Responding to Grief, Trauma, and Distress After a Suicide

21st Annual Crisis Intervention Conference
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Franklin Cook, MA, CPC (bit.ly/fjcxbio)

- Began current career as a volunteer
- Worked in community suicide prevention and peer grief support programs at all levels, from implementation to governance
- Main interests
  - Community of practice for peer grief support helpers
  - Dialogue-based individual support & small-group work
  - Expanding best practices
- Champion of peer support models

"... champion of peer support models"

Workshop: Principles of Peer Support Applied to Helping the Suicide Bereaved
- Today: 2:30 p.m. to 4:30 p.m.
- Location: Bamboo Room

The workshop is designed for people directly involved in peer grief support after suicide:
- Peer helper for SOSL
- SOSL receiving peer help
- Provider: Close collaboration with peer helpers
Participant Learning Objective #1:
Explain the purpose of the new national guidelines on postvention.

bit.ly/supportpriority

National Strategy for Suicide Prevention Objective 10.1:
• Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide
• Promote the full implementation of the guidelines at all levels

bit.ly/dsnatlguide

U.S. Guidelines: Evidence shows ...

1. Exposure to suicide can be very harmful
2. Numerous “kinds” of people are exposed
3. People are affected in different ways
4. A large number of people are exposed
5. Many people feel close to the deceased
6. Some people are severely affected
7. Some have ill effects for a long time

These findings are reinforced by “reports from clinical experience and the narratives of loss survivors.”

(1) Exposure Can Be Very Harmful

Research evidence links exposure to a suicide to:
• Increased risk of suicide
• Increased risk of attempt
• Increased risk of mental illness, etc.
### Increased Risk of Suicide

<table>
<thead>
<tr>
<th>Study</th>
<th>Relationship</th>
<th>Effect on Risk of Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agerbo, 2005</td>
<td>Anyone: Loss of a relative</td>
<td>3-fold increase in the mourner’s chance of suicide</td>
</tr>
<tr>
<td>Agerbo, 2005</td>
<td>Women: Loss of a husband</td>
<td>16-fold increase in chance of dying by suicide vs. 3-fold for women = other means</td>
</tr>
<tr>
<td>Agerbo, 2005</td>
<td>Men: Loss of a wife</td>
<td>46-fold increase in chances of dying by suicide vs. 10-fold for women = other means</td>
</tr>
<tr>
<td>Hedström et al., 2008</td>
<td>Men: Loss in the workplace</td>
<td>3.6-fold increase in chance of dying by suicide vs. men who were not exposed</td>
</tr>
<tr>
<td>Hedström et al., 2008</td>
<td>Men: Loss of a family member</td>
<td>8.3-fold increase in chance of dying by suicide vs. non-exposed men</td>
</tr>
<tr>
<td>Rostila et al., 2013</td>
<td>Anyone: Loss of a sibling</td>
<td>Higher rates of suicide</td>
</tr>
<tr>
<td>Insel, Gould, 2008</td>
<td>Adolescents: Loss of a peer</td>
<td>1%-5% of all adolescent suicides</td>
</tr>
<tr>
<td>Gould et al., 1990</td>
<td>15-19-year-olds: Loss of a peer</td>
<td>2-4 times greater risk of suicide</td>
</tr>
<tr>
<td>Multiple studies</td>
<td>Teens, 20s: Loss of a peer</td>
<td>Especially vulnerable to adverse effects, with possible link to suicide contagion</td>
</tr>
</tbody>
</table>

### Increased Risk of Suicide Attempt

<table>
<thead>
<tr>
<th>Study</th>
<th>History</th>
<th>Effect on Risk of Attempt &amp;/or Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>De Leo &amp; Heller, 2008</td>
<td>Family or friend suicide</td>
<td>Increased rates of self-harm, particularly for adolescents</td>
</tr>
<tr>
<td>Multiple studies</td>
<td>Youth: Loss of a parent</td>
<td>Increased rates of suicide attempts and fatalities</td>
</tr>
<tr>
<td>Swanson &amp; Colman, 2013</td>
<td>12-13-year-olds: Loss of a peer</td>
<td>Increased rates of ideation and attempts two years and longer after fatality</td>
</tr>
<tr>
<td>Feigelman &amp; Gorman, 2008</td>
<td>Teens: Loss of a peer</td>
<td>Increased rates of ideation and attempts up to a year after fatality</td>
</tr>
<tr>
<td>Mann et al., 2005</td>
<td>Mood disorder + attempt</td>
<td>2x as likely + relative who attempted or died vs. mood disorder but no attempt</td>
</tr>
<tr>
<td>De Leo et al., 2008</td>
<td>Nonfatal suicidal behavior in peers</td>
<td>Strong predictor of similar behavior</td>
</tr>
<tr>
<td>Roy &amp; Janal, 2005</td>
<td>Family history of suicidal behavior</td>
<td>An independent risk factor for early first attempt and additional attempts</td>
</tr>
</tbody>
</table>

### Increased Risk of Mental Illness, etc.

<table>
<thead>
<tr>
<th>Study</th>
<th>Relationship</th>
<th>Effect on Mental Health, Stigma, etc.</th>
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</thead>
<tbody>
<tr>
<td>Multiple studies</td>
<td>Suicide fatality</td>
<td>Mental health effects x 5-10 years</td>
</tr>
<tr>
<td>Clarke, Wrobley, '04</td>
<td>Elderly parents: Loss of a child</td>
<td>Increased incidence of mental health effects</td>
</tr>
<tr>
<td>Saarinen et al., 2002</td>
<td>Loss of a spouse</td>
<td>Mental health effects + social isolation x 10 years</td>
</tr>
<tr>
<td>Feigelman et al., 2012</td>
<td>Parents: Loss of a child</td>
<td>• Mental health effects and increased depression x 10 years • Suicidal ideation x five or more years</td>
</tr>
<tr>
<td>Tsuchiya et al., 2005</td>
<td>Loss of a parent</td>
<td>Increased incidence of bipolar disorder</td>
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<tr>
<td>Multiple studies</td>
<td>Loss of relative - Loss of friend - Mom: Child loss</td>
<td>Increased incidence of depression</td>
</tr>
<tr>
<td>Brent et al., 2009</td>
<td>Youth: Loss of a parent</td>
<td>Increased incidence of depression &amp; substance abuse</td>
</tr>
<tr>
<td>Multiple studies</td>
<td>Suicide fatality</td>
<td>Increased incidence of complicated grief disorder</td>
</tr>
<tr>
<td>Multiple studies</td>
<td>Suicide fatality</td>
<td>Increased social strain + stigmatization</td>
</tr>
</tbody>
</table>
(2) Various People Are Exposed

- Suicide Exposed
  - Everyone who has any connection to the deceased or to the death itself, including witnesses
- Suicide Affected
  - Those for whom the exposure causes a reaction, which may be mild, moderate or severe, self-limiting or ongoing
- Suicide Bereaved, Short-Term
  - People who have an attachment bond with the deceased and gradually adapt to the loss over time
- Suicide Bereaved, Long-Term
  - Those for whom grieving becomes a protracted struggle that includes diminished functioning in important aspects of their life


(3) People are affected in different ways

(4) Large Number of People Exposed

Total Exposed = 115
- Some Degree of Closeness = 71/115
- Higher Degree of Closeness = 42/115
- Very High Degree of Closeness = 21/115

18%

(5) Many Exposed Feel Very Close
(6) Many People Severely Affected

- Total Exposed = 115
- Life Disrupted
  - Short Time = 53
- Major Life Disruption = 25
- Devastating Effects = 11

1. Exposure to suicide can be very harmful
2. Numerous "kinds" of people are exposed
3. People are affected in different ways
4. A large number of people are exposed
5. Many people feel close to the deceased
6. Some people are severely affected
7. Some have ill effects for a long time

10%

Exposure: General Population

- Data consistently show that almost half of people report lifetime exposure to a suicide.
- No distinguishing demographic characteristics (gender, age, marital status, veteran, rural vs. urban, etc.)

(Cerel et al., 2016)

What Are the Limits of Exposure?

San Francisco Chronicle

COMEDIAN MADE THE WORLD LAUGH
(7) Effects Can Be Long-Lasting
Several studies show mental health effects 5-10 years after a suicide, including:

- Loss of a spouse, after 10 years:
  - Continued mental health symptoms
  - Continued social isolation
- Loss of a child, self-ratings showed
  - Suicidal ideation after 5 years
  - Lower mental health and increased depression after 10 years

Suicide Exposure: A Mental Health Crisis
“Suicide is not only the tragic culmination of a personal crisis for the deceased individual. It is also frequently the beginning of a momentous—and sometimes tragic—cascade of events that will unfold over a long expanse of time among diverse individuals and groups.”

(SOSL Task Force, 2015)

Create Systems Change in Postvention

<table>
<thead>
<tr>
<th>CURRENT</th>
<th>TRANSFORMED SYSTEMS</th>
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<tbody>
<tr>
<td>Primary population</td>
<td>People at high risk of suicide ... plus people affected by grief, trauma, distress at high risk of any negative effects</td>
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<tr>
<td>Time frame</td>
<td>Crisis response, short-term ... plus follow-up, ongoing, long-term services</td>
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<tr>
<td>Types of assistance</td>
<td>Funeral, psychological services ... plus comprehensive grief support services ...</td>
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<tr>
<td>Outreach channels</td>
<td>Medical settings, schools ... plus workplaces and other groups and organizations</td>
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<tr>
<td>Interventions focus</td>
<td>Individuals ... plus communities and “environments”</td>
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</tbody>
</table>
Vision of U.S. National Guidelines

A world where communities and organizations provide everyone who is exposed to a suicide access to effective services and support immediately—and for as long as necessary—to decrease their risk of suicide, to strengthen their mental health, and to help them cope with grief.

Participant Learning Objective #2

Explain what is different about suicide and how a fatality might affect the family members of the deceased and others who are bereaved by the death.

Death by Suicide is Unique

CDC Definition: Suicide is “death caused by self-directed injurious behavior with an intent to die [imminently] as a result of the behavior.”

Suicide grief ought to be treated as a phenomenon in its own right because ...

“... suicide itself is a singular manner of death” (U.S. Guidelines, 2015).
Key to Understanding Suicide Grief

- Suicide grief is paradoxical.
  - It is the same as all other grief.
  AND
  - It is different than any other grief.

GUIDING PRINCIPLE OF SUICIDE GRIEF SUPPORT

Relate to a SOSL not based on what makes suicide grief the same as or different than other grief but based on discovering what the grief experience is like for the individual person in front of you.

Two Vital Questions

- What is different, generally ...
  - ... about suicide as a way to die, i.e., about what happens to people who die by suicide? (Part 1)
  - ... about bereaved people’s reactions to suicide, i.e., about what happens in response to the death? (Part 2)

Suicide Grief: Part 1

What is different ...
  ... about suicide as a way to die (i.e., about what happens to the deceased)?
Factors in Death by Suicide

What is different about suicide is the degree to which
• the deceased acted with volition;
• the death was preventable;
• the deceased is stigmatized; and
• the death was traumatic.

To what degree was there VOLITION?

Volition is what defines suicide:
• Deceased must be the intentional agent of his own death
• What autonomy, intention, or control was present:
  • In the deceased's decision?
  • In the deceased's action?

To what degree was it PREVENTABLE?

What happened (or didn’t happen):
• Within the person and to the person?
• Before the person died and over a lifetime?
• Various (often conflicting) points of view:
  • From experts (people directly involved)
  • From family, groups (work, etc.), society
To what degree was there STIGMA?

- Thwarted help-seeking, weakened social connections, increased isolation
- Subjected to prejudicial, discriminatory, harmful behavior
- Self stigmatization: Identified with and/or generated negative judgments

To what degree was there TRAUMA?

Is suicide inherently traumatic ... because of the psychological force needed for a person to perform a fatal act directed at himself in opposition to the biological will to live?

<table>
<thead>
<tr>
<th>METHOD</th>
<th>#</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Firearm</td>
<td>19,392</td>
<td>51</td>
</tr>
<tr>
<td>Suffocation (hanging)</td>
<td>9,493</td>
<td>25</td>
</tr>
<tr>
<td>Poisoning (medicine/car exhaust)</td>
<td>6,599</td>
<td>17</td>
</tr>
<tr>
<td>Fall</td>
<td>761</td>
<td>&lt;2</td>
</tr>
<tr>
<td>Cut/pierce</td>
<td>673</td>
<td>&gt;2</td>
</tr>
<tr>
<td>Drowning</td>
<td>409</td>
<td>1</td>
</tr>
<tr>
<td>Fire/burn</td>
<td>131</td>
<td>&gt;1</td>
</tr>
<tr>
<td>Transportation</td>
<td>114</td>
<td>&gt;1</td>
</tr>
<tr>
<td>Other/Unspecified</td>
<td>772</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>38,364</td>
<td>100</td>
</tr>
</tbody>
</table>

Suicide Grief: Part 2

What is different ... about bereaved people’s reactions to suicide, i.e., about *what happens in response to the death?*

- Suicide grief is paradoxical:
  - It is *the same as* all other grief.
  - It is *different than* any other grief.
From SOSL Point of View

There is a story* about each suicide shaped by factors such as the degree to which

- the deceased acted with volition;
- the death was preventable;
- the deceased is stigmatized; and
- the death was traumatic.

*There are numerous stories, influenced by different people’s individual experiences and perceptions. Each bereaved person has a quite individual story.

Effects of Volition on SOSL

For suicide loss survivors, their belief about the deceased’s volition often becomes a central feature of their grief—and can have a profound impact on the meaning they attribute to the death.

U.S. National Guidelines, p. 14

Effects of Preventability on SOSL

[There can be a] perception that if suicide in general is preventable, then every suicide is preventable, and therefore, “my loved one’s suicide could have—and should have—been prevented.” This perception ... can add greatly to the suffering of the suicide bereaved.

U.S. National Guidelines, p. 14
Effects of Stigma on SOSL

When stigma contributes to a lack of support or sympathy—or to unkindness or even cruelty from other people—it can contribute to secondary wounds that may have a profound impact on loss survivors.

U.S. National Guidelines, p. 15

The Effects of Trauma on SOSL

When the death of a loved one involves trauma, there is a chance that whatever violence befell the deceased will traumatize the bereaved.

U.S. National Guidelines, p. 15

Key Aspects of Suicide Grief

- Shock
- Disbelief
- Asking “Why?”
- Shame
- Guilt / Blame
- Abandonment / Rejection
- Anger
- Fear
- Relief
- Suicide Risk
- Family / Social Issues
- Suicide Prevention Activism

(Jordan & McIntosh, 2011, pp. 29–33)
Shock

- Sudden, unexpected, and violent
- Unfamiliar and unnatural
  - Unimaginable or unacceptable
  - Fundamentally wrong (bad, evil)
  - Punishing (retribution)
- Overwhelming (like a natural disaster)

Disbelief

- “I can’t believe it!”
  - Doubled and intensified
  - Extended over time (even a lifetime)
- Denial of suicide itself
  - Concealment of manner of death
  - Refusal to admit that it was suicide
- Intimacy negated
  - Who the person “really was”
  - What the relationship was “really like”

Asking “Why?”

- May be persistent, compulsive, all-encompassing — and necessary
- Existential questions:
  - Reason for the deceased to have existed?
  - World governed by cause and effect?
- Often complex, troubling answers or absence of answers
- Fundamental need for a narrative (a story)
- Mixed value of answers (including “there is no answer”)
Shame

- Stigma’s purpose is to produce shame.
- Doubts about deceased’s and SOSL’s:
  - Morality (good vs. evil person)
  - Eligibility for redemption (forgivable vs. unforgivable; going to heaven vs. hell),
  - Character (strong vs. weak, generous vs. selfish, courageous vs. cowardly, etc.)
  - Normality (sane vs. “crazy”)
  - Value (significant life vs. wasted life).

Guilt

- Starting place for many SOSL:
  - I am at fault!
  - I am responsible.
  - What should/could I have done/not done?
  - Failure to protect = failure of love
  - Counter-factual thinking (magical powers)
  - Single proximal incident seen as causal
  - Guilt “haunts” SOSL (tyranny of hindsight)

Blame

- Guilt is self-blame
- Makes sense of incomprehensible
- Assigns causality
- Any person, influence, circumstance is eligible for blame
- Culture insists on responsibility, accountability
- Negates guilt (some else is to blame)
Abandonment & Rejection

• Being separated, being left alone
  • Redoubles pain
  • Seen as punishment
• Ultimate personal affront
  • Death preferable to connection
  • Negation of self-worth
• Denied opportunity for consultation, help, protection

Anger

• “Self murder”: Victim is also perpetrator
• Link to other reactions:
  • Guilt = Anger at self
  • Blame = Anger at “other”
  • Abandonment = Anger at deceased
• All-encompassing, all-consuming
  • Anger at God, at “the world”
  • Long-lasting, no resolution
• Prompted by secondary losses

Fear

• Life-or-death realities confirmed:
  • My power, control is limited
  • Other people are autonomous
  • Suicide can happen to anyone
  • Death happens to everyone
• Strong need for vigilance (can be an obsessive need)
• Linked to secondary losses
Relief

- Long, painful, stressful trajectory
- Abusive or damaging relationship
- Extended, harrowing “suicide watch”
- End of loved one’s pain & suffering
- Problematic aspects of relief:
  - Judged = Inappropriate, unacceptable
  - Can be contradictory, confusing
  - Must be kept “secret” (link to guilt)
  - Misunderstood: Not grieving, unemotional

Increased Risk of Suicide

- Wish to die is common
  - Escape pain of loss
  - Join loved one in an afterlife
- Extremely challenging:
  - Take risk seriously
  - Do not overreact
- Be responsive:
  - Safety first
  - Effective referral

Individualized Assistance

- I don’t teach a person what I know about grief. What I know about grief prepares me to be taught about the person’s grief.
- The most powerful tool is *discovering*:
  - What happened from the person’s POV?
  - What is the person’s experience of grief?

[This] involves an acceptance of and a caring for the client as a person, with permission for him to have his own feelings and experiences, and to find his own meanings in them.

Disaster Response Best Practices

- Promote SAFETY
- Promote CALM
- Promote CONNECTEDNESS
- Promote HOPE
- Promote SELF-EFFICACY


Promote Safety

- Respond methodically and decisively to present danger or risk (e.g., suicide)
- Communicate and demonstrate your interest in the person's safety
- Focus on basic needs (food, water, comfort, shelter, medical attention)
- Advise on danger of alcohol, drugs, etc.
- Protect privacy (including from media)

Promote Calm

- Be calm yourself (and compassionate, nonjudgmental)
- Give accurate information
- Listen with patience to what the person wants to share
- Don't solicit the person’s story (or “interrogate”)
- Normalize intense emotions, thoughts
- Suggest calming practices (deep breathing, visualization)
### Promote Hope
- Express hopefulness (no platitudes, no predictions)
- Reinforce gains, strengths, assets (as they materialize)
- Reinforce that survival (healing, recovery) is possible

### Promote Connectedness
- Help contact family, clergy, other key people
- Be aware of private space for family
- Point to resources, if applicable and available

### Promote Self-Efficacy
- Focus on the immediate next step
- Encourage small, achievable steps
- Don’t over-manage the situation
- Ask for the survivor’s engagement
- Clarify survivor’s needs (don’t assume)
- Don’t be critical
Survivors' Needs after the Crisis

- Help affirming or validating the sense of loss, through nonjudgmental listening and behavior
- Help anticipating emotional triggers and decreasing the intensity of reactions to trauma
- Help facing grief in doses and finding ways to take a break from intense grief
- Help retelling the story of the death in a safe way
- Help exploring a continuing relationship with the deceased


Survivors' Needs after the Crisis

- Help finding effective ways to manage changes in family dynamics and social relations—and practicing what to say in particular situations
- Help with activities to remember and honor the deceased
- Help returning to daily functions and looking toward the future
- Help engaging in culturally familiar and supportive ways to cope with grief


Possibility of Clinical Care Needed

- Having thoughts of suicide
- Feeling depressed or traumatized for weeks with no relief
- Repeatedly experiencing loss of control (anger or rage, guilt or regret, blame or revenge)
- Coping through the use of alcohol, drugs, or other unhealthy means
- Being unable to function in essential ways (personal hygiene, household tasks, routine responsibilities)

(Adapted from SAVE, 2011)
Symptoms of PTSD

- Reliving the event: Feeling as if it is happening again (flashback); nightmares; trigger response
- Avoiding reminders: Related situations, people; no talking or thinking about it; keeping busy
- Negative beliefs, feelings: No positive, loving feelings; avoid relationships; world = dangerous
- Feeling keyed up (hyperarousal): On the lookout; being startled; poor sleep, concentration

National Center for Trauma-Informed Care
Links: Presentation & Training Manual
bit.ly/nticlinks

Participant Learning Objective #3

Describe a framework for a systematic response to suicide that includes the immediate aftermath, ongoing support, clinical treatment, and survivors' lifelong needs.
Overarching Standards

- Employ best practices
- Evidence-based
- Congruent with practice principles
- Meet diverse needs
- Culturally appropriate
- Access (location, timing, affordability, etc.)
- Individuals, families, communities
- Connect with a higher level of care
- In sync across disciplines, systems

Postvention Program Principles

- Comprehensive, various approaches
- Risk & protective factors
- Evidence-based, best practices
- Across the lifespan
- Culturally attuned
- Establish physical & psychological safety
- Person-centered (caregiver = partner, strengths-based; person’s POV credible & needs legitimate)
- Address trauma
- Whole person approach
- Include recovery, resilience, and natural supports
- Include focus on prevention

Multi-Level, Integrated Response

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>PURPOSE</th>
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<tbody>
<tr>
<td>IMMEDIATE RESPONSE</td>
<td>Providing everyone exposed with:</td>
</tr>
<tr>
<td></td>
<td>- Crisis assistance</td>
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<td></td>
<td>- Practical assistance</td>
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<td></td>
<td>- Triage, intervention, referral</td>
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<tr>
<td>SUPPORT</td>
<td>Helping people:</td>
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<td></td>
<td>- Cope with grief</td>
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<td>- Heal from loss</td>
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<td></td>
<td>- Recover from distress</td>
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<td>- Engage in self-care</td>
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<tr>
<td>TREATMENT</td>
<td>Intervening to address:</td>
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<td></td>
<td>- Complicated grief</td>
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<td></td>
<td>- Major Depression, PTSD, etc.</td>
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<tr>
<td></td>
<td>- Possibly debilitating conditions</td>
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<tr>
<td>Examples of providers</td>
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<tr>
<td></td>
<td>- First responders</td>
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<td></td>
<td>- Emergency services</td>
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<td></td>
<td>- Funeral professionals</td>
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<td></td>
<td>- Faith leaders</td>
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<td>- Licensed clinicians</td>
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<td></td>
<td>- Peer helpers</td>
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<td>- Grief specialists</td>
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Immediate Aftermath

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</table>

Providing everyone exposed with:
• Crisis assistance
• Practical assistance
• Triage, intervention, referral
• Follow-up across systems

• Disaster response & mental health crisis response principles
  • Promote safety, calm, hope, connectedness, community- and self-efficacy
  • Models such as … Psychological First Aid & Skills for Psychological Recovery

Support Services

Develop and maintain infrastructure and capacity to provide emotional and practical support, guidance, psychoeducation, etc.

• Professionals: Grief counselors, mental health and social workers, physicians, nurses
• Community caregivers: Funeral directors, faith leaders, volunteers, hospice staff, school counselors, social services workers
• Peer-to-peer helpers: F2F groups, 1-on-1, via telephone and Internet, at healing conferences, retreats, and memorial services

Clinical Treatment

Deliver clinical interventions for complicated grief, PTSD, depression, suicidality, and other acute or potentially debilitating conditions.

• Mental health clinicians knowledgeable and skilled with people exposed to suicide
• Medical interventions (e.g., pharmacotherapy) but not substitute for therapy, psychosocial Tx
• Across the lifespan: Access to individual, couple, family, group interventions & Tx
## Implement Across Roles, Systems

### LEVELS OF CARE IN AFTERMATH OF SUICIDE

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>Example of Providers</th>
<th>PURPOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMMEDIATE RESPONSE</td>
<td>First responders, emergency services, funeral professionals, faith leaders, licensed clinicians</td>
<td></td>
</tr>
<tr>
<td>SUPPORT</td>
<td>Funeral professionals, faith leaders, family services, grief specialists, peer helpers, licensed clinicians</td>
<td></td>
</tr>
<tr>
<td>TREATMENT</td>
<td>Licensed clinicians</td>
<td></td>
</tr>
</tbody>
</table>

**Psychoeducational Info, Referral Networks, Media Messages**

**Orgs, Workplaces, Schools: Comprehensive Response**

**Engage in self-care**

**Education, Licensing, Certification, Job-Related Requirements**

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## Vision of U.S. National Guidelines

A world where communities and organizations provide everyone who is exposed to a suicide access to effective services and support immediately—and for as long as necessary—to decrease their risk of suicide, to strengthen their mental health, and to help them cope with grief.

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## For More Information

All Blog Posts
- bit.ly/guidelinesposts

Download Guidelines
- bit.ly/respondingsuicide

Information Portal
- bit.ly/supportpriority

Resource Directory
- bit.ly/afterasuicide

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