Recovering from Suicide Loss

Self-help for Those Who Have Lost Someone to Suicide

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Contents:

In memory of PAS 1968-1996

About this booklet:

We are sorry for your loss. We truly know how you feel. We hope we can offer you some helpful information

Losing someone to suicide is the worse loss that anyone can endure. No one is ever prepared for it. When someone is lost to suicide the aftermath is often clouded by the misconceptions and stigma that surround both mental illness and suicide.

This booklet is for those bereaved by a suicide. It is based on the self-help philosophy of Survivors of Suicide, Inc. (SOS), a group of individuals who have lost someone close to suicide.

It covers concerns often discussed at SOS support group meetings. It tries to put these issues into a mental health wellness context. It also draws on what research has learned about both suicide and suicide loss.

We have used a question and answer format because the grief journey that a suicide loss sets you on is often driven by a search for answers.

Please see your health care provider as soon as possible after your loss. If you have been in treatment for depression or other mental illness you should immediately contact your mental health provider. Tell your doctor or therapist about your loss and your grief.

This booklet is not meant to replace the advice

of qualified health care professionals.

What is suicide loss recovery?

Recovery means, “to regain,” “to get back,” or “to restore.” Recovery is not “healing” or “getting over it” or “closure.” These terms sound nice and hopeful but they really do not apply to what you have experienced.

A suicide, to some degree, always changes those that it affects. However, you can get back, recover, that sense of things being normal that you felt before your loss. You can get to a different normal, a “new normal.” That is what recovery is all about.

Recovery from a suicide loss is a process of learning to deal with each day’s challenges without losing ground or falling back. It is adding coping skills, and getting to the point where you are living with your grief rather than only grieving. Self-help aids recovery.

In regard to suicide loss, a significant lessening of most of the emotions that you are feeling right now marks progress towards recovery. The anxiety, the sadness, the depression, the stress, and the pain gradually become manageable and eventually move into the background. Your everyday personal, social, school, or work-related activities become less of a strain and more routine.

Recovery is not just letting things take their course. It is active. It is something that you have to work at and work towards. It is how you get back your well being and quality of life. Recovery is the goal of your journey through suicide grief.

How can I help myself with my recovery?

In the first weeks and months of your bereavement, you need to see that what you feel is normal, to get support, and to gain insight into your loss.

You are probably asking: "How can what I feel possibly be considered 'normal'?" Suicide is the most abnormal death; suicide loss is the most abnormal loss. It is severely traumatic. Your emotional response is immensely distressing but perfectly normal given what has happened.

Support is mentioned a lot in the pages to follow. This may be something you didn't need with past losses. This is because those were probably comparatively "normal" deaths. They may have involved old age or natural causes, and may have been expected. You felt the loss but you recovered quickly. The present situation is very different.

Suicide loss makes you vulnerable to other problems. You may experience some or none of them, but you must be aware of them and alert for their signs in yourself and those who share your loss. Depression and severe anxiety reactions can occur (or return). Complicated grief reactions can occur. Recurrence or relapse can occur. Suicidal ideation can sometimes occur.

We will discuss these needs and concerns.

Sometimes those who experience a suicide loss may be troubled by thoughts of suicide. If this occurs immediately call your local crisis center or the National Suicide Prevention LifeLine at 1-800-273-TALK (8255). If someone close to you says or indicates that they may attempt suicide immediately call 9-1-1.

NATIONAL
SUICIDE
PREVENTION
LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Why do things seem out of control?

You have suffered a very severe emotional shock. Suicide is the worst traumatic loss. It is sudden. It is unexpected. It may also have been violent. Suicide destroys interpersonal relationships and personal roles.

Suicide tears someone that you loved or cared for from your life, and it also temporarily shatters you and leaves you changed in many ways.

You may feel betrayed, angry, out of control, disoriented, and hurt. You may feel that the one you lost has let you down by leaving you behind to mourn. You may feel angry that he or she never gave you the chance to help.

You may feel guilty because you feel that you should have or could have done something. You may feel responsible because of something that you said or did or didn't do. These feelings are common, but most suicides are the result of many things overtime not just one event.

This is what happens after a suicide. Suicide overwhelms anyone whom it affects. It is not "painless." Suicide loss is incomprehensible to anyone who has not lived it.

In most cases, what you are feeling will pass in time or at least ease significantly. How long this takes depends on you, your personal resilience, and the support that you give and receive. You can recover and come to terms with what has happened. You are taking some of the first steps in this process right now by learning some things that will help you on your way.

Why did this happen?

This is the big question. Your search for an answer may start before the tears have left your eyes. Every suicide is different. Studies of suicide suggest that intense psychological pain and extreme feelings of hopelessness play a role.

Psychological pain comes about when there is a seemingly irresolvable and totally frustrating life situation. This may be a compelling personal or interpersonal problem, a serious financial bind, job loss, legal charges, or something else.

Whatever the nature of this problem, it is something that an individual may find devastating and something that cannot be resolved. This may generate feelings of entrapment and that there is no way out. Coping and problem-solving skills do not suffice and self-esteem and control diminish. This brings about hopelessness and may give rise to suicidal ideation.

A new theory is that suicide may occur when someone believes that he/she is a burden to others, believes that he/she does not belong, and has acquired the ability for lethal self-harm. Their beliefs need not be true, but that is what the person may believe. These perceptions may create an intense desire to die.

The ability to take one's life can result from past attempts, mentally working through a suicide plan, practicing the plan, prior experiences involving violence or abuse, or a history of self-injury. When someone who wants to die has or acquires the capability to act, develops suicidal intent, and forms a suicide plan centered on a means of suicide, a potentially lethal suicide attempt may occur.

Suicide risk is increased by misuse or abuse of alcohol or prescription or street drugs. These lessen inhibitions, increase impulsiveness, impair judgment, and weaken the sense of consequences for one's acts. This makes things worst when thoughts of suicide are present.

Suicide is not predictable. We can determine if someone is suicidal but we can't tell if, when, or how they may attempt suicide. Suicide is generally the outcome of a process over time and infrequently the result of a single recent experience.

Why didn't I know?

This is another question that you may struggle with for a long time. It is difficult to determine when someone is at risk of suicide. Also while some individuals share their feelings, not all do. Suicide notes, when present, cannot be taken literally as they are written by individuals in extreme psychological distress.

Those who are feeling suicidal may make some effort to hide it. This is often the case with male teenagers and men who may fear seeming weak or incurring shame or stigma if they asked for help.

While there are several distinct warning signs, not all suicidal individuals show any signs of their risk or danger. Even when there is concern it may be very hard to accept that someone you know so well is in danger of suicide.

Being life-affirming makes it hard to recognize the opposite state in others. It is hard for us to believe that someone that we care for dearly, someone that we would do anything for, may be suicidal.

This may happen with those who have made previous suicide attempts. We wanted to believe that our loved one or friend was no longer at risk. Few of those who attempt suicide go on to complete suicide, but no one can tell for sure who will.

Some individuals may be chronically suicidal. They say they have persistent suicidal thoughts and they may make suicide frequent threats. Not all who behave this way may make an attempt or harm themselves in any way, but some do. Those around them may not realize they were at serious risk despite their “talk” until they died by suicide

Why didn't my loved one or friend tell me?

Some individuals find it very hard to ask for help. Suicidal individuals may believe that "everyone would be better off without me." They may feel completely disconnected from everyone. This may keep them from saying anything to those they most care for.

As noted above, some may feel shame at being suicidal. While suicide bears less stigma than in the past, it is still stigmatized, and many suicidal individuals stigmatize themselves. Personal and religious beliefs may keep them from disclosing their feelings.

Psychological pain is distracting and consuming. It makes its sufferers self-centered and feeling apart from those around them. Severe psychological pain is alienating. It takes away the sense of control and the belief that anything can be done about it.

Being suicidal may distance those struggling with it from those who care about them. Most suicidal individuals do not really want to die. They want to end the pain and hopelessness. Many who complete suicide struggle with this ambivalence to the end.

Suicide is also related to changes in the brain and to chemical imbalances. These factors may override the ability to reach out, increase impulsivity, or lower resistance to self-harm.

Just because the one we lost didn't or couldn't share their anguish doesn't mean that he or she didn't care for those now suffering because of the loss. Tunnel vision is part of being suicidal. Also everything we are learning about suicide indicates that it is the outcome of the victim's suffering not an effort to cause others pain. Indeed victims may mistakenly believe that their death may positively affect others.

Why didn't anybody do something?

Suicide is not foreseeable in a given timeframe. To some degree it can be determined that someone is *at risk* of completing suicide. It may also be possible to assess the level of risk present. However, there is no way to definitively project *if or when* a particular individual may complete suicide.

Sometimes suicidal individuals do share their intentions with others. Those whom they tell may simply not believe them, underestimate or just not understand the risk, or simply not know what to do. They may not realize that risk is growing, and may let down their guard.

Even professionals have a hard time seeing that someone's suicidal. Many suicidal individuals contact a health care provider shortly before their deaths but do not explicitly share their suicidality. Limited use of suicide risk screenings and assessments may also cause these conditions to go unrecognized.

Mental health professionals may miss warning and danger signs of suicide. Some individuals drop out of treatment before anyone can recognize that they are at risk. Others simply never share their thoughts or plans for self-harm or suicide.

Suicides also happen because suicide prevention efforts are limited. Crisis intervention services can help, but they may be called too late. A psychiatric hospitalization may help stabilize a suicidal individual but it does not prevent the future onset of suicidal behavior.

Treatment for mental illness can lower suicide risk for some, but not every suicide victim has mental illness (see next section). Moreover suicide may be the result of many factors and addressing one may be ineffective.

A critical unmet need is the lack of aftercare and support specifically for suicide attempters or those who have experienced other serious suicidal behavior. Someone who made a past attempt had a plan and the ability to carry it out. They remain at very high risk and may require significant services to avoid future attempts.

What role does mental illness play in suicide?

Among the myths of suicide are the widespread beliefs that mental illness causes suicide or that only those who are mentally ill complete suicide. Neither is true.

The incidence of suicide is known to be high among those suffering from illnesses such as major depression, bipolar disorder, and schizophrenia. However, mental illness, even depression, is only one risk factor for suicide, not a cause.

Other serious risk factors include abuse, trauma, alcohol use, poor problem-solving, under-treatment, financial and legal problems, social isolation, and chronic illness and a prior attempt. Suicide is more common among individuals with mental illness because they may have more risk factors for suicide and less resilience. Co-occurring mental illness and substance abuse increases the risk of suicide.

Reports show that about 40% of suicide victims had a history of mental illness. This says that not enough is being done to prevent suicide among those dealing with mental illness. Every community needs suicide prevention resources for people with serious mental illness, for those who have made suicide attempts, and others at high risk.

Ignorance about mental illness contributes to suicide. Stigma keeps many from seeking help. They may increase their risk by letting what they think others may think about them stand in the way of doing something about their problems.

Even when your loved one or friend had a serious mental illness it was very probably not that alone that caused her or his death.

What about suicide loss and mental illness?

Any significant interpersonal loss may greatly increase stress and vulnerability to mental illness, particularly depressive and anxiety disorders. When the loss is caused by suicide the vulnerability is greater.

For some, the mental health consequences of the suicide loss may pass as they recover from their loss. For others problems may persist. That is why you must see your medical or behavioral health provider. Help is available for some of the problems that may accompany grief.

Individuals with a history of mental illness may be very seriously affected by the loss of a relative or friend to suicide. Their support system may be weakened or lost. Emotional turbulence may make an illness worse or trigger a recurrence or relapse. Retraumatization may also occur when someone has more than one suicide loss.

Suicide loss influences attitude and motivation. It is hard to feel positive after a suicide and it's often hard to do anything but grieve. It is especially hard to care about yourself. Treatment and sobriety may be casualties. Don't let this happen.

The more you let your loss impact your wellness the more you are complicating your bereavement and increasing your own risk. You may come to feel so bad that you don't care about yourself. Don't let suicide be like that bunny in the commercial – *don't let it keep going*.

Take care of yourself. Seek support. Get more help if needed.

Does suicide loss recovery follow any pattern?

There isn't a standard, one-size-fits-all grieving process. It is different for each of us. However, there seem to be some phases that we each experience. These do not necessarily unfold sequentially but it is easier to discuss them that way. Bear in mind also that where you grieve affects how you grieve. Those in grief-unfriendly settings or jobs may find their recovery from suicide loss impeded.

We all seem to face an initial period after the loss when nothing literally fits and everything hurts. It has been called a "personal 9/11" because of the extent of anguish, uncertainty, and emotion. It can be a time of panic, blame, and incrimination. Some say they felt that they were "going crazy" at this point in their bereavement.

This may be followed by a phase when you feel that you are breaking down emotionally. Pain, stress, and depression bring this about. You feel apart from those who do not share your loss. You feel a loss of control over your life, a sense of powerlessness. This is a time when you may be at high risk of crisis.

These phases may last some time. Gradually you may rebound emotionally. Your grief eases. The emotional pain holds at a level you can bear. You seem to have more energy and some interests that were set aside may come back. This is a kind of pre-recovery stage. You are moving in the right direction.

In the last phase you seem to arrive at a changed sense of who you are as a result of your loss. You are not "better" or "stronger" just different. Your personal beliefs and values are affected by what you have experienced. Part of this is the emergence of a "new normal." You can function better and you feel normal again.

The initial phases of suicide loss are not good times to make major decisions of any kind if you can avoid having to do so.

How can I help myself get through my bereavement?

Initially you can do two things. The first is to acknowledge your loss as a suicide and avoid denial. Don't adopt a mentality of silence. Try to talk about what happened to your loved one or friend. The second is to seek support, particularly from among those closest to you. Offer them your support and understanding.

Next you need to adopt a damage control mode. It is hard to stand against the emotional forces washing over you. Try to control you reactions as much as possible. Try to resolve any feelings of anger and to move away from any sense of guilt. Suicide is something that happens to someone. It is not caused by somebody.

Gradually self-help capabilities come back. Learning will come easier. You will be less encumbered by the emotion that you felt earlier. You may develop a partial understanding of the "why." You can more objectively examine feelings of guilt, blame, or responsibility. Self-worth and self-esteem are rebuilding.

At some point you develop a perspective on your loss that you can live with. This may make you feel uncomfortable. Don't feel guilty because you feel better. You need to get to a "new normal" and return to wellness. You are not leaving your loved one or friend behind. You are only outgrowing the more hurtful aspects of your loss.

Because of the stigma, misconceptions, and just plain ignorance surrounding suicide friends, co-workers, even close relatives may say things about your loved one and how they died that are hurtful. They may even question your feelings. You don't need this and you don't have to take it. If possible the best tack may be to distance yourself from such people and conserve your emotional resources.

What is a suicide loss support group?

Support is critical to recovery from suicide loss. Suicide loss support groups provide this needed help.

Mutual self-help is helping by helping others. Being part of a group provides a sense of belonging, acceptance, and normalization.

A support group is empowering and enhances self-esteem and coping ability. Information sharing and education are key elements. Many suicide grievers describe support groups as “safe places” where they can be with others who understand their loss and their feelings.

Recovery from suicide loss begins when you start to open up. By telling your story you are organizing thoughts and feelings. This may be the first step in understanding the "why", "what ifs", and "why didn't I?"

Most grief support group meetings simply involve participants introducing themselves, saying what they are comfortable in saying about their loss, and sharing feelings on grieving. Facilitators may suggest topics or share copies of materials for possible discussion.

SOS support groups are “open-ended.” You can join the group at any time. The groups are ongoing and peer-led by a suicide griever. Group leaders are facilitators. They try to assure that each meeting is meaningful and effective for all in attendance. Other groups are “closed ended” with a set number of consecutive sessions typically over several weeks addressing preset topics.

Information about local SOS support groups is available at 215-545-2242, at www.sosphilly.org, phillysos@hotmail.com or @PhillySOS. There are also support groups in other parts of the PA/NJ/DE area. The American Foundation for Suicide Prevention (www.afsp.org) maintains a national list of suicide loss support groups.

What about the Internet and other resources?

Suicide loss support groups, such as those offered by SOS, appear to be becoming more available. However, many communities still lack such supports. For this reason and others some may turn to on-line resources or the growing print and electronic literature of personal experiences with suicide loss for help.

Obviously the same cautions that apply to the Internet in general should be observed in seeking or using on-line support. Technology is changing too quickly to comment on each of the various formats available. However, here are some things to consider before joining any on-line mode:

- Who is the sponsor (i.e., person, organization, etc.)?
- Is there a screening of prospective members?
- Is there a moderator and what is their background?
- Are there provisions to protect privacy and confidentiality?
- Are there guidelines regarding discussions?

These questions are usually answered for those attending a face-to-face groups and don't seem unreasonable to ask.

There is a sizeable and swelling number of personal and quasi-biographical accounts of suicide loss. These may offer some useful insights and coping methods. Many originated as self-help strategies for the authors. Those without anyone to share their grief with may draw some vicarious support from the author's experience.

The principal caveat with personal stories of suicide loss is not to see them as prescriptive. "Lived experience" can enhance understanding and demonstrate that recovery from suicide loss is possible. Nonetheless we each have our own grief journey and what worked for another may not suffice at all for us.

What will I need later to help my recovery?

Your work isn't over when you are able to finally put these first seemingly endless weeks and months behind you. You still have a long road to travel before you will feel that you have recovered from your loss.

You must be ready to deal with "triggers." These are events or things that may rekindle your grief and possibly cause you to lose ground on your movement towards recovery.

The most common triggers are occasions that remind you of your loss. Chief among these are anniversaries of your loss. The first holidays after the loss and those that follow may be problematic, especially if they involved family get-togethers.

The best way to handle these occasions is to not go it alone. Draw on the support of those you trust. Think about going out for dinner to avoid seeing the empty chair instead of eating at home or at a relative's.

Another trigger may be the death of someone close or even a beloved pet. You may find yourself taking this loss harder than you expected. This is because you still have some open grief issues. Don't be reluctant to seek help if you feel that you need it.

We all grieve in our own way. We each have our own path to recovery from our loss. Proceed at your own pace. Don't set impractical goals or let others impose unrealistic expectations or timeframes for you. It is not uncommon to be told: "You should be over this by now!" You may never really "get over it" and you don't really have to.

What may complicate my grief?

Situations like these may worsen your loss experience:

- Inability to express your grief – You may be in a setting where open grieving is not possible or you may be around others who discourage your grieving or deny your loss. If you can't control your circumstances grieve as you can in private.
- Witnessing a suicide or finding the body – Being present when the suicide took place or coming across the body may increase the trauma you experience. Try to replace the image in your mind with that of a past pleasant memory or photo.
- Not being nearby - Being away from those who share your loss may cause you to feel isolated in your pain. Try to find a way to pay your respects if you are unable to attend the service. A personal memorial may help.
- Controversial suicide – Most suicides are only known to a few people. Others may be "newsworthy" because of the method or public stature of the victim. The media can be insensitive to the bereaved and their questions may be hurtful.
- Legal issues – The police, EMTs, and the medical examiner or coroner are part of every suicide because it is an unnatural death. Their involvement and questions are necessary but may be painful.
- Problematic relationship – You may have been estranged from your friend or loved one at the time of her/his death. Try to connect with the memory of when things were better.
- Going back to work/school too soon – This may not be a choice. Three-day funeral leaves won't do. You may not be up to the benign let alone negative aspects of the workplace early on. If you can, think about taking time to be ready for re-entry.

Concluding remarks

Hopefully this booklet has provided some meaningful information or at least answered some of your questions and concerns about the aftermath of a suicide. There is much more to learn in the months and years ahead. This is just a very basic orientation to a very difficult and complex process.

This booklet is not intended to be a suicide loss handbook or even Suicide Loss 1.0. What was said here is meant to be suggestive not definitive. It is offered more as a user's guide than an operations manual. It conveys much of what is shared at an SOS group. More importantly, it reflects the SOS perspective on the experience of a suicide. Such a loss will always be part of our lives, but it can come to occupy a place that does not interfere with living our lives at some point. That is recovery.

In closing, we want to acknowledge the useful feedback that SOS has received since this booklet was first issued. Comments, criticism, and corrections on this edition are also most welcome and will be incorporated into any future reprints as appropriate.

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