian, employed, mostly female suicide bereaved participants grieving a total of 16 deaths collectively. This is at least double the rates of up to 10% to 20% of CG reported in the general population.^{17,18} Further, Mitchell and colleagues report that suicide survivors closely related to the deceased experience rates of complicated grief at twice the level as friends, coworkers, and relatives (57% to 80% vs 14% to 28%).

Individuals from that same sample who developed CG were almost 10 times more likely to have reported suicidal ideation 1 month after the death of their loved ones, controlling for depression.³⁰ In another sample of participants with CG, suicide bereaved participants reported twice the rate of recurrent and current depression compared with other bereaved individuals, reported higher rates of suicidal ideation before the death, and were at least as likely to report suicidal ideation since the death as other bereaved participants suffering from complicated grief.⁵⁸ Finally, Latham and Prigerson found that CG is associated with higher levels of suicidal ideation independent of PTSD and depression.²⁹

One study⁴⁹ suggests that 3 to 5 years is the time point at which grief after a suicide loss begins to integrate, raising the question of how the time frame used in discussions of normal and integrated grief applies to grief after suicide, and therefore what is the "normal" timeline for grief after suicide. That said, in at least one sample studied,⁵⁹ symptoms of traumatic grief 6 months after a peer suicide predicted the onset of depression or PTSD at subsequent timepoints. Therefore, it is important for clinicians to know how to identify traumatic grief in order to provide appropriate support and treatment when needed.

Treatment

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Considering that grief is a normal, adaptive response to loss, noncomplicated grief that is not comorbid with depression does not warrant any formal intervention in most circumstances. However, in light of the above delineated stigma, anger, and guilt associated with suicide loss, reassurance, support, and information provided by family, friends, and, sometimes, clergy is often not available or sufficient for survivors of suicide loss. Although there exists a paucity of treatment studies in survivors of suicide,⁶⁰ most experts agree that: (i) initial attention should be focused on traumatic distress; (ii) self-help support groups can be beneficial; and (iii) there is a role for both pharmacotherapy and psychotherapy in those already showing adverse mental health effects or at high risk for severe and persistent difficulties.^{37,61}

Support groups

While few survivors seek help,⁶² many survivors who attend support groups find them to be at least moderately helpful,⁶³ particularly survivors who either do not have adequate social support in the family or immediate community, or who are unable to access friends or acquaintances because of stigma or other roadblocks.⁶⁴ For many survivors, participation in support groups is felt to be their only access to people who they feel can understand them, or the only place where their feelings are acceptable, thus providing them with their only means of catharsis. The universality of their experiences provides great reassurance that they are not alone in their feelings and that others have faced similar experiences and have come out not only intact but often stronger. The bonds that develop among people can be very

strong as they join a club whose “dues” are high and as they offer each other mutual support. Through such supports, individuals may receive helpful suggestions for taking care of real-life obligations such as dealing with estates and legal issues: talking to others, including children; developing fitting memorials for the deceased; coping with holidays and special events; and setting realistic goals for one's new life which now has such a huge and unfillable void.

Common components of successful support groups include providing accurate information, permission to grieve, normalization of affects and behaviors that may be totally out of keeping with the person's usual state, and most important, conveying to survivors that they are not alone. Often it is helpful to see others who have “survived” the suicides of their own loved ones, and eventually it may even be helpful to have the opportunity to help others. Support groups that are relatively homogeneous (eg, suicide survivors rather than any bereaved, or those who have lost children rather than other losses) are often the most helpful.³⁵ Survivors of suicide loss groups may also be particularly effective for children who have lost a parent or family member by suicide.⁶¹

Survivors can locate support groups on Web sites belonging to groups such as the American Foundation for Suicide Prevention (AFSP) and the American Association of Suicidology (AAS) which host directories of over 400 suicide support groups throughout the United States. To locate support groups worldwide, survivors can visit the Web site of the International Association for Suicide Prevention (IASP), an organization officially affiliated with the World Health Organization. With membership in over 50 countries across the globe, the IASP postvention (suicide bereavement) taskforce offers a multitude of resources to survivors including survivor guides, 24/7 helplines for people of all age groups including child survivors, and does so in multiple languages. Some survivors are wary of groups and may prefer individual counseling or family therapy, indeed suicide has a profound effect on the entire family,^{11,37} or even Web-based support groups or bibliotherapy.⁶⁴⁻⁶⁷ These same organizations also sponsor organized survivors' events such as suicide prevention walks and survivors of suicide days, but too few people know about the events and some may find it difficult to go to their first event unless they go with support of a friend or a family member. Many survivors who attend these events extol their benefits and comment on the sense of belonging, of being part of a larger community, and of non-judgmental acceptance that they experience.

Suicide bereavement comorbid with depression or post-traumatic stress disorder

For survivors whose loss has triggered a depressive episode or PTSD, support groups often are not enough. Many clinicians avoid prescribing medication or formal psychotherapy even in the face of a full major depressive syndrome or PTSD, falsely rationalizing that depressive and trauma symptoms are normal in the face of loss and that treatment might “interfere” with the grieving process. But studies have shown that appropriate treatment for these symptoms is indicated and efficacious.⁶⁸⁻⁷⁰ Thus, if a suicide survivor is experiencing a Major Depressive Disorder (MDD) or PTSD, the clinician should consider medications and/or psychotherapy as indicated for these clinical conditions.

Clinicians often are unclear as to both if, and when, to initiate treatment. As in other, non-bereavement instances of MDD, the decision rests on various factors, including the severity, intensity, and pervasiveness of symptoms, comorbidities, past history of MDD, previous outcomes to treatments, safety, and patient preferences. A second decision point regards how to treat comorbid psychiatric conditions. At present, there is no single form of psychotherapy and/or antidepressant medication ready to be hailed as the treatment of first choice for MDD or PTSD in the context of suicide bereavement.¹⁵ However, there is no reason to suspect that psychotherapy should not be as effective, either alone or in combination with medications, as it is in other, non-bereavement or non-suicide-related instances of MDD or PTSD. Meanwhile, several studies document the effectiveness of antidepressant medications for bereavement-related depression.⁶⁸⁻⁷⁴ All classes of antidepressant medications are about equally effective, but differences in their side effect profiles usually dictate which medication is best suited for an individual patient. The authors recommend following American Psychiatric Association Treatment Guidelines⁷⁵ for the treatment of depression and PTSD and providing an integrative approach based on the individual's needs, resources and availability of treatment, that incorporates support, education, cognitive and interpersonal techniques, psychodynamic principles, grief-specific strategies, bright light, exercise, and cutting-edge medication management.⁷⁶

Suicide bereavement and complicated grief

As previously outlined, survivors of suicide loss are at increased risk of developing CG. Without treatment, CG symptoms follow an unrelenting course. The effectiveness and role of pharmacologic management of CG are not yet established, but the literature suggests preliminary promise for the use of bupropion⁶⁹ and escitalopram.^{77,78}

Although not specific to suicide bereavement, studies support the use of cognitive behavioral therapy (CBT),^{79,80} time-limited interpretive group therapy,^{81,82} and complicated grief therapy⁸³ for the treatment of CG. Complicated grief treatment (CGT) is a modification of interpersonal psychotherapy, adding elements of cognitive behavioral therapy, exposure, gestalt, and motivational interviewing. The basic principle underlying CGT is that acute grief will transition instinctively to integrated grief if the complications of the grief are addressed and the natural mourning process is supported. Each session includes loss-focused grief work as well as restoration-focused attention. The loss-focused grief work aids the bereaved in accepting the loss, talking about the death and surrounding events, starting to take pleasure and comfort in memories of the loved one, and feeling a deep sense of connection with the deceased. It uses imagery and other exercises that resemble exposure techniques coupled with cognitive restructuring. The restoration-focused work helps the person become free to pursue personal goals, engage in meaningful relationships with others, and experience satisfaction and enjoyment. Studies support the robust efficacy of CGT for the treatment of complicated grief, even in situations of great severity, chronicity, and comorbidity.⁸³⁻⁸⁵

When complicated grief occurs in the context of suicide bereavement, the psychiatric and psychological literature provide few, if any, empirically based guidelines.^{62,86} It is not unlikely that the CGT described above may be beneficial for many suicide survivors with CG, but the therapy may need to be modified to provide more emphasis on the recurrent themes of suicide bereavement: the quest to understand why, guilt, rejection, shame, anger, and stigma. The role of medications is not at all clear, but since there is some evidence that medications may be of benefit in non-suicide-related CG, pharmacotherapy may also be helpful to suicide survivors with CG. Since CG often co-occurs with MDD and PTSD, attention to these disorders may also be necessary; for example, depression focused psychotherapy, antidepressant medication, and prolonged exposure⁵¹ may be indicated in specific situations as an adjunct to CGT, as an alternative to CGT, or if therapy does not result in an optimal outcome. While research suggests that it is the exposure component of CGT that is the essence of its effectiveness,⁸⁷ whether or not this level of exposure therapy is sufficient to treat suicide survivors with or without CG and/ or PTSD remains to be explored. More research on the needs of suicide survivors, including individualized treatment approaches for unique patient profiles, is badly needed.⁶⁰

Conclusions

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Suicide survivors face unique challenges that can impede the normal grieving process, putting survivors at increased risk for developing complicated grief, concurrent depression, PTSD, and suicidal ideation. If left untreated, these conditions can lead to prolonged suffering, impaired functioning, negative health outcomes, and can even be fatal. Because of the stigma associated with suicide, survivors may feel they are unable to secure enough support from friends or family, but may benefit from attending support groups with other survivors who uniquely share their experiences and offer a haven for survivors to feel understood. Because suicide survivors are at higher risk for developing PTSD and complicated grief and may be more susceptible to depression, it is important for survivors and clinicians to be mindful of and address troubling symptoms should they occur. Treatment should include the best combinations of education, psychotherapy, and pharmacotherapy, often with a focus on depression, guilt, and trauma. While the field of suicide bereavement research is growing, there remains a need for more knowledge on the psychological sequelae of suicide bereavement and its treatment in general, and particularly among the elderly, those with pre-existing mental illnesses, men, and minorities.⁸⁸

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A Handbook for Survivors of Suicide

by Jeffrey Jackson



American Association
of Suicidology

About this book

his is a book for people who have lost a loved one to suicide, written by someone who has suffered the same loss.

I lost my wife, Gail, to suicide several years ago. She was 33 when she took a deliberate overdose of pills. The emotional journey of the ensuing weeks, months, and years has been the most difficult of my life. But I survived and have learned from my experience. Most of all, I have rebuilt my life and found happiness again. **Impossible as it may seem right now, you will survive this, too.**

This book is *not* intended to be a complete guide for the suicide survivor—it only scratches the surface. There’s much more you can learn about coping with your unique grief than what is offered here. There are many wonderful books on the subject—some of which are listed inside—that I recommend heartily. However, I’ve written this book as a kind of “bite-sized” overview. It’s deliberately short and to the point to make the information inside more accessible. You may even find it useful to carry it around with you for awhile and refer to it during difficult moments.

This is also not a book about suicide prevention; there are many other publications that address that challenge.

This book is for you.



*For the person you lost, the
pain is over.
Now it's time to start healing yours.*

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Someone you love has ended their own life — and yours is forever changed.

You are a “survivor of suicide,” and as that unwelcome designation implies, your survival—your *emotional* survival—will depend on how well you learn to cope with your tragedy. The bad news: Surviving this will be the second worst experience of your life. The good news:

The worst is already over.

What you’re enduring is one of the most horrific ordeals possible in human experience. In the weeks and months after a suicide, survivors ride a roller coaster of emotions unlike any other.

Suicide is different. On top of all the grief that people experience after a “conventional” death, you must walk a gauntlet of guilt, confusion and emotional turmoil that is in many ways unique to survivors of suicide.

“**How long will it take to get over this?**” you may ask yourself. The truth is that you will never “get over” it, but don’t let that thought discourage you. After all, what kind of people would we be if we truly got over it, as if it were something as trivial as a virus? Your hope lies in getting *through* it, putting your loss in its proper perspective, and accepting your life as it now lies before you, forever changed. If you can do that, the peace you seek will follow.



Why we say suicide “survivor”

We apply the term “survivor” to our experience because it accurately reflects the difficulties that face people who have lost a loved one to suicide.

Some people prefer the term “suicide griever,” fearing confusion with someone who has attempted suicide themselves. Likewise, some prefer the phrase “completed suicide” to “committed suicide,” feeling the latter implies a criminal act.

But there are no rules you need obey. Do and say whatever makes you feel most comfortable.

Suicide is Different

Death touches all of our lives sooner or later. Sometimes it is expected, as with the passing of an elderly relative; sometimes it comes suddenly in the form of a tragic accident.

But **suicide is different**. The person you have lost seems to have chosen death, and that simple fact makes a world of difference for those left to grieve. The suicide survivor faces all the same emotions as anyone who mourns a death, but they also face a somewhat unique set of painful feelings on top of their grief...

- ◉ **GUILT.** Rarely in other deaths do we encounter any feelings of responsibility. Diseases, accidents, old age... we know instinctively that we cannot cause or control these things. But the suicide survivor—even if they were only on the periphery of the deceased's life—invariably feels that they might have, could have, or should have done something to prevent the suicide. This mistaken assumption is the suicide survivor's greatest enemy. (See page 16).
- ◉ **STIGMA.** Society still attaches a stigma to suicide, and it is largely misunderstood. While mourners usually receive sympathy and compassion, the suicide survivor may encounter blame, judgement, or exclusion.
- ◉ **ANGER.** It's not uncommon to feel some form of anger toward a lost loved one, but it's intensified for survivors of suicide. For us, the person we lost is also the murderer of the person we lost, bringing new meaning to the term "love-hate" relationship. (See page 21).
- ◉ **DISCONNECTION.** When we lose a loved one to disease or an accident, it is easier to retain happy memories of them. We know that, if they could choose, they would still be here with us. But it's not as easy for the suicide survivor. Because our loved one seems to have made a choice that is abhorrent to us, we feel disconnected and "divorced" from their memory. We are in a state of conflict with them, and we are left to resolve that conflict alone.

The Emotional Roller Coaster

The challenge of coping with a loved one's suicide is one of the most trying ordeals anyone ever has to face, but make no mistake—**you must confront it.** If you attempt to ignore it—sweep it under the carpet of your life—you may only be delaying an even deeper pain. There are people who have suffered breakdowns *decades* after a suicide, because they refused or were forbidden to ever talk about it.

Time heals, but time alone cannot heal the suicide survivor. You must use that time to heal yourself and lean on the help and support of others. It might take years to truly restore your emotional well-being, but you can be assured one thing: **it will get easier.**

However, some of the difficult emotions you should come to expect include...



The American Psychiatric Association ranks the trauma of losing a loved one to suicide as "catastrophic"—on par with that of a concentration camp experience.

- ⊙ **You may "backslide" from time to time.** You might have a few days in a row where you feel better and then find your sadness return suddenly—perhaps even years later. This is natural, so don't be discouraged. You will have ups and downs, but generally, coping with your loss will get easier over time.
- ⊙ **You will encounter painful reminders unexpectedly.** A song on the radio... the scent of their favorite dish... a photograph. Any of these could bring on sudden feelings of sadness or even the sensation that you are reliving the experience of the suicide. When it happens, stay calm. Get away from the reminder if you need to and focus on positive thoughts.

- ⊙ **Friends and relatives may not offer the support you need.** You will truly learn who your friends are during this crisis. A casual acquaintance may turn out to be your most reliable supporter, while a lifelong friend might turn a deaf ear. Lean on the people who are ready, willing, and able to help you and, rather than suffer the anger, try to forgive those who can't.
- ⊙ **People may make insensitive remarks.** Suicide is generally misunderstood, and people will feel inept at offering you comfort. This is simply human nature and, while it would be wonderful if people rose above it, try not to be too hard on those who can't. If you encounter someone who seems determined to upset you with morbid curiosity, their own self-important theories, or some form of a "guilt-trip," simply sidestep them by saying "I'd rather not talk about it right now," and avoid conversing with them in the future.
- ⊙ **Your fear of people's judgment may haunt you needlessly.** It's common to project our own feelings of guilt onto others by assuming that they are judging us harshly in their minds. Give people the benefit of the doubt and remind yourself that you are not a mind reader.
- ⊙ **Others may tire of talking about it long before you do.** Talking through your feelings and fears is essential for recovery from your trauma. Unfortunately, while your closest supporters may be willing to listen and share with you for a few weeks or months, there's likely to come a time when their thoughts move on from the suicide while yours are still racing. This is why support groups are so valuable. (See page 28.) Fellow survivors understand what you're feeling in a way that even your closest friends cannot. Your fellow group members will never grow weary of offering supportive words and sympathetic ears.
- ⊙ **You may feel bad about feeling good.** You'll laugh at a joke, smile at a movie, or enjoy a breath of fresh, spring air, and then it will hit you: "How dare I feel good?" It's common to feel guilty when positive emotions start resurfacing, as if you're somehow trivializing your loss. Don't feel guilty for enjoying the simple human pleasures of daily life. You are entitled to them as much as anyone, if not more. There will be plenty of time for tears. Take

whatever happiness life sends your way, no matter how small or brief.

⊙ **Holidays, birthdays, and the anniversary of the suicide are often difficult.**

Generally, the first year, with all its "firsts" will be the toughest, but these events may always be difficult times for you. Rest assured that the anticipation of these days is far worse than the day itself. It's only twenty-four hours, and it will pass as quickly as any other day.

⊙ **New milestones may bring feelings of guilt.** As our lives naturally move forward, each new milestone—a wedding, a birth, an accomplishment—may be accompanied by new feelings of guilt and sadness. These events remind us that our lives are moving forward—without our

lost loved one. This may even taste of betrayal, as if we are leaving them behind. We must remind ourselves that we have chosen to live. Can it not be fairly said that, if there is a divide between us, it is they—not we—who have placed it there?

⊙ **You may entertain thoughts of suicide yourself.** The risk of committing suicide is far greater for those who come from a family in which



Write yourself a script

Suicide survivors often find themselves faced with uncomfortable questions from outsiders. It will help if you can anticipate some of these and write yourself a "script" of answers that you can mentally keep at the ready.

For example, when someone probes for details of the suicide that you are not comfortable discussing with them, you might simply say, "I don't really want to talk about it right now," or "I'm sure we can find something happier to discuss."

When new acquaintances learn of your loss, they may ask, "How did they die?" You should have no reservations about saying plainly, "They took their own life," or a straightforward "They committed suicide."

But if this is a casual acquaintance that you wish to deny this information, you would be equally justified in saying, "They suffered a long illness," which may very much be the truth.

The more you fear these kinds of inquiries, the better a prepared "script" of answers will serve you.

suicide has been attempted. This may be due to the fact that our loved one's death has made the very idea of suicide far more real in our lives, making it very common for survivors to have suicidal thoughts themselves. However, you must balance your fear of this with the knowledge that suicide is most often preceded by a history of clinical depression. If you share this trait with your loved one, then you may have a reason to seek professional help. However, you now know better than anyone the pain and destruction that suicide causes in the lives of those we love. The very fact that you are reading a book like this one shows that your desire to heal and live far outweighs any desire you have to end your life.



Explaining suicide to children

As confusing as it is to adults, think of the bewilderment suicide must produce in children. Their young minds are naturally inquiring and are likely to be less shy about asking questions than grownups. Others may need to be coaxed into sharing their feelings.

Above all, lies should not be used to shelter children from reality. This will only create the potential for later (and greater) trauma when the truth is ultimately discovered, as it almost always is. Depending on their age, children can be taught that the person you've lost had an "illness inside their brain, and it made them so sad that they didn't want to live anymore." A careful balance must be struck between not portraying the suicide victim as a bad person but making it clear that their choice was bad, so as to clearly teach the child that suicide is not an acceptable course of action.

It is also important to explain that not everyone who gets sick or feels sad dies from it. Teach them that there is help available for people who get sick or feel depressed—help from doctors, friends, and from you, should they ever need it.

Shock & Grief

"It's like a bad dream."

"It's like walking in quicksand."

"I feel as if they're going to walk through the door any minute."

"I feel like they've killed me, too."

"All I do is cry." "How will I ever be happy again?"

The shock and grief that consumes us after we lose someone to suicide is overwhelming. It feels like a hole out of which we cannot possibly climb. But these are natural feelings that will dull as you pass beyond the early stages of the grieving process.

The best thing you can do is simply let yourself feel this way. Don't feel that you have to "hold it together" for anyone else—not even for the benefit of children. If you need to talk about it until you're hoarse, then do it with anyone who will listen. If you need to cry, then cry. (In fact, think of a day in which you cry as a "good day.")

It is never too early to start healing. Find a support group or a qualified therapist as soon as possible. (See pages 28-29). Even the longest journey begins with a single step, and you are taking that step now simply by getting up each morning and choosing life.



Guard your physical health.

Your own health is probably the last thing on your mind as you attempt to cope with your tragedy. However, you're at risk and should take extra care. Shock erodes your body's natural resistance to disease and you're probably not getting enough sleep and nutrition. Some sleeplessness and loss of appetite is normal; but if it persists, you should consult your doctor.



Stages of Grief

While you may hear or read about a detailed list of “grief stages,” it’s truly different for each person. Some of the common emotions experienced by anyone who mourns are listed below. You may encounter some or all of them, and in no particular order...

SHOCK. The daze one feels immediately after a tragedy is actually the mind’s first line of defense. It insulates you from having to process the entire magnitude of it, allowing you to function until you can get your bearings. (See page 7).

DENIAL. Death is the most difficult of all realities to accept. It is common to feel a sense of impossibility, or that it’s all just a bad dream. In time, our minds become more able to analyze the tragic event in a rational, realistic way, allowing denial to give way to less troubling emotions.

GUILT. Guilt comes from a mistaken belief that we could have, or should have, prevented the death from happening, or from regret over irreconciled aspects of the relationship. In truth, we all do the best we can given our human shortcomings. We cannot predict the future, nor do we have power over the events in our universe. It is human nature to subconsciously blame oneself rather than accept these truths. (See page 16).

SADNESS. Once the “reactive” emotions have either passed or become manageable, the basic sadness that accompanies any loss moves to the forefront. This may be felt more acutely when confronted with reminders or special occasions. As we gradually learn to accept our loss and embrace happy memories of our lost loved one, we make room in our hearts for happiness to re-enter.

ANGER. It is common to feel anger toward the person you have lost. Many who mourn feel a sense of abandonment. Others feel anger toward a real or perceived culprit. (See page 21).

ACCEPTANCE. This is the mourner’s goal, to accept this tragic event as something that could not have been prevented, and cannot be changed. Only with acceptance, can you move on with your life. (See page 24).

“Why?”

Why did they do it?” This is the question that will occupy much of your thoughts for some time. And if you think you know the answer, you should think again, because chances are you’re only seeing part of the picture.

The Condition vs. The Catalyst. Most suicides are occasioned by a “catalyst” event: the breakup of a relationship, losing a job, or learning of bad news. Misconceptions arise when we mistake one of these isolated events for the *cause* of the suicide. Instead, it is more likely just the “straw that broke the camel’s back.” Scratch the surface and you will likely find years of emotional distress that comprise the suicide victim’s “condition.”

That condition may be evident in some of these ways...

- ⊙ **Emotional illness.** Up to 70% of people who die by suicide may suffer from what psychiatrists call an “affective illness” such as major depression or a bipolar disorder.¹
- ⊙ **Prior attempts.** Often disguised as reckless behavior, many suicide victims have a history of prior attempts.
- ⊙ **Morbid thoughts.** Many suicidal people are unusually comfortable with the idea of death, or convinced that a dark fate awaits them.
- ⊙ **Hypersensitivity to pain.** Suicidal individuals often exhibit disproportionate emotional reactions to problems and



A Theory: The Accumulation of Pain

In this author’s observation, suicidal depression is pain that seems to “accumulate” from many experiences.

While most people find ways to cope with life’s common difficulties, the suicidal person—while seeming to move past each setback, loss, and misfortune—continues to carry pain from each trauma with them throughout their lives.

With each new hurt both great and small, a little more pain is added to this tragic cargo until it becomes unbearable.

hardships—sometimes even to the hardships of others. Some go to great lengths to help others because they simply cannot bear the idea of pain, even if it is not their own.

⊙ **A chronic need for control.**

Many people who go on to die by suicide exhibit an obsessive need for control—what you and I might call a “control freak.” Their natural inability to cope with pain and misfortune compels them to try to prevent it by orchestrating the events in their world to an extreme degree.

The presence of any of these or other factors demonstrates that **suicide is rarely a sudden occurrence**. It is far more often the result of a long, debilitating breakdown of an individual’s emotional health.

The Suicidal Mind. Attempting to decipher precisely the thoughts of the suicide victim is much like trying to understand a foreign language by eavesdropping on a conversation. You can analyze the sounds and syllables all day long, but it’s not likely you’re going to understand much of what was said.

Based on the accounts of those who have attempted suicide and lived to tell about it, we know that **the primary goal of a suicide is not to end life, but to end pain**. People in the grips of a suicidal depression are battling an emotional agony that, to them, is so severe as to make dying a less objectionable alternative than living. One likened the feeling to “being at the bottom of a deep, dark hole and, rather than fighting to get out, wanting to burrow deeper into the bottom.”²



“Is suicide a choice?”

Choice implies that a suicidal person can reasonably look at alternatives and select among them. If they could rationally choose, it would not be suicide. Suicide happens when... no other choices are seen.”

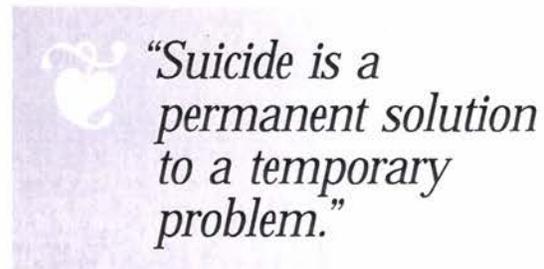
—Adina Wroblewski, *Suicide: Why?* (1995)

One of the more painful emotions felt by survivors comes when we try to empathize with the severity of this pain. We try to envision what we would have to feel to make the same choice, and when we imagine our loved one in that kind of pain it's almost too much to even consider.

But there is a *flaw* in this thought process. You are imagining what suicidal depression looks like through *your* eyes—the eyes of a rational, healthy mind. **The suicidal person has a distorted view of their world.** Problems that seem solvable to us seem impossible to them. Pain is amplified beyond reason and death appears to offer the only possible relief. In fact, it is not uncommon for depressed patients to stop taking an anti-depressant as soon as its beneficial effects start to kick in. This may be caused by a fear of drug dependency, but some theorize that it comes from a fear of having to face the world now that a tool for doing so has been provided.

The disease is preferable to the cure. Instead of being a “last resort,” the severely depressed person may view suicide as a plausible “Plan B.” It is this skewed vision that once caused

someone to wisely describe suicide as **a permanent “solution” to a temporary problem.**



“Suicide is a permanent solution to a temporary problem.”

Suicide notes, when present, can mislead more than they inform. By looking for answers in a suicide note, we assume that the victim fully understood everything that was happening to them, which may not be the case.

Chase the “Why?” It's okay to want to understand as much about your loved one's suicide as possible. Seeking these answers is a necessary part of your grief. Some people

dissect the circumstances of the suicide with the zeal of a detective. Examine and re-examine your loved one’s suicide as much or as little as you need to. But be prepared to face the distinct possibility that many of the answers you seek may be unknowable.

Only after you’ve exhausted your deductive abilities can you finally **let go of the “Why?”** There will come a time when you will hopefully accept that a satisfying explanation for your loss may not exist. And, even if it did, it wouldn’t change what has happened.

Once you can let go of “Why?” you’ve taken a great step toward acceptance—the key to healing your wounded heart.



Learning from the stories of others

In the stories of others, suicide survivors may recognize common threads that help us understand that we are not alone in the confusing sorrow we face. Below are just a few of the more illuminating ones I’ve encountered...

The “Logical” Suicide. Sarah*, a woman of 65 was battling cancer and suffering great pain every day. While her husband was out one afternoon, she ended her life with an overdose. This seems like a somewhat logical act—except that, 40 years earlier, when still young and physically fit, Sarah sank into a deep depression triggered by, of all things, a cancelled luncheon appointment and threatened to throw herself from the balcony of a hotel room. Is suicide, for some, a tendency that is “built in”—an inevitable fate—or was Sarah suffering from a recurrent undiagnosed and untreated depression?

The Man Who Had it All. George*, an enormously successful businessman, killed himself the day after closing on a merger worth millions of dollars to his company. In his suicide note, he wrote that, despite his achievements, he had always felt like an imposter; that he was driven by the need to prove something, but inside, felt empty and unworthy. Further, he never felt he got sufficient attention from his parents who demanded his performance, then ignored his accomplishments. Throughout his life he never sought help to deal with these issues.

The “Sudden” Suicide. Phillip* was very depressed over being recently diagnosed with a serious—but manageable—illness. He shot himself with a starter’s pistol that he and his wife used in their sporting activities. However, as far as his wife knew, they owned only blanks for the gun. Later, her son recalled that, years earlier as a small child, he stumbled across an envelope of bullets hidden among his father’s belongings. This “recently depressed” man had planned his suicide—ten years earlier.

The “Suitcase.” Joan* took her own life despite years of medical treatment for her emotional problems, hospitalization, and several rescues from previous attempts. In her note, she described her pain as a “heavy suitcase” that she had been carrying her whole life. Whenever something bad happened to her, she wrote “it was like a wheel had fallen off... then a buckle would break... then the handle.” Had emotional pain been “accumulating” inside this woman until it overwhelmed her?

The Holocaust Victim. One of the most famous stories of suicide is the death of Tadeusz Borowski, author and Holocaust survivor. Despite surviving the horrors of Auschwitz, Borowski ended his life five years later by gas poisoning—three days after the birth of his daughter. How could a man face down the trauma of the Holocaust and fail to cope with ordinary life? Was Mr. Borowski’s suicide an echo of his earlier trauma? Were his emotional wounds so deep that their pain continued to resonate and build for years afterward?

The Vengeful Survivor. Mary* attended my local support group and seemed to be having a harder time coping than any of us—despite the fact that five years had passed since her son’s suicide. She spoke of her son as one might speak of a martyred saint, refusing to consider, even briefly, that her son bore any responsibility for his suicide. Instead, she focused on a list of culprits whom she felt were to blame—her son’s employer, psychologist, and ex-girlfriend topping the list. It seemed, for Mary, that her healing was impeded by her quest for a scapegoat in her son’s suicide, and by her unwillingness to accept the reality of the emotional crisis he was likely suffering.

Suicide Facts & Myths

- ⊙ **FACT: Nearly 30,000 Americans commit suicide each year.**
Suicide is the 11th leading cause of death in the nation, claiming twice as many lives each year as HIV/AIDS.³
- ⊙ **FACT: Male suicides outnumber female suicides by 4 to 1.**
However, three times as many women attempt suicide. The reason for this is not certain, but many feel male tendencies towards greater aggressiveness makes their attempts more often fatal.³
- ✗ **MYTH: Teenagers are more likely to kill themselves.**
A common misconception caused by media coverage of teen suicides. In fact, white males over 65 are the people most likely to die by suicide. However, the suicide rate for white males aged 15–24 has tripled since 1950, and has more than doubled for children aged 10–14.⁴
- ⊙ **FACT: Up to 70% of all people who die by suicide may suffer from an affective illness such as depression or bipolar disorder.¹**
- ⊙ **FACT: Alcoholism is a factor in about 20% of all suicides.** Up to 18% of alcoholics may die by suicide.⁵
- ✗ **MYTH: If there was no note, then it couldn't have been suicide.**
Only one in four or five people who commit suicide leave a note. The absence of a note does not indicate an accidental suicide, nor does the presence of one reflect the thoughts of a rational mind.¹
- ✗ **MYTH: People who talk about committing suicide, don't.** Suicide victims often make their suicidal feelings and intentions known. While this does not necessarily mean that the suicide could have been prevented, anyone who threatens or talks of suicide should be taken seriously and urged to seek professional help as soon as possible.⁶

- ⊙ **FACT: Firearms are now used in more suicides than homicides.**
It's the fastest-growing method, used in nearly 60% of all suicides. Next is hanging/strangulation/suffocation at nearly 20%; solid & liquid poisons/overdoses comprise about 10%; gas poisons are used about 6% of the time; the remaining number of suicides employ other methods including jumping from a high place, cutting & piercing, drowning, jumping/lying before moving object, burns & fire, and crashing of a motor vehicle.⁷

- ✗ **MYTH: Someone who attempts suicide will not try it again.** Many suicide victims have made prior attempts, sometimes several. These attempts can be in the form of reckless behavior that is not recognized as suicidal.⁸

- ✗ **MYTH: Suicide is hereditary.** There is no "suicide gene." However, if you come from a family where someone has killed himself, you are at greater risk of suicide than the average person. The reason isn't clear, but part of it may be due to the example set by the relative, and part of it due to inherited factors such as depression and temperament.⁶

- ⊙ **FACT: Up to 15% of all fatal traffic accidents may be suicides** according to some experts.⁹

- ✗ **MYTH: Once a suicidal crisis has passed, the person is out of danger.** Many suicides in which there was a prior attempt occur during a period of perceived improvement in mood and state of mind. It is theorized that this is because the individual has regained the energy to put his suicidal thoughts into action.⁸

- ✗ **MYTH: Most people kill themselves during winter or the Christmas holidays.** In fact, the most common season for suicide is spring, when the contrast between depression and nature's annual rebirth may make life seem increasingly intolerable for the suicidal.

Battling Guilt

Guilt is the one negative emotion that seems to be universal to all survivors of suicide, and overcoming it is perhaps our greatest obstacle on the path to healing. Guilt is your worst enemy, because it is a false accusation.

You are not responsible for your loved one's suicide in any way, shape, or form. Write it down. Say it to yourself over and over again, (even when it feels false). Tattoo it onto your brain. Because it's the truth.

Why do suicide survivors tend to blame themselves? Psychiatrists theorize that human nature subconsciously resists so strongly the idea that we cannot control all the events of our lives that we would rather fault ourselves for a tragic occurrence than accept our inability to prevent it. Simply put, we don't like admitting to ourselves that we're only human, so we blame ourselves instead.

One of the most unusual aspects of survivor guilt is that it is usually a solo trip—each survivor tends to blame *primarily* themselves. Try asking another person who is also mourning your lost loved one about any guilt feelings that are haunting them. Chances are you will find that each person—no matter how close or removed they were from the suicide victim—willingly takes the lion's share of blame on themselves. If they were the one closest to the deceased then they theorize, "I should've known exactly what was going on in their mind." If they were distanced from that person, they feel, "If I'd only been closer to them..." Well, you can't all



"Guilt is what we feel when we place our anger where it doesn't belong—on ourselves."

be to blame, can you? Isn't it far more logical that *none* of you are responsible?

Well, then who is? The simple truth of the matter is that **only one person is responsible for any suicide: the victim.** But that's a tough pill to swallow, so instead of ascribing responsibility to our suffering loved one, we nobly sacrifice by taking it on ourselves.

It's understandable to feel such love and empathy toward the person we lost that we are loathe to place blame on them. **The key lies in understanding the difference between blame and responsibility.** Blame is accusatory and judgmental, but assigning responsibility need only be a simple acknowledgement of fact.

It's unclear how much control, if any, suicide victims have over their actions. And if clinical depression is at the root, then we could easily think of suicides as victims of disease, just like cancer victims. This is why a person who dies by suicide doesn't deserve blame. However, on some level, there was a conscious choice made by that person, even if it was made with a clouded mind. So the *responsibility* does lie with them.

Acknowledging this simple fact does not mean that you did not love them, nor does it mean that you are holding them in contempt. It means that you are looking at a tragic event clearly and accepting it for what it is.



A guilt-busting exercise: Make a list of all the things that you did to help and comfort your lost loved one. You'll probably find the list is longer than you realized.

Guilt is anger turned inward. Suicide produces many painful and confusing emotions in survivors, one of which is frustration at being so violently cut off from the victim—from the chance to help them, talk with them, or even simply to say goodbye. This frustration produces anger, and when we turn this anger upon ourselves, the result is guilt.

Guilt can also come from an **unfounded assumption** that others are silently blaming us. Both parents and spouses express fear that the world at large will brand them as failures in their respective roles because of the suicide. While some small-minded people may think or even speak such accusations, most will not, so don't project negative thoughts onto others by judging yourself for them.



"If only I had..."

A true tale of two mothers

There were two young women who died by suicide, both about the same age, both after a years-long battle with depression. Each had made several suicide attempts. They would refuse professional help and stop taking their medication just when it seemed to begin helping.

Fearing for her life, the first woman's mother had her committed—against her wishes—to a psychiatric clinic for treatment. While there, despite being on "suicide watch," the young girl asphyxiated herself with her bedsheets.

The second woman's mother constantly urged her daughter to seek professional help. However, fearing that she would worsen her daughter's depression, she refused to force her into any kind of institutionalized care. One day, she killed herself with an overdose of medication.

Afterwards, both mothers blamed themselves for not preventing their daughter's suicides. The irony is that **each blamed themselves for not doing exactly what the other one did.**

The first mother felt that if she hadn't isolated her daughter in that institution, she wouldn't have lost her. The second was sure that if she only had committed her daughter, she would've been saved.

We often fail to realize that, even if we could turn back the clock and do things differently, it wouldn't necessarily change the outcome.

Parents of children who die by suicide often battle an added type of guilt. Even if they do not blame themselves for not directly intervening in the suicidal act, they often feel guilt over some perceived mistake in raising their children. “Where did I go wrong?,” “I pushed them too hard.” and “If we hadn’t gotten divorced...” are just a few on the list of self-recriminations. But parents need to remind themselves that, while they have great influence over their children’s lives, they do not personally create every aspect of their children’s being, as a sculptor carves a statue. From their earliest years, children are shaped by an assortment of outside influences beyond the control of parents. Even children and teenagers have to bear responsibility for their actions.

Spouses also tend to feel acutely guilty for a suicide. The natural partnership that comprises marriage implies a mutual responsibility to look after each other. But spouses need to realize that the root causes of suicide—notably clinical depression—are beyond the control of even the most devoted husband or wife and that **even mental health professionals often fail to detect the warning signs of suicide.**

“I’m glad they did it.” Though rarely expressed aloud, many survivors feel a measure of relief, especially when the suicide victim’s emotional battles were well known to them and punctuated with traumatic episodes and suicide attempts. To breathe easier because they—and you—are now spared from future torment is understandable. However, such feelings of relief are usually followed by a rush of guilt for having had them. If you have these feelings, recognize them as natural, and give yourself a break. Anyone who has had to witness and suffer the long, emotional descent of a loved one would feel a pang of relief at that rocky road’s end.

Moving forward with your life brings its own dose of guilt. Whether it's returning to the simple routine of daily subsistence or embarking on new journeys in life, survivors often feel as if this is some affront to the person we've lost. "How can I live knowing they're not here?" your mind may taunt you. Your strength lies in knowing that, while your lost loved one has chosen death, you have chosen *life*—and **life is a gift that we honor by living.**



Mistaken assumptions

The suicide survivor is prone to many self-defeating assumptions, all of which are likely to be mistaken...

"I know why they did it." The motivations behind suicide are complex and often inexplicable (see page 9). False conclusions about your loved one's suicide may only add to your own pain.

"If I'd only done (X), they'd still be alive." Thinking that you (or anyone else) had could have prevented the suicide, is assuming that we all have far more power over the lives of others than we actually do. Furthermore, many suicide victims persist and succeed in ending their lives despite being rescued before.

"It's their wife's/parents'/doctor's fault." Blaming others is a form of denial. Only by facing the truth of your loss and the responsibility that lies with the victim can you recover from grief.

"I know what people think about me." While suicide survivors are still often stigmatized, our fear of it becomes self-fulfilling when we mistakenly project negative thoughts onto others.

"I will never be able to enjoy life again." Don't deny your mind's natural ability to heal. While your life may be forever changed, it need not be forever painful.

Anger & Blame

Negative emotions surround the suicide survivor, complicating our road back from sorrow. **Anger is a natural part of the grieving process**, but survivors of suicide are far more susceptible to it—and not without justification.

Anyone who mourns may feel anger—frustration at being powerless in the face of death or rage at some real or perceived culprit. However, those who mourn a suicide know the identity of the responsible party—and who wouldn't feel anger toward the person who ended the life of someone we love and who devastated everyone around us? Many will be loathe to view their loved one in such harsh light, but the concept is there in our minds, at the core of our despair.

At some point, that anger may surface. If you feel such anger, don't try to repress it—let it out. It's a natural part of your healing process. You won't hate them forever. Quite the contrary—once expressed, it will be easier for you to let go of your anger and begin to embrace positive thoughts and happy memories of your lost loved one.

Blaming others. Some survivors feel the need for a culprit, again out of a reluctance to place responsibility on the suicide victim.

“It's the doctor's fault.” “His wife/mother/brother drove him to it.” “If only the government had a better program...” Some even pour their frustration into crusades against some perceived social evil that is responsible for their loved one's suicide. While these people seem to have a productive focus for their grief, they are only hurting themselves by not facing the truth of their loved one's suicide. **Their road back to peace is made longer and rockier by misdirected anger.**

Special Circumstances

While all suicide survivors face many of the same challenges, each may also face difficulties unique to their relationship with the victim...

- ⊙ **Parents** face the potential for unique forms of guilt, although it is just as unfounded as the guilt typically experienced by survivors. While parents might forgive themselves for being unable to intervene in the suicidal act, they may blame themselves for some perceived mistake made in raising their child. Parents need to understand that children—even young children—are not entirely of their parents' making. Outside influences from friends, school, the media, and the world at large also shape each child's psyche. Our children are individuals who, by virtue of having the power to commit a violent act, are responsible for that act.
- ⊙ **Spouses** often suffer additional guilt over a perceived failure of responsibility, or because of the perceived or actual accusations of others. (Families of suicide victims have been known to direct blame at the surviving spouse.) While husbands and wives vow to care for one another, we must realize that even the most caring spouse cannot assume responsibility for their partner's suicide. Spouses may also feel a greater sense of abandonment and some may come to judge their entire relationship in the light of their spouse's final act. Guilt continues to resurface if surviving spouses eventually move on to new relationships. Again, we must remind ourselves of what is really the root cause of the tragedy—depression, emotional illness, and other factors beyond our control—not our shortcomings as wife or husband.
- ⊙ **Siblings** often identify closely with one another, making the suicide of one especially painful for those left behind. It can be a reminder of our own mortality. (Older generations are supposed to die, but not your own.) Siblings may not receive the same level of sympathy or support as parents, children or spouses. Parents may overcompensate after the loss of a child by focusing uncomfortably on the surviving sibling(s)—or withdraw from them, seemingly having nothing left to give. It's essential that families pull together with mutual support and by sharing their feelings openly.

In his book, *Suicide and Its Aftermath*, author Bruce Conley states, “Many deaths leave survivors with unfinished business, but few may be said to create more of it than suicide.”

In addition to all the challenges described on the preceding pages, there are some special situations that (believe it or not) bring even worse complications...

- ⊙ **Suicide “witnesses.”** If you actually saw your loved one commit suicide or discovered their body, then you face the additional pain and shock of that experience. Often, that horrible vision of their final physical injury haunts us. Try your best to supplant that image. A photo, a memory, or even funereal viewing may help to replace it with one that more truly reflects who your loved one was.
- ⊙ **The public suicide.** Suicide victims who choose a public method—such as jumping from a building—potentially leave their loved ones with added complications. There may be unwelcome media attention and a greater level of involvement by the authorities. If you face this situation, make sure you enlist the services of an attorney who is both knowledgeable about and sensitive to suicide issues. And don’t let legal or logistic battles distract you from the very private healing you need to do.
- ⊙ **Accused!** Sometimes, survivors face more than the judgment of others—they face formal accusations of responsibility, either from fellow survivors or from the authorities. For the latter, bear in mind that police are compelled to treat any apparent suicide as a murder until the facts are ascertained. If an unfortunate clouding of facts makes you a genuine suspect in a criminal investigation, again, an attorney who has specific understanding of suicide cases is imperative. Likewise if you face the rare (but not unheard of) harassment or legal action by someone who unfairly holds you responsible. Your greater challenge in this event will be not allowing a false accusation to undermine your knowledge that the only person responsible for a suicide is the victim.

Acceptance

A cceptance is the key to healing for the survivor of suicide, but it is a deceptively simple concept. First of all, most of us operate under the assumption that we are already “accepting” the suicide. After all, only a deluded few would fail to believe that the event actually *happened*. That’s “acceptance,” isn’t it?

It may be the beginnings of acceptance, but it’s not the entire understanding. Accepting a suicide means not only acknowledging the basic reality, but accepting the contributing factors and the ramifications of it—*without* embellishing them with invented ideas, either positive or negative.

For example, you might have to accept that your loved one lost a very long battle with depression. If you were to embellish this reality either *positively* (by denying the fact that such a severe emotional illness could have existed within them) or *negatively* (by unfairly holding yourself responsible for not having “cured” them of it), then you are not truly accepting the suicide for what it is—a tragic event that, while wholly unwelcome, was beyond the control of you and those around you



Reconciling with a suicide victim

Losing someone to a “conventional” death, while difficult, does not interfere with our happy memories of them. But suicide survivors often feel disconnected and “divorced” from the memory of their lost loved one. Because they chose to end their lives—to our rational minds, an inconceivable act—we are now in a state of conflict with them. At some point, we need to “reconcile” with them—and somehow, we have to accomplish this alone.

Unfortunately, this usually takes some time. For most survivors, it’s a reward that lies somewhat down the road, after we have passed through all the fury of our emotional gauntlet and achieved acceptance—acceptance of our human limitations, of our loved one’s debilitated condition, and of our lives as they now lay before us.

In this way, acceptance is not unlike a process of separating myth from fact. Here are some examples...

MYTH we must reject....

FACT we must accept...

It's my fault that this happened.
Or...
It's the fault of their doctor/
spouse/parents, etc.

The only person who truly bears responsibility for a suicide is the victim.

If I had managed to stop this suicide attempt, they would've been okay.

I have no way of knowing what would've happened if events had played out differently. Many people go on to commit suicide, despite repeated rescues, even while under the care of trained mental health professionals.

The person I lost is a horrible person for having done this.

The person I lost was probably suffering from an emotional illness, and should be judged otherwise.

The person I lost was a saint who could never do any wrong.

The person I lost made a tragic, regrettable choice to end their life.

I should have seen this coming.

I cannot predict the future, and did the best I could with the knowledge I had.

I should have been able to save them.

I am only human and can't control all the events around me.

I can never be happy again.

My life will be forever changed by my loss, but my life will go on.

Moving On

“**L**ife goes on.” “Time heals.” “Tomorrow is another day.” If you haven’t already, you will likely be offered these time-worn adages until they make you want to scream. But our discomfort when faced with these tiny kernels of truth may come from a *reluctance* to see our lives move past this tragedy—as if continuing to live is an affront to the memory of our lost loved one.

Conversely, one shouldn’t try to “move on” until truly ready to. Trying to bravely brush aside your feelings of grief and pain will only prolong them.

When should we start getting on with life? The answer is different for each one of us. First and foremost, it’s essential that we confront the confusing and troubling emotions that suicide has left in us. Some survivors might come to a reasoned and acceptable understanding of their tragedy within a few months, but most will take a year to get through the toughest parts, and a year or two more to truly feel ready to live again.

It’s a good idea to **refrain from making any major life decisions in the first year.** (You are likely to regret rash choices made in an hour of grief.) However, life has a way of moving us forward, ready or not. New events and happenings unfold; new faces enter our lives. Sometimes the very arrival of these new developments only serves to remind us that our loved one is not here to share in them. It might even feel like you are “leaving” them behind. But you will never leave the memory of your loved one behind any more than you can take their physical being with you. With time and healing, you will be able to cherish fond memories of them—celebrating their life as you continue to live yours.



The Suicide Survivor's Affirmation

by Jeffrey Jackson

Someone I loved very much has ended their own life. I will never truly know all that was happening in their mind that brought them to that tragic choice.

However, there are things of which I can be reasonably certain...

- If they were here, even they could not fully explain their mindset or answer all of my questions.
- In their state of mind, they could not have fully comprehended the reality of their own death.
- They could not have fully appreciated the devastating impact their suicide would have on the people in their life.

As such, by their last act, they made their most tragic mistake, unknowingly creating unparalleled pain in the hearts of those whom they most loved.

The person I lost is beyond my help now in every way but one:

I can help them by working to ease the pain they have caused and by not allowing their most enduring legacy to be one of tragedy. They benefit from this help whether or not I perceive them as welcoming it, in the same way that we help the aggressor whenever we nurse his victim—by minimizing the damage he has caused.

As a result, each and every day, I can help the person I lost by...

- ...enjoying life.**
- ...smiling and laughing.**
- ...not dwelling in feelings of sadness or remorse.**
- ...loving others.**
- ...taking new steps in life toward positive new horizons.**
- ...helping those who feel their loss to do the same.**
- ...and, in short, not letting their mistake continue to create sorrow, neither in the world around me, nor in myself.**

I will try to picture my lost loved one asking me to do this every day—to please help undo the damage they caused in whatever little ways possible.

And I promise that I will.

Support

Don't try to go it alone. There are lots of people who understand what you're going through and are ready, willing, and able to help.

- ⊙ **Support groups** provide one of the most valuable resources for suicide survivors. Here, you can meet and talk with (or just listen to, if you prefer) people who are in your shoes. You can openly express your feelings and experiences with a group of caring individuals who will never judge you, rebuff you, or make you feel awkward. In addition to receiving help, you'll find tremendous benefit in the help your testimony will undoubtedly offer to others. Some groups are run by mental health professionals, while others are run by peers. To find one near you, contact...

The American Association of Suicidology

(202) 237-2280 www.suicidology.org

The American Foundation for Suicide Prevention

(888) 333-AFSP (2377) www.afsp.org

Compassionate Friends

(877) 969-0010 www.compassionatefriends.org

The Link's National Resource Center for Suicide Prevention and Aftercare

(404) 256-2919 www.thelink.org

SPAN USA — Suicide Prevention Action Network

(888) 649-1366 www.spanusa.org

- ⊙ **Books** about suicide and healing in its aftermath offer great comfort and support for many survivors. A list of the more popular ones includes...

No Time to Say Goodbye

by Carla Fine, published by Doubleday

Why Suicide?

by Eustace Chesser, published by Arrow Books

Healing After the Suicide of A Loved One

by Ann Smolin and John Guinan, published by
Simon & Schuster

Life After Suicide: A Ray of Hope For Those Left Behind

by E. Betsy Ross, published by Insight Books

My Son... My Son: A Guide to Healing After Death, Loss or

Suicide by Iris Bolton with Curtis Mitchell, published by Bolton Press

- ⊙ **Mental health professionals** can offer tremendous healing and guidance for suicide survivors. Below are just a few of the organizations through which you might find a qualified therapist or counselor:

American Psychiatric Association

(800) 964-2000 www.psych.org

American Psychological Association

(800) 374-2721 www.apa.org

National Board for Certified Counselors and Affiliates

(336) 547-0607 www.nbcc.org



The Suicide Survivor's Bill of Rights

I have the right **to be free of guilt.**

I have the right **not to feel responsible for the suicide death.**

I have the right **to express my feelings and emotions, even if they do not seem acceptable, as long as they do not interfere with the rights of others.**

I have the right **to have my questions answered honestly by authorities and family members.**

I have the right **not to be deceived because others feel they can spare me further grief.**

I have the right **to maintain a sense of hopefulness.**

I have the right **to peace and dignity.**

I have the right **to positive feelings about one I lost through suicide, regardless of events prior to or at the time of the untimely death.**

I have the right **to retain my individuality and not be judged because of the suicide death.**

I have the right **to seek counseling and support groups to enable me to explore my feelings honestly to further the acceptance process.**

I have the right **to reach acceptance.**

I have the right **to a new beginning. I have the right to be.**

In memory of Paul Trider, with thanks to Jann Gingold, M.S., Dr. Elisabeth Kübler-Ross, and Rev. Henry Milan. Reprinted by permission of JoAnn Mecca, Center for Inner Growth and Wholeness, 123B Wolcott Hill Road, Wethersfield CT. ©1984 JoAnne Mecca. All rights reserved.

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Copies in .pdf format can be downloaded from the internet, free of charge, at <http://www.suicidology.org>

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This book is dedicated to the life of immeasurable value that was lived by Gail Beth Levine Jackson.

May you have found the peace that eluded you when you were here.
