

Help at hand

Supporting survivors of suicide loss



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

a guide for
FUNERAL DIRECTORS

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Disclaimer

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“The anguish is a palpable pain in my heart, so profound that it’s a physical ache.”

A father, speaking of the suicide loss seven years prior of his only child, an 18-year-old son

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FUNERAL DIRECTORS AS LIFESAVERS

a message from national leaders in suicide prevention

Funeral directors and the funeral services industry serve as a vital line of first response to those impacted by the profound and crippling effects of suicide loss.

That's because suicide claims 80 percent more lives each year in our country than homicide. These 32,000 self-inflicted deaths leave behind much more. Research shows that those closest to someone who dies by suicide are themselves vulnerable to self-harm through substance use disorders and violence that can be self-inflicted—and culminate in suicide (Centers for Disease Control and Prevention, 2009).

Because of its profound impact on our nation and its citizens, suicide has recently been identified as a major public health threat, much like diabetes or heart disease. And in that vein, it has received significant attention at the federal level, culminating in the 2001 National Strategy for Suicide Prevention issued by the U.S. Surgeon General.

Our National Strategy positions suicide as it should be—a tragedy that can be prevented in many cases. Lives can be saved if the right people, equipped with the right knowledge, intervene at the right time.

Our National Strategy positions suicide as it should be—a tragedy that can be prevented in many cases. Lives can be saved if the right people, equipped with the right knowledge, intervene at the right time.

This is where funeral directors come into play. In your close role with survivors of suicide loss in the immediate aftermath, you play a vital and powerful role. And in partnership with other early responders, including clergy and law enforcement, you can lessen the leveling blow that families are dealt when they lose a loved one to suicide. It's in this role that we applaud you and the vital work that you do in helping prevent suicide in our country and communities.

We, SPAN USA and SPRC, have collaboratively partnered to produce and disseminate this guide. We hope it proves helpful.

JERRY REED, Ph.D., M.S.W.
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Suicide Prevention Resource Center
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OBJECTIVE 2.3

Increase the number of national professional, voluntary, and other groups that integrate suicide prevention activities into their ongoing programs and activities.

OBJECTIVE 7.5

Increase the proportion of those who provide key services to suicide survivors who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors.

—U.S. NATIONAL
STRATEGY FOR
SUICIDE
PREVENTION, 2001



DEATH BY SUICIDE

what's different?

"I was too hard
on her."

"My love wasn't
enough to keep
him here."

"What did I do
to make her
leave me?"

"I should have seen
something was
horribly wrong."

The end of life can come by many means. But suicide is the most complicated for those left behind. Why?

Suicide is violent, but so is homicide. It's swift and doesn't leave time for closure, but so is a fatal car crash. Death by suicide can encompass all these characteristics.

Where suicide differs from other deaths is inherent in the act. Suicide is a deliberate end to life that most of us could not consider. It doesn't seem possible that someone could engage in such behavior. Could life be so bad someone could extinguish it forever?

Perhaps answers lie in what can bring someone to the brink of suicide. Research has shown that about 60 percent of youth and about 90 percent of adults who die by suicide had a mental illness and/or alcohol or substance use disorder (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999).

The problem is, these disorders often go unrecognized or untreated. People may grapple with explosive anger, anxiety attacks, debilitating depression or mood swings, but they, and those close to them, may not recognize these behaviors as treatable or changeable.

Also, alcoholism and/or substance use disorders and other addictions are often present in those who die by suicide and who use these substances to self-medicate what's been called the unrelenting "psychache" they feel.

Bottom line? People who die by suicide don't necessarily want to die. On the contrary, they feel they must end the intense and ongoing pain of living.



SUDDEN LOSS

what survivors feel

Death of a loved one by suicide can be jolting and unforgiving. The impact on those closest to the deceased—parent, sibling, spouse, child, friend—can be profound and long lasting. People close to the deceased are known as “survivors” of suicide loss. It may be challenging for survivors to cope and function in the days to come. They may compartmentalize their grief and keep it in a place deep within themselves. Most are changed by such a traumatic death.

Questions can preoccupy survivors of suicide loss. These questions may be incessant, and can be part of coping with suicide loss. They can lead survivors to assume guilt in bearing responsibility for another’s death. This level of responsibility—perceived or actual—is often not as common when death comes about by other means.

When someone fails to recognize potential for suicide in one closest to them, they feel exposed and vulnerable to their core. Feelings of incompetence in other aspects of their lives may rise to the surface. These perceptions of self, while often distorted, can be intensified by societal response to suicide, and the stigma it brings.

“What did you miss?” “What a coward.” “How could he do this to you?” “What a waste.” These comments may be heard in the halls of your funeral home. They may be spoken with an overtone of concern for the bereaved, yet they signal stigma and shame. Comments such as these intensify the grief and guilt already burdened upon the bereaved by the abrupt loss of their loved one.

“If I couldn’t see that he might kill himself, how can I be competent at my work? In my relationships? I failed him because I’m blind to the really important things. And that doesn’t bode well for me in any aspect of my life.”

—AS STATED BY
A SURVIVOR OF
SUICIDE LOSS

STIGMA OF SUICIDE

subtle messages in mere words

SUICIDE: A SIN?

Some view suicide as a sin, one that may condemn a person. The anguish that can precede suicide is incomprehensible to most of us. Prior to death, the deceased's judgment may be clouded by mental illness, alcohol or tunnel vision that can distort rational thought. In recent years many faith communities have come to accept suicide as the tragic outcome of mental illness. Yet many in society still consider suicide as a sin, thus perpetuating this stigmatizing view of an act that is frequently based in mental illness.

Few issues in society are as stigma laden as suicide. This stigma is intensified, say experts, by language commonly used to describe suicidal people and gestures. Experts suggest choosing words with care when talking with those who have had a loss to suicide to minimize stigma. Consider the following:

“She committed suicide.”

The word “commit” implies something morally wrong, as in the religious concept of committing a sin or crime. Yet research shows that about 60 percent of youth and about 90 percent of adults who die by suicide have an underlying mental and/or alcohol or substance use disorder that is not their fault, just as cancer or heart disease is not the fault of those who die from these illnesses (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999).

better choice **“She completed suicide” or “She died by suicide.”**

“He attempted suicide before he succeeded.”

We succeed at good things in life—education, relationships, skills and hobbies. So to say someone “succeeded” at killing themselves is inappropriate in its positive implications for a tragic act.

better choice **“He died by suicide after a prior attempt.”**

“Sometimes people make poor choices.”

We wouldn't say that someone who died from cancer made poor choices. The same goes for suicide. Research has shown that people who die by suicide see no other way. Many do not want to die, but succumb to the excruciating pain of living. To them, in the midst of mental illness or overwhelming anxiety, loss or hopelessness, the decision to die is not about “choice” but escaping pain. To call suicide a choice—and a poor one at that—minimizes the extreme suffering that preceded it.

better choice **“Life is so unfair.”**

“What a waste. How selfish of him.”

Many people who die by suicide may have struggled against incredible odds, perhaps for years. Their last act may seem a response to an emotional blow—job

TURBULENT EMOTIONS OF SUICIDE LOSS

As after other deaths, those left in the wake of suicide feel a multitude of emotions such as denial, fear, anger and abandonment. Suicide can heighten these feelings or bring others such as:

loss, end of a relationship, health diagnosis, brush with the law. Yet for many, an underlying mental or alcohol and/or substance use disorder has made them vulnerable to suicide. These disorders can bring distress, anguish and despair. To call suicide a waste or a selfish act makes light of the complexity of this loss and events leading up to it.

better choice

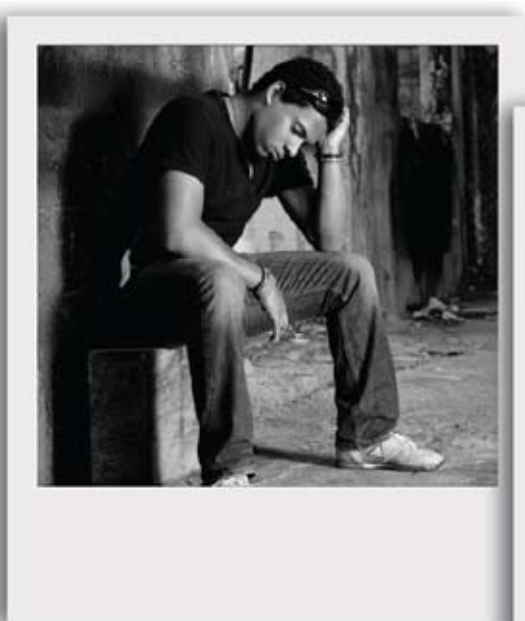
“What a tragedy.”

“Don’t feel guilty. You did all you could.”

Telling survivors of suicide loss not to feel guilty can be futile, no matter how good your intentions. Moreover, your efforts to ease survivors’ guilt can run counter to their instincts. Loved ones may think they have not done all they could for the person who died by suicide. They may need to work through those feelings on their own or with a mental-health professional. Telling survivors not to feel the guilt they’re already experiencing may make them feel worse, because their feelings are being dismissed or diminished, not acknowledged and accepted by others. Instead, giving survivors permission to be where they’re emotionally at can be a gift.

better choice

“I’m here to support you wherever you are at.”



anguish

“I feel a palpable pain in my heart, so profound that it’s a physical ache.”

guilt

“If only I would have not gone to work that day, he would still be alive.”

betrayal

“We were supposed to be in this together—be there for one another. But she abandoned me to deal with the awful aftermath of all this.”

relief

“Living with him was so hard. I have a sense of relief that he isn’t suffering anymore, but I feel incredibly guilty about being relieved that he’s dead.”

incompetence

“I’m supposed to protect my loved ones. But she wanted out so bad that I couldn’t even protect her from herself.”

CALMING THE STORM

showing sensitivity to complex needs of survivors

ILLS THAT CAN ACCOMPANY SUICIDE LOSS

Exhaustion

Migraines

Post-traumatic stress disorder

Memory problems

Colitis

Alcoholism

Sleep problems

Anxiety

Crying spells

Heart trouble

Fear of being alone

Ulcers

Difficulty with relationships

Clinical depression

Thoughts of suicide

How funeral directors interact with survivors of suicide loss can affect survivors' stress levels immediately following the death and in days and months to come. Showing sensitivity in your interactions with survivors can lessen feelings of stigma or shame they may already be experiencing. Consider the following when dealing with survivors:

PALLBEARERS: Choose with care

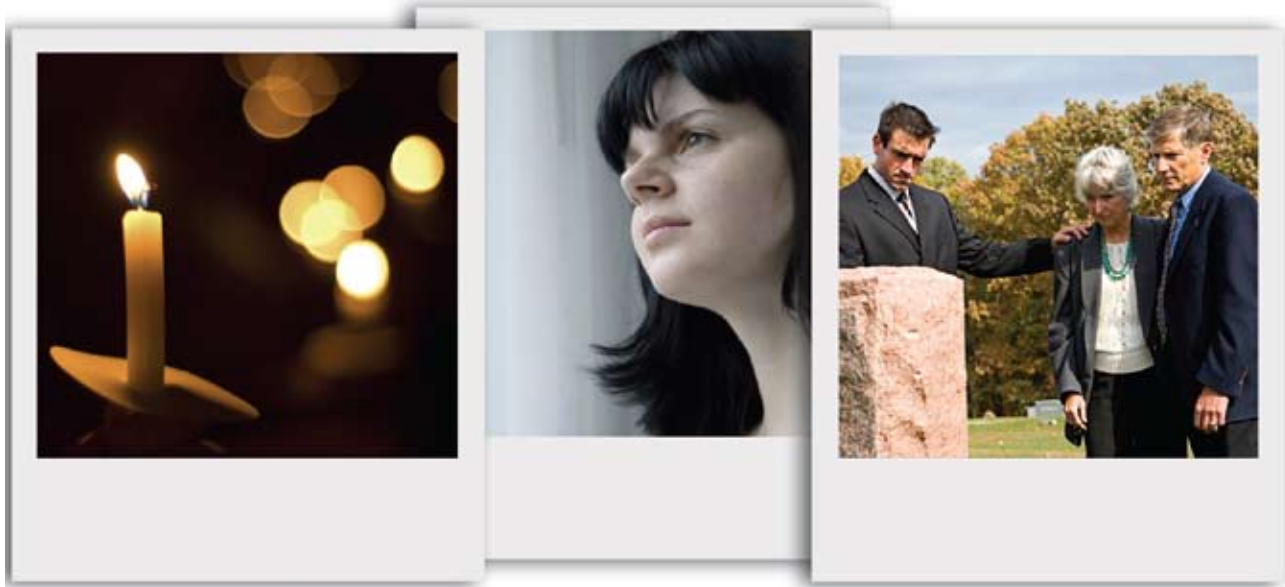
Those closest to the deceased may suffer even greater emotional pain by being a pallbearer. Or, on the contrary, loved ones might view this as a chance to do something tangible for the deceased. Given the documented potential for "cluster suicides" and "suicide contagion" particularly by vulnerable teens and young adults, you might suggest that close friends of a teen who died by suicide not be pallbearers. But give them a choice, and respect their wishes.

CLOTHING: Offer options

Soiled clothing the deceased was wearing at the time of death may be medical waste to you, but it may be precious and irreplaceable to loved ones. So never dispose of garments without first asking family members if they would like to see or keep them. Survivors may feel the need to connect with their loved one through the personal scent that can permeate clothing. A shirt, a shoe, pants or a jacket all can become part of a survivor's story and grief journey. Do not deprive them of these items.

BODY CONTACT: Be flexible

Physical contact with the deceased, immediately following the death and during the wake, may be important to survivors of suicide loss. If the body is marred by the means of death, merely touching the deceased's hand may be enough for loved ones. Once the body is prepared for visitation, give the immediate family ample time with the deceased, and plan to do light restoration if needed before the visitation. Cautioning survivors not to touch the deceased to preserve restorative art and body appearance for the wake can seem unsympathetic and insensitive to survivors.



BREAK TIME: Vital and valued

As with other bereft individuals, survivors of suicide loss may be depleted emotionally and physically during visitation and the funeral service. Given the traumatic nature of suicide loss, it's vital that survivors have ample time to retreat from crowds and regroup. You may want to schedule a break between an afternoon and evening visitation so the bereaved can eat and rest. Be sure that water is available to survivors during the wake, as they may be dehydrated from tears shed.

ERRATIC BEHAVIOR: Show compassion

Be astute for signs of the bereaved exhibiting mental imbalance or being under the influence of drugs or alcohol. Show them compassion, even if their behavior is erratic, uneven and impacting interactions or decision making. Contact other family members or friends who can assist the bereaved. Let them know they are not alone. Allow them to tell the story of their loss and events preceding it. Those left behind may be coping in the early days as best they can, given their own vulnerabilities and struggles, compounded by their loss to suicide.

MENTAL ILLNESS: Inquire about

If you are concerned that a bereaved individual may be at risk for suicide, encourage him to seek professional help or to call a national crisis hotline such as 1-800-273-TALK. If the risk for suicide is acute (see FAQ on page 10 and sidebar on page 11), do not leave him alone. Contact someone on his behalf and suggest that he take the person at potential risk to an emergency room.

"I've seen family members come in after a suicide under the influence of alcohol or drugs. These people are struggling to come to terms with the death, its means and its sudden nature. Often I'll ask them if I can contact others to help them. I'll inquire if they're in a 12-step program like AA, Alcoholics Anonymous, and (suggest that they) can gain support from friends there."

—30-YEAR CAREER
FUNERAL DIRECTOR

FREQUENTLY ASKED QUESTIONS

about suicide loss and its immediate aftermath

RELIEF MAY BE REAL

Those who succumb to suicide may have placed heavy emotional and financial burdens on loved ones prior to death. So there may be a sense of relief when this person passes, a feeling that “perhaps this was for the best” and the deceased is at peace. It is not the role of funeral directors or others to judge, or to encourage loved ones to experience or acknowledge feelings of grief or profound sorrow that they simply don’t have—and maybe never will.

FAQ Is it okay to talk about manner of death with those closest to the deceased?

Yes. Family members know that, by virtue of services you provide, you are well aware of how their loved one died—suffocation, gunshot, poisoning or other. But tread lightly in sharing details about their loved one’s last moments. Although family might inquire as to whether their loved one suffered before dying, the coroner or medical examiner is best suited to discuss the cause of death and the deceased’s last moments in detail.

FAQ How should I respond when survivors ask whether death by gunshot was accidental or a suicide?

The matter of “official cause of death” is something between the coroner, law enforcement and family members. Loved ones would not typically look to funeral directors to inform them that the cause of death was suicide; this is not the role that funeral directors play in the minds of survivors of suicide loss.

FAQ Doesn’t it aid the grieving process to acknowledge the true cause of death?

It’s not likely. In the days immediately following the death, survivors are grappling with a whole host of emotions and realities: (1) their loved one has died; (2) the death was sudden; (3) the death was violent; (4) it’s unlikely they had time to say goodbye. It may be too much for these survivors of suicide loss to accept the additional reality that their loved one died by suicide, with deliberation. Sometimes family members will adamantly deny that the deceased died by suicide, and will even attempt to have death records altered to reflect the death as accidental. Whether this is helpful or not to their grief journey is not for funeral directors to determine or attempt to influence. Your pressing survivors of suicide loss to acknowledge the death was deliberate—particularly in those early days when you’re servicing them—may only strengthen their denial and alienate them from comfort you can provide.

FAQ How should I respond when other people inquire about how the person died?

If the family is open about the death being a suicide, you can say the person died by suicide. If the family is not open about the manner of death, you might state only the cause of death, such as gunshot wound. Don’t go into unnecessary detail, such as location of wound or method of injury.

FAQ**Is it okay to acknowledge the death as self-inflicted in the obituary?**

Yes, but only if the family supports this. Even when a family openly talks with you about the death being a suicide, that's different from putting it in writing in an obituary. While being more open about suicide and its causes can counter stigma surrounding it, survivors may be ill-equipped in those early days to be fully open about the manner of death. But if they are willing, noting that the departed "suffered from clinical depression" or another mental disorder can counter societal stigma about mental illness.

FAQ**Should I be concerned that someone pre-planning his or her funeral arrangements may be considering suicide?**

It is probably a rare event that someone pre-planning his funeral arrangements is preparing to kill himself, but it does happen. The problem is that there is no way to tell who is planning to die by suicide unless you ask. Knowing who is at risk and how to engage them is important. For example, someone who has had a significant loss, has any emotional or mental illness and/or substance use disorder, or has easy access to guns and lethal quantities of prescription drugs is at higher risk. To begin a discussion about suicide with someone who is pre-planning, explore the reasons for his or her pre-planning at this time. Absent a logical explanation, such as old age or a terminal illness, you should introduce the question of suicide in a non-judgmental way, for example: "Sometimes when people who appear to be relatively healthy pre-plan their funerals, it is because they are thinking about ending their own lives. I am wondering if it is possible that you have been thinking of ending your own life." If you have any concerns that someone is considering suicide, refer them to a local mental-health professional or the National Suicide Prevention Lifeline (NSPL) at 1-800-273-TALK (8255) (learn more on page 12), or contact a family member. If you are concerned about someone, even though he claims that he is not considering suicide, give him contact information for NSPL or a mental-health professional to use if he should need it in the future. Other resources are listed on pages 14-15.

FAQ**How are young people affected by the suicide of a close friend or sibling?**

Adolescents generally attempt suicide more often than other age groups, and vulnerable youths may be at higher risk following exposure to a suicide, directly through someone they know or indirectly through the media, word of mouth or the Internet.

FAQ**Are there outreach services that I can refer survivors of suicide loss to?**

You may want to suggest that bereaved individuals see their primary care physician, a member of the clergy or a mental-health professional to help cope with the trauma of suicide loss. Suicide bereavement support groups can also help in offering a "safe place" to share grief and experiences. You may also want to refer survivors of suicide to local and national organizations (see Resources section of this guide on pages 14-15).

SURVIVORS OF SUICIDE LOSS: AT INCREASED RISK

Given the emotional pain of suicide loss, one would think those remaining would steer clear of suicide. But survivors can be at risk for suicide and may exhibit the red-flag behaviors below. You may wish to refer them to the National Suicide Prevention Lifeline at 1-800-273-TALK.

ACUTE RISK:

Talking about killing themselves

Actively seeking access to firearms, pills or other means

INDICATORS OF POTENTIAL FOR SUICIDE:

A past attempt

Mental illness and/or substance use disorder

Access to firearms

Overwhelming hopelessness

Extreme anxiety or agitation

Profound mood changes

Reckless and risky behaviors

Extreme anger, rage or revenge seeking

Isolating from others

Feeling trapped

With help comes hope

NATIONAL

SUICIDE

PREVENTION

LIFELINE™

I-800-273-TALK

www.suicidepreventionlifeline.org

Help is available for you or someone you care about, 24-7

COMPASSION FATIGUE

tending to those in need—yourself first and foremost

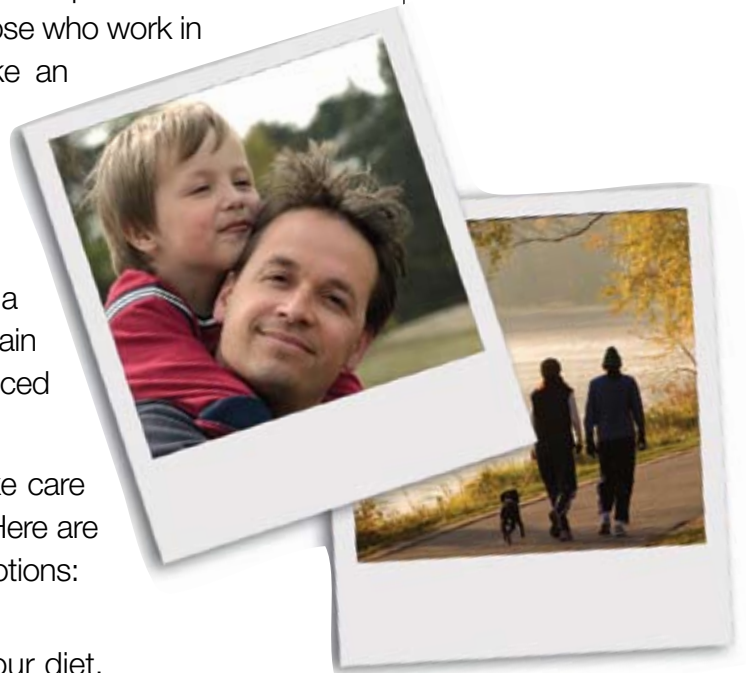
A suicide may be a personal act, but its effects ripple through society, including those closest to the deceased, and those tending to its aftermath. This includes funeral directors, well accustomed to serving people in the throes of intense emotional distress.

Given the profound nature of suicide and the complex bereavement it provokes, survivors may direct anger and blame at those who work in funeral services. Suicide, by its very nature, may take an emotional toll not only on survivors but funeral directors and staff. This toll can add to stress, which if not addressed, may lead to compassion fatigue and burnout in caregivers.

So it's important for those in the funeral services arena to take good care of themselves so they can remain empathetic, supportive and effective—even when faced with serving families affected by suicide.

To guard against compassion fatigue or burnout, take care not to eliminate the very things that can revitalize you. Here are some suggestions for managing stress and difficult emotions:

- ✓ Eat healthier food and eliminate junk food from your diet.
- ✓ Take a leisurely walk or exercise vigorously to reduce stress and re-energize yourself.
- ✓ Embrace physical activity such as golf, bowling or running.
- ✓ Spend quiet time alone for self-reflection.
- ✓ Make time for meaningful conversation with family or close friends every day.
- ✓ Rediscover former hobbies such as music, reading or gardening.
- ✓ Be kind to your body and spirit by getting enough sleep.
- ✓ Take time off, even a day or two, to recharge and replenish.
- ✓ Listen to music on your car radio or at home instead of watching television.
- ✓ Use your computer to play a round of solitaire or laugh at some online jokes.
- ✓ Practice yoga or meditation in a class or on your own.
- ✓ Play with your pet.
- ✓ Ask for help if you need assistance managing daily activities.



RESOURCES

boosting your value through enhanced services



FOR YOU

Suicide Prevention Resource Center (SPRC)

Prevention support, resources and training to assist suicide prevention practitioners, individuals and communities.

<http://www.sprc.org>

Suicide Prevention Action Network USA (SPAN USA)

State, local and national organizations. Co-sponsors the annual national "Healing After Suicide" conference with AAS.

<http://www.spanusa.org>

Coming to Terms with Suicide

From the National Funeral Directors Association.

<http://www.nfda.org/page.php?pid=193>

National Strategy for Suicide Prevention (NSSP) (2001)

Suicide facts and statistics, frequently asked questions, and information on what our country is doing to counter the major public health threat that suicide poses. From the U.S. Department of Health and Human Services.

<http://www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp>

NAMI-NH's Frameworks Youth Suicide Prevention Project: Postvention

Community Response to Suicide. For funeral directors and others seeking training in this comprehensive, community-focused, and evidence-based public health model.

http://www.naminh.org/documents/funeraldirpostvention10_000.pdf

FOR YOUR CLIENTS

National Suicide Prevention Lifeline

1-800-273-TALK (8255)

A 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis. Those needing help are routed to the closest possible crisis center in their area. Call for yourself, or someone you care about.

<http://www.suicidepreventionlifeline.org>

American Association of Suicidology (AAS)

Dedicated to the understanding and prevention of suicide, with resources and listing of support groups. Co-sponsors annual national "Healing After Suicide" conference with SPAN USA.

<http://www.suicidology.org>

American Foundation for Suicide Prevention (AFSP)

Supports research, education and treatment programs aimed at the prevention of suicide; includes resources for survivors of suicide loss. Website includes support groups, National Survivors of Suicide Day, Survivor Outreach Program, resources and materials, survivor research.

<http://www.afsp.org>

SAMHSA, the Substance Abuse and Mental Health Services Administration

A public health agency within the U.S. Department of Health and Human Services that is responsible for improving the accountability, capacity and effectiveness of the nation's substance abuse prevention, addictions treatment, and mental health services delivery system.

<http://www.samhsa.gov>

MORE RESOURCES

enriching your understanding of suicide loss

National Institute of Mental Health (NIMH)

The nation's mental health research agency, charged with reducing the burden of mental and behavioral disorders through research on mind, brain, and behavior.

<http://www.nimh.nih.gov>

National Institute on Drug Abuse (NIDA)

The mission of the National Institute on Drug Abuse is to lead the nation bringing the power of science to bear on drug abuse and addiction.

<http://www.nida.nih.gov>

RECOMMENDED READING

Adolescent Suicide: Assessment and Intervention

By Alan L. Berman, David A. Jobes and Morton M. Silverman

2005 APA Books, Washington, DC, ISBN-10: 1591471931, ISBN-13: 978-1591471936

After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances

By Suicide Prevention Resource Center

2005 Education Development Center, Inc., Newton, MA

<http://www.sprc.org/library/aftersuicide.pdf>

But I Didn't Get to Say Goodbye: For Parents and Professionals Helping Child Suicide Survivors

By Barbara Rubel

2000 Griefwork Center, Inc., Kendall Park, NJ, ISBN-10: 1892906007, ISBN-13: 978-1892906007

Children of Jonah: Personal Stories by Survivors of Suicide Attempts

By James T. Clemons

2001 Capital Books, Inc., Sterling, VA, ISBN-10: 1892123541, ISBN-13: 978-1892123541

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

By Iris Bolton

1991 Bolton Press, Atlanta, GA, ISBN-10: 0961632615, ISBN-13: 978-0961632618

My Uncle Keith Died

By Carol Ann Loehr, Julianne Cosentino, and James Mojonnier

2006 Trafford Publishing, Victoria, BC, Canada, ISBN-10: 142510262X, ISBN-13: 978-1425102623

Someone I Love Died By Suicide

by Doreen Cammarata, Michael Ives Volk, and Leela Accetta

2001 Grief Guidance, Inc., Palm Beach Gardens, FL, ISBN-10: 0970933290, ISBN-13: 978-0970933294

Touched By Suicide: Hope and Healing After Loss

By Michael F. Myers and Carla Fine

2006 Gotham Books, Penguin Group (USA) Inc., New York, NY, ISBN-10: 1592402283

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