MYTHS AND FACTS ABOUT SUICIDE

MYTH 1
A person who talks about completing suicide won't actually do it.

MYTH 2
Suicide usually occurs without warning.

MYTH 3
A suicidal person fully intends to dies.

MYTH 4
If a person attempts suicide once, he or she remains at constant risk for suicide throughout life.

MYTH 5
If a person shows improvement after a suicidal crisis, the risk has passed.

MYTH 6
Suicide occurs most often among the very rich and the very poor.

MYTH 7
Families can pass on a predisposition to suicidal behavior.

MYTH 8
All suicidal persons are mentally ill, and only a psychotic person will complete suicide.

FACT 1
About 80% of persons who complete suicide express their intentions to one and often more than one person.

FACT 2
A person planning suicide usually gives clues about his or her intentions, although in some cases, suicidal intent is carefully concealed.

FACT 3
Most suicidal people feel ambivalent toward death and arrange an attempted suicide in the hope that someone will intervene.

FACT 4
Suicidal intentions are often limited to a specific period of time, especially if help is sought and received. Help can be effective.

FACT 5
Most suicides occur within three months or so after the onset of improvement, when the person has the energy to act on intentions.

FACT 6
Suicide occurs in equal proportions among persons of all socioeconomic levels.

FACT 7
Suicide is not an inherited trait, but an individual characteristic resulting from a combination of variables. One variable may

be that another family member has died by suicide.

FACT 8
Studies of hundreds of suicide notes indicate that suicidal persons are not necessarily mentally ill

SUICIDE STATISTICS
In the United States and Alabama

Suicide in the U.S.	Suicide in Alabama
Over 44,000 people died by suicide in 2015.	In 2015, over 750 people completed suicide.
10th leading cause of death in 2015	11th leading cause of death in 2011
U.S. age-adjusted fatality rate in 2015 • 13.26 per 100,000 people.	Alabama age-adjusted fatality rate in 2015 • **14.87** deaths per 100,000 people.
In 2015: 49.8% of suicides completed with the use of a gun 26.8% suffocation 15.4% poisoning 7.9% other method	In 2013: 69% of suicides completed with the use of a gun 18% suffocation 6% poisoning 7% other method
One young person dies from suicide in the U.S. every two hours.	In a survey of Alabama youth, 8% reported attempting suicide, and 12% had made plans.
3rd leading cause of death for 15-24 year olds	3rd leading cause of death for 15-24 year olds
Among 25-34 year olds • 13.6 deaths per 100,000	Among 25-34 year olds • 15.46 deaths per 100,000
Elderly make up 12.3% of population, but 19.4% of suicides.	Elderly make up 13% of population, but 18% of all suicides in Alabama
Depressive symptoms occur in up to 80% of people who complete suicide.	
White males account for 73% of all suicides.	White males account for 73% of all suicides.

Compiled from information from the Alabama Task Force on Suicide at www.adph.org/suicideprevention.

About the Suicide Paradigm
Some thoughts on changing our conception of suicide

Suicide is the outcome of neurobiological breakdown. The process begins in severe stress and pain generated by a serious life crisis. These increase as the crisis, or the individual's perception of it, worsens. Feelings of control and self-esteem deteriorate.

Suicidality occurs when the stress induces pain so unbearable that death is seen as the only relief.

Suicidality entails changes in brain chemistry and physiology. Suicidal individuals manifest various chemical imbalances.

As one becomes suicidal he or she is no longer capable of choice. Suicidality is a state of total pain which, coupled with neurological impairment, limits the perceived options to either enduring or ending utter agony.

The paradigm concept is the idea that in any field there is a set of assumptions shared by most of those working in the field. The prevailing paradigm determines what gets studied, and how the findings are interpreted.

A paradigm becomes entrenched and self-sustaining. It provides continuity and stability. Its tenets are defended and change is resisted.

Paradigms only change when new concepts arise which cannot be rejected or assimilated.

The study of suicide and the treatment of suicidal individuals involves a shared paradigm. New insights are laying the groundwork for a new paradigm, which entails a change in how we see suicide.

Old Paradigm	New Paradigm
Suicide - Killing of oneself	Penacide - Killing the pain
Goal: End Life	Goal: End Pain/suffering
Event or behavior	Process of debilitation
Decision and a personal choice	Disease outcome; no choice involved beyond crisis point in the process of debilitation
A means of control or manipulation	The result of severe stress and psychological pain

Voluntary action	Involuntary response
Individual is a decision-maker	Individual is a victim
A psychological phenomenon involving the mind	A physiological or neurobiological phenomenon involving the brain

Rights of Suicidal Individuals

For those who are at risk of completing suicide

In an era of strong advocacy for consumer, client, and patient rights, one group has been forgotten. Those who are suicidal or at risk of becoming so are accorded little protection in professional ethics codes and similar instruments. This deficiency has been amplified by the debate about assisted suicide and the "right to suicide." Most suicides are "unassisted" and those at risk are entitled to more than the right to die.

- ***Suicidal individuals have the right to have any expression of intent taken very seriously by those to whom they have communicated.*** Those at risk often make a "cry for help." This should be regarded as a sincere request for aid.

- ***Suicidal individuals have the right to have their suicidal risk viewed as their most serious problem. There is no problem more serious.*** Those at risk may have other problems, which may be related to their suicidality. However, once the potential for suicide is determined it must take precedence until it is abated.

- ***Suicidal individuals have the right to be seen as wanting to be helped. They want their pain to end. They do not want to die.*** Those at risk are often ambivalent about living or dying because they may equate living with pain and dying with freedom from pain. Intervene on the side of life.

- ***Suicidal individuals have the right to have their condition brought to the attention of someone in their life who cares for them.*** Family members and friends are available and easily mobilized. Moreover they stand to be irrevocably harmed if a suicide occurs. Let them help.

- ***Suicidal individuals have the right to know that they are experiencing a chemical deficiency in their bodies brought on by stress and/or mental illness.*** Those at risk have a deteriorating sense of self-esteem and control. They must know that they are not causing what is happening in their bodies.

- ***Suicidal individuals have the right to know that medications are available which present viable means for stabilizing their situation.*** Those at risk must have early access to antidepressants and other drugs, which may take time to reach clinical effectiveness.

- ***Suicidal individuals have a right to acknowledgment of their pain, which may be physical, psychological, or emotional in origin.*** Those at risk have severe stress and psychological pain. Ask about their pain, and help to ameliorate it.

- ***Suicidal individuals have a right to meaningful intervention by those responsible for their care when they are manifesting critical symptoms.*** Those at risk cannot help themselves because of the process of debilitation that they are experiencing. At some point they can only be helped by others.

COMMON ERRORS OF SUICIDE INTERVENTIONISTS

SUPERFICIAL REASSURANCE

*Caregiver is . . .*Too optimistic, emphasizes positive aspects of situational risks thus alienating the distressed person, rejects and contradicts the client's anguish or hopelessness, Prematurely offers prepackaged meaning for expressed difficulties (such as religious or secular philosophy), discounts the depth of pain.

Inappropriate responses: "You have so much to live for." "God works in mysterious ways." "Things can't be all that bad."

AVOIDANCE OF STRONG FEELINGS

*Caregiver . . .*Retreats into intellectualization or premature advice giving, while avoiding empathic understanding. Models the containment of strong emotions, thus failing to allow the client free expression of angst.

Inappropriate responses: "Your tears suggest that you're depressed. Maybe we should consider some medication."

PROFESSIONALISM

Caregiver . . . Insulates or protects oneself from complicated pairings with by seeking refuge in the boundaries afforded by one's professional role. Overly distances and detaches, conveying disinterest. Fails to build upon the relationship qualities of the therapeutic alliance.

Inappropriate responses: You can tell me, I'm a professional and have been trained to be objective about these things." "I never have clients who are suicidal." "If you become suicidal, I'll have to refer you to another therapist."

INADEQUATE ASSESSMENT OF SUICIDAL INTENT

Communications of suicidal intent (even veiled or indirect signals) may be met with reassurance, and even more direct statements of intent are ignored or contradicted.

Inappropriate response: "You sound as if you're suicidal, but what is really bothering you?"

FAILURE TO IDENTIFY THE PRECIPITATING EVENT

*Caregiver . . .*Fails to recognize and acknowledge key triggers of suicidal behaviors. Under-appreciates the context and precipitating events which, when considered fully, could guide the development of actions within intervention. Fails to grasp that clients need their pain.

Inappropriate response: "What do you think your deceased wife would want from you? Don't you think she'd want you to be more productive, to get on with your life?"

PASSIVITY

Caregiver . . .Fails to be active, engaging, focused, and structuring. Passivity misses connecting/ joining with the client, misses collaborative alliance.

Inappropriate responses: "I'm here to listen..." "It must be very hard to talk about what's bothering you."

INSUFFICIENT DIRECTIVENESS

Caregiver . . .Fails to negotiate safe structures. Misses the point that crises need more directive management, such as, "Would you put the gun down?" as contrasted with--

Inappropriate response: "It seems as if holding the gun makes you feel more in control."

ADVICE GIVING

Caregiver . . .Fails to facilitate within the client the development of problem-solving skills and the opportunity to participate in his/her own solution/rescue.

Inappropriate responses: "You're not thinking rationally. We need to identify an alternative way to interpret what happened."

STEREOTYPICAL RESPONSES

Caregiver . . .Takes shortcuts in the form of unwarranted, stereotypical assumptions based on demographic profiles, typologies, etc. Treats client as a statistic rather than as a unique individual.

Inappropriate responses: "Most men in your age group have this difficulty."

DEFENSIVENESS

Distressed individuals in crisis may become more difficult with which to work, focusing on, displacing upon and perhaps attacking the caregiver. Fails to respond nondefensively.

Inappropriate responses: "Well, no, I have never been suicidal myself, but I can still help you." "Sure, I've had suicidal thoughts myself, but I've always found better solutions to my problems."

DEMOGRAPHIC INFORMATION AND COMMON PREDICTORS

FEATURES	MANIFESTATIONS	COMMENTS
Age	Suicide rises with age. For white males, the older he is, the more at risk he is.	White males over 65 have a suicide rate 4 times that of the national average.
Gender	More males complete suicide. More females attempt suicide.	Males choose more lethal means.
Ethnicity	More white people complete suicide than persons of color.	Statistics show an increase in young African-American males, ages 15-24.
Loss	The more irrevocable the loss, the greater the risk.	Suicide is associated with an accumulation of losses throughout life.
Substance Abuse	Alcohol increases the risk of completed suicide.	Drug abuse is correlated with more attempts.
Mental illness	Prior psychiatric hospitalization increases level of risk.	It is estimated that 1/3 of all completed suicides have a diagnosable depressive illness.
Physical illness	Sudden onset of a serious illness or chronic conditions with poor prognosis and/or intense pain indicates greatly increased risk.	Illness generally places a strain on defenses and coping skills, thus increasing risk.
Downward economic mobility	Unemployment, frequent job changes, direction of reduced status or reduced earnings increases risk.	Consider how one's identity is impacted by these setbacks.
Living in the city center	Areas of high crime, alcoholism, mental illness, poverty, or family disorganization.	Urban conditions increase social isolation and alienation.
Relationship disruption	The more final the change, the greater the risk.	Marriage is protection for males. Women survive better without a mate than do men.
Previous attempts	Prior attempts are considered high risk.	The more lethal the earlier attempts, the greater the rate of subsequent completed suicide.
Family or close friends attempted or completed	Presence of loved ones with attempts or completions increases risk.	"Modeling" of behavior plants the seed that suicide is an accepted way of coping.
History of physical or sexual abuse	Themes of vulnerability, post-traumatic stress, etc., complicate coping.	History of abuse reduces chances for self-empathy

Absence of a support system	Lack of resources and social support is correlated with completed suicide.	Consider how capable he/she is of developing new resources

There is no “one type of suicidal person.”
Often, a combination of variables may place a person at risk.

TEN BEHAVIOR WARNING SIGNS THAT SOMEONE MAY BE AT RISK FOR SUICIDE

FEATURES	MANIFESTATIONS	COMMENTS
Quiet, withdrawn, few friends	Often not recognized as significant because the person is not in obvious trouble. Withdrawal = invisible.	Assess for social isolation.
Changes in behavior	Personality changes, e.g., from being friendly to withdrawn, from being quiet to being a disturbance.	Among adolescents, it's difficult to distinguish "typical" adolescent conduct from risk factor.
Increased failure or role strain	Role strain at school, work, home, with friends and with mates.	Youth often demonstrate role strain at school.
Recent family changes	Illness, job loss, increased consumption of alcohol, poor health	Past history of prior strains is essential to understand current crisis.
Recent loss of a family member	Death, divorce, end of relationship, separation, someone leaving home, estrangement	Examine what meaning does the loss have for him or her.
Despair and hopelessness	Note the manifestation of hopelessness in many forms – behavior, written, verbal	Hopelessness is even more closely associated with suicide than with depression.
Symptomatic acts	Taking unnecessary risks, drinking and drugging, inappropriate aggression or submission, giving away possessions.	Examine what is a shift from behaviors, say, before things began to feel so bad.
Statements such as	"Life is not worth living." "I'm finished." "No one would care if I was gone." "I want to end it all."	Any statements like this are NOT attention-seeking but rather help-seeking. Treat very seriously.
Presence of a plan	Storing up medication, buying a gun, etc.	The presence of a means or recent attempts to secure a means should be regarded very seriously.

Negative or fearful thoughts	"I must be crazy." "It's the end of the road." "What's the point?"	Refusal of help should be treated seriously.

Watch for the three H's of suicidality:
Hopelessness - Utter despair and inability to see beyond the crisis.
Haplessness - Loss of enjoyment in previously pleasurable activities.
Helplessness - Inability to ask for or to receive help. A belief that nothing will help.

F.A.C.T.S
Suicide Warning Signs

F for Feelings

- **Hopelessness** "It will never get any better." "There's nothing anyone can do."
- Fear of losing control, fear of going crazy, fear of harming oneself or others.
- **Helplessness**, a feeling that "no one cares," "everyone would be better off without me."
- Overwhelming guilt, shame, self-hatred.
- Pervasive sadness

A for Actions or Events

- Drug or alcohol abuse
- Themes of death or destruction in talk or written materials (letters, notes)
- Nightmares
- Agitation, restlessness
- Aggression, recklessness

C for Change

- In personality - more withdrawn, tired, apathetic, indecisive or more boisterous, talkative, outgoing. Different temperament than usual.
- In thoughts - can't concentrate on schoolwork, routine tasks, etc.
- In sleep patterns - oversleeping, excessive sleeping, insomnia
- In eating habits - loss of appetite, weight gain/loss, overeating, change in eating rituals
- In activities - loss of interest in friends, hobbies, personal grooming, or other activities
- Sudden improvement after a period of being down or withdrawn, "too euphoric"

T for Threats

- Statements, e.g., "How long does it take to bleed to death?"
- Threats, e.g., "I won't be around much longer."
- Plans, e.g., putting affairs in order, giving away favorite things, obtaining a weapon.
- Gestures, or attempts, e.g., overdose, wrist cutting.

S for Situations

- **Recent loss** through death, divorce, end of relationship, separation, loss of job, money, status, pride, self-esteem, loss of religious faith or spirituality
- Changes that feel overwhelming

Of course, aside from the more overt gestures or threats, none of these signs are a definite indication that the person is going to complete suicide. Many people are depressed and never end their lives by suicide. Many experience losses or evidence changes in behavior or demeanor with not indication of suicidal tendencies. However, if a number of these signs occur, they may

be important clues that help is needed. Act immediately and get resources. Risk is extremely high if the individual has access to a gun and has been using drugs/alcohol.

QUESTIONS FOR ASSESSING EMERGENCY VS. SUICIDAL RISK

What is emergency risk?	**What is suicidal risk?**
Emergency risk directly corresponds to warning sighs. When you are assessing for emergency risk, you are examining the immediacy of the situation, or the potential that the caller/client will act on his or suicidal ideation or threat.	Suicidal risk suggest that there are some indications that the individual may have a possibility of a suicidal profile, based on history, family dynamics, demographic information, etc., but he or she is not actively suicidal with a plan or a method in place. The likelihood that he or she would attempt suicide is not seen as being an impending emergency.
ASSESSING EMERGENCY RISK	**ASSESSING SUICIDAL RISK**
Do you have a plan to complete suicide? • *Yes, I do…details are clear.*	Do you have a plan or a method/means? • *Not really, I haven't gotten that far.*
When were you planning to kill yourself? • *I'm gonna do it. Today, tomorrow, in the immediate future. I can't go on.*	When were you planning to kill yourself? • *I don't know; it's just something that I've thought about.*
Where would you do it? • *A specific site is mentioned.*	Where would you do it? • *No real particular idea.*
Where are the pills (gun, knife)? How many pills do you have? Gun loaded? • *The means is very readily available, I have the method ready.*	Have you ever tried to kill yourself before? • *If yes, the risk may increase, but without a plan or a means, the risk may not be considered an emergency.*
Have you ever tried to take your life before? When? What happened? • If yes, risk is heightened.	How do you feel about the fact that your first attempt did not result in a completed suicide? • *I am so relieved, or I got the help I needed or I'm a failure at everything…a "failed" attempt may have meaning one way or the other.*
What's happened in your life that makes you want to end everything? • *Look for a sudden and painful loss, or a loss on top of accumulated losses.*	What has happened in your life that makes you want to end everything? • *The reason may be more diffuse.*
Who have you talked with about wanting to end your life? • *Although suicides are not identical, many will have given signs to others of their intent.*	Who have you talked with about wanting to end your life? • *Be curious if he or she has been spreading warning signs to others.*
On a scale of 1-10, (1 being normally upbeat, 10 being extremely depressed or hopeless) how would you say you feel? • *Higher the number = greater the risk.*	On a scale of 1-10, (1 being normally upbeat, 10 being extremely depressed or hopeless) how would you say you feel? • *Lower the number = lower the risk.*
What might you feel your suicide would help you to do? (As contrasted with 'Why' do you want to kill yourself?) • *End the pain…. high risk.*	What might you feel your suicide would do to help you to do? • *It would hurt my loved ones. I couldn't do that to them.*

Do you know someone who has died by suicide? • *Increased exposure may increase risk.*	Do you know someone who has died by suicide? • *No one, really.*
Are you currently drinking alcohol or using drugs? • *Intoxication reduces inhibition and results in impaired judgment.*	What is your relationship with alcohol or drugs? • *Look at the possibility that alcohol or drugs may play a part in his or her life and/or risk.*

QUICK AT-A-GLANCE SUICIDE RISK ASSESSMENT

VARIABLE		**LOW RISK**	**MODERATE RISK**	**HIGH RISK**
Previous Attempts		None	Over 6 months	Within last 6 months
Plan	**Method**	Pills, slash wrists	Car wreck	Gun, hanging
	Specificity	Vague, no plan	Some specifics	Very specific
	Availability of means	Not available Will have to get	Available Has close by	Has in hand or in progress
	When	48 hours or more or Unspecified	24 - 48 hours	within 24 hours
Chance of intervention		Others present	Others expected	Alone, isolated
Substance Abuse		Not using	Limited use	Evidence of intoxication
Degree of ambivalence		acknowledges desire to live	Aware of some desire to live	Decision is made
Stressful Life Event or Change		Problems are chronic	Within past 1-2 years	Sudden loss or traumatic precipitating event

COURSE OF ACTION		Treat in Community Setting	Consult Supervisor	Need to be contained to ensure safety

Remember, **lethality** is not the same but is related to **reversibility**. One may ingest chemicals or suffocate with a sock, and yet take a long time to die, but irreversible damage may be done, thus rendering "life" and survival highly compromised or could result in death.

SMART Plan of Action for Suicidal Clients

Develop a plan of action. These are not necessarily in a specific order.

	Primary focus	Objectives	Action examples
S	**Small**	Keep interventions small, concrete and behavioral.	"I'd like for you to put the gun down." "Would you eat a meal and take a nap before you do anything else?"
	Specific	Specifically, define what you will do, and what the client will do.	"You'll call the VA tomorrow with the referrals that I've given you." "You want someone who will listen [as opposed to "You want to be happy."]
	Safety Plan	Get a commitment from client that he/she will not hurt self before the Crisis Center.	"If at any time in the next 24 hours, if you begin to feel like hurting yourself, you will not hurt yourself, and instead, call the Crisis Center." "What are three things you could do that are self-soothing?"
M	**Means**	Assess for suicide or emergency risk; lethality, risk factors, warning signs.	"You say you've taken some pills...what kind and how many?" "You have a gun there; is it loaded?" "You've cut your wrists?"
	Match	Match your intervention to the means.	"I'm seriously worried about you and I'd like to call the paramedics." "What is your number/address?" "Is there anyone there w/ you?"
	Measurable	Make the plan of action measurable, not magical.	"So, you'd like to walk around the block 2 times before you call back." "You'd like to nap until 5:00 am and then re-evaluate." "You'll eat a sandwich after we hang up."
A	**Ambivalence**	Notice for your client that they state they want to die, YET they are asking for help.	"It sure does sound like you've given up all hope, and yet I'm aware that you called me [or us here at the Center] to connect with someone." "Just when it seemed that no-one understood, you reached out to me."
	Assess	Assess, assess, assess.	"Is there anyone there with you?" "Has something happened recently?" "Have you been drinking?" "Have you attempted suicide before?"
	Anticipate	Anticipate what problems you might have with the call and predictors for your client.	**Possible problems:** "Supervisor, I need you!" "My client is difficult to understand. Intoxication is making the assessment difficult to gather." **Possible Predictors:** "Our plan is a good one, but it does not make all the losses go away." "You may feel vulnerable tomorrow, but that is normal"
R	**Remove Means**	Engage the client in removing the means for suicide.	"I'd like for you to put the gun down...would you do that please?" "Would you flush the pills down the toilet?"
	Relationship	Respond to the relationship. When the call gets shaky, rebuild rapport.	"I really care, and I'm feeling worried for you." "Tell me more about what that [hopeless, angry, etc.] feels like." "Even though I don't know you, I sure do care."

	Realistic	Strive for realism. The plan of action should be do-able, within the client's reach.	"So even though you don't have transportation, you think you have a friend who might help you?" "So you think you can make that phone call tomorrow when business hours resume?"
T	**Test**	Test your client's understanding of your agreement, what happens next.	"So just to be clear, you're going to call your friend in the morning...Does that sound like something you could do?"
	Time	Commit to a time frame: Scale back to a time frame he/she can commit.	"Do you think you could keep this promise until tomorrow?" "What about till in the morning?"
	Tomorrow	Clarify what tomorrow's plan might include.	"If you need to check back with us, you'll do it." "So tomorrow you're going to call your counselor/ doctor?"

Third Party Suicide Calls

In general, people who are suicidal but don't call the hotline are likely even more at-risk than someone who calls. In many cases those at-risk individuals come to our attention because someone who cares about them calls us – a third party call.

Many times we can make the third-party caller an ally and use their contact with the person at-risk to help us keep them safe. We can train the caller about suicidal intervention and risk assessment. It is unfair, however, to give third-party callers the responsibility for actually providing the suicide intervention. They are personally and psychologically too close to the person at risk to be objective and effective as interventionists.

It is also unfair to expect that the third-party caller will welcome being identified to the person at-risk as the one who called about them. That is expecting too much of the caller. Sometimes they will agree but more often not.

Active intervention suggests that what the caller does or what they permit is not important. What is important is that the crisis worker talk directly to the person at risk. As noted above, these persons at–risk may, in fact, be the most suicidal callers we talk to. It is not appropriate to call the at-risk person directly without their permission. Encourage the caller to give the person our contact information or participate in a 3-way call. Calling without permission may damage the relationship between the at-risk person and the third party caller, it may violate confidentiality, and it may agitate or anger the at-risk person.

Suggestions for Third-Party Callers

- Educate the caller to ask the person directly "are you feeling suicidal". They cannot put the idea in the person's head if it is not already there.
- Take the threat seriously; don't interpret it as a phase. Manipulative people do kill themselves.
- Educate the caller about suicide risk factors and warning signs.

- If there is an immediate risk/emergency (i.e. attempt in progress), have the caller take action by calling 911 or allow the Crisis Center to call 911.
- Encourage the caller to call the Crisis Center as needed. Take time, if possible, to see how the caller

Additionally:

- Without themselves in danger, have the caller remove guns or other suicide tools from the household.
- Keep as much contact as possible with the suicidal person. Use more than one person if necessary.
- Notify safe significant people in the client's life, and inform them of the risk. Don't keep it a secret.

Safety Plan

I, ___________________________________, agree not to kill myself, attempt to kill myself, cause harm to myself, or harm anyone else.

I agree not to engage in activities that are harmful to me, such as drinking, taking pills, driving alone, handling weapons, or using reckless behavior.

I agree to get rid of things that I could use to kill or harm myself, such as guns or pills or any other harmful device.

I am committed to keeping this promise from this moment until ___________________________.

I promise to eat well and to get rest and sleep.

Five healthy things that I could do to soothe myself are:

1. ____
2. ____
3. ____
4. ____
5. ____

I agree that if things become difficult for me and I feel that I might hurt myself, I will call my counselor immediately at his/her phone number ____.

In the event of an emergency, who is someone that you trust that your counselor or the Crisis Center could contact?

Name:____

Relationship to you:____

Phone numbers: ______________________________Address:____________________________

Name:____

Relationship to you:____

Phone numbers: ______________________________Address:____________________________

If my counselor is not available, I will call the Crisis Center at 323-7777.

First Aid Kit for Suicide Survivors

Some Information That May Help You and Your Family

Why did my loved one or friend complete suicide?

There are as many “reasons” as there are suicides because each case is unique. The one person who may be able to answer this question is now gone.

The majority of suicides (80% or more) are the result of untreated depression or other mental illness. Many survivors mistake a “triggering event” such as a relational breakup or personal failure as a “cause.” Despite what survivors may read in a seemingly “rational” and explicit suicide note, suicidal acts are desperate attempts to escape extreme and often enduring mental anguish, pain, and/or stress.

This is more related to a person’s ability to cope than a rational response to actual life events. Depression and other illnesses contribute to low self-esteem and undermine one’s confidence and ability to accurately perceive and deal effectively with stresses that a healthy person takes in stride or adjusts to more quickly and successfully.

Why didn’t my loved one or friend tell me how he felt and why didn’t I know?

Despite the fact that suicides often appear well planned, the act itself is typically an impulsive one. He or she may not have known until the crisis hit that the moment to “do-and-die” had arrived. Those serious about killing themselves often wait until an opportune time when they know they can succeed without being rescued. This is why people known to have “a plan” are considered to be at highest risk.

The vast majority of suicides are unexpected and unanticipated. Even those whose loved one was under “suicide watch” are shocked and dismayed at the ingenuity and determination of a suicide. Suicides are “masters of deception” because they fear they will be labeled crazy or that their pain will not be taken seriously or that help will be ineffective.

Again, it is all part of their lack of coping skills and skewed perception of themselves and those around them.

One of the heaviest burdens for survivors is guilt that they didn’t know their loved one was in danger. Typically, “warning signs” exist only in hindsight. Our society is poorly educated about suicide and mental illness, and what we think we know is often wrong. Also, family histories of suicidal behavior and other mental illnesses have traditionally been kept “in the closet.”

Parents are especially prone to blaming themselves for not knowing something so fundamental as the state of their child’s mental health. But if parents are taught anything at all about

depression and suicide (and they are **not**), it is typically a "laundry list" of signs which closely mimic "typical" teenage behavior! Most cases of depression are diagnosed only in the wake of a failed attempt or some other serious behavioral problem or disorder such as ADHD or drug and alcohol abuse. And even then, people are not well informed about how closely these other conditions are correlated with suicide.

Does this mean that my family and I are at risk of completing suicide too?

Maybe. There are two reasons why this is so: 1) Depression and some other mental illnesses run in families, and 2) because psychological trauma is related to brain chemical imbalances and because suicide grief is the most powerful and debilitating, survivors are one of the high-risk groups for suicide ideation/behavior.

What happens now? What kind of feelings or emotions can I expect?

Guilt, anger, blame, fear, confusion, despair, betrayal, abandonment, even total lack of feelings or numbness are quite common in the months after suicide loss. All are valid and must be allowed to work on you before you can ever hope to control them (that comes only with time). Above all, anticipate revisiting feelings and emotions you'd already experienced and "worked through."

The best description of suicide grief is a jagged and jarring roller coaster ride that tends to spiral in endless loops.

What can I do to help me and my family deal with these feelings?

You deal with them best by accepting them and talking about them with loved ones and survivors. Consider therapy or grief counseling. Find a support group. You may find one family member or friend who allows you to grieve and respects your feelings, whatever they are at the moment. Be open to helping another family member or friend by allowing them the same "grieving space." Grief is unique and so is the amount of time needed to work through it.

Will it ever get better, will we ever feel differently?

Support, family, and individual dynamics are factors in how well grief work "works." But, yes, long-term survivors say that while the intensity of the loss remains constant, the frequency of intense feelings tends to lessen over time. The first and second years appear to be the hardest.

Suicide Survivor Rights

For those whose lives have been changed by suicide

- ***We have the right to grief that is complex and long term, and which may be disabling.*** Death is a normal life crisis; suicide is an abnormal life crisis.

- ***We have the right to be free of stigma.*** In many places, suicide still causes shame and survivors are ostracized. This impairs our grief and afflicts us as it did those we lost.

- ***We have the right to be angry about our loss and to be able to express it appropriately, whether at the one we have lost, at others who ignored or were negligent about our loved one's health, or at ourselves.*** Anger is a normal, healthy, emotional response to the loss that we have suffered.

- ***We have the right to grieve in a manner and time frame that works best for us.*** We don't have to "get over it" or “move on.”

- ***We have the right to regard our lost one as a victim.*** Suicide is caused by severe stress and pain. It is the fatal outcome of a process of debilitation. It is not a decision or choice.

- ***We have the right to understand "why."*** All who grieve yearn for those lost and search for them. We also seek the rationale for the act. We deserve full and accurate medical disclosure about factors that may have contributed to the death of our loved one. This should entail blood serum levels, neurobiological analyses and full toxicology reports.

- ***We have the right to cooperation from police and the health care community if we seek more detailed information on how our loss came about***. We should be able to learn as much as we feel we need to know about our loss.

- ***We have the right to know the truth about our loss.*** Silence kills.

- ***We have the right to have our loss and grief accepted, understood, and supported.*** All bereaved individuals are entitled to express their loss and to have access to support and help if they so wish.

- ***We have the right to channel our experience to prevent suicide, aid the suicidal or other survivors, or to help others better understand the impact of suicide.*** Helping others who are at risk, especially other survivors, may be the best way that we can help ourselves.

- ***We have the right to not be the same as we were before.*** Other ends to grief do not necessarily apply to us. We survive, we go on, we change, but we do not find "closure."

Left-Out Suicide Survivors

Those Whose Loss and Grief are Overlooked

All suicide survivors face many sad and painful personal challenges. Some must also face the hurtful and unnecessary challenge of not being seen as survivors because their relationship to the victim is denied, minimized, or unrecognized by others. These include:

- **Common-law Spouses**
- **Gay or Lesbian Partners**
- **Estranged or Divorced Spouses**
- **Parents of Adult Victims**
- **Friends of Teens and Young Adult Victims**

"Left-out" survivors run greater risks of problems than those whose loss is accepted and supported. ***All bereaved individuals are entitled to the opportunity to express their loss.*** This is especially true with suicide survivors.

Unmarried heterosexual partners, common-law spouses, and homosexual partners often suffer multiple losses when their loved one completes suicide. They may be excluded from planning, participating in, or even from attending funeral or memorial services by the victim's relatives. They may be cut off from homes and possessions to which they contributed if the victim did not make provisions for them. Families who deny such individuals their right to share in their grief should see that they might be separating themselves from the most important and meaningful aspects of their loved one's life.

Estranged, separated, and divorced spouses may also be similarly treated by their current or former in-laws and other relatives or friends of the victim. Some may not even be told of the death or about the services.

Sometimes these survivors find themselves targets of anger and blame from the victim's family. Some may even blame themselves. Just like any other survivors, these individuals may be grieving and need support and understanding.

Parents of adult suicide victims may not be treated in the same way as the parents of younger victims. Adult suicide victims are often seen as having made a "choice" to die, and deemed less "worthy" of mourning than younger victims.

The parents of married victims may be denied a meaningful role in their child's services or in the settling of their affairs. Relational fallout from a suicide often means grandparents and grandchildren may be unwillingly estranged at a time when each generation needs the other most.

The grief of close friends of younger victims is often overlooked. Teens and young adults are often more closely bonded to friends than to relatives and may be more bereft than if the loss was in their family member.

Straight Talk about Suicide Survivor Risk
Insight and Advice for You and Your Family

Suicide is often the beginning of a number of serious and even life threatening problems for the survivors. Among these are:

Complicated Grief Reactions: Suicides are traumatic because they are sudden, unexpected, and often violent. They involve lengthy bereavements, feelings of guilt and anger, and loss of trust. If a survivor is unable to mourn normally, grief may become "hidden" or "delayed" for years. In the interim depression and/or other physical and mental problems may arise. The grief of young children, teens, unmarried partners, and the parents of adult victims may be especially challenging if it is not recognized or seen as justified by others.

Post Traumatic Stress Disorder (PTSD): Suicide loss is one of the most abnormal and traumatic of life experiences. Those who see the act or discover the body may be especially affected by the more serious symptoms of PTSD. PTSD involves strong feelings of powerlessness and helplessness. Sufferers may have "flash-backs" to the event and relive the horror and the shock. These elements may lead to depression and other problems. PTSD breaks down one's normal coping ability, and scientists are finding a physical component in the brain chemistry of sufferers as well. Those affected can benefit from counseling and new therapies such as EMDR.

Depressive and Affective Disorders: Survivors may face "double jeopardy" in regard to these conditions. All survivors are at risk of emotional disorders because of the overwhelming nature of their loss. Family members may be physiologically predisposed to depression and related disorders by genetically determined factors that they share with their lost loved one. Grief reactions and PTSD may "trigger" depression. These same stressors may also create chemical imbalances, most notably of the neurotransmitter serotonin, which are linked to depression.

Suicidality: This is the state of being suicidal and ranges from thoughts of suicide (suicidal ideation) to suicide attempts. The saddest and greatest concern is that suicide survivors are themselves at high risk of suicide. This is because the experience of the suicide can create the same state of mind among survivors that led to the loss of their loved one. Suicidality is not normal or automatic among survivors, but it may be linked to any of the serious problems that survivor's face.

What You Can Do:

1. Be alert to signs of these problems in yourself and in others close to your loved one.
2. Don’t wait for them to happen. Find help or support as soon as possible.
3. See your family doctor and share your concerns.
4. Consider grief counseling or similar help on an individual or family basis.
5. **Consider attending the Survivors of Suicide Support (SOS) Group at the Crisis Center.**
6. Pastoral counseling may be useful because of the impact on beliefs and values.

SUICIDE ASSESSMENT CASES

Assess both the suicide risk and the emergency risk involved in each of the cases. Be prepared to discuss how you arrived at this conclusion. If you think there is insufficient information to make an assessment, please state what information you think is needed. Give it your best shot. You are not expected to have "all the right answers." Fill out a Suicide Assessment Form for **one** of the three (3) cases. **Use a separate piece of paper to record any additional comments, questions, etc. you might have.**

(1) You receive a call at 8:00 p.m. on Friday night from Richard, age 50. Richard describes himself as being depressed and firmly states that he is going to kill himself tonight – he has a loaded .38. He tells you that he is "worth more dead than alive" and that "this time he won't fail." Exploring these statements, you find out that two months ago Richard was in a near fatal car crash when he intended to complete suicide so that his family would be provided for through his double indemnity insurance policy. At that time, Richard, who is a Second Vice President of a large chemical company, did not receive an expected promotion. Richard has been drinking prior to calling. You also find out that Richard has chosen tonight to kill himself because it is the first night in the last two months that another family member has not been at home with him. Richard went to see a "shrink" three months ago for one visit. He describes that experience as having been a waste of time. Richard's mother had a history of suicide attempts prior to her death by heart attack a year ago. You experience difficulty hearing his ambivalence about suicide and Richard states that he only called to ask us to explain his death to his family.

(2) A sobbing woman calls Sunday night and in between sobs reveals that she is Erica, age 24. She lives alone and works nights at a self-service gas station. Erica reports that she was raped nine months ago while on duty at a gas station. She has not reported the assault nor has she talked about it with anyone. She describes a loss of energy, appetite and ability to sleep for any extended length of time. She has no history of prior suicide attempts. She as hospitalized for depression in 1982. Erica was under the care of a Dr. Clark in Tennessee. She is calling tonight because her boyfriend terminated their relationship. He also accused her of being "uptight and frigid." She tells you to hold on for a minute and returns to say that she had just cut her wrists.

(3) David is a student at a local county school. He is unable to study or sleep. He is concerned that he is going to fail his classes and not graduate. His girl friend has recently broken up with him and refuses to even talk to him. He continues to call her and only becomes more agitated when she refuses to talk to him. David is vague about why specifically he is calling. He does mention 10 minutes into the call that he knows where his mom keeps her gun and that he has taken it out into the woods before to shoot. His mom does not know about this. He wants the counselor to call his ex-girlfriend for him. He says he "might not make it through the night." He does talk of the youth pastor at his church fondly and mentions him by name several times.