After a Suicide Death:  
When Postvention is Prevention

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Death rates for 8 of the 10 leading causes of death have decreased significantly, but not for the 10th leading cause — suicide  
*For ages 18 to 35, the prime of one’s life, only unintentional injuries account for more deaths*

- National suicide rate has increased to 13.5 suicide deaths per 100,000
- Wisconsin suicide rate is 4x homicide rate
- Approximately 48 million people are exposed to suicide bereavement every year (survivors)

Zero Suicide Initiative:  
“Sensitizes and challenges” us to move beyond what we accept about suicide risk.

Survivors are at elevated risk for suicide.

Postvention is a valuable form of prevention by reducing the number of future suicide deaths and reducing risk of depression, anxiety, substance abuse and other mental disorders that often follow a suicide death.
Why People Die by Suicide

Psychology of Suicide
- Mental anguish is experiential state that leads person to seek death as escape
- Suicide ideation/talk are not feelings, but thoughts on how to solve a problem or end pain
- Motivation behind suicidal act is the need to relieve pain and suffering
- Most suicide attempts are “last ditch” efforts to live, to get help in order to survive or die in their attempt to be understood

Why Does Suicide Happen
- Humans are solution-oriented beings
- Suicide works as a solution to pain = life ends, pain ends
- People kill themselves because they decide to kill themselves
- Decision often made after weighing pros and cons/internal dialogue, preparation and planning
Suicide isn’t Chosen or Committed

- Choice implies suicidal person can reasonably look at alternatives and select among them
- Decisions are driven by pain, not choice
  - If could rationally choose, wouldn’t be suicide
- Children plan & implement suicide without fully understanding consequences of their actions
- Just because suicide is self-inflicted doesn’t mean it is voluntary or chosen
- Suicide happens when all alternatives are exhausted, when no other choices are seen

The Survivor Experience

“The person who suicides leaves his/her psychological skeleton in the survivor's emotional closet”

Trauma of Witnessing Suicide

- Suicide eye-witnessed or heard by family
- ME or law enforcement request on-scene crisis response when suicide so violent or traumatic
  - Request may be as much for responding law enforcement as it is for the survivors
- Often prior traumatic events triggered including past suicide attempts and deaths in family
- Given stigma, taboo of suicide, family struggles to share truth or facts surrounding suicide death even to investigators
**Trauma of Discovery**

- Frequently suicide communication discovered in a note, text, so family/friends begin to search
- 911/police contacted to check on welfare of person or to search/discover body
- Often family/friends discover the body of their loved one in their home/garage, backyard or office
- Family may try to move person (cut down if hanging, move out of garage if CO)
- After discovery, 911 instructs family to check for pulse, attempt rescue, render first aid or CPR

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**Traumatic Memory**

- Memory of discovery
  - Spotty recall of the discovery experience
  - Looked away, could not see, shut door
  - Vivid details of the body = images, smells, sounds, reactions, actions during discovery
- Shock, horror of finding loved one dead, often no warning or preparation
- Explaining to others who are present or involved, children, elderly, vulnerable adults
- Police and ME/coroner death investigation begins

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**Trauma of Death Investigation**

- Police direct survivors to leave their house during death investigation if person suicides at home
- Looking for evidence/clues to the cause: suicide communications/notes, recent threats/acts, history of attempts, current/past mental illness/depression
- Personal papers, computers, cell phones, pill bottles
- If death looks suspicious, survivors interviewed, questioned, tested (gun powder residue)
- Deceased no longer transported to hospital to be pronounced dead = greater exposure for the survivors to the body and investigation
Trauma of Notification

- Survivors are notified of suicide death often by medical examiner investigator or coroner
- Call or show up at the home
- Next of kin receive ME/coroner notification
- Police notification if reside outside of county
- Receiving notification "too much" for most, shock/disbelief, unreal takes over
- Effort to call in family/friends, clergy to help
- When people have just moved or lead solitary lives, there may be no one to come to comfort
- Survivor needs help explaining to vulnerable/special needs survivors: children, elderly, disabled

Suspected vs. Ruled Suicide

- Autopsy
- Toxicology
- Death investigation of evidence
- Medical examiner or forensic pathologist makes final ruling of cause of death often 6+ months after death

Trauma vs. Grief
Grief vs. Trauma

- Grief is an acceptable reaction to loss
- Trauma is often undetected or misdiagnosed
- Grief is sadness while trauma is terror
- Grief feels real while shock/trauma feels unreal
- Grief is owned while trauma is disowned
- Grief is easier to talk about; trauma has no words
- Trauma symptoms may interfere with the ability to find a way through the grieving process, leaving survivors with unresolved or complicated grief

Traumatic Aftermath of Suicide

- Difficult to mourn the loss when all the brain remembers is the trauma of the loss
- Memory of their loved one is now linked with the last minutes of their life when they killed themselves
- Survivors cope using avoidance or distancing, which further complicates and prolongs recovery
- “Psychological priority” given to trauma over grief
- Trauma of losing someone to suicide may need to be dealt with first before addressing the grief
- Elevated risk and psychiatric complications

Suicide Bereavement: Search for the “Why?”
Suicide Bereavement is Unique

- Death by suicide is unique
- Involves questions about deceased’s volition
- Effects of trauma
- Degree that suicide is preventable
- Role of stigma in people’s treatment of the deceased and the bereaved

Survivors’ Struggle

- Overestimate their own power to influence or control events that led to suicide
- Unaware of or underestimate all other things that contributed to suicide death
- Make thinking errors in evaluating actions taken before suicide in light of what they have come to know after suicide (hindsight bias)

Stigma and Secrecy

- Survivors often don’t seek help for themselves or family especially children even if risk known
- Report death as accident, illness or unknown especially to children, elderly and family members with disabilities
  - Sometimes no obituary, no service/memorial
- Past family suicides and prior suicidal behaviors are kept secret including notes
- Secrecy and blaming takes over leaving survivors lost in the loss experience
Blame and Self-Blame

- Disbelief, unreal/bad dream reactions to the discovery, investigation or notification
- Denial and avoidance of the suicide or
- Overwhelmed by the trauma of the experience
- Self-blame for not knowing or preventing suicide
- Anger and blaming professionals for not saving loved one
- Stigma and taboo associated with suicide keeps survivors from seeking help for themselves, family even if there is risk

Healing Narrative

- Many complex factors contributed to suicide, but were not knowable or even in their control before suicide death
- Learn to tolerate not knowing everything
- More realistic to live with incomplete understanding of the suicide death
- Search is not discovery of the absolute truth, but to construct account that is bearable, believable and compassionate

Re-Construct Narrative of Suicide

- Complex
  - Many factors contributed to death not just one thing
  - Avoid oversimplifying, rarely result of single factor
- Realistic
  - My role in contributing to the death was limited or even nonexistent and I recognize the limitations of what I could have done
- Compassionate
  - I and others did the best that was possible given who we are and what we had to deal with at the time
After-Suicide Complications

Survivors at Elevated Risk
- Suicide (suicide cluster)
- Self-injuring behavior
- Substance abuse
- Depression
- Trauma
- Anxiety
- Mood disorders
- Attachment disorders

Survivors at Risk for Suicide
- 1.6 times more likely to have suicidal ideation
- 2.9 times more likely to have suicide plans
- 3.7 times more likely to have made a suicide attempt
Studies on Survivor Risk

- Suicide deaths in immediate family associated with 2.1 fold increase in risk for completion of suicide
- In young survivors <21, paternal suicide associated with a 2.3 fold increase, and maternal suicide associated with 4.8 fold increase of risk for suicide
- Loss of a child or spouse to suicide associated with increased risk of suicide in survivors (especially mothers)

Parent Survivors' Suicide Ideation

- Almost 49% report ideation during first 5 years
- 18% still report ideation ten years and beyond
- Mothers bereaved 5 or more years reported ideation at rate > 6 times rate for a non-bereaved, demographically equivalent sample of women

Psychiatric Complications

- Greater rates of bipolar disorder in persons exposed to the suicide of a parent
- Greater depression across all kinship losses
- Greater depression in adolescent and young adult friends losing a peer
- Greater depression in bereaved mothers
- Greater depression and substance abuse in youth losing a parent
Postvention Helps Because

- Of the sudden and often violent nature of suicide
- Grief that follows may be complex and elongated
  - Survivors feel angry, unsafe, conflicted/confused
- Suicide can be suggestive and permission-giving to others who are vulnerable
- Postvention provides sense of safety & structure for survivors and serves as valuable form of prevention after suicide death

Postvention

What is Postvention?
Organized response to the aftermath of a suicide to accomplish one or more of the following:
- To prevent suicide among people who are at high risk after exposure to the suicide
- To facilitate the healing of trauma and distress resulting from suicide death
- To mitigate other negative effects of exposure to suicide
- To help organizations (workplaces, hospitals, schools) respond more effectively after suicide
Postvention Services

- Recognize the elevated risk of survivors for suicide and other complications
- Help survivors connect with other survivors for support and direction
- Provide services for survivors
  - In counseling sessions for existing clients
  - Information and referral for non-clients
  - Survivor support groups

Crisis Postvention Services

- Mental health crisis response
- Risk concerns for others affected by suicide death
- Multiple suicides or cluster effect
- Unable to function at work or home
  - Can’t sleep or eat
  - Method of suicide so violent or incomprehensible
  - Vulnerable survivors struggling with depression, substance abuse and trauma
- Immediate/pressing need to talk, get information direction and support
- Explaining suicide death to children, vulnerable adults
**Crisis Outreach to Survivors**

- Phone or in-person crisis outreach to help with traumatic aftereffects
- Assess if survivor/s are at risk to self/others
- Help them to identify their resources, counseling, clergy, friends/family
- Give them a “mental map” or model to help them feel some control
- Suggest using what has work in past crises
- Provide written informational handouts
- Referral to survivor support groups when ready

**When Treatment Referral Indicated**

- Increased risk for self harm or suicide
- Signs of major depression, trauma or other mental disorders including substance abuse
  - Trauma of discovery
  - Method of death violent or incomprehensible
- Children and teens as survivors
- Culture, ethnicity, language, special needs
- Counseling + survivor support group

**Postvention Outreach**

- Short-term outreach to survivors
  - After funeral, memorial service unless specific request for immediate response
  - Provides bridge to SOS services when people feeling alone/lost in their loss
  - Learn about survivors’ experience, any unique needs, offering support and direction and informing them of the support group experience
- Most survivors appreciate sharing their loss experience, having it validated and normalized
Challenges

- Reluctance to seek help
  - Taboo, immoral/sin, weak, “crazy”
  - No health insurance or ability to pay
- Rural vs. urban
  - Lack of services and resources
  - Farming or isolated community
- County Mental Health and Human Services
  - Contracted agencies that provide crisis services
  - Your local crisis line or toll-free national crisis line 1.800.273.TALK
  - Hospital, hospice, faith-based grief groups?

Postvention Services in Your County

- Partner with county coroner or ME and law enforcement who respond to suicide deaths
- Involve local county mental health, faith and school communities
- Include long-term survivors of suicide who have lived experience of losing loved one to suicide
- Get training locally or from AFSP*
- For small counties with few suicides, provide postvention response as needed vs. ongoing

*American Foundation for Suicide Prevention

Coroner or ME Referrals

- Request ME/coroner contact your organization regarding suspected suicide deaths in your county
- Provide names and contact info of survivors
- Circumstances of the death including where death occurred, who were the discoverers,
- Explain you are hoping to reach out to survivors to support them during days/weeks after suicide
- “Group-ready” after month when able to tell their story and hear others share their loss experiences
Postvention Referrals

Postvention for Your Clients
- If client has experienced suicide death, address it in counseling session or case management services
- Learn about details of the loss especially if client involved in discovery, feeling self doubt/self blame
- Does client identify with suicide victim which may increase risk of suicide, psychiatric complications
- Check if client has access to lethal means including firearms and other means
- Assess suicide risk status, other mental disorders substance abuse and need for safety planning
- Give client permission and opportunity to debrief

Referral to Survivor Support Group
- Determine if client is at risk for suicide or other psychiatric complications
- Hold off on support group referral if client is at risk
- Too much, too soon: wait at least one month
  - Hearing multiple suicide loss stories
- Client’s mental health stability
- Consider counseling + support group or survivor support services provided within session
- Request survivor consult to join session
- Provide handouts on survivor of suicide grief
SOS Support Group 101
- County agency/organization provides community service for residents who are survivors of suicide
- Smaller counties join together to share resources and sponsor survivors of suicide support group
- No-cost, drop-in group for survivors 18+ years
- Provides a safe, structured place to meet and get support from other survivors
- Facilitated by survivor volunteer and clinician
- Meets monthly or twice a month

Professional Self and Organizational Care

Clinician Survivors
- When your client dies by suicide = clinician survivor (see AAS clinician survivor taskforce)
- Helpful to receive information about the circumstances surrounding suicide death
  - Understand context and circumstances
  - Determine if systems change may be indicated
- Essential to learn who else may be at risk for suicide within family/supports and may need crisis follow up
### Compassion Fatigue
- "Cost of caring" caused by
  - Exposure: hearing stories of sadness and pain
  - Empathy: seeing survivor perspective is a major resource used to help traumatized people
  - Hard not to identify since most of us have experienced some sort of trauma in our own lives
  - Your loss may get "triggered" during or cumulatively in sessions
  - Include self-care in your survivor support services

### Support Group Facilitator Self-Care
- Safety and structure in survivor support groups
  - Clear start and end time
  - Stated ground rules
  - Group size
  - "Two facilitator" guideline
  - Recovery time between group meetings
  - Having professional back up or resources
  - Debrief after support groups
  - Team sharing goals and objectives
  - Boundaries and balance in life
  - Team meetings for information and support

### Does Your Organization?
- Have a plan for coordinated postvention response for survivors of suicide
- Provide specialized training for appropriate staff in working with trauma and suicide bereavement
- Identify and reach out to highly impacted individuals/clinician survivors in the organization
- Provide resource information to new survivors of suicide and connect them to support groups
Suicide as a Teachable Moment

- Learn about suicide loss
- Find out where to get help for suicide loss
  - Support groups located in or close to your county
- Understand about grief & trauma after suicide
- Use appropriate responses to the bereaved
- Provide psycho-education & peer support activities within your agency/organization
- Follow up longer term in community

Take-Away Message

- Suicide leaves a heavy toll in its wake
- **Survivors of Suicide Loss Task Force** believes an organized and systematic response to the impact of suicide on all people exposed to a fatality must be a key element of all suicide prevention planning and implementation efforts by our nation, states, tribes, and local communities
- Postvention is prevention of future suicides and mental disorders