Suicide survivors: Tips for health professionals

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The topic of suicide has always been defined by its silence -- we hide it, we deny it, we're ashamed to discuss it. This stigmatization is especially painful for suicide survivors whose overwhelming guilt and shame is often intensified and reinforced by society's lack of support and even outright finger pointing at what their role might have been in their loved one's decision to die.

Surviving the suicide of a loved one transports those who have been left behind into a world filled with confusion, shock, and chaos.[[1](javascript:void(0);)] Survivors feel they are somehow to blame for their loved one's death, that they should have had the foresight to see what was happening and been able to intervene. They try to find sense and rationality in the suicide, and many find it easier to tolerate their own failings than accept that someone they loved has died by their own will.

The taboo against suicide makes it difficult for survivors to discuss their loved one's death -- and life -- and many cover up, lie, or avoid the subject all together. This only serves to increase their feelings of isolation and dislocation from all that once seemed familiar and safe. In addition, the legal and religious issues surrounding death by suicide can be confusing, intimidating, and even frightening.

Many suicide survivors start off skeptical about getting help for themselves and their families, especially if their loved ones had been in any kind of analysis, therapy, or counseling at the time of their suicide. They reason that the professional should have seen the impending signs of anguish and despair, and either tried to intervene more actively, or told them what was going on, or both.

Survivors who do seek out help are often discouraged by a system that they perceive places greater emphasis on the whys and motives of their loved one's suicide than the pain and confusion that they are feeling. Others tell of going to mental health professionals who are uncomfortable with the subject of death or suicide or both, and who discourage them from joining suicide support groups.

On the other hand, a great number of survivors emphasize the crucial role that their mental health therapist had in their healing process. Many consider therapy a "safe place" where they can speak openly and without shame about a topic still considered off-limits and judged harshly even in today's society. Suicide is a death like no other, and those who are left behind to struggle with it must confront a pain like no other.[[2](javascript:void(0);)]

If you are a health professional treating a survivor, consider the route to care. This could take at least 3 different forms. Have you learned that the individual is a survivor in the course of history taking? Has the individual come to you with the loss of a loved one as the "chief complaint"? Is the individual already known to you because the deceased was your patient and you have met the person before?

When it is an incidental finding that the person is a survivor, how you respond is key. Try asking an open-ended question: "Describe your mom for me." "Tell me about finding your husband." How your patient responds should give you clues about their use of denial as a coping mechanism, how much residual pain may be still there, what might be some of the unexplored dynamics, and how much resolution of the loss has occurred. Some therapists unconsciously reveal their empathy in an almost reflexive way when the patient mentions losing a loved one to suicide. "Oh dear" or "I'm so sorry" are examples. If the death was violent and the patient describes it graphically ("Tell you about my dad? He blew his head off with a shotgun when we were eating Christmas dinner two years ago"), some therapists vocalize shock or horror (eg, "Oh my God" or "ugh").

When being a survivor is the reason for coming to you, never forget that the survivor is your patient, not the deceased. Allow exposition of your patient's story. Introduce structure and guidance only as necessary to facilitate expression of thoughts and feelings. Complete a thorough assessment as you normally would. In the family history, are there other deaths by suicide? If so, how does your patient feel about this? Assess your patient for suicide risk. But be careful and compassionate. Your differential diagnoses may range throughout DSM-IV. Medication may or may not be indicated. A thorough dynamic history will help you to appreciate possible or potential transference issues with you. Be sensitive to language -- never say "successful suicide." Some people may have ambivalent or angry feelings about the expressions "committed suicide" or "completed suicide." Most acceptable are "died by suicide," "suicided," or "killed herself" or "killed himself."

If the deceased was your patient, clarify whether the survivor has consulted you simply to understand better, to have questions answered, and to receive some consolation. Or has the person come for assessment and ongoing treatment? Consider the range of emotions that this person may have about their loss, you as their loved one's caregiver, and your integrity and strength. This may be very confusing and contradictory. Although your deceased patient's confidentiality continues after death, you will be able to help the survivor(s) with your attitude (empathy, kindness, active listening), your professional responses about losing someone to suicide, and suggestions of community resources.

Examination of countertransference is essential in providing exemplary care to suicide survivors.[[3](javascript:void(0);),[4](javascript:void(0);)] How comfortable are you with deaths by suicide as a possible, potential, or probable outcome at times of your professional work? How interested are you in healthy introspection? How open are you to therapy for yourself? Are you in supervision with someone or do you have access to a mentor? Do you work in isolation or with others? Remember that when we lose a patient to suicide, we become a survivor ourselves. We need to grieve too -- at the same time that we are expected to continue to help grieving loved ones -- and our other patients who have no idea what we're coming to terms with. Hopefully, our ability to identify and to empathically connect with other survivors helps us to simultaneously heal ourselves as we endeavor to help others.

1. Fine C. No Time to Say Goodbye: Surviving the Suicide of a Loved One. New York: Doubleday; 1999.
2. Jamison KR. Night Falls Fast: Understanding Suicide. New York: Alfred A. Knopf; 1999:292.
3. Gitlin MJ. A psychiatrist's reaction to a patient’s suicide. Am J Psychiatry. 1999;156:1630-1634. [Abstract](https://www.medscape.com/viewarticle/$$intapp$$/px/medlineapp/getdoc?pmi=10518176&cid=med)
4. Hendin H, Lipschitz A, Maltsberger JT, et al. Therapists' reactions to patients' suicides. Am J Psychiatry. 2000;157:2022-2027. [Abstract](https://www.medscape.com/viewarticle/$$intapp$$/px/medlineapp/getdoc?pmi=11097970&cid=med)