Fostering Hope Counseling

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Co-Author – Finding Your Way After the Suicide of Someone You Love (Zondervan, 2005)

Norm Wright – "This book is the best I've read on the subject and I use it when working with survivors. I highly recommend it"

AACC workshop: Sept. 13, 2013. Left Behind: Suicide and Complicated Grief

Why is this topic relevant?

- How many of you have lost someone you know to suicide on a personal level?
- How many of you have lost a client to suicide?
- How many of you fit into both categories?
- One person said, "There are two kinds of therapists – those who have lost a client to suicide and those who will."
- Suicide is something that will touch most of us at some point in our lives, either in a professional or personal way or both.
- There are some differences between suicide and other kinds of death related losses, and it's important to understand those differences for the kind of work that we do.

General suicide info – stats, etc.

- 2010 Stats from the Centers for Disease Control and Prevention report 38,364 deaths by suicide.
- Someone died by suicide every 13.7 minutes
- Suicide is the 10th leading cause of death in the US
- Rates fairly consistent in 1990s – 2008. In 2008, rates started rising again. The 2008 numbers were the highest in 15 years.

- WHY – economy, war, 911, military, drugs/alcohol, hopelessness, mental illness, isolation, hopelessness, divorce rate.
- It is estimated that 90% of those who die by suicide have a diagnosable/treatable psychiatric disorder at the time of their death (depression, Bi-Polar, Schizophrenia, alcohol abuse and dependence, drug abuse and dependence, PTSD, eating disorders, personality disorders, etc).
- Men die more often, women attempt more often
- Whites have the highest number of suicides, Native Americans 2nd
- Highest rates – 40-59 Highest increasing rates – men over 65
- Suicides in the military continue to climb – it is the leading cause of death in the Army, Navy, and Marines. One suicide every 18 minutes. Non combat related suicides.
- It is estimated that every suicide touches at least 6-8 people.
- It is estimated that the suicide risk among survivors is 1.5 to 5 times higher than for others. A multi-state study of suicides found that 14% had lost a relative to suicide. Adolescents who have lost a friend to suicide are almost 3 times more likely to complete suicide than those who have not.

Survivors of Suicide

- A survivor of suicide is anyone who remains alive following the suicide death of someone with whom they had a significant relationship or an emotional bond. As many survivors have said, "It's an exclusive club that we join without wanting to." Term "Survivors of Suicide" recognized in the 1960s. Researchers interviewing relatives of suicide victims found that family members remained profoundly bereaved and had an intense need to talk about their loss. Most of those who have experienced a suicide loss don't think of themselves as "survivors" but only as deeply bereaved. There is some confusion regarding the term "survivor" as that is also used for those who have attempted suicide. Change in terminology, but will use "survivors" for purposes of this discussion.

What makes a loss by suicide different than other losses and can lead to complicated grieving?

- Sudden and traumatic
- Can be especially violent
- It can have long lasting cognitive and emotional consequences, especially for those who witness the suicide or find the body

- Feelings are intensified because this is something the deceased did to themselves
- It can have a longer healing process – 2 years or longer before the survivor feels they are ready to move on
- Survivors often feel responsible for the loss and can experience deep guilt
- In addition to dealing with the death, there can be additional trauma in having to deal with the police, medical professionals, the coroner, crisis counselors, other first responders, and often the media
- The stigma attached to suicide can create barriers for people to find the help they need for support. It insinuates that there is something wrong with the survivor. Because of this reaction, some survivors never talk about it or seek the help they need, preferring to "go it alone." Many experience unresolved and complicated grief.
- There is often rejection and blame by family and friends. People don't know what to say so they avoid the one grieving. This adds to the guilt and loss that is already overwhelming them.
- Oftentimes survivors don't know what to tell others about the loss.
- Many survivors who have a relationship with God have a crisis of faith. Sometimes they experience a lack of support from their faith community. It is not uncommon for a survivor to change churches or stop going to church altogether. The average length of time most churches help those who are grieving is 3 weeks.
- Mental health issues and unresolved grief from the past can exacerbate suicide grief
- Because of the suddenness of the loss, those left behind don't have time to prepare. This can have devastating effects on the family system – finances, roles are changed
- Because of the nature of suicide and the unanswered questions, it is difficult to experience closure

Why?

- Survivors constantly ask themselves the "why" question.
- Why did my loved one choose death over life? Why didn't I see it coming?
- Some survivors can answer that question with some certainty, many cannot.
- Who really knows what goes on in the minds of those who end their pain this way? Family issues, financial problems, difficulties in school or work, relationship issues, gender-identity issues, addictive behaviors,

physical disabilities, hopelessness, PTSD, depression and other mental/emotional disorders, and a myriad of other reasons.

- Survivors need to talk through the "why questions" with trusted others in the early stages after the loss. If you are counseling a survivor, let them continue to ask this question until they don't need to any longer and can accept that they may never know the answers. The why questions become less important and the focus shifts to, "Where do we go from here?" Linda Flatt – lost her 25 year old son to suicide. She said, "The only person (except for God) with the answers to my questions is unavailable to hear them. And it occurs to me that he might not know the answers himself."
- In addition to the deceased, God is often the recipient of the why questions. Why did You allow this to happen? Why didn't You stop it? (Deut. 29:29 – The secret things belong to the Lord, but the things revealed belong to us and our children forever).
- As healing occurs, many survivors change the question from "why" to "what do I do with this now," as they seek to use their experience to help others.

Specific aspects of suicide grief:

There are common aspects to all grief work, but these are exacerbated for the suicide survivor and tend to last longer and can lead to complicated grieving.

- **Emotional**
  Denial, numbness, shock, sadness, crying, anxiety, fear, depression, guilt, pain, anger, rejection, feelings of failure, feeling like you are going crazy, PTSD
- **Physical**
  Chest pains, sleep disturbances, low energy, achyness, headache, lowered resistance so are sick more often
- **Cognitive**
  Feeling as though you are in a fog, difficulty concentrating, forgetfulness, inattention, loss of productivity, memory loss, worrying
- **Behavioral**
  Self-medicating, thoughts of suicide or death
- **Social/relational**
  Loss of interest, isolation, withdrawal, loss of relationships
- **Spiritual**
  Crisis of faith, anger at God for having these feelings, feeling abandoned by God, questions that remain – where is my loved one, why did God allow this to happen?

Complicated Grief:

Most people experiencing normal grief and bereavement have a period of sorrow with physical, emotional, relational, and spiritual reactions. Gradually these feelings ease and it's possible to accept the loss and move on.

For some people, feelings of loss are debilitating and don't improve even after time passes. This is known as complicated grief. In complicated grief, painful emotions are so long lasting and severe that people have trouble accepting the loss and resuming their lives.

Complicated grief is like being in a chronic, heightened state of mourning.

Some symptoms of complicated grief include:

- Extreme focus on the loss and reminders of the loved one
- Intense longing or pining for the deceased over a long period of time
- Problems accepting the death
- Numbness or detachment
- Bitterness about the loss
- Inability to enjoy life or to function with normal living
- Trouble eating or sleeping
- Depression or deep sadness beyond that expected in normal grief
- Withdrawal from relationships, lack of social support
- Feeling that life holds no meaning or purpose
- Compounded losses – several losses in a short period of time, making it more difficult to deal with the current loss
- Suicidal thoughts or actions

The exact cause of complicated grief is not known, but it is thought to involve an interaction between inherited traits, environment, the body's chemical makeup, personality, past losses and how the person has or has not healed from those, how loss was dealt with in the family of origin, the nature of the death (sudden, traumatic, suicide), presence or lack of support systems, relationship to the deceased, lack of resilience or adaptability to life changes.

Counseling survivors:

- It's important to know and understand your own feelings about suicide
- Assess where the client is in his/her grieving process. There's currently no consensus among mental health experts about how much time must

pass before complicated grief can be diagnosed. Some suggest diagnosing after 2 months if symptoms haven't improved, others suggest waiting 6 months. This is complicated by the fact that grief is such an individual process.

- To assess for complicated grief – look for a lack of improvement of symptoms over time, and a significant impact on the client's ability to function in daily life. Most survivors start to show improvement in functioning after 6 months.
- Assess and treat for PTSD and major depression. Medication may be indicated if the client has not shown improvement after a few months. Suggest a visit with their primary care provider and a physical if they haven't had one in awhile to rule out any physical issues that may be adding to their mental and emotional state.
- Assess for suicide thoughts/ideation (thoughts, plan, means, previous attempts, suicide in family). Do this often. Many survivors will say they want to die, but won't follow through on this. Let the client know you will breach confidentiality if you feel they are a danger to themselves. Most states have a mandated responsibility to report when a client is a danger themselves or others. Make sure they are safe (have crisis numbers, plan to deal with weapons/medications, etc, increase counseling sessions, phone check in).
- Provide them with resources – support groups, grief groups, suicide organizations. Some ideas are on your notes. Help them see they are responsible for their own healing. By taking responsibility, they won't become victims, blaming others.
- Encourage them not to withdraw and isolate themselves. Ask about their support systems. Suggest they reach out to their faith community. Also encourage them to ask for help, although that can be difficult. Friends and others go back to their own lives, often leaving survivors alone and feeling abandoned.
- Encourage survivors to talk – they need to talk in order to process. Have them tell you their story. If a survivor trusts you with their care, you will be a lifeline for them.
- They must allow themselves to take all the time they need to grieve and not let anyone hurry them through it. Must feel the pain to heal.
- Talk to them about good self-care – taking care of themselves physically – eating right, exercise, resting. Encourage them to not dull the pain with alcohol, medications, or other things.
- Suggest good coping and relaxation skills – journaling, music, prayer, reading, stress management, etc.

- Normalize things for them – their reactions and questions are normal. They are not going crazy. Others have felt like they do after this kind of loss.
- Try to reduce the stigma, shame, and guilt associated with the suicide. Most survivors will have guilt – the overriding belief that they failed their loved one in some way, that they didn't do enough, and that the suicide is their fault. Help them distinguish between real and false guilt. Redirect faulty thinking – help them focus on the positive things they brought to the relationship. Some survivors feel guilty when they start to move on. Help them see that they can't change the past, they did the best they could, and that there were probably a lot of factors that went into their loved one's decision. Healing starts when survivors realize they are not responsible for the actions, and therefore, the consequences of others.
- Help them to set boundaries and make it ok to "avoid" people who are critical, negative, blaming, or who say hurtful things.
- Encourage them to not make major decisions until they can think clearly without their emotions interfering with sound judgment.
- Grief is an individual process. Help them understand that others won't grieve as they do and that, even though they may be grieving the same death, everyone does it differently – relationship to deceased, male/female, etc. Help make it ok for them to grieve as they do and to let others grieve as they feel comfortable doing.
- If the loss was a child, the loss can put a wedge in a marriage.
- Memories are lurking around every corner and can knock the wind out of them all over again. Preparing for anniversary dates is important.
- Help them with their spiritual questions – why did God allow this, why didn't He prevent this, where is my loved one, is it ok to be angry at God, why did God abandon me? Encourage prayer, Bible study when ready.
- Healing occurs when the survivor can come to a healthy acceptance of what happened. Give them hope that they will get through this, the future can come with a deeper relationship with God and others. They can laugh again and feel joy again.
- There will still be sad and difficult times in the days and years ahead. These are normal but will not carry the weight of the early loss. The pain gets "softer." Suicide is part of their history, but not all of their history.
- Encourage forgiveness – others, the deceased, themselves.
- When they are ready to "move on" help them prepare for this. Many want to find a new purpose and meaning for their lives. Their perspective has changed. Help them find their "new normal." Ask them, "What would moving beyond survival look like for you, and are you willing to do what is required to get there?" Help them formulate a new vision and direction.

Clinicians as Survivors

- The American Association of Suicidology offers as one of their services a network for clinician survivors called the Clinician Survivor Task Force. These are professionals who have lost clients to suicide. Many of them have also experienced a suicide personally.
- The Task Force provides consultation support and education to psychotherapists and other mental health professionals to assist them in understanding and responding to their personal/professional loss resulting from the suicide death of a patient/client and/or family member.
- Approximately 1 in 5 therapists (and as many as 1 in 2 psychiatrists and psychiatric trainees) loses a patient to suicide during the course of their career. For clinician-survivors, litigation issues, stigma around suicide and the feared negative reactions and judgments of colleagues often exacerbate the pain and grief of the loss itself.
- The initial goal of the Task Force was to begin to shed light on the topic of the clinician's suicide loss so that clinicians could start to reduce their isolation, speak about their experiences and begin the healing process.
- Although there are clear differences between the nature of patient and family suicide losses, it is clear that there is a great deal of commonality in the impact of these losses, particularly in the ways in which they affect clinical work, professional relationships and professional identities. In addition, Clinician Survivors of each type of loss may face potential stigma and isolation from colleagues, both in relation to the suicide itself and to subsequent personal vulnerability.
- Fully one in six psychiatric patients who die by suicide die in active treatment with a healthcare provider
- Approximately 50% of those who die by suicide in America will have seen a mental health provider at some time in their life.
- Interns, residents and other novice clinicians have been found to experience higher rates of suicide among their clients than more seasoned clinicians.
- Suicide malpractice is the leading cause of legal action against all behavioral healthcare providers, regardless of discipline.
- Experiencing the loss of a client by suicide can be psychologically traumatic for the provider, and may even become a career-ending event.
- Few training institutions or graduate programs prepare students for this possible traumatic loss.
- If you have not had in depth training in suicide risk assessment and risk management, you are encouraged to do so

- If counseling a client who appears suicidal or who is at risk for suicide, seek supervision and/or consultation from a colleague who has experience in dealing with suicide.

What to do in the aftermath of a client suicide:

- Understand your loss – reading, research, educate yourself, talking with other survivors
- Self-care- take the same steps we talked about in reference to clients who have had a suicide loss – counseling, journaling, music, support group
- Turn to your faith community if supportive
- Seek professional help or an understanding colleague to walk you through the grieving process and to help you answer the "professional" questions you might have
- Find support from clinicians who have had a suicide loss – AAS Clinician Survivor Task Force.
- Don't isolate or tough it out. Seek help.
- My help

What to do in the aftermath of a client suicide: The deceased and family

- How do you follow up, or do you?
- According to the Clinician Survivor Task Force:
    - The primary care provider should call the family and express condolences. This call should be sincere but brief. Simple, heartfelt language is always best, e.g., "I am sorry for your loss. Please let me know if there is anything I can do." If this first step seems problematic, consultation with a colleague is advised.

- What are your thoughts on this? What are your thoughts on this ethically? Who holds the privilege?

- What do specific ethic codes say?
    - NASW – Social workers should protect the confidentiality of deceased clients consistent with standards
    - ACA – Counselors protect the confidentiality of deceased clients, consistent with legal requirements and agency or setting policies.
    - AAMT – not addressed. The assumption being that you would talk about the death if you had been treating the family during family

therapy. If the family didn't know the client was in counseling then issues of confidentiality would apply.
    - If you looked at this from the stand point of a dual relationship – ACA might be ok with this, NASW and AAMFT would not.

- So, the dilemma is this: Do you go by the book so to speak, or do you put ethics aside and respond from a compassionate, caring, human point of view – the very values that brought us into this profession in the first place? AND – what is your motivation if you choose to do this?