What Emergency Responders Need to Know About Suicide Loss

A Suicide Postvention Handbook

Montgomery County Emergency Service, Inc.
50 Beech Drive
Norristown, PA 19403-5421

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About this booklet:

There are about 400 suicides every year in the five southeastern Pennsylvania counties. That's roughly one suicide every 22 hours. Most of these deaths bring together two groups of people under very unpleasant circumstances. These are emergency responders and family members or others close to the victim.

This booklet is for both these groups, but especially the Police Officers, Emergency Medical Technicians, and Crisis Intervention Specialists whose duties may:

- Put them at the scene of a recent suicide or
- Require them to notify a family about the loss of a loved one to suicide

Suicides may not occur every day in your community, but you will inevitably be involved in the aftermath of one, if this has not already happened. Most emergency professionals are not really prepared for dealing with the people they encounter after a suicide.

What do you say? What do you do? How do you help those struggling with this tragedy? How do your attitudes toward suicide affect your behavior? We are going to try to help you answer these questions and others like them.

FYI: Herein suicide is "completed" not "committed." Suicide has been decriminalized for a long time. Likewise an individual lost to suicide is a "victim" because suicide is the outcome of a process of psychological breakdown that can happen to anybody.

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The comments and encouragement of EMS 305, the MCES psychiatric ambulance service, the MCES Crisis Center, the MCES Mobile Crisis Service, and other MCES professional staff who reviewed drafts of this booklet is greatly appreciated.

Contents:

What is suicide postvention?……4

Why do suicides happen?……5

Who's doing the dying and how?……6

Some misconceptions about suicide……7

What is different about suicide loss?……8

What are the immediate needs of suicide grievers?……9

Postvention "First Aid" ……10

Behaviors to Avoid if Possible……11

Some Things Best Not said……12

Questions that may come from Family and Friends……13

Suicide Grief Support Sources……14

Toward a Proactive Postvention Model……15

Objective 7.5: By 2005, increase the proportion of those who provide key services to suicide survivors (i.e., emergency medical technicians, firefighters, law enforcement officers…) who have received training that addresses their own exposure to suicide and the unique need of suicide survivors.

"First responders have the opportunity to set the tone for being respectful and sensitive to the needs of survivors and the need to be prepared themselves for the impact such events may have on their own thoughts and emotions."

National Strategy for Suicide Prevention: Goals and Objectives for Action
US Department of Health and Human Services (2001)
www.mentalhealth.org/suicideprevention

What is suicide postvention?

You already know something about prevention and intervention, but postvention may be new to you. Postvention includes all interventions that attempt to reduce the negative consequences that may affect those close to the victim after a suicide✷ has occurred.

Postvention facilitates recovery of individuals emotionally devastated by a suicide. "Healing" or "getting over it" or "closure" don't apply. Recovery means eventually rebuilding a normal life around the loss. This may take help and that's postvention.

There are three objectives to any postvention effort:

- Ease the trauma and related effects of the suicide loss
- Prevent the onset of adverse grief reactions and complications
- Minimize the risk of suicidal behavior

Postvention involves (i) providing aid and support with the grieving process and (ii) assisting those who may be vulnerable to anxiety and depressive disorders, suicidal ideation, self-medicating, and other harmful outcomes of severe grief reactions.

Postvention should begin as soon as possible after the suicide loss. That's where you come in. You are likely to be among the first to reach those close to a recent suicide victim. This booklet will help you get postvention started in the right direction.

✷ *It is understood that there may be uncertainty about the cause of some deaths at the scene. We are concerned with the aftermath of deaths that will be reported as suicides. However, a postvention orientation will be helpful in any unnatural/unexpected death.*

Why do suicides happen?

Every suicide is different and the circumstances leading up to it are always unique to the individual involved. However, the common underlying factor is intense psychological pain and extreme hopelessness on the part of the individual taking his or her life.

Psychological pain arises when there is some seemingly irresolvable and totally frustrating situation in an individual's life. This may be a compelling personal, interpersonal, financial loss and/or problem, or something else.

Whatever the nature of this problem it is something that he/she cannot resolve. Coping and problem-solving skills fail. Next self-esteem and sense of control over his/her life diminishes significantly. This brings about hopelessness.

Hopelessness may lead to suicidal thinking. Without strong protective factors (e.g., social supports, religion) and in the presence of high risk factors (e.g., drinking, access to a gun), suicide may occur. Death is the means not the end.

The risk of suicide is greatly increased by drinking or using drugs, which lessen inhibitions and increase impulsiveness. These substances heighten vulnerability to thoughts of suicide and make things, like depression, much worst.

Some suicides may be sudden and impulsive, but most are the result of a process that happens over many weeks or months. As it unfolds it offers many points for getting help. While not every suicide can realistically be prevented, suicide is preventable.

Suicide also has a physiological dimension. Researchers have found that chemical imbalances in the body and faulty neural processes in the brain play a role in suicide.

For more information about suicide download a copy of "What Everyone Should Know About Suicide" at www.mces.org or call Montgomery County Emergency Service (MCES) at 610-279-6100 for a copy or e-mail tsalvatore@mces.org.

Who's doing the dying and how?

There are 29000-30000 reported suicides in the US every year. In Delaware County there are about 60 suicides a year; in Montgomery County, there are 70 suicides.

Men from their 20s to mid-80s represent about 80% of all suicide victims. Elders, those age 65 and older, account for about 20% of all suicides. Men 80-84 have the highest suicide rate of any age group. Regardless of age suicide is always a premature and unexpected death.

Women complete suicide less often than men do because they tend to be less involved with alcohol, they use different means, and they do seek help. Older women rarely complete suicide. Females attempt suicide more than males.

In regard to race and ethnicity the overwhelming majority of suicide victims are white, suicides in the Afro-American community are increasing. Suicides are uncommon among Asians and most Latinos. The suicide among non-white women of any age is very low.

Firearms, most commonly handguns, are the lethal means in most suicides. Guns are involved in 65%-70% of male suicides across all age groups and in 40%-45% of adult female suicides. Guns are part of the reason that more males die by suicide than females. More women are now using guns to complete suicide than in the past.

What do the numbers say? Most suicide calls involve an adult white male who died violently and was found by someone close to him in life. He left 6-8 folks behind who will be have a very hard time dealing with his loss. These are the people who will need postvention.

For more statistical information about suicide in your county or municipality call the county health department (in Bucks, Chester, Montgomery counties) or go to www.dsf.health.state.pa.us/health/site/default.asp (PA Dept. of Health).

Some misconceptions about suicide:

Attitudes about suicide affect how you behave towards those close to the victim. You may share many popular myths about suicide or be influenced by beliefs about suicide that are part of your professional cultures.

Some see suicide as the result of personal weakness. This misconception may lead to judging the victim and to marginalizing her or him as a "loser." This attitude may come across even if nothing is said.

You may also see suicide as "making sense" in some cases (e.g., with devastating illness, disability, legal, or financial problems). This makes suicide seem like a normal or rational decision. Saying someone "committed suicide" conveys that he or she was in control, but really the pain is the driving force.

As for mental illness, drugs, and alcohol, they increase the risk of suicide but don't cause it. People with mental illness do take their lives, but their deaths are usually the result of a combination of factors.✷ Depression is found among most suicidal individuals, and drugs and alcohol make it worse. They also reduce inhibitions and can be lethal when mixed with suicidal ideation.

Another myth is that victims really want to die and that they'll "do it" sooner or later. Those who are suicidal don't necessarily want to die, they just want to end unbearable emotional pain. Being suicidal is not a permanent condition. It passes, as you may have seen after taking someone to a crisis center.

✷ *Suicide loss is especially detrimental to those with a serious mental illness such as depression, bipolar disorder, or schizophrenia. It may rapidly trigger relapse, crisis, or even suicidality. Such individuals should be referred to a crisis center or to their mental health provider ASAP. They will need more specialized help than is outlined here.*

What is different about suicide loss?

One way to understand suicide loss is to think of it in terms of the layers of grief that it involves. It starts with the same grief that we all feel when we lose somebody that we loved or cared for a lot.

The first layer relates to suicides being avoidable. Grievers feel responsible and guilty because they "didn't do anything." Parents agonize that they let their child down when most needed. Blame for the loss may also be directed at a third party (i.e., a therapist, school, friends, etc.).

The second layer relates to the seeming intentional nature of a suicide. Those left to grieve may feel that the victim chose to leave them, which generates anger, betrayal, abandonment, and rejection. Emergency responders may notice these feelings.

The third layer relates to suicide's unanticipated nature, which leads to a search for the "why." Most family members and friends never saw it coming. Being blindsided by suicide generates anxiety, fear, and a sense of vulnerability. These feelings come early.

The fourth layer flows from the stigma and shame still attached to suicide. Churches and public attitudes are better than they used to be, but old beliefs die hard. Those close to the victim may even be blamed for the death.

Helplessness shapes the last layer. It opens the door for hopelessness, the mindset behind the emotional pain that precipitated the victim's suicide. Suicide grievers are at high risk of suicidal behavior. Many victims had family histories of suicide.

"Grief Counseling Resource Guide: A Field Manual" is a good overview of grief issues. It is available from the NY State Office of Mental Health at www.omh.state.ny.us/omhweb/grief

What are the immediate needs of suicide grievers?

In the first hours and days, suicide grievers may need any or all of the following:

- To see that what they are feeling is normal – Those bereaved by suicide often think that they are suffering a severe psychiatric breakdown. To understand what they are going through try to think about a 9/11 happening in your head.
- Support – Most people have no personal experience with a sudden, unexpected, and possibly violent death. Whatever got them through any previous deaths will fail them now. Suicide loss is best endured with help. Most suicide grievers benefit from contact with others who have lost loved ones to suicide. This is available through suicide loss support groups (see page 14).
- Time to deal with their loss and grief – The usual 1-3 days of funeral leave was not designed with suicide loss in mind. Most grievers will not have the energy or motivation to go to work or school and they will not really be there if they do. They need to take things slowly and take care of themselves and their families.
- To know what to say to any children – It is generally felt that kids should hear the truth. It is suggested that younger children be told that the death was caused by a brain illness that makes people want to hurt themselves. It should be explained that this illness can be treated and is preventable but that it is sometimes very hard to recognize.

Suicide grievers are the secondary victims of the suicide. They manifest many of the physical and behavioral signs of victims of disasters or trauma.

A booklet for suicide grievers entitled "Recovery from Suicide Loss" is available from Survivors of Suicide, Inc. at phillysos.tripod.com. A supply of printed copies will be provided free on request to emergency responders by calling 215-545-2242 or sending an e-mail to phillysos@hotmail.com.

Postvention "First Aid"

Suicide postvention isn't in your job description, but you are in a unique position to help. You don't have to become a grief counselor. Here's what you do:

A. Establish rapport with griever(s) – Extend offer of help and caring by "being there." Introduce yourself and identify other responders on the scene. If you feel that you are forcing things, just back off. If not, sit down with them.

B. Initiate grief normalization – Let them discuss their feelings and concerns. Be ready for a lot of emotion and conflicting sentiments. Don't try to sort things out for them. They'll get to that later. Let them know that their emotional turmoil is okay given the abnormal nature of the loss.

C. Facilitate understanding of critical incident processing – Explain the investigative activities that occur with any unnatural death. Tell them why the ME will take the body and how they can arrange pick-up by the funeral director.

D. Assist in mobilizing the support system – Help grievers identify those who may be resources, e.g., family physician, clergyperson, other family members, or trusted friends. Don't say they have to make these contacts, just note they may be helpful.

E. Share information on community services – Provide contact information on local grief support resources like Survivors of Suicide or other services, which the grievers may reach out to if necessary.

F. Encourage their follow-through and withdraw – Urge them to see their family physician as soon as possible. Grief isn't a medical problem but it impacts health and may aggravate pre-existing conditions.

These simple actions can get the family started toward recovery from their loss.

We know that being involved with a suicide is not easy for emergency responders so after you've helped the family, please remember to take care of yourself. Suicides can be intense and may produce critical incident stress.

Behaviors to try to avoid:

Here are some things that can cause problems for you and for the family members and some suggestions for handling them:

- Crime scene processing – "Treat all deaths as homicides at first, even suicides" or "Consider suicide notes as a questionable documents." Every police officer has heard something to this effect, but they were not told how upsetting this is to those struggling with the loss. Try to respect their feelings as best you can. Have a colleague not engaged in the investigation attend to the family's postvention needs.

- Information gathering – Some of the answers that you need are related to determining the cause of death. The family's sure that it is a suicide or that it is not a suicide. Don't take sides, or judge their motives, or try to get them to accept any apparent cause. The best course is to get "just the facts" in a way that is as minimally disturbing as possible to the bereaved informants (and you).

- Interference with the scene – Sometimes the family is totally immobilized. Others cut down the body, move the gun, throw away the pill bottle, start to cleanup, or hide any note. A lecture on death scene procedures won't help. Say that you understand but that they're cooperation is essential. Tell them things need to be left as they were for a bit and any note left for them will be returned.

- Officiousness – Suicide scenes often involve a struggle between a family that has lost control and emergency responders who are trying to take control. Falling back on authority will not help and will only leave a lasting resentment. Policies and standing orders need to be applied with a little flexibility in some cases and suicides are one of them. Do what you can do.

Some things best *not* said:

Given what you've read so far you can understand that remarks like these may do more harm than good regardless of the speaker's intentions:

"It was his/her time."
(A suicide is never anybody's "time")

"There was nothing anyone could have done."
(This is neither convincing or comforting)

"Did you know that he/she was mentally ill?"
(As if suicide wasn't stigmatizing enough)

"God wanted her/him more than you did."
(Saying "He's with God now" would be better, if you must say it at all)

"I know exactly how you feel."
(*You may "understand" how they feel, but hopefully you don't really "know")*

"You know, you have to let her/him go."
(They really don't, but now is not the time to even think about it)

"All that anger will keep you from healing."
(Be more concerned about provoking unnecessary anger)

"Don't blame yourself, it wasn't your fault. It was his free choice."
(This only gives the grievers something else to be upset about)

"Too bad that he/she wasn't stronger."
(No, it's too bad that he/she didn't get the help that was needed)

"He's in a much better place now."
(Try saying this to a new widow with 3 children facing foreclosure)

Questions that may come from family and friends:

Emergency responders may hear some of the following questions:

- What happens to personal effects or other property of the victim removed by the police or the Medical Examiner's staff?
- Who gets suicide notes addressed to individuals who are not part of the victim's family or household?
- What happens to the gun (if one was involved) after the determination of the cause of death? Can disposal of the gun be arranged?
- Will an autopsy be performed on the victim? Who has access to the results of the autopsy?
- What about tissue or organ donations?
- Is it possible to see the body at the Coroner's/ME's Office? Where is the county morgue located?
- How is transport of the body from the ME's Coroner's/Office set up?
- How do you get copies of the death certificate?
- How can the scene be cleaned up?

Someone at the scene might be able to respond to some of these questions. Any assistance that emergency responders can give would be of help. However, it is okay to direct people to someone better able to respond or to sources like the phonebook.

Suicide grief support sources:

Mutual self-help groups create a sense of belonging, acceptance, and normalization. They are empowering and enhance coping ability. Suicide loss groups as "safe places" where grievers are with others who understand their feelings.

At meetings participants introduce themselves, say what they are comfortable in saying about their loss, and share thoughts and feelings. Facilitators may share copies of materials for discussion. Information and education are key elements.

Some groups are "open-ended." There is no fixed agenda and it can be joined at any time. Other groups may follow a set agenda over a period of time, usually 8 to 10 weeks.

Suicide grievers lead many groups. Group leaders act as facilitators and try to assure that each meeting is meaningful for all in attendance.

Sponsors of self-help support groups for suicide grievers include Survivors of Suicide (SOS), a resource specifically for suicide grievers, and The Compassionate Friends, a grief resource to those who have lost a child of any age to any cause.

Grief counselors, hospitals and hospices also have groups. To Live Again (610-353-7740) provides mutual support to those who have lost spouses to any cause.

Grief Support Source	Phone	Web Site
Survivors of Suicide, Inc. (SOS)	215-545-2242	phillysos.tripod.com
Compassionate Friends/Delaware Co.	610-874-7712	www.geocities.com/tcfdelco
Compassionate Friends/North Penn	215-884-6691	
Compassionate Friends/Abington	215-643-8531	www.abingtontcf.org

Some grief services for children: the Safe Harbor Program Abington Memorial Health Center, Willow Grove, PA, 215-481-5983; Peter's Place Center for Grieving Children & Families, Berwyn, PA, 610-889-7400; and the Center for Loss and Bereavement, Skippack, PA, 610-222-4110.

Toward a proactive postvention model:

Some communities have specialized postvention resources. These resources remain few between because there is little public awareness of a need for them. Here are some strategies for meeting this need:

- Victim Services Model: This approach basically extends the mission of a victim services unit or agency, which are available in many areas, to include suicide postvention. Such entities serve those affected by very traumatic events. With additional training they could readily assist those traumatized by suicide.

- Medical Examiner's Office-based Model: Postvention services have been added to the Medical Examiner's Office. The ME staff are involved with every suicide and are often in contact with the next-of-kin or others close to the victim. Delaware and Philadelphia counties have used this approach.

- Crisis Center Model: The American Association of Suicidology, which accredits crisis centers, promotes their involvement in suicide postvention. These services offer a natural "fit" with their roles in crisis intervention, linkages to mobile crisis services, and working relationships with police and EMTs.

- Agency/Church Model: In some areas social service and mental health agencies and religious groups have developed postvention capabilities. These entities are able to offer support on a long- term basis, if necessary. They usually must add "24/7" access and linkages to the emergency response system.

Each approach has advantages and disadvantages. However, any of these approaches could go far in meeting a critically unmet need in the community.

"What Emergency Responder Needs to Know about Suicide Loss"

Reader Feedback

Please help us improve this booklet by completing this form.

Name (Optional): ____________________________ Date: ___________________

Job Title/Position:____

Do you feel that there is a definite need for a booklet like this?

[ ] No [ ] Somewhat Needed [ ] Very Needed

Do you feel that this booklet is clear and easy to read/understand?

[ ] No [ ] Somewhat Clear [ ] Very Clear

Do you feel that this booklet is well organized?

[ ] No [ ] Somewhat Organized [ ] Very Organized

Is the information presented useful to better understanding suicide loss?

[ ] No [ ] Somewhat Helpful [ ] Very Helpful

Do you feel that the information presented is objective?

[ ] No [ ] Somewhat Objective [ ] Very Objective

Do you feel that the range of topics covered is complete?

[ ] No [ ] Somewhat Complete [ ] Very Complete

Will the information offered be of value to you on the job?

[ ] No [ ] Somewhat Valuable [ ] Very Valuable

Please give us any comments and suggestions for improving this booklet: __________

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Thanks! Please mail to Tony Salvatore, MCES, 50 Beech Dr., Norristown, PA 19403-5421;

Fax: 610-279-0978