

suicide postvention counselling



square

suicide **qu**estions **an**swers **re**sources

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An education resource for primary health care, specialist and community settings

Most people who die by suicide have sought help in the weeks before death. Therefore the nature and quality of response offered by workers in primary health care is crucial.

Even a simple interaction like listening can be significant.

Everyone can make a difference.





note

This Booklet is designed to be used with the rest of the **square** resources, not alone or as a substitute for an informed professional response. Its main focus is on adults although much of it is also relevant to young people. Those seeking specific guidance about working with young people should source relevant Australian, state government and local information.

You will find information in the service setting books that will be helpful in your own practice. This will be particularly relevant where referrals are made or received from these services or there is a shared care arrangement in place.

Your service will also have its own policies, procedures and protocols around suicide risk assessment and referral. It is very important to ensure that you are familiar with these as well as the information provided in this Booklet.

In addition it may be useful to consult the South Australian Emergency Demand Management policies, which cover best practice and specific procedures on matters such as admission, care and discharge, contingency planning, restraint and seclusion, emergency transport, assessment and crisis intervention service.

The experience of consumers and carers has been incorporated into these training materials. This reflects the priority placed on consumer and carer participation in decision and policy making. The contribution of these consumers and carers is gratefully acknowledged.

Note: All names used in quotes from consumers are pseudonyms to ensure anonymity and protect confidentiality.

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how to use this resource

This booklet is part of an integrated resource – **square** suicide **questions answers resources** developed for South Australia as part of the National Suicide Prevention Strategy (NSPS). **square** consists of 3 layers, each progressively providing more detailed information about suicide prevention.

- A** The first layer is the **Desk Guide**, a quick reference providing key information, tools, guidelines and questions.
- B** The second layer is a series of **9 booklets**
 - 1 Foundations for effective practice**
 - 2 Community setting**
 - 3 Primary health care setting**
 - 4 In-patient setting**
 - 5 Emergency department setting**
 - 6 Community mental health setting**
 - 7 Forensic setting**
 - 8 Mental health in-patient setting**
 - 9 Suicide postvention counselling.**

This booklet, **Suicide postvention counselling**, is aimed at generic counsellors and health workers who in their professional roles may encounter people who have been bereaved through suicide. It is designed to be used in conjunction with the **Foundations booklet** which has been written for a broad audience and provides the foundations which underpin the following 8 booklets addressing specific settings and audiences.

- C** The third layer is the **square** CD-ROM/Website **www.square.org.au**. It is intended for those readers who want a more in-depth discussion and application of the key topics covered in the Desk Guide and the booklets. It contains discussion papers, video clips, resource lists, some downloadable forms and plans, and pdf files of all the **square** print materials – the 9 booklets and the Desk Guide.



section 1 | **introduction**





introduction

About this booklet

This booklet is about suicide postvention – that is providing prompt and effective counselling and related support for people bereaved through suicide. It has been written for counsellors and health workers whose practice involves working with people bereaved in this way. Postvention aims to:

...reduce the after-effects of a traumatic event in the lives of those affected and to help those bereaved live longer, more productively and less stressfully than they are likely to do otherwise.

[National Advisory Council on Suicide Prevention 2004]

Because some bereaved people may themselves be at risk of mental ill health and suicide, postvention is regarded as a form of suicide prevention.

Wilson & Clark (2005) suggest that postvention is a neglected and under-serviced area the world over and that the specific needs of the health workers who support the bereaved are also neglected.

This booklet seeks to fill that gap by providing counsellors with information to help them understand more about suicide and its impact. It includes suggestions about counselling bereaved survivors to help them deal with both the emotional consequences and practical issues relating to a suicide.

Counselling a person bereaved by suicide is in some ways similar to other grief counselling. But it is also different because of the complexity of the emotions that are felt by family, friends and others close to someone who has ended his or her own life.

Unlike most other deaths, the event of suicide may involve media interest, insensitive questioning about details, social judgements or confusion about how to respond, as well as legal requirements such as a coronial inquiry or inquest, all of which can contribute to the pain of grief.

Note: This booklet is part of a set of **square** resources. As with the other **square** materials, the main focus of this booklet is on adults. Nonetheless, some resources for children and young people are included, and there is some discussion of particular postvention issues and strategies for young people and their parents.

Why is suicide postvention important?

Suicide is not uncommon

About 2300 Australians die from suicide every year. This is more than the total number of deaths from road accidents, industrial accidents and homicides, together. Suicide is therefore a major public health issue with significant human, social and economic costs. The actual number of suicides is likely to be greater than this because some suicide deaths are not reported or identified as such. Suicide is a leading cause of death among young and middle-aged males. There are also many more people who harm themselves or attempt suicide.

Suicide has a wide impact

Every suicide can affect a large number of people – parents, children, siblings, partners, members of the extended family, friends, peers and colleagues. It is estimated that about one in four people know of someone who took their own life, and for every death, at least six others are severely affected by grief. Yet suicide is still surrounded by a great deal of silence and stigma. People are reluctant to talk about it, both with those who are at risk and also with family members, friends and others who are affected. It is still a topic which is often surrounded by secrecy and associated with feelings of guilt and shame.

The reverberations of a suicide can be felt in local networks such as schools or workplaces and may also impact on the wider community.

Bereaved people may be at risk

There are a number of reasons for paying attention to postvention. Grief over the death of a loved one in any circumstances is likely to affect individuals' physical, emotional, cognitive, mental, social and spiritual wellbeing. Wilson & Clark explain that bereavement carries increased risks of mortality and suicide, cardiovascular disease, mental ill health such as depression and anxiety, substance misuse, diminished social support, relationship breakdown and physical symptoms (2005, p. 23).

People bereaved through suicide may grieve differently and possibly more intensely. They may also have different needs from those bereaved through other kinds of death. These differences are discussed more fully later. It is also recognised that people bereaved through suicide may themselves have a higher risk of depression and suicide than others.

A suicide therefore identifies a population at risk of the complications of the grieving process as well as of further suicide. Bereavement support is therefore necessary not only as a humanitarian responsibility to relieve suffering and mental illness, but also as suicide prevention [Wilson & Clark, 2005, p.26]

Who has a role in postvention?

It is now widely accepted that suicide prevention is a whole of community responsibility. Everyone can play a part.

The same is true of postvention. While medical practitioners, specialists, health workers and generic counsellors have special skills and opportunities to assist those who have lost loved ones to suicide, it is also true that friends, neighbours, colleagues, teachers and others may be able to help. Counsellors may be able to enlist the help of this broader network or may be asked for resources or advice.

The role of counselling after a suicide

The primary role of the counsellor is to offer a safe, non-judgemental and empathic space in which the grieving person feels listened to, and supported, in expressing whatever is troubling them at any given time.

The counselling process provides different things for different individuals, but in general it provides support for bereaved people to:

- better understand what is happening in their lives
- recognise that their experiences and feelings are typical or 'normal' responses to a trauma
- feel accepted
- identify strengths and skills
- develop and build on strengths and skills
- map positive pathways for future health and wellbeing
- devise their own solutions
- begin to take steps along the pathways that have been mapped.

In these ways, individuals who might otherwise feel overwhelmed by events, experiences, thoughts and feelings, can be 'safely held' within a supportive framework, to make sense of what is happening and feel more in control of it.



section 2 | **suicide: an overview**



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suicide: an overview

Suicidal thoughts or acts cannot simply be thought of as a medical illness. Suicide challenges counsellors and health workers to engage empathically with complex psychosocial issues and to be open to understanding some of the deepest meanings people hold about their life (and potential death).

Suicide is a complex problem involving a number of compounding factors. Risk factors may be genetic, biological, psychological, social, cultural, or environmental. They may be ongoing, such as chronic physical or mental illness, or shorter term, such as experiencing a significant loss. Some explanations of suicide focus on individual, psychological characteristics or genetically determined factors. Others focus more on social and cultural factors. The best insights are likely to be based on information derived from several perspectives.

Commonly recognised risk factors for suicide

While the presence of the following factors may identify a population at greater risk of suicide, the existence of such factors does not inevitably lead to self harm or suicide.

- Mental illness, particularly depression, is the most important risk factor, especially where substance misuse is also involved. The World Health Organization (2006) estimates that up to 90% of people who suicide have a mental disorder.
- While a specific catalyst such as a relationship ending or a bereavement may precipitate the act, the underlying condition may well have been much longer term.
- Many people who suicide may have had a history of prior attempts of suicide.
- Other contributing factors might include: death of a loved one (through suicide or other causes), end of a significant relationship, financial problems or events that threaten one's livelihood (e.g. a drought), impending legal issues, concerns about sexual identity, social isolation, sexual abuse (in childhood or as an adult), domestic violence, post-war trauma and chronic ill health.
- Social disadvantage – poverty, unemployment, homelessness – also has an effect on suicide rates.
- Ease of access to lethal means of suicide may also be a factor in suicidal thoughts being enacted. (Hence the current emphasis of the National Suicide Prevention Strategy on reducing access to means.)

Why people suicide

People suicide for many different and complex reasons. The catalyst may be a long standing ‘condition’ (e.g. a long term mental illness or chronic pain) or a more immediate precipitating trauma. There may be multiple, overlapping causes.

It is important that counsellors understand the risk factors for suicide so they are able to discuss with bereaved people what is known about why people decide to end their lives. Working through this information may help them understand that the suicide may not have been predictable or preventable and may have been the result of many years of emotional distress. This may also help bereaved people deal with other frequently preoccupying *What if* or *If only* speculations about their own potential role in preventing the suicide – *What if I had checked up on him that day?.... If only I had listened more to her.... If only I had searched the house for potential weapons* etc.

Suicide notes

Suicide notes, when they are left, rarely explain the deep seated factors which led to the suicide.

More often than not there are no notes left. But when they are written they often focus on what tipped the person over the edge, rather than the longer period of emotional turmoil that had come before. They can express anger or can attribute blame, and can be very hurtful and destructive. Bereaved people need to be helped to understand this and to deal with the often negative feelings that are expressed.

[Jill Chapman, Facilitator, Bereaved Through Suicide support group]

Counsellors need to acknowledge that while there are usually no single or simple explanations for a particular suicide, those bereaved by a suicide are often preoccupied with the question: *Why did they do it?* – and may need to explore this at some length. Seeking an answer to this question may be fruitless, but nonetheless a necessary part of the grief journey.

The search for ‘why’ is futile. It’s not like a road map where you get lost and can say ‘I should have turned left here’. You can’t look at someone’s life and pinpoint a particular time or place where someone took a suicidal path or made a choice that led ultimately to suicide. [Jill Chapman, Facilitator, Bereaved Through Suicide support group]

Myths and facts about suicide

Myth	Fact
Suicidal people want to die.	People who have attempted suicide often say they wanted to end their pain. Most people are ambivalent and often fluctuate between wanting to live and wanting to die. Some people, especially young males, often indulge in risky behaviours that could result in death, and may appear indifferent to this potential.
If you ask about suicidal intent you could encourage a suicide.	Not true. In fact your concern is likely to lower anxiety and reduce the likelihood.
People who talk about killing themselves rarely suicide.	Most people who suicide have given some signal of their intention.
People who talk about suicide when under the influence of alcohol or drugs do not need to be taken seriously.	Anyone who talks about suicide should be taken seriously. Alcohol and other drugs are involved in many suicides.
Suicidal people rarely seek medical help.	Most suicidal people visit a GP in the days, weeks or months before they attempt suicide.
Suicidal attempts are just attention-seeking, 'cries for help' or 'acting out'.	Many people who attempt suicide go on to complete it, sometimes much later. The attempt may be a rehearsal. Also, a suicidal attempt may well be a cry for help from someone in profound distress, and this should not be ignored.
Suicide is an extremely rare occurrence.	Suicide statistics are likely to be an under-estimate of the real number. There are also many more people who harm themselves or attempt suicide.
Suicide only affects certain sorts of people.	Anyone may be vulnerable when confronting difficult circumstances or when experiencing feelings of depression or hopelessness.
When someone seems to be suicidal, someone else is probably taking care of it. It is not my business to interfere.	Suicide is a community responsibility. Any concerned person can make a difference. Many distraught people do not have networks of support.
If someone talks about their suicidal intent, for confidentiality reasons you must honour this confidence.	You have a duty of care to ensure safety if you believe that the person presents an immediate risk to themselves or others. Ideally, you should always try and seek permission from the client to inform or involve relevant others.

Legal processes following a suicide

Depending on how soon a counsellor sees a bereaved person after the death, there may be questions about the role of the police, the coroner and the funeral director. In these circumstances, personal support and assistance to access relevant sources of information can be provided.

What the police will do

The police will need to investigate the death, and may question family members and friends and ask them to make a statement. The police may ask for someone to formally 'identify the body'. It is advisable to have someone support a bereaved person in such a process and for them to be prepared (e.g. by the police or mortuary staff) for what they might see and be asked. The suicide site will be treated as a crime scene until cause of death can be ascertained.

Role of the State Coroner

It is a legal requirement for the State Coroner to investigate the circumstances and cause of 'reportable deaths'. These include unexpected deaths, those where the person dies in a violent or unnatural manner or apparent suicides. The police or a doctor may notify the Coroner of a death that may be 'reportable'. Many Coroners' Offices (including South Australia's) provide a wide range of free counselling services for the family and friends of the deceased (ph. 08 8204 0600).

Autopsies, inquests and medical reports

It may be necessary for an autopsy or post mortem to be performed by a pathologist to help explain the cause of death, and this may delay the release of the deceased person's body to the next of kin. The Coroner will decide whether an inquest is also necessary to determine the cause and circumstances of death. An inquest is a formal court hearing conducted by the Coroner, in which the circumstances surrounding a death are examined. Only a small number of deaths reported to the Coroner will actually result in an inquest.

For more information about the South Australian Coronial process, including post mortems, inquests, viewing the body, the timing of funeral arrangements, death certificates, legal representation etc. go to <http://www.courts.sa.gov.au/courts/coroner/> . For information about other states go to the National Coroners Information System at http://www.ncis.org.au/web_pages/the_coronial_process.htm

Dealing with other services

Bereaved people may need to be prepared to deal with a whole range of services. These might include banks; insurance and superannuation companies; real estate agents; motor vehicle departments; telephone and internet providers; solicitors; and many others who have provided services to the deceased person. They may need assistance in drawing up lists and contact details of such services. A sample checklist can be found in the *Information and Support Pack for those Bereaved by Suicide or Sudden Death* (See page 38).

Funerals

Information about funeral directors and the services they provide can be found at the Australian Funeral Directors Association website. The *Frequently Asked Questions* at <http://www.afda.org.au/faqs.asp> are particularly useful. Funeral Directors may also advise on which other services to contact.

It is not recommended to make any far-reaching life decisions immediately after the death of a loved one. So while there may be a need to attend to some matters quickly, people may need to be advised to move slowly and seek advice and support before making major decisions.

Media representations of suicide and their effects

The way suicide is reported in the media is important. There is evidence that sensationalist and melodramatic media reporting can be linked to an increase in suicide rates. Sensitive and appropriate reporting also has the potential to reduce suicide. As the Hunter Institute of Mental Health writes:

People in despair may be influenced by media reports of suicide, particularly where they identify with the person in the report or where suicide is romanticised, glamorised or otherwise portrayed as an 'acceptable' course of action.

Recently there has been a great deal of attention given to the potential of the Internet to provide an anonymous forum for suicidal ideation and information about suicide methods, possibly posing additional risks for vulnerable adolescents. There is no evidence that suicide rates increase with access to the Internet, and in fact there may be positive as well as negative effects, as with any form of communication.

Chatrooms provide a space for adolescents - whether suicidal or interested in suicide - to exchange their thoughts, and may therefore allow risks and fantasies to be reduced, or may possibly increase the desire to commit suicide [Becker et al. 2005].

The postvention counsellor needs to be aware of a number of potential effects of the media and the Internet on bereaved people:

- Family and friends of people who suicide may feel hounded by the media's attention.
- They may be distressed by a media focus on suicide and speculation about suicide, even when it is couched as being 'in the public interest'.
- The daily repetition in the media of phrases such as 'suicide bomber' may be distressing to those bereaved by suicide.
- Graphic or explicit messages, diary entries and videos on youth websites such as MySpace and YouTube may have a harmful impact on others, for example, bereaved parents.

Counsellors need to check whether the media has played a role in intensifying the distress felt by bereaved people and gauge whether they need specific counselling to deal with this aspect of their grief.

For more information about suicide prevention and the role of the media go to the Hunter Institute's excellent Mindframe website at www.mindframe-media.com Their website and their online Newsletter *Mindframe News* provide excellent research summaries about the media and mental health and guidelines for media professionals, including information relevant to reporting on Indigenous and culturally and linguistically diverse issues.



section 3 | **grief and
bereavement**



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grief and bereavement



The bereavement journey

There are some commonly experienced reactions to bereavement that are often referred to as stages or phases. Caution should be taken, however, not to imply that these phases are all inevitable or smoothly sequential. While grief has common markers the nature of grieving is very individual in terms of what is experienced, when and for how long. Grief may also be revisited at anniversary times or when other losses are experienced.

High quality counselling involves attending to the unique concerns of each person, without making prior assumptions about their needs. However, when grief is the presenting reason, or part of the reason, for seeking counselling support, the following areas of work are likely to be relevant.

- Coming to terms with the reality of the death and the inevitability of an associated grieving process (rather than denial of either the death or the emotions and meanings connected with it)
- Finding ways to acknowledge and manage emotional pain (rather than finding ways to avoid it)¹
- Adjusting to the changed environment
- Acceptance of self and others and allowing positive feelings into life (rather than thinking exclusively of the deceased person with feelings of despair)
- Building a connection with the deceased person that feels comfortable and real (rather than idealising or blaming him or her), and enables the forging of new relationships (living effectively in the world)².

Intensely felt grief responses often swing between the devastation of the loss and gradual experiences of restoration (in relation to bereaved people themselves and to their relationship with the deceased). An effective counsellor can be extremely significant in providing a safe relationship, process and context in which an individual can manage and move towards integrating these stressful challenges.

Some people are not sure what counselling involves. For example, a man in his forties, whose mother had recently suicided, said in his first session with his counsellor:

I'm not the sort of person who weeps and lets everything out, and anyway I have to be strong for the rest of my family.

He was reassured when his counsellor explained that there was no expectation in counselling to feel or behave in any prescribed way and that people grieve differently. The counsellor commented about this scenario:

I think he had the idea that I would require or expect him to have an emotional catharsis, and that this was the aim of the counselling process. I think it was therapeutically helpful for him to be reassured that there were no expectations about how he 'should' grieve.

¹ Adapted from Shear, K. (2007) The Marion Kenworthy Lecture, Columbia University School of Social Work.
<http://www.columbia.edu/cu/ssw/wedseries/index.html>

² Worden, W. (1991) *Grief Counselling and Grief Therapy*, Routledge: London

Common grief responses

As we have emphasised throughout this booklet, grief responses are highly individual. However, common responses include:

- **Shock:** A shock reaction often numbs emotions and works to protect against the magnitude of the event of a death. During this stage people can often act effectively in practical ways, for example making funeral arrangements. Operating in this effective, yet unemotional, way can feel very disturbing. It is important to reassure people that shock is a common and protective mechanism.
- **Denial:** Denial involves a process of not believing, at some level, that the death has occurred. This may mean that a grieving person behaves in some ways as if their loved one is still alive. Accepting that the death was a suicide may also be difficult. Denial can be a part of a process of adjustment, and gently helping someone through it can be important.
- **Guilt:** Feelings of regret about lost opportunities for making contact or spending time together are often intense when someone dies. Guilt may also be felt if bereaved people are able to take pleasure in any pleasurable activities following the death of someone they have been close to. Social attitudes and responses are often further complicated and confused when the death is a suicide, and these can contribute to a bereaved person feeling guilty. Many people who are bereaved through suicide struggle with overwhelming feelings that they could have, or should have, prevented the death.
- **Sadness:** When the reactions described above have settled to some extent, a profound sadness often develops. This feeling is often accompanied by acute feelings of loneliness and pain at the idea of going about life without the deceased person.
- **Anger:** People may experience anger about a death because it has left them feeling abandoned, hurt and/or betrayed. Anger may manifest in all sorts of ways and be very confusing for the bereaved person and those around them. Such responses may be stronger when a person is bereaved through suicide. Anger may also be directed at other people who are perceived to be to blame (including health workers involved in the deceased's care).
- **Acceptance:** Acceptance is not about grief dissolving or being 'finished'. Rather, it can be seen as an integration of the processes of grief into a bereaved person's life over time, and the lessening of the acuteness of its effect.

[Adapted from Jackson, J (2003) A Handbook for Survivors of Suicide, American Association of Suicidology.]

How suicide grief is different from other grief

The grief experienced by people who are bereaved through suicide may have similar themes to the grief experienced by anyone, over any sudden death. However, there are likely to be some important differences as well. These differences can include:

Suicidal ideation and behaviour

People bereaved through suicide are themselves at greater risk of self harm and suicide. If you are counselling someone bereaved through suicide, it is important to keep a high index of awareness about suicide risk, to assess it, and if necessary, refer appropriately. Be alert to statements such as: *Sometimes it feels like there's no point in going on*. If a person makes comments such as this, it is important to ask specifically and clearly whether they have thoughts or plans of self harm. Do not be reluctant to bring this topic out into the open – it is not the case that talking about suicide will increase its likelihood. On the contrary, being able to tell someone who is trusted about such thinking or planning means that appropriate support can be negotiated and arranged. (See the **Foundations for Effective Practice** booklet for more information.)

Intense shock

The shock and disbelief associated with a death by suicide can be extraordinarily intense. A bereaved person may experience recurring graphic images and nightmares about the death, even if they did not witness it. Finding the body is usually associated with severe trauma. People who are bereaved by suicide can replay the details of this horrific experience over and over. This replaying and retelling is a normal response to the traumatic experience. Being receptive to a person's need to tell the story many times can be therapeutically helpful.

Family disruption or breakdown

Family breakdown, including serious rifts between family members, can occur or intensify when someone in the family dies. These dynamics can be especially acute in the event of death through suicide. A bereaved person may explicitly or implicitly blame others or feel that someone else could have prevented the death. Such feelings are likely to be complex, and experiencing them is likely to generate and/or re-open a range of issues and emotions that may need therapeutic support.

Stigma, shame, social rejection and alienation

Many people are personally unfamiliar with death and dying processes and not always aware of the feelings involved in grief and loss. Therefore, they are not always sure how to respond helpfully to a bereaved person, even when they want to. Suicide is an issue that creates an even more complicated range of responses because of the cultural taboos that surround it. A bereaved person may also have feelings of shame about the event and not know how to talk about it to others. These factors can mean that the bereaved person feels unsupported and sometimes judged by those around them. Given that profound feelings of emptiness and loneliness are often associated with grief anyway, if social distancing also occurs it can add to or create feelings of alienation and isolation. People in counselling may need assistance to identify and articulate their needs for support and to find ways to tell others about the death.

Betrayal and abandonment

The feeling of being abandoned and betrayed can occur in any grief response. People often hold assumptions or expectations about a shared future or an ongoing friendship, and these may not always be conscious. When all of these expectations are suddenly removed, it is not uncommon for an individual to feel a sense of betrayal and abandonment. In the event of death through suicide such feelings can be exacerbated because the deceased person is perceived to have chosen death. Therefore, in the eyes of the bereaved, the deceased person can be seen to have broken bonds and fundamental trust. People who suicide may indeed have chosen to die or could have been acting in a confused and disturbed state of mind and felt compelled to end their pain. In this sense the concept of choice is in fact, not simple.

Loss of faith and confidence

Sometimes people who are bereaved through suicide find it difficult to trust other people or to trust in their own judgements. They may experience a loss of certainty about a whole range of things they had previously held to be true. This may include their religious faith. They may also experience a loss of self confidence and reduced self esteem.

Intense levels of grief for a number of years, often associated with depression

Some of the feelings associated with grief are similar to those experienced in depressive illness, and these may be felt acutely after a death by suicide. They may include feelings of unreality, despair, pointlessness and difficulty in seeing any way to feel positively about anything again. These are all common responses to a major loss and can be expected for a sustained period of time. Depending on the intensity of these feelings, the length of time a bereaved person experiences them, and their wishes and preferences, it may be appropriate to enlist support in addition to counselling, e.g. from a GP, relaxation therapist, or a support group.

Substance misuse

People who are living with grief may use alcohol and other drugs to alleviate the pain. They may also use or misuse prescription drugs in combination with alcohol or other drugs. Because of the mix of emotions and the intensity of the pain felt by people bereaved through suicide, misuse of substances may be especially common. Depending on the levels of usage, this can create additional risks to the person's safety and wellbeing. It may also influence the person's relationships with others, both in the family (where others are also likely to be grieving) and in wider work and social contexts.



section 4 | **working with people
bereaved through
suicide**



working with people bereaved through suicide



Engagement

Effective engagement is the single most important therapeutic response to a person who is bereaved through suicide. Engagement is essentially about connecting with the person and demonstrating genuine interest and concern. It involves providing the opportunity for people to describe what is going on for them in their own way, as fully and honestly as they are able to.

Listening well is a fundamental skill which involves giving full attention. Questions at this stage should be minimal and asked in an open way to encourage people to elaborate on their feelings and experiences. The more comprehensive people are encouraged to be, the more likely it is that the counsellor will have enough information to be able to select the most useful lines of therapeutic enquiry.

People bereaved through suicide have explained that they know when they are being offered a high quality of genuine attention. Similarly, people 'pick up' when the person they are speaking to is distracted, or using a formulaic response. A bereaved father consulting his GP after his son's suicide, explained:

As you enter his room you feel relaxed as it's not a typical clinical doctor's room, just enough clutter on the desk to make it look like home. In fact my impression is usually more like sitting in a family den. His is a big wooden chair with leather cushioning and is always turned to face the patient squarely with him slouched very comfortably within. While I am sure he is in control of time, to me it seems that I am setting the pace, and have never been conscious of any pressure to move along and depart. To the contrary I have been in his room on one occasion for about forty minutes and when finally leaving, being walked to the desk to hear: 'If Mr. _____ rings me I need to know about it straight away.' A comforting feeling indeed.

Language

It is important to be sensitive about the language you use with a person who is bereaved through suicide. Some words and phrases may create discomfort and can inhibit or disrupt a process of positive engagement. Consultation with people who have been bereaved through suicide highlighted some examples that had been experienced as difficult. These are represented in the table below.

Words & phrases	Possible reactions	Possible alternatives
Committed Suicide	<i>Committed</i> sounds like a sin or a crime.	Took his/her own life Ended his/her life Died through suicide Suicided.
Seeking/finding closure or resolution	I do not want his/her life closed. They will always be with me – and so will my grief.	Travelling along the grief journey. Experiencing different aspects of grief.
Beginning to get over it	I will never get over it.	Moving through intense shock.
It will take time	What does this mean? Months? years? What is it that will take time?	Grieving is a process involving all sorts of different feelings and levels of intensity. Each person takes their own time with this.
It's important to move on	It's not like losing or changing a job. You may want me to get over it because you would feel more comfortable. But that's not how it is.	It's important to allow all the feelings to emerge and to know that they are a normal and healthy part of grieving.

Normalising bereavement

Normalising is a process of validating the reality of an individual's experiences, taking the person and the experiences seriously, and conveying that such experiences are common after a traumatic event.

Many who have experienced bereavement through suicide, describe a range of frightening and overwhelming feelings. These can include feeling that they are going crazy, that they do not feel real, that they feel desperate or unable to cope with anything anymore. It is important to let people know that all such responses are a common reaction to experiencing trauma. It is often helpful to give them literature about bereavement and contact details about support groups.

When you're feeling grief and looking for explanations, you can become obsessed with quite trivial details about the past or your relationship with the person. These trivial details can take on a huge importance in your mind. It's good to be told that this is normal, to be told that lots of people feel that way, that it's OK'

Diverse and complex relationships

Relationships are complex, and this also applies to relationships with someone who has died. Depending on the quality and daily reality of the relationship with the deceased, a bereaved person may in fact express relief or satisfaction that someone has died. In this case, it is not necessarily appropriate to assume that sadness is at the forefront of this person's emotions (although it may also be present).

It is also important to be open to understanding the significance of a range of relationships, not only those that are socially understood to be important, such as family relationships. Some friendships, for example, are experienced as closer than any family ties. In addition, be aware that some people may feel particular alienation when a loved one dies – for example, former separated partners of the deceased, a gay or lesbian partner, someone whom the deceased person had not spoken about to others. In such circumstances an empathic, client-centred counselling approach is especially important.

A strengths based approach

A strengths based counselling approach identifies the strengths and abilities of individuals (as well as the difficulties that they are experiencing) and works collaboratively in a therapeutic alliance to use these strengths. This approach is one in which counsellors start from a position that understands individuals have a repertoire of skills, feelings and meanings that are not static. Rather, they are multi-layered, contextual and open to change and growth. In this way, people are not defined by deficits, but are seen as active agents who are working with a counsellor to find the best tools and options to navigate extremely difficult terrain.

If bereaved people are living through intense grief or trauma, it is possible that they will feel as though they have no strength or resilience at all. They may feel a sense of unreality or as if their whole world is falling apart. As well as listening well and exploring the dimensions of these experiences, it is important also to identify and name strengths that are apparent. The very fact that the person has sought counselling is, for example, a very positive action.

A strengths based approach in relation to bereavement through suicide is likely to focus on small steps within a short time frame. For example, it can be important for a person to recognise that their feelings and thoughts are different at different times during a given day, or that some days are different to others.

Individuals may have more needs or strengths in one particular aspect of their life, and priorities may change over time. Noticing which area predominates by paying close attention to the language that they use, will be a guide for where to focus attention and support at any given time. For example, some people may find reflective processes and strategies more helpful than planning activities and tasks, and vice versa.

Recognising and making visible the person's current skills and abilities is important. Identifying these can be affirming and can support the person to have faith in their capacity to get through the most stressful times.

Therapeutic strategies

If a person is bereaved through suicide, first steps towards recovery may be small. It is possible for people to be acutely affected by grief and associated responses for months and even years after the event. This can also have a ripple effect on relationships. The most helpful therapeutic response is to work with the person from wherever they are at, at any given time.

It may seem that the person is going over the 'same ground.' However, retelling their 'story' is an important part of a healing journey. It is likely that this story will change in subtle ways as it is retold. These small shifts in emphasis and insight in fact assist a bereaved person to integrate the reality of the death. It is important to maintain a strengths based approach and to recognise that for some people, 'surviving' each day is in itself an achievement. It is useful to review at appropriate intervals, in collaboration with the person, which particular strategies might be useful. Strategies might include:

- Bringing significant others into a counselling session
- Attending a support group
- Writing in a journal or making a scrapbook of the deceased person's life
- Working out ways to celebrate the person's life
- Preparing for special dates and anniversaries
- Writing feelings and thoughts in letter form, whether or not the letter is posted
- Making lists of things that have helped, e.g. meeting with friends
- Noting any achievements, e.g. being able to leave the house, attending counselling
- Identifying any things that the bereaved person would like people to do, or not to do – this may be written down for selected people
- Listing people whom the person finds supportive, and discussing how to best utilise their support
- Working out how to tell people that the death was the result of suicide
- Planning and undertaking beneficial activities e.g. exercise.

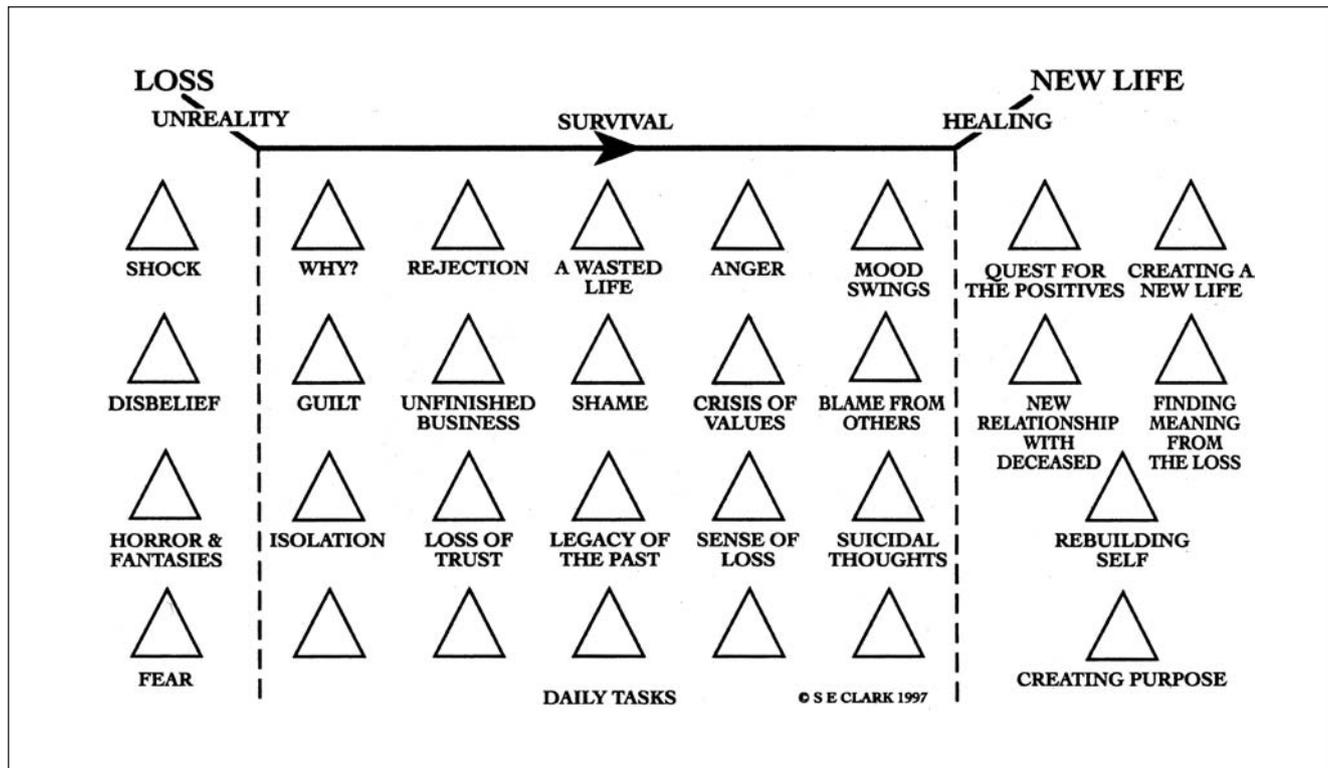
Sheila Clark's 'Grief Map' on the following page may also be a useful tool to employ.

The grief map

Common emotions following a suicide bereavement have been plotted on a map by Sheila Clark (1995, p.24). The triangles on this map represent mountains to be climbed on a grief journey. It may be helpful to give this map to bereaved people and encourage them to underline the mountains that are relevant to their journey, cross out those that don't seem so relevant, and identify their progress on others. Some emotions may be particular to individuals, so there are blank triangles for these to be named. Clark suggests that bereaved people shade in each triangle (mountain) to the height they perceive they have climbed.

In examining the completed map people are then able to identify:

- What issues they have dealt with
- What successes they can identify
- What issues they think they need to work on.



[Used with the permission of Sheila Clark]



section 5 | **suicide risk
assessment**



suicide risk assessment



Risk assessment guide

People bereaved by suicide may themselves be at risk of suicide. Counsellors may find useful the following risk assessment guide from the Mental Health in South Australia Emergency Demand Management Policy and Procedure Series (2002). It forms part of the risk assessment, referral and follow up form developed for private practitioners. The form and the accompanying guidelines can be downloaded from the **square** CD-ROM/Website www.square.org.au. There are specific questions (designed by Dr Randall Long) which can be asked of people to help with this assessment. They can be found in the **Foundations for Effective Practice** booklet and in the **square Desk Guide**.

Please note form continues over the following pages.

risk of harm to: self others both

<input type="checkbox"/> none	<input type="checkbox"/> low	<input type="checkbox"/> moderate	<input type="checkbox"/> significant	<input type="checkbox"/> extreme
No thoughts or action of harm.	Fleeting thoughts of harming themselves or harming others but no plans, current low alcohol or drug use.	Current thoughts/distress, past actions without intent or plans, moderate alcohol or drug use.	Current thoughts/past impulsive actions/recent impulsivity/some plans, but not well developed. Increased alcohol or drug use.	Current thoughts with expressed intentions/past history/plans. Unstable mental illness. High alcohol or drug use, intoxicated, violent to self/others, means at hand for harm to self/others.

level of problem with functioning

<input type="checkbox"/> none/mild	<input type="checkbox"/> moderate	<input type="checkbox"/> significant impairment in one area	<input type="checkbox"/> serious impairment in several areas	<input type="checkbox"/> extreme impairment
No more than everyday problems/slight impairment when distressed.	Moderate difficulty in social, occupational or school functioning. Reduced ability to cope unassisted.	Significant impairment in either social, occupational or school functioning.	Serious impairment in several areas such as social, occupational or school functioning	Inability to function in almost all areas.

Risk assessment guide

level of support available

<input type="checkbox"/> no problems/ highly supportive	<input type="checkbox"/> moderately supportive	<input type="checkbox"/> limited support	<input type="checkbox"/> minimal	<input type="checkbox"/> no support in all areas
Most aspects are highly supportive. Effective involvement of self, family or professional.	Variety of support available and able to help in times of need.	Few sources of help, support system has incomplete ability to participate in treatment.	Few sources of support and not motivated.	No support available.

history of response to treatment

<input type="checkbox"/> no problem/ minimal difficulties	<input type="checkbox"/> moderate response	<input type="checkbox"/> poor response	<input type="checkbox"/> minimal response	<input type="checkbox"/> no response
Most forms of treatment have been successful, or new client.	Some responses in the medium term to highly structured interventions.	Responds only in the short term with highly structured interventions.	Minimal response even in highly structured interventions.	No response to any treatment in the past.

Risk assessment guide

attitude and engagement to treatment

<input type="checkbox"/> no problem/ very constructive	<input type="checkbox"/> moderate response	<input type="checkbox"/> poor engagement	<input type="checkbox"/> minimal response	<input type="checkbox"/> no response
Accepts illness and agrees with treatment, or new client.	Variable/ ambivalent response to treatment.	Rarely accepts diagnosis.	Client never cooperates willingly.	Client has only been able to be treated in an involuntary capacity.

Is the person's risk level changeable? **Highly Changeable** yes no

Are there factors that indicate a level of uncertainty in this risk assessment? **Low Assessment Confidence** yes no
(e.g. poor engagement, gaps or conflicting information)

overall assessment of risk

<input type="checkbox"/> none	<input type="checkbox"/> low	<input type="checkbox"/> medium	<input type="checkbox"/> high	<input type="checkbox"/> extreme
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Note Risk assessment is not a precise 'science'. A form such as the one above is a valuable guide, but your professional judgement and experience are also crucial. Remember too, that a person's risk of suicide may be highly changeable, fluctuating at different times and in response to certain events.

You will find an explanation and discussion of these questions in Dr Randall Long's **Risk Assessment paper** on the **square** CD-ROM/Website **www.square.org.au**

Action following risk assessment

A counsellor who assesses an individual as being at actual or potential risk of suicidal behaviour should always take action. Depending on the circumstances, this may mean managing the situation yourself. But it is useful to remember that you are not alone. There are various supports that you can call upon, e.g. discussing it with someone else in your workplace, reporting to someone like a manager, referral to a GP or specialist, or calling SA Emergency Mental Health Services (ph. 131 465).

It is especially important to actively follow up people whom you believe to be at risk. If such a person breaks an appointment, for example, it is appropriate to check on their wellbeing. It may also be helpful to find out whether there is someone with whom the person feels safe, who could be supportive while further assessment is being arranged.

Note: Your own service or agency may also have its own policies, procedures and protocols around suicide risk assessment and referral. It is very important to ensure that you are familiar with these as well as the information provided in this Booklet.



section 6 | **practice issues**



practice issues



Good practice and self care

It is important for counsellors to remember that while they can assess the risk of suicide, they cannot always prevent a particular suicide, even if they have carefully exercised their duty of care (see p.41). Working with individuals to empower them to develop the necessary skills to maintain a positive focus on life is likely to be the most viable and productive contribution a counsellor can make towards suicide prevention.

It is also important to remember that suicide prevention is a whole of community responsibility. You are not working alone. The **square** resource is premised on communication, collaboration and co-ordination. This means:

- Good communication, involving clear documentation and timely and effective transfer of information
- Collaborative practice – not only an effective strategy for the wellbeing of the bereaved person, but also a cost effective use of community expertise and resources
- Successful collaboration, requiring sharing information, valuing and understanding other workers' roles, knowledge and experience, and including the bereaved person as part of the team
- Coordination – clearly articulated pathways for referral and mechanisms for coordinated planning, review and feedback.

Counsellors also need to attend to their own emotional and mental wellbeing. After a critical incident with a very distressed or suicidal person, you may need to ensure you have opportunities to debrief with a colleague or colleagues. It is important to keep in mind the positive strategies that you use for self care, both for your own wellbeing and to maintain effectiveness in your role as a counsellor.

Some useful reminders

- Remember that while you can assess the risk of suicide and act appropriately, you cannot always prevent it
- It is positive to acknowledge when you don't know the answer to something
- In these circumstances it is important to seek information and assistance from others with relevant experience
- Debrief with a skilled colleague after a critical incident
- Supporting people to develop their own skills is likely to be more effective than attempting to 'rescue' individuals who are at risk
- Reflective thinking is integral to self care
- Review your own professional needs with the same seriousness as you review client needs, and seek help if necessary.

Duty of care

All health workers, including counsellors, have a duty of care to the people they treat. This means that they must take steps to ensure that the people they care for do not come to foreseeable harm by their actions or their failure to act.

Counsellors are expected to be well informed about the risk factors for depression and suicide when counselling someone grieving the death of a loved one, whether that death was due to suicide or other causes. It is important that counsellors notice responses to grief that may mean the person should be referred to a GP or a specialist, or in urgent situations, to Emergency Health Services. Alerts will include: the degree of distress, suicidal ideation, self medication with alcohol or other substances and a range of physical symptoms.

Counsellors should keep some documentation of their sessions with clients, including any referrals or shared care arrangements they have made, and they should actively follow up with people whom they believe to be at risk. If it is believed that a person is at risk of self harm or suicide and they break an appointment, follow up (e.g. with a phone call) is advisable. In negotiation with the person it can also be supportive to involve family members, carers and significant others, as appropriate.

Counsellors are expected to be up to date with relevant duty of care protocols and practices applicable to their context, and to take reasonable care in undertaking their duties. If a counsellor fails to adopt and use the standard of care and skills that a court would reasonably expect from someone with their professional skills, training and experience, they may be found guilty of negligence.

Confidentiality

Information about a client should not be given to anyone else without the person's permission, unless there is a strong belief that they present an immediate risk to themselves or others. In circumstances like this, duty of care would be more important than a potential breach of confidentiality.

Ideally, counsellors will be able to discuss and negotiate confidentiality and duty of care issues that may arise if information about a person in their care needs to be provided to other agencies. It is also advisable that counsellors document (in relevant electronic or hard copy file records) conversations with clients regarding confidentiality and release of information. In this way practitioners would be able to avoid this potential legal dilemma.



section 7 | **resources**





resources

Please note: For a comprehensive list of resources relating to suicide prevention and postvention refer to the **Resources** section of the **square** CD-ROM/Website www.square.org.au
Below is a selection of some useful postvention resources for both counsellors and their clients.

For counsellors

Clark, Sheila (1995). *After suicide: Help for the bereaved*. Melbourne: Michelle Anderson Publishing.

"This is an extremely valuable book which will be of great support and assistance to those who are bereaved through the tragedy of suicide. It shows practical commonsense and careful guidelines to help people find their way through this time. This book would be of great value to general practitioners and all those who may be involved in providing support and care for bereaved people following a suicide." (Prof. Beverley Raphael).

Pietila, M. (2002). 'Support groups: A psychological or social device for suicide bereavement?' *British Journal of Guidance and Counselling*, 30, pp. 401-414.

Excellent article highlighting the cultural and moral specificity of how we grieve. Suggests that particular types of grieving are normalised or promoted, and that other forms are disavowed. This is particularly applicable to how practitioners may feel able to grieve, and the gender specificity of which types of grieving are publicly possible. Suggests that there is a gap between the utility of support groups as a shared space of understood meaning, and the prohibition of certain types of public grief.

Talbot, Kay (2002). *What forever means after the death of a child: Transcending the trauma, living with the loss*. New York: Brunner-Routledge.

This book builds on empirical and qualitative research and gives examples of what helps and what hinders bereaved parents as their grief and loss evolve. Talbot encourages clinicians to help parents reframe their role as the child's biographer, through continuing rather than breaking the bond with their deceased child. Examples demonstrate how bereaved parents reconstruct personal identity, resolve spiritual and existential crises, reach out to help others, and create productive futures that honour their children and provide new meaning to their lives.

Wilson, A. & Clark, S. (2005). *South Australian Suicide Postvention Project, Report to Mental Health Services Department of Health, University of Adelaide, September 2005*

http://digital.library.adelaide.edu.au/dspace/bitstream/2440/24871/1/South_Australian_Suicide_Postvention_Report.pdf

The Project's purpose was to examine current approaches to postvention for those bereaved through suicide in metropolitan Adelaide from the perspective of consumers, service providers and organisations. [It includes] a review of published and unpublished literature and research from both Australian and international contexts. One of the most salient features of this research was the emphasis placed on ensuring that research data, results and conclusions were grounded in the experiences, beliefs and ideas of the bereaved, service providers and organisations.

Suicide Risk Assessment & Intervention: Men at Risk eLearning Tool.

This innovative and interactive eLearning tool, produced by Crisis Support Services, is a valuable, educative resource for professionals working with men who may be at risk of harming themselves, to equip them with the knowledge and skills to assess and respond to suicide risk. It can be downloaded from <http://www.crisissupport.org.au/suicideelearning.html>

For bereaved clients

An Information and Support Pack for those Bereaved by Suicide or Sudden Death has been disseminated nationally since September 2003. It contains information about dealing with practical matters such as funeral and coronial processes; very helpful material on the emotions associated with grief and mourning; suggestions about what helps; a section on grief and mourning the Nunga way; ideas for helping children and teenagers deal with bereavement; and a section specifically on suicide. It also contains a comprehensive list of relevant books, websites and services. A South Australian version of this is downloadable from the LIFE website http://www.livingisforeveryone.com.au/files/clife/kit_sa.pdf

Survivors of Suicide: Coping with the Suicide of a Loved One.

This brochure published by Lifeline Australia is a reprint of an American publication. It draws on the experiences of bereaved survivors and is written in a very engaging personal style. Its content includes facts about suicide and a detailed discussion of the grief process. There is a section on how suicide affects children. The booklet is available for order through Lifeline's Information Service by phoning 1300 13 11 14 or online at www.justask.org.au A PDF version of the booklet can be found at <http://www.readthesigns.com.au/documents/survivors.pdf>

SOS: A Handbook for Survivors of Suicide, American Association of Suicidology.

This is designed to be a pocket-sized, quick-reference booklet for suicide survivors. Written by fellow survivor Jeffrey Jackson, it is brief, clear, and packed with essential information covering nearly every aspect of the survivor ordeal – from the emotional roller-coaster, to the elusive quest for 'Why?'. It includes a Suicide Survivor's Affirmation and a Survivor's Bill of Rights. It can be downloaded from the American Association of Suicidology's website: <http://www.suicidology.org> Click on the Survivors link.

Clark, Sheila (1995). After suicide: Help for the bereaved.

Melbourne: Michelle Anderson Publishing. See counsellor resources above for details.

Coping with sorrow, loss and grief.

This self help tool kit has been developed by the Illawarra Aboriginal Medical Service in conjunction with Lifeline. It is the latest in a series of Indigenous specific self-help brochures, providing mental health information. While this one does not deal specifically with suicide issues it has some valuable advice for dealing with loss and grief and recognises that mental health issues vary across cultures, locations and other demographics. It can be obtained by phoning the Lifeline Information Service on 1300 13 11 14 or it can be downloaded at: http://www.lifeline.org.au/find_help/info_service/toolkits

Video

Messages of hope: An insight into the lives of the bereaved

Produced by the Bereaved Through Suicide Support Group, Adelaide.

A series of interviews with people bereaved through suicide, giving an insight into their thoughts, feelings and hopes.

For and about children

Reach Out! www.reachout.com.au

Reach Out! is a web-based service that inspires young people to help themselves through tough times. The aim of the service is to improve young people's mental health and wellbeing by providing support information and referrals in a format that appeals to young people. It includes fact sheets such as: *When someone takes their own life* and *After someone has died: some practical issues*. There are also a number of fact sheets dealing with managing grief.

Kids' Health www.cyh.com

The Child and Youth Health web site is part of the Children, Youth and Women's Health Service in South Australia. This Kids' Health site is designed for 6 to 12 year olds and offers information and advice about being healthy and happy. Under the Health Topics heading there is some information on suicide, stress, depression and advice for 'When someone you love has committed suicide.' There is also a Teen Health site and a site for young people aged 18 to 25.

Focus Adolescent Services <http://www.focusas.com/Suicide.html>

This is an American site with useful information and links relating to teen suicide, depression, substance misuse and other risk factors.

Web support for counsellors and clients

GriefLink (SA) <http://www.grieflink.asn.au/frameset.html>

GriefLink is a resource on death-related grief for the community and practitioners. As the site is based in South Australia some information about support services and educational activities is specific to SA. Has a page on 'Resources for Grief Associated with Suicide'.

Suicide Prevention Australia www.suicidepreventionaust.org

Suicide Prevention Australia is a non-profit, non-government organisation working as a public health advocate in suicide prevention. SPA is the only national umbrella body active in suicide prevention throughout Australia, promoting community awareness and advocacy; collaboration and partnerships between communities, practitioners, research and industry; and information access and sharing.

beyondblue www.beyondblue.org.au

beyondblue is the national depression initiative, a bipartisan initiative of the Australian, state and territory governments with a key goal of raising community awareness about depression and reducing stigma associated with the illness. The website includes information about depression and anxiety, treatments, assistance with staying well, frequently asked questions and links to other sites. There is a section on Depression and Suicide.

Mental health and wellbeing publications <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs>

A - Z listing of mental health and wellbeing publications.

Mindframe <http://www.mindframe-media.com/>

The Mindframe-media website has been developed by the Hunter Institute as an online companion for their Mindframe resource. Their website and their online Newsletter Mindframe News provide excellent research summaries about the media and mental health, and guidelines for media professionals, including information relevant to reporting on Indigenous and culturally and linguistically diverse issues. There are subsites for media professionals as well as the mental health sector.

American Foundation for Suicide Prevention <http://www.afsp.org/>

This website has an excellent section on Surviving Suicide Loss, with summaries of research on survivors and personal survivor stories.

The Suicide Paradigm <http://members.tripod.com/~LifeGard/>

This is an American site of general interest for those who have experienced suicide loss and those who want to know more about suicide and its aftermath. It includes information about suicide, pain management, loss and grief, frequently asked questions, discussion of ethical issues, research, and media coverage. There are links to some very useful downloads (e.g. Postvention Handbooks for First Responders and for Clergy; A Postvention Primer for Providers; and several self help booklets 'What everyone needs to know about suicide (and shouldn't be afraid to ask)' and a 'Handbook for those who have lost someone to Suicide'.

Support services:

Lifeline <http://www.lifeline.org.au>

Lifeline is committed to enhancing the wellbeing of the community through the provision of services, the core of which is a 24-hour crisis telephone counselling service. Its website also includes information about suicide prevention, risk factors, and suicide bereavement and postvention. For help finding services, call the Lifeline Information Service on **1300 13 11 14**.

Kids Helpline 1800 55 1800

Mens Line Australia 1300 78 99 78

24 hour counselling service for men

Bereaved Through Suicide (08) 8332 8240

An Adelaide based group aiming to: provide support and care to those grieving the loss of someone through suicide; provide an understanding of the process of grief; help with healing and recovery; increase the understanding of suicide grief in the community.
Email: support@bts.org.au **Note:** At the time of writing, their website (www.bts.org.au) is still under construction.

Living beyond Suicide (08) 83014200

This is an early intervention postvention response service funded by the Australian Government and provided by Anglicare SA Inc. From late in 2007 the project will provide emotional support for South Australian families affected by suicide bereavement. For more information go to <http://www.anglicare-sa.org.au/services/loss.html>

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for further information
www.square.org.au

erisups



Australian Government
Department of Health and Ageing



Government of South Australia
Department of Health

Relationships Australia
SOUTH AUSTRALIA

