



MENTAL ILLNESS AND SUICIDE

A Family Guide to Facing and Reducing the Risks

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Mental Illness And Suicide: A Family Guide To Facing And Reducing The Risks is the result of a joint project of the World Federation for Mental Health and the World Fellowship for Schizophrenia and Allied Disorders. This joint project was undertaken and completed during the process of merging the World Fellowship for Schizophrenia and Allied Disorders into the organization and program structure of the World Federation for Mental Health.

Disclaimer

This guide is for information only and is not intended as treatment or counseling or as a substitute for professional advice. Much of the content has been provided by families from their bona fide experiences and from the experiences of those who have attempted suicide. If you need clinical care, professional advice or counseling, please contact your mental health care provider.

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Introduction

Mental Illness and Suicide: A Family Guide to Facing and Reducing the Risks has been developed as an adjunct to the World Federation for Mental Health (WFMH) World Mental Health Day theme for 2006 and its monograph: Building Awareness – Reducing the Risk: Mental Illness and Suicide (2006).

The World Fellowship for Schizophrenia and Allied Disorders (WFSAD), recently merged with WFMH, had envisioned a suicide prevention project that would focus on the families/caregivers of those with psychiatric disorders. The objective was to help make families aware of the higher risk that the mentally ill face for suicide and to give them skills that might help. Under the auspices of WFMH, that program has now come to fruition in the form of this guide and attendant workshop and literature.

Generous funding was provided by H. Lundbeck A/S, Eli Lilly and Company and the Charles E. Kubly Foundation.

The Rationale for This Guide

More than 90% of all cases of suicide are associated with mental disorders such as depression, schizophrenia and alcoholism. Therefore, reducing the global suicide rate means effectively addressing the serious and growing burden of mental illness around the world.

Dr Benedetto Saraceno, Director of the Department of Mental Health, WHO

The principal findings are now well established. For example, approximately 25% of all people who die by suicide have been in contact with mental health services in the year before death; half of these have been in contact with mental health services in the week before death; suicides cluster in the first year after onset of illness; and 63% of those who die by suicide have a history of self-harm.

UK Department of Health (1999a) Safer Services: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. London: Department of Health.

While professionals in developed countries are often introduced to suicide prevention and risk prevention programs through their teaching bodies and continuing education programs, in the developing world few such opportunities are available. Families in “the West” have some, if limited, access to information through a growing number of suicide prevention programs, while those in the developing world often have little or no access to such programs.

The World Health Organization (WHO) has produced, with the assistance of experts from around the world, a series of guidelines that have a critical role in suicide prevention. The guidelines are for a variety of audiences including health workers, teachers, prison officers, media professionals and survivors of suicide. These resources are now available in more than a dozen languages.

This guide extrapolates from these – and other sources – suicide information that will be useful for families/caregivers and for those with mental illness in both developing and developed countries. Our researchers have worked from evidence-based materials, and from the personal experiences of numerous families through our large network of families and friends of the mentally ill.

WFMH, through its Center for Family and Consumer Advocacy and Support, has undertaken the development of this guide based on scientific evidence that specifically focuses on 1) the families of people living with mental illnesses and 2) those who are unwell with psychiatric disorders, sometimes called “consumers” (or “users” in Europe and elsewhere). The work takes into account the paucity of mental health services and the almost non-existent suicide prevention programs in many parts of the world.

In developing the guide we have taken into account the Principles of Suicide Prevention Effectiveness taken from the Suicide Prevention Resource Center at <http://www.sprc.org/library/prevtoolkit.pdf> (see Table 1). We hope that our readers who are about to embark on suicide prevention workshops for families and caregivers will consider these principles as they roll out their program.

Principles of Suicide Prevention Effectiveness

Table 1

- » *Prevention programs should be designed to enhance protective factors. They should also work toward reversing or reducing known risk factors. Risk for negative health outcomes can be reduced or eliminated for some or all of a population.*
- » *Prevention programs should be long-term, with repeat interventions to reinforce the original prevention goals.*
- » *Family-focused prevention efforts may have a greater impact than strategies that focus only on individuals.*
- » *Community programs that include media campaigns and policy changes are more effective when individual and family interventions accompany them.*
- » *Community programs need to strengthen norms that support help-seeking behavior in all settings, including family, work, school and community.*
- » *Prevention programming should be adapted to address the specific nature of the problem in the local community or population group.*
- » *The higher the level of risk of the target population, the more intensive the prevention effort must be and the earlier it must begin.*

- » *Prevention programs should be age-specific, developmentally appropriate, and culturally sensitive.*
- » *Prevention programs should be implemented with no or minimal differences from how they were designed and tested.*

The Overarching Goals of the Guide Include:

- To help reduce the risk of suicide among people living with serious mental illnesses through focusing on informing families/ caregivers
- To build awareness and skills among family caregivers of people living with serious mental illness
- To introduce preventative support systems to families in all parts of the world (serving families and caregivers in both developed and developing countries)
- To recognize the emotional distress and trauma from suicide and suicide attempts that is common to all families no matter where they live

For Whom is the Guide Intended?

This guide is intended for all family caregivers and consumers, through providing it to family and consumer self-help and support organizations, as well as to mental health services with family programs, among the WFMH membership and beyond. The guide and accompanying workshop facilitator's handbook will be advertised on the WFMH website and will be available to the general public through the Center for Family and Consumer Advocacy and Support section of the WFMH website (<http://www.wfmh.org/00CtrCarerConsumer.htm>). The program will also be provided on CDs or through downloading the files. Workshops will be held at various conferences and WFMH congresses in order to introduce the Guide to a wider audience.

Section 1

Talking about Suicide

Not until it is “OK” to be mentally ill, as it is to be physically ill, will we as a society have, at last, accepted the reality of mental illness as part our human existence. Not until our everyday language becomes sensitized to the need to eliminate stigma will we address the needs of those suffering from mental illness. Anyone may suffer a mental illness. Anyone may die by suicide.

(Dan Neville TD, President, Irish Association of Suicidology)

We will talk about, and quote from, the traumatic experiences of families and sufferers relating to suicide as we progress, but first let us think about the various views expressed by the general public.

Separating the Facts from the Myths

Remember that suicide can only be understood within the context of the individual culture, which must be the basis for any suicide prevention program and will also influence the reactions to the 10 statements provided below. An example of considering the cultural context of suicide is that in some countries suicide is still considered a criminal offense and this will influence how people there think and behave.

The “comments” that follow the statements center on whether they are true, false, or whether there is a “grey area” somewhere in between. We trust that these will give an overview of the topic, rather than an in-depth debate.

Read the statement, cover the comment/discussion with your arm and consider what you think about the question. If you are reading this on your own consider asking any family members what they think. Is it right, wrong, true, false, or some of all of these? You may decide upon different answers to the ones given, but this exercise will get you thinking and as we continue you will see how we reached these conclusions.

1. The people who talk about suicide don't do it.

Comment: Not all people talk about it, but when they do, they should be taken seriously and asked about it. Ways of asking are discussed in Section 4

2. People with mental illness have a high incidence of suicide.

Comment: Those with serious depression are very likely to attempt suicide and have a high incidence, particularly if they are not taking medication for the condition. Of those with schizophrenia, the figures for suicide are 10% of those suffering the disorder. This figure was calculated for a 10-year period of illness.

3. The problems people have are not enough for them to take their lives by suicide.

Comment: No one can judge what is important or not important in another person's life. What is important to one person is not important to another. Young people may consider things important that an older person would not. We cannot estimate other people's trauma or mental anguish.

4. If someone is going to die by suicide nothing can stop them.

Comment: In general people want to live and by using a caring approach to finding out what has brought the person to this situation, and by learning how to approach a person, the event may be averted in some cases. In persons with mental illness it is useful to speak about the amazing research that is now happening that will provide better medications and treatment to help their symptoms and promote recovery.

5. If a person is thinking about suicide, a weapon close by may precipitate it.

Comment: Availability of a poisonous chemical, knife, gun, etc. may precipitate the act of suicide. If you have suspicions that a person may take his life, try to remove any temptation to do so.

6. When people seem to cheer up it is a sign that the danger is past.

Comment: For those who have mental illnesses there is a great risk when there is an apparent upturn in a person's condition. Sometimes, new insight into their illness can make people vulnerable to suicide attempts. Take as much time with the person now they seem a bit better as you did when they were very ill.

7. Suicide or attempted suicide usually happens without warning.

Comment: There are nearly always warning signs that someone is thinking about suicide for people who are closely involved with the person. These could be things they say or things they do which might not be in character with usual behavior. However, these signs are not always obvious so we must be vigilant.

8. People who attempt suicide are just seeking attention.

Comment: Anyone who attempts suicide is seriously thinking of ending their life. Take any attempt seriously and talk to the person about it. There is also the possibility that this is a cry for help, so that your care and attention and willingness to talk about it may be just what the person needs.

9. Assisting people who are thinking about suicide can help prevent it.

Comment: Through seriously asking a person the right questions and listening to them, it is quite possible that the person will see that there are good reasons for living.

10. Suicide occurs mainly in the rich/poor.

Comment: No one is immune. Everyone has thoughts and feelings. Anyone can suffer intolerable stress, pressure or pain that can put them at risk.

The 10 statements above and subsequent comments/discussion of them will have given you some idea of suicide as it could relate to you and your family and culture. In many countries suicide is highly feared. Certain religions consider it a sin so that relatives can feel a great deal of shame about a family member's suicide attempts as well as actual suicides. Society's solution can also be to ignore suicide and this makes it equally difficult when you are dealing with someone who could consider it.

When families take part in education courses on mental illness, there is a great deal of emphasis on dealing with a crisis but rarely is the crisis of a possible suicide given more than a page or two. Thus even families who have made the effort to educate and inform themselves often do not get in-depth information about the possibility of suicide. It is only when their loved ones intimate that they are thinking about suicide, or the family picks up clues about this possibility that the family realizes how little they know.

It is as well to prepare in advance even when no risk is perceived.

Some readers are likely to have been traumatized by suicide attempts of their family member(s) with mental illness. They are coping with both serious mental illness (SMI) and the threat of suicide. Both the guide and the workshop that is part of this program have made every effort to be sensitive to this highly charged emotional subject.

It is not common to talk about suicide except to really close family members and even then the subject is difficult. The possibility of one of our loved ones taking his/her life is more than most of us can bear and the thought that we might not have recognized the symptoms or realized the serious nature of the individual's thoughts and feelings is intolerable.

In this guide we hope that you will learn more about how to prevent or at least reduce the risk of someone you love dying by suicide, through better understanding of some of the reasons that people take their own lives.

Mental Illness is Only One Part of Your Relative

Too often people classify a person with serious mental illness through their illness, thinking of them as the disorder they have, and not as a person who happens to have a mental disorder. This leads to an impersonal approach to the person. Even families can be guilty of this, e.g., talking about them as if they are not in the room – and this is particularly so when the person is acutely ill. As the person comes out of his psychosis it is important to encourage normal activities and normal conversations, so that the whole family can see the individual who is ill apart from the disorder. Some dreams may be lost due to illness, so it is important to build new, perhaps simpler dreams for the future.

It's not Easy to Talk About Suicide

If you have heard of anyone who attempted or died by suicide it is unlikely that you have given it more than the occasional thought. When suicide comes closer to home, with a friend or neighbor, you realize how difficult it is to speak about it and how conflicted are people's emotions about it. Where do you find the words and what are the right words to say? It is a fearful subject and remains close to a taboo subject no matter where it happens.

Here is a small part of one family's experience.

It was the first time I saw my son on a gurney. He lifted up his head and asked, "Mama? Where am I?" and started to weep. It took us all night to get the truth out of him, while he lay flat on his back and hallucinated. That night it went from teenage rebellion to something much more frightening.

Sueann Jackson Land. Globe and Mail, Jan 3.2009

People who attempt suicide are often frowned upon and made to feel ashamed. The families of those who die by suicide often feel a great responsibility – the great shame of failure. There should be no shame. Suicide is the result of severe psychic trauma and is not easily or willingly chosen by those who attempt it, nor is it easily foreseen by friends and family.

Section 2

Understanding Suicidal Ideation*:

Why People Commit Suicide; What's Going on in Their Minds

Now let's look at the underlying factors that contribute to why a person may contemplate suicide.

Key Factors Underlying Suicide Risk

1. Major Depressive Disorder

The risk of suicide in people with Major Depressive Disorder is about 20 times that of the general population. Individuals who have had multiple episodes of depression are at greater risk for suicide than those who have had one episode.

(From the American Association of Suicidology document, Facts about Suicide)

Suicide can be accomplished in a sudden impulsive act or a carefully planned event. It usually occurs during a depressive or a mixed episode, but some people with bipolar disorder kill themselves accidentally or on impulse when they are psychotic and in the manic phase.

(From the Bipolar Disorder Survival Guide by David Jay Miklowitz. Guilford Press)

It is very important for a family to understand what a relative with major depression is going through. Families should inform themselves of the symptoms of major depression in order to be able to understand, make allowances for, and possibly help, their relative who is unwell.

Communication is often the key. The following list of symptoms will alert you to the onset of an episode of depression. They do not in themselves indicate suicidal thinking.

* Definition of "suicide ideation": ideas and concepts about suicide; mental health professionals use this term.

Characteristic Symptoms of Depression

Depression may be experienced very differently from person to person. The symptoms need to be severe enough to interfere with daily living and/or work activities to be considered an indicator of major depression. Four or more of the nine symptoms below, lasting for two weeks or more, require professional help.

- Noticeable change in sleep pattern
- Noticeable change in appetite
- Decreased ability to experience pleasure, e.g., loss of interest and pleasure in things formerly enjoyed
- Feelings of worthlessness, hopelessness, emptiness, helplessness
- Inappropriate guilt and self blame
- Problems with thinking, concentration and attention
- Recurrent thoughts of death or suicide
- Overwhelming sadness and grief
- Physical symptoms, fatigue, loss of libido

People also report the following symptoms:

- Depressed mood
- Decreased ability to make decisions
- Physical aches and pains
- Despondency
- Lack of motivation
- Becoming withdrawn
- Preoccupation with negative thoughts
- Self-blame
- Unreliability
- Excessive drinking
- Mixed-up thoughts
- Restlessness
- Anxiety
- Irrational fears and phobias

When people are severely depressed it is difficult to know if you “have got through” to them in your conversations. They are so “enclosed” or “weighed down” by their symptoms that conversations with them will be difficult. They may not be able to respond in any meaningful way. They often feel that they cannot endure another day. There will be more on this later in this guide.

2. Severe Mood Swings

People with bipolar disorder who experience severe mood swings that take them from depression to mania and back are at high risk for suicide. Not only do they experience the symptoms of depression listed above, they also experience mania. The symptoms listed below will alert you to the symptoms of mania. These symptoms do not of themselves indicate a risk of suicide.

Characteristic Symptoms of Mania

- Inappropriate elation
- Inappropriate irritability
- Severe insomnia
- Grandiose notions
- Increased talking
- Disconnected and racing thoughts
- Increased sexual desire
- Markedly increased energy
- Poor judgment
- Distractibility, can't concentrate well
- Spending sprees
- Inappropriate social behavior
- Euphoric mood
- Provocative, intrusive or aggressive behavior
- Lack of insight into the condition

(See also Appendix 1 - a pamphlet on “Warning Signs of Mental Illness, Managing a Crisis, the Risk of Suicide”)

3. Presence of Psychotic Symptoms

Command Voices

Many people with schizophrenia or bipolar disorder – and in some cases with depression – hear voices. These voices may be uncomfortable, demoralizing, threatening or commanding. By no means all people with a psychotic disorder suffer command voices and the majority of these do not act upon them. However, it is possible that someone can die by suicide as a result of acting on his/her voices. Voices are very real to people and are not like thoughts running through one's head, but rather like someone in the room telling you to do something. An example would be voices telling them that by jumping off a certain bridge they will save the world from destruction. These voices are very intrusive. However, they can usually be controlled by antipsychotic medications.

Thought and Cognition Difficulties

Many people have no insight into their psychosis and no idea that their cognition could be impaired. This lack of insight may be a protective factor against suicide. However, when psychotic symptoms abate and the person is not in an acute state, suicide may seem like an escape from a constantly muddled mind and the psychic pain that many people describe.

4. Family Susceptibility or History

Other people in the family have previously attempted or died by suicide; this action may seem like a credible solution to the person's problems.

History of Impulsivity; Aggressiveness and Risk Taking

Impulsivity has also been associated with death by suicide and is one of the most frequently implicated risk factors for engaging in maladaptive behaviors, such as serious self-injury (Anestis, Selby, & Joiner, 2007). However, recent research has shown that although people who attempt suicide tend to be more impulsive than those who do not, the actual act of suicide is generally not done impulsively. Despite these findings, there unfortunately continues to be a widespread misconception that the majority of suicides, particularly in adolescents, are impulsive in the moment (e.g., Carey, 2008).

(Revisiting Impulsivity in Suicide. A.R. Smith, T.K. Witte, et al. Behav Sci Law. 2008; 26(6); 779-797)

According to other research, suicide ideation may indeed have links to people with impulsive personality characteristics. Higher impulsivity seems to have been found in people who have made previous suicide attempts. However, it is difficult to tell whether people act impulsively or whether they have been planning suicide without appearing to give any advance notice to friends and family. Just because your relative may have acted impulsively in other areas of their lives does not necessarily mean that they will act impulsively with regard to attempting suicide. It seems that there is no definitive evidence for suicide being commonly a result of aggressiveness, risk taking or impulsivity.

Habitual Intense Anxiety

We all get anxious from time to time, especially with the expectation of new experiences, examinations, meeting new people. However, habitual intense anxiety is a continual and heightened experience of anxiety that creates extreme stress in the individual. Getting on a bus is a difficult challenge. Walking down a busy street can be equally stressful. Living your life with constant anxiety may provoke thoughts of suicide. Anxiety can be treated with medications that can be of great help to sufferers. Therefore it is important to get medical treatment to help reduce these distressing symptoms.

Section 3

Risk Factors that may Trigger Suicide:

Ideas to Reduce their Effect

Everyone may be at risk of suicide at some time in their lives depending on circumstance, but the focus of this guide is those with serious mental illness (sometimes called SMI). Suicide “triggers” refer to factors about a person’s condition and/or in their environment that may provoke the action of suicide. Such things may not be triggers to some, while they can be significant triggers for others. Reducing or eliminating these may help to reduce and redirect the person’s thoughts and actions concerning suicide. One important risk factor is the existence of a previous suicide attempt. See Table 2 in Section 4 for a summary of the more important risk factors.

Internal Emotions and Feelings as Triggers and Warning Signs

“Suicide is not chosen; it happens when pain exceeds resources for coping with pain.”

(From: <http://www.metanoia.org/suicide/>)

Impaired Reasoning

Some people with severe mental illness may have impaired reasoning due to their condition. People with thinking difficulties or muddled thinking may misunderstand the motives of the actions of their family, friends or others. This may result in all kinds of difficulties and misunderstandings, even provoking the person to self harm. Problems of thinking (called cognitive problems) are generally not very responsive to medication.

Family should keep communications simple and short and regularly express their regard for the person. Arguing about any misunderstandings may simply escalate difficulties.

Avoidance of Social Contact – Withdrawal

In all the serious mental illnesses, withdrawal can be a problem. Young people with schizophrenia isolate themselves in their bedrooms. People with depression tend to stay in bed a lot of the time. It is difficult to know exactly the reason for this but the complex surroundings of a normal life may be too much for the person who is dealing with a considerably active or traumatic inner life.

Reach out carefully to the person despite their withdrawal. Forcing someone to join in with family life does not usually have the desired result. Gentle persuasion to be involved one on one with family members may be of benefit. It may also help to talk with the person about their withdrawal and show a genuine desire to understand. Ask questions and LISTEN to the answers (see Section 4: What To Do When Suicide Seems Likely or Imminent).

Hopelessness – Depth of Depression

People with serious mental illness often have feelings of hopelessness. Those with depression have seriously low moods that are difficult to change, even with medications and/or psychological therapy.

Be tolerant, loving and encouraging, raise the person's spirits in some way to encourage feelings of self worth. Learning more about SMI is the key to understanding. Try to persuade other family and friends away from criticism and negative attitudes.

Sense of Being a Burden

People with SMI may believe that they are a burden to their families through their illness or other factors in their lives. They may feel that their families or friends would be better off without them. They may describe themselves as bad people.

If a family suspects that this is what their relative is feeling, efforts can be made to make the person feel valued as a good person, and wanted, needed and loved. Love, trust and sincerity are all important. Family education about mental illness often helps family caregivers to be less burdened, or to be more adept at managing, and coping with, the burden (if it is considered a burden) or stresses of caring.

Sleep Disturbance

Sleep disturbance and sleep deprivation are well known to disorient people. Encourage the person to get up and stay up and engage in walking or other physical activity so that when it is bed time the person feels tired.

Feeling Isolated and Alone

For many reasons a number of people with SMI leave the family home to live in their own apartment or a group home, or other residence. They have few friends frequently, so that opportunities to talk and share experiences are limited. A 2008 study by the national mental illness charity in Australia, SANE, discovered that many people with SMI hadn't touched another person in a whole six-month period.

Though you may not live with your relative you should keep in touch with them regularly, if possible call them on the telephone, drop in to talk to them and leave a greeting/post card if they are out. In general make them feel needed and wanted. Other family members can be encouraged to do their part; siblings and cousins can plan to meet the person for tea or go on some other pleasant activity (other than going to the doctor).

Lack of Self-Esteem

After several years of illness, and even before that, many people lose their self-esteem when any efforts they make to secure a good future are dashed (e.g., inability to get or to keep a job).

In many cases SMI causes moderate or severe impairment, so that encouraging them to do small tasks around the home can help, both to raise esteem and build trust and a loving relationship. For example, you can ask the person to help shop for and carry home groceries. Gardening is another pleasant activity to share. Versions of activities the person used to do before getting sick can also be considered, so long as they are not too demanding. Do not be annoyed if they are not done as well as you had hoped.

External Events and Influences as Triggers and Warning Signs

Substance Abuse

People with SMI are very prone to substance abuse whether it be binge drinking, serious abuse of alcohol or the taking of street drugs. It is difficult to tell families that they should not tolerate such behavior when zero tolerance can lead to homelessness, incarceration and more. Substance abuse may provoke impulsive behavior.

Be extra vigilant. To buy drugs and alcohol the person needs money. If the person comes to his family for money be sure to limit amounts given. Try to explain that there are consequences to such actions and that you are worried. Ask why your relative needs to do this. It may not be for the reasons that you have in mind. See if you can assist in some way.

Quarrels and Upheavals in the Family

Disagreements and quarrels are common in all families but are often more common in families where everyone is trying to cope with mental illness.

Family caregivers should learn as much as possible about the illness that their loved one has in order to recognize what is illness and what is not. Keeping a positive approach and restricting angry outbursts to when you are alone may help reduce friction. Family members as well as their relative who is unwell may have had their hopes for the person dashed but they must not blame their relative for this or indicate any disappointment.

Release from Hospital/Premature Discharge

It has been documented that on many occasions SMI patients are discharged without being fully stabilized and sometimes without their family's knowledge, certainly without a discharge plan. Discharge planning is essential to assure a good outcome for the person, transferring his care to mental health services in the community and to his home and family. Sending the patient out of the hospital with no plan has sometimes had unfortunate results including harm to self and/or to others.

As soon as your relative is admitted to hospital seek to be involved in the planning for his discharge and maintain communication. Make sure your name and contact procedure are known to the persons responsible for his/her hospital stay.

Improved Condition – Increased Insight

When people are very sick with SMI they may have no insight into their condition. They continue to rely on a brain that is not functioning normally and do not see that anything has changed. After

the treatment of acute psychosis or reduction in depressive or manic symptoms, people often see their situation more clearly, especially if they do not feel recovered in any way.

Thus families must be extra vigilant when their relative improves, especially after discharge from hospital. Take extra care to maintain contact and a helping relationship with the responsible hospital staff.

Negative Life Events – Severe Disappointments

The death of a relative or other loved one, the death of a pet, the break up with a partner – all of these are extremely emotional events that cause a great deal of trauma to all human beings, well or unwell. For those with SMI these events may be even more traumatic.

Do not exclude your ill relative from funerals or other expressions of grief, thinking to save them. At these times it is more important than ever to be inclusive. Assign another family member or friend to accompany your ill relative if there is a special gathering or other event.

Suicide Reports in the Media; Celebrity Death by Suicide

It has been well documented that front-page suicides reported in the media result in a number of “copy cat” suicides. Many newspapers now report any local suicides on an inside page and avoid tabloid type reporting.

It is best not to discuss in any detail any local event of this kind with your relative or within their hearing. By this we do not mean that suicide should not be discussed, but rather it should not be discussed in relation to media reports.

Incarceration

Jail is no place for a person with SMI who has committed only a minor crime. However, with few courts that are especially set up to deal with those with SMI, people are often given short or not-so-short jail terms.

Let the justice system know that there is a caring and interested family involved to minimize the trauma of incarceration. In some jurisdictions it is permitted for the family to submit a letter to be read by the judge. Be sure to visit the person and to assist in their release. Avoid using the criminal justice system as a means of getting your relative treated. Inevitably this does not turn out well.

Teasing, Cruelty, Rejection, Bullying

Few are more susceptible to rejection, teasing, bullying and cruelty than those with SMI. There is little a family can do to reduce these external factors. Trying to ensure that the person is dressed neatly and appropriately can help disguise any outward appearance of mental instability, but probably the best support is to show your respect for your ill relative at all times regardless of their appearance or behavior.

Employment or Occupational Problems

Society defines people by their occupation. “What do you do?” is a very common question when you meet a person for the first time. Many people with SMI want a job just as everyone does, but finding one can be difficult. What’s more, because people with SMI usually need a bit of extra guidance when they take a job it is sometimes difficult for them to stay employed. Though many people do not divulge their SMI to their employer, some employers are more understanding if they know about it, and may be prepared to make adjustments to the job to make it easier to keep. The job you did before you became unwell may not be the job for you at this time. Taking a high stress position may result in failure.

Marital Difficulties Due to SMI or for Other Associated Reasons

Marriage can be difficult for a person with mental illness, especially if the spouse has no understanding of the condition. For many people, even with understanding, living with someone who has SMI is difficult and stressful. For many, living with a spouse who is mentally ill becomes too much for their own mental health and in many cases separation occurs which may put the unwell person in an unstable and “at risk” position.

However, sometimes separations work out for the better, especially when there are family and friends to give emotional and perhaps financial support. Before such a situation occurs, practical support from family will often reduce the stresses that the couple is feeling. Marriage is a very private affair. People are loath to tell other family members about their marital problems unless these become very obvious, so it may be difficult to provide help.

Lack of Appreciation, Neglect and High Levels of Criticism by Family

High levels of criticism that are not accompanied with any sense of a strong bond of love are well known to worsen a person’s SMI. People with SMI are not to be blamed for their illness. It is no one’s fault.

The family should retain their sense of respect and love for the person because s/he has to fight every day to live as normal a life as possible in a society that generally does not understand what the person is going through.

Avoid pushing your relative too hard, for example, to succeed or to get better. The family may have high expectations for the future of the person that need to be adjusted to a level more suitable for someone coping with mental illness

Medications - see Section 5

Section 4

Do You Feel Suicidal Now?

I know when I woke up in Critical Care in the Hospital and saw my father holding my hand beside the bed that I was glad to be alive.

(Grace – personal communication)

If you are in severe mental pain, and considering suicide, talk to someone. Your life is worthwhile, even if you do not think so at this moment. You have unbearable pain; try to share it with someone right now. Please do not do anything rash.

You Need to Talk to Someone Right Away

You need to talk to someone who will understand the extreme distress you are feeling. Tell yourself that you do not need to die now. Consider that you could put it off for a day, or two days or even a week. Confide in a close friend or family member. Phone or meet someone close to you who knows what it is like to think of taking one's life. It may be a nurse or doctor you know. Such a person might be reached at the contact numbers and addresses below.

- Send an anonymous e-mail to The Samaritans. <<http://www.metanoia.org/suicidelsamaritans.htm>>
At this address you can find contact numbers in all parts of the world. You can also email to jo@samaritans.org
- Call 1-800-SUICIDE in the U.S.
- Go to <http://suicidehotlines.com/> - also for hotlines in the U.S.
- http://www.iasp.info/resources/Crisis_Centres/?s=Help=1 – centers like The Befrienders and other suicide organizations in all parts of the world.
- The International Association for Suicide Prevention <http://www.iasp.org>
- If you live in India, telephone or email SNEHA. Helpline Phone: 91-44-2464 0050; Helpline Email: help@snehaindia.org
- Go to <http://www.metanoia.org/suicide/>

- Look in the front of your phone book for a Crisis or Distress Line. If you feel too exhausted or confused to do this, please ask someone to help you.
- Call a psychotherapist or call your family doctor or your psychiatrist.
- Carefully choose a friend or a minister, rabbi or imam, someone who is likely to listen to you.

Avoiding Suicidal Thoughts and Feelings

An extract from *Monochrome Days* – A first-hand account of one teenager’s experience with depression. Cait Irwin. Pps 44-45. Oxford 2007.

It was only a few weeks before that I had first considered suicide as a legitimate solution to my problems. Now my last reason for living was fast slipping away. My love for family and friends was no longer strong enough to battle the irrational thoughts that were tumbling through my brain. My last thread pulled apart. My spirit instantly flooded with enough hopelessness to make me feel mortally wounded. I wanted to die. I needed to end this pain now.

My mind was made up. Suddenly, with eerie calm, my body was ready to join the spirit that had died weeks before. I felt like a preprogrammed robot as I swung my legs out of bed. I walked across the room to my art desk. With strange detachment, I thought of the many creative moments I had spent at this desk. Now it was only the place where I was choosing to die.

I clicked on the desk lamp and reached for my box of carving knives. Inside the box were two handles and a row of different shaped Exacto knife blades. My art supplies had become my means of self-destruction. In retrospect, our lack of knowledge about depression was what kept all these tools within easy reach. When I picked up one of the knives, I believed that I was making a logical choice, but my “logic” was far from rational at that moment. The metal handle felt cool and dry in my sweaty palm, and all awareness of the outside world slipped away.

You might say that what happened next was divine intervention, mother’s intuition, or just dumb luck. But right at that moment, my mom walked to the foot of the stairs and called up to me. She asked if I was all right, because she knew I had been having trouble sleeping. She had stayed up late because she couldn’t sleep either.

Her voice cut through the darkness and struck me so hard that I was knocked back into reality. Suddenly, seeing what I was about to do, I was filled with fear and self-loathing. With a shaky voice, I lied and called back that I was okay. But in truth, I was utterly terrified. For a moment, I had welcomed and accepted suicide. It’s extremely unnerving to realize that you have managed to outwit the basic human instinct telling you to do whatever is necessary to survive.

I turned off the desk lamp and quietly climbed back into bed. My body would not stop trembling, and I felt queasy. As on so many other nights, sleep did not come. But I remained there, secure in my bed, as the final hours until morning ticked away.

For Family and Friends:

Warning Signs of an Imminent Suicide Attempt

The following are indicators that a relative or friend may be about to attempt suicide. The person may:

- Have unusual changes of mood or calm (possibly following making the decision)
- Be preoccupied with unsolvable problems; preoccupied with death
- Appear to be putting their life in order – arranging things or giving personal items or money away
- Have withdrawn from friends and family
- Seem unable to relate to others
- Have definite ideas of how to die by suicide
- Express extreme feelings of failure, uselessness, emptiness, disappointment and hopelessness

What to Do When Suicide Seems Likely or Imminent

If the threat of suicide seems imminent it is already too late to make a plan to help you make the right decisions. If you suspect that the person is thinking about suicide “now” by actions or words, find out how imminent suicide is by asking direct questions:

- Do you have a plan about suicide?
- Do you intend to commit suicide?
- How will you do it?
- Have you all the things you need to do it?
- When have you planned to do it?

The answers to these questions may give you the time you need to try and avert it by getting in touch with the psychiatrist, emergency services, etc., and by keeping the person involved with you and away from their plan.

Table 2 describes warning signs of suicide.

What Warning Signs Should You Watch For?

Table 2

Along with other signs of depression or mania, watch for these red flags that may signal suicidal thoughts or feelings in an adolescent:

- | | |
|--|--|
| » <i>Withdrawal from friends, family and activities</i> | » <i>Making statements such as “Nothing matters anymore”, “I won’t be a problem much longer”, or “You won’t see me again.”</i> |
| » <i>Violent actions, rebellious behavior, or running away</i> | » <i>Giving away prized possessions, throwing out important belongings, or otherwise putting his or her affairs in order</i> |
| » <i>Drug or alcohol abuse</i> | » <i>Becoming cheerful overnight after a period of depression</i> |
| » <i>Unusual neglect of his or her appearance</i> | » <i>Having hallucinations or bizarre thoughts</i> |
| » <i>Inability to tolerate praise or reward</i> | |
| » <i>Describing himself or herself as a bad person</i> | |

(Taken from If your Adolescent Has Depression or Bipolar Disorder – An Essential Resource for Parents, Oxford University Press. 2005 www.oup.com, pp. 56/7)

Non-Imminent But Still Serious Situations

In situations you believe suicide is non-imminent but still a serious risk, you may be able to determine the person's state of mind by less direct questions. Ways of going about this are suggested below.

You must be absolutely sincere in your approach to the person. Don't be afraid to ask the questions in the list below. From the answers you will establish exactly what the situation is and obtain an idea of what you need to do.

1. Have you a plan to die by suicide? How? And how soon? (The more complete the plan the more likely the person is to act upon it.)
2. What is the pain you are experiencing like; can we find ways to ease the pain?
3. Are there times when the pain lifts? How do you feel then?
4. Do you have anyone, anything that you can call upon to help you?
5. Have you attempted suicide before?
6. Are you seeing your doctor or mental health worker regularly and often?

Tables 3 and 4 contain ideas that are taken from the pages of authors with expertise in family caring for people with mental disorders.

Special Interview Suggestions

Table 3

- » *Suicide is a sensitive and personal matter. Talk to the person in private. Give her/him enough time to feel comfortable and to share her/his reasons frankly*
- » *Do not make judgments about character*
- » *Do not make reassuring statements without fully understanding the situation because this may make the person feel even more hopeless*
- » *Talk to family or friends for their version of the person's recent life situation and health. You may need to form a trusting relationship with one person who can help support the individual at home.*

(From Surviving Manic Depression by Torrey and Knable. Chapter 13, pps.256, 257)

In their book *The Complete Family Guide to Schizophrenia*, Kim T. Mueser and Susan Gingerich (pages 215-218) suggest questions that will elicit the kind of information that you need to know (Table 4). You will notice that the danger of suicide increases with each question.

- » *Have you been feeling sad or unhappy?*
- » *Does it ever seem like things will never get better?*
- » *Have you felt so bad that you thought about hurting yourself?*
- » *Do you have any thoughts of ending your life?*
- » *Have you had thoughts of how you might kill yourself?*
- » *Have you made any plans to do so?*
- » *What are your plans? What do you intend to do? When do you plan to do it?*
- » *Is there anything that might hold you back, such as people you care about, religious beliefs, responsibilities to others, or something you still want to do or see?*

Can the Event be Averted?

Here are a variety of suggestions that may avert the person from acting:

- Call or contact the person's mental health professional immediately and advise them of the urgency of the situation
- Call your local Crisis Line telephone number if one exists. This is often to be found in the front of the telephone book
- Ask a close friend of the person in crisis to come and talk with their friend
- Stay with the person
- Get a promise not to use alcohol or drugs if these are a factor
- **Give hope:** talk about alleviating his/her problems; attempt to ease loneliness and pain; listen rather than talk, using the tips for listening below:
 - * *Do not judge – just listen carefully*
 - * *Avoid inserting your own opinions*
 - * *Focus on what the other is saying*
 - * *Ask questions that involve their thinking and feeling*
 - * *Let the other person direct the conversation*
 - * *Try to understand the person's perspective – see their point of view*
 - * *Keep your focus on the other person and what they are saying*
 - * *Actively encourage the person to talk through verbal and non-verbal cues*
 - * *Reflect on the essence of what has been said*
- If the person has tried suicide before ask how they got through it and what happened subsequently
- With the person's permission link them to their mental health professional(s): case worker; mental health clinic; family doctor/ psychiatrist, as soon as possible
- Talk about the protective factors: a relative or pet that depends on them; read Section 3 again for some immediate ideas for this situation

- Draw up a plan, both for the person and for yourself, based on your conversations. Write it down. If it seems appropriate, get the person to write a plan as well. The plans should be signed. The action of writing it is like a contract and may help to avoid any self harm. Keep it simple. The plan(s) will contain:
 - * *Delaying action to give time for the person to reconsider*
 - * *An agreement by the person to certain actions they will take to delay going through with suicidal action*
 - * *Any other material that is relevant to the specific situation (e.g., removal of weapon, keys, etc.)*
- Follow up on the plan with regular contact from the family and friends' network that you have developed previously.
- Remove any means of suicide (see Section 5); do this with the person as a sign of their commitment not to attempt suicide that night

A second book that gives information about what to ask and what to do is *Surviving Manic Depression* by Torrey and Knable. We have covered the “ask” questions above. The “act” statements below are also important. At the risk of over emphasizing these ideas we provide Table 5.

What to Do If You Believe Someone Is Suicidal?		Table 5
<p>Ask</p> <ul style="list-style-type: none"> » <i>Ask if the person is thinking of harming himself or herself</i> » <i>Ask if the person has a plan</i> » <i>Ask if the person has made preparations to carry out the plan</i> 	<p>Act</p> <ul style="list-style-type: none"> » <i>Act by taking away the means of committing suicide (e.g., pills, weapons)</i> » <i>Act by notifying the person's psychiatrist</i> » <i>Act by instituting hospitalization, either voluntary or involuntary, if necessary</i> » <i>Act as if it is an emergency; it often is</i> 	

(From Surviving Manic Depression, Torrey and Knable. Chapter 13, pp.256, 257)

Section 5

Pro-active Ways of Helping to Avoid Suicide

His family works full-time to keep him safe from himself— his parents, his five siblings and his wife play their own parts in the watch. They would never call it a burden, but their lives are consumed, at times, with his illness.

*Globe and Mail, Canada. June 20, 2008. “Some are born to endless night”.
Erin Anderssen (N.B. The title of this article is a quote from William Blake,
the 18th century English poet.)*

Seeking Help

Help is available for people who are thinking about suicide (also known as “suicide ideation”). The help may be medical, psychological or cultural.

Medical

People who are having ideas about suicide need medical help as well as the support of relatives and friends. It is best to let the person’s doctor know in advance of the possibility or likelihood of suicide. This can facilitate admission into hospital care, either voluntarily or through legal means, i.e. using the country’s Mental Health Act, if there is one, for someone who will not go willingly to hospital. In hospital the person will get treatment with appropriate medications. Each jurisdiction has its own rules for voluntary (willing) and involuntary (unwilling) admission to hospital. It is useful for families to know what these laws are.

Psychological

Therapy can be effective to address suicide ideation. One type of therapy is called cognitive behavioral therapy. This therapy involves challenging and changing the person's beliefs through talk therapy directed specifically at suicide ideation. Cognitive therapy is also used to alleviate depression.

A less formal therapy is having someone listen and give the individual sufficient time and space to share their emotions, being non-intrusive and non-judgmental in the therapeutic approach.

Interpersonal therapy addresses communications skills and helps people express and understand themselves better in their relationships with family and friends.

Therapy from a psychologist is not always available or desired by the person, but the advice given in this guide for families may provide them with the means to converse naturally with the person.

“Do you know why it’s worth it?” Ann [a sister] will say, looking back. “Because you love your family, and you love your brother. ... Some days you want to boot him in the ---. But that’s just part of being a family.”

(Ibid)

Cultural and Social

Support from your local community can be an invaluable asset to families facing the possibility of suicide. Although the person may not be able to initiate contact themselves, the family can involve their church members who can give a befriending hand. Although suicide is a taboo in many cultures, within the circle of family, friends, ministers giving pastoral visits and the wider community, a sense of worth for the person may be achieved.

Developing Strategies for Dealing with Suicidal Thoughts

Strategies may be developed to help a person dealing with suicidal thoughts; the following list provides suggestions.

- Monitor any symptoms of depression
- Encourage social exchanges between friends and family and between the professional involved
- In some places there are peer support meetings for people suffering mental illness. These are self-help, self-directed meetings sometimes held in a mental health agency where people who have mental illness, but are stable enough, can go and talk about anything they want, to people who are likely to empathize with them. If the person is reluctant to do the investigating, a brother or sister might be a good person to find out what is available. In peer support groups, however, people can be from a variety of age groups and situations
- Having an animal to love and be loved by. The person has to be able to handle the responsibility of a pet, especially if he lives outside the family home, but could still be responsible, for instance, for walking a dog that lives at the family home
- The person could be encouraged to return to a former hobby that was previously much enjoyed: e.g., artistic endeavors, sports activity, etc.

The Methods/Weapons Used and Ways to Remove or Eliminate Them

It is not unlikely that you will have had thoughts about things in the person's home that might provide a means of carrying out a suicide. Many of you will have removed knives, chemicals, pills, etc. just in case, knowing that if tools to commit suicide are available they may trigger the event. Though you may not be able to control some of the means of suicide, you should be aware of them. Some of these means are listed below. If the person lives with the family, it should be emphasized that the family cannot be responsible if their loved one attempts or commits suicide by means of something connected to the home.

Chemicals

Household cleaning products or pesticides, as used on farms, are common and unpleasant methods of suicide. Pesticides are a significant cause of suicide in developing countries.

Weapons

Common and easily available means of self harm are: ropes, knives and guns. Families may remove the offending items from plain view so that they are not a temptation. Ammunition should be locked away. In the general community, ropes may not be considered as weapons but they are the most common method of suicide in western nations. Another common method is cutting one's self.

Violent Actions

- **Jumping or Throwing Self**

People who are reckless or impulsive are at risk for suicide by this means. Whereas the individual needs to think about the method and make a plan if other means might be used, this way can be achieved with very little forethought. Metro or underground train services or high bridges are often chosen as a method. It is difficult to see how family can prevent this type of suicide.

It is unwise for a person who is at times unstable to live on an upper floor of an apartment building (block of flats).

- **Driving Fast and Recklessly or Carbon monoxide Poisoning**

Crashing a car at speed gives the appearance of an accident and may remove some of the guilt felt when more obvious methods are chosen. Using the exhaust fumes from a vehicle to induce unconsciousness and death is also one method used. Removing the car keys when other symptoms you recognize as triggers are present will avoid the person starting or using a car.

The Role of Medications

- **Stopping or Failing to Take Medications**

- * *People suffering from depression are at high risk for suicide particularly if they are not taking appropriately prescribed medications*

- **As a Means**

- * *Hoarding one's medications until the person thinks there are enough to commit suicide*

- **As a Protective Factor**

- * *Lithium is used as a protective factor in bipolar disorder (it controls mood swings). Lithium is a common medication for this condition that is effective. Blood testing helps monitor any ill effects of this medication*

- **As a Trigger**
 - * *Poorly controlled symptoms (physician's assessment needed)*
 - * *Poorly controlled changes in medications (stopping suddenly; changing medication without correct titration). If a medication is stopped suddenly it can induce psychotic symptoms that may be a risk for self harm.*
- **As a Contributing Factor**
 - * *Incorrectly prescribed medications (e.g., in a small percentage of people taking some anti-depressant medications, symptoms of agitation and suicide ideation must be watched for)*

Be Prepared – Make a Family Crisis Plan

If your relative has shown suicidal tendencies in the past, it is likely that s/he may show these again in the future. For this reason you should be as prepared as possible. The procedures described in Section 4 are designed for when suicide may be imminent. The Family Crisis Plan described here is for advanced planning. Though it is not possible always to forestall suicidal action, the plan may enable quick hospitalization and treatment.

- It is recommended that the whole family, including if possible, the ill person when they are having a good period, have input into the Family Crisis Plan. Write it down in simple language and put it where you can easily find it. Give each member of your support team a copy of the Plan. This work is exhausting. Do not try to work with your unwell relative by yourself. Involve your family and any mental health professionals who care for your relative
- Watch out for continuing symptoms that signify unrest or anxiety in your relative
- Note the names and telephone numbers of those willing to keep the person and the family safe in crisis situations
- Note down how hospital procedures work; know the names and telephone numbers of the professionals you need to call. If your relative is admitted to hospital find out the name of the doctor in charge of your relative and be prepared to talk to him in a calm and business-like manner to make sure you are kept informed
- If your country has mental health laws, learn about how these laws will affect you if your relative needs involuntary hospitalization or if s/he attempts suicide
- Learn in advance whether a doctor will be able to admit your relative for treatment as a willing or unwilling (involuntary) patient. Learn the best way to attempt to admit your relative – e.g., through his doctor or through the emergency department
- Some police forces have emergency task forces that have specialists in suicide available. Find out whether this is available from your police service

Section 6

After a Suicide Attempt

After a suicide attempt family caregivers and the person who acted will likely face a myriad of consequences and feelings. The following section provides insight to help all involved if they contend with such a difficult time.

Possible Consequences

Serious Injury

Serious injury can occur from a suicide attempt. People have been known, not only to break bones, but to suffer serious injuries to their brain or other organs or become paralyzed. Fear of this happening has made some people think twice about the attempt.

After the injury, family and friends are often involved in the physical care of the person: visits to the hospital, consultation with doctors, etc. If and when recovery occurs, the family and the person may return to the same set of circumstances that were in place before the suicide attempt took place. In addition they will all have the added guilt and shame that come from the event. Perhaps some of you reading this are in this situation, yet you have taken the courage to see what more can be learned about preventing suicide.

In the countries where suicide is still seen as a crime, persons may even be charged by the police though this is less and less likely to happen as a more enlightened approach to mental health and suicide comes about. Sometimes families prefer to pass the attempt off as an accident to avoid police action.

Stigmatizing and Avoidance by Friends and By Society

Immediately after the event, close friends will gather around you to do what they can to assuage your distress and that of your relative getting over their suicide attempt. However, according to family experience, this does not last past one or two months; by that time it may seem that many expect you to have overcome your difficulties and to have resumed a relatively normal life. This will also happen to families who have experienced a death by suicide. People do not seem to have the perseverance necessary to help grieving and stressed families for long. The same may apply to someone taking time off work. A few days may be given graciously but after that one's employer may not believe that you should need any more time off.

Potential of Sensational Media Coverage

It is a fact that in many countries newspapers and other media cover suicides in a sensational manner. In some countries the press has been made aware – often through anti-stigma campaigns – that such reporting may trigger other suicides. In those places suicides are more modestly reported and sometimes not reported at all.

The Need to Handle the Grief and Bewilderment

Feelings of Families after a Suicide Attempt

Many families will not have seen the risk in advance. This is why courses and guides like this one are important to make families aware and to educate them about how they can attempt to avoid such a catastrophic outcome to the life of their loved one.

When a suicide or a suicide attempt occurs, the family feels betrayed, guilty, angry, helpless and depressed. They also feel ashamed. This complexity of emotions – together with the need to keep the person safe after the attempt – puts a great burden on close family and friends.

For everyone the event will be a great shock. Even those family members who considered themselves prepared for any possibility will experience shock as well as an array of other emotions.

While the family is overcome with what has happened, the person her/himself feels bewildered by the situation, with feelings riding an emotional roller-coaster. In addition s/he is likely to feel extreme shame. This is sometimes deepened if the individual is in hospital with a 24-hour watch over the patient's room. (This extra vigilance is considered necessary after an attempt as the person is especially vulnerable.)

A suicide attempt is traumatic for both the person and their family. Again all the emotions must be gone through before more positive emotions are introduced and the person is reconnected with hope and a reason to live.

It is quite normal that everyone goes through the “denial, shame, blame, guilt and anger” that are a normal part of the grieving process. However, the danger is that family members transfer their own feeling to others in the family, pointing fingers of blame and guilt that will stir up more and more distress and multiply these emotions. Try to consider that **NO ONE IS TO BLAME** for what has happened.

Approaching the Person

The skills we need for approaching the person are ones that do not generally come easily to us and it is useful to know how you might handle this.

- **Make Safety a Priority**

- * *People who have attempted suicide are at high risk to try again immediately after a “failed” attempt. Do your utmost to keep the person safe. If your relative is in hospital, consult with those caring for them there and be sure that there is a well thought-out discharge plan and that family members or close friends are involved in it*
- * *Ensure that you and your family are honest with the person. Trust is one of the most important values between people*

- **Ways to Talk to the Person**

- * *See “Can the Event be Averted?” in Section 4 for listening and conversation skills*
- * *Be straightforward. Talk honestly and do not beat around the bush. Speak with goodwill and kindness*
- * *Instill hope – even when you yourself are feeling low. Some of the things to say will be similar to those things you say when the person is at risk for suicide*
- * *Give the person a future. Work on things in the future life of the family that will give the person pleasure and a reason to live*

Feelings of Those Who Have Survived a Suicide Attempt

One person who attempted suicide by cutting herself and was interrupted by her husband describes some of her motivation. The increasing feeling that she must die by suicide felt like a fireball in her mouth. First of all it was too hot to bear, but each time she considered the fireball of suicide its heat diminished until it seemed an acceptable solution. But once her attempt failed her pain seemed to dissipate and after a time she was able to pick up both her life and her marriage.

The fortunate outcome to this story was that the woman’s need to die by suicide dissipated. However, part of the story shows that people continue to think of suicide after one attempt unless set on another course.

What They Have Said About Surviving

- “I felt very low and worthless. I thought I should try again.”
- “One friend asked me ‘Why didn’t you come to me for help?’ Others I thought were friends abandoned me like I was nothing to them.”
- “I know when I woke up in Critical Care in the Hospital and saw my father holding my hand beside the bed that I was glad to be alive.”
- “It was my close friend that pulled me through and gave me a reason to live. He came regularly to the hospital and his love and care made me feel life was worthwhile.”
- “I spent months in the hospital recovering from my injuries. I just hadn’t thought about that when I decided to end my life.”

- An interview with a person who had attempted suicide revealed how she felt before and after the attempt.

At the time I attempted suicide I felt I could not endure life any more and that I had to end it. Each moment felt like an eternity. Depression took over. Time stood still for me. I didn't think of my family or friends.

When I regained consciousness in the hospital after the attempt I did not know why I was there or what had happened to me. I wondered if I had been in a car accident. It was only when the nurse put my file on my lap as they wheeled me for tests that I took a look at it and read "suicide attempt". I was shocked and couldn't believe it.

I was touched when family, friends and members of my church came to visit me and left me tokens of their love. There were beautiful vases of flowers and cards all around the ward. I believe that this sustained me through this difficult time.

One thing that was very disturbing was when a psychiatrist asked me why I didn't leave a suicide note. I felt he had seen too many Hollywood movies. Suicide notes just weren't part of my disturbed thinking. As I said, the depression took over completely.

I think everyone should realize that every person is unique. It is dangerous to generalize. Since my attempt, I have had to build my own support network. My family had their own lives and some of them just didn't want to talk about it. Although I still have suicidal thoughts I am dissuaded by the knowledge of what I put my family through. I have built myself a balanced life through taking on activities, exercising and making friends.

(Grace – personal communication)

Advice They Gave

- "Life is worth fighting for. I know that now."
- "If only I had admitted my problems – to my doctor or someone – this might never have happened. I was very foolish, but at the time I didn't see it like that."
- "I stopped taking a medication that was helping me because of the side effects. I shouldn't have done that. I am taking it again now and haven't thought about suicide for a long time."
- "I still get suicidal thoughts, but I do everything I can to distract myself."

Section 7

After a Suicide

After a death from suicide or a suicide attempt families must go through the grieving process, the denial, guilt, shame, blame and anger that are an integral part of grief and bereavement. Many families went through this cycle when they first discovered their loved one had mental illness. They now grieve again. Stopping the death may not have been possible. Nevertheless, families at first may blame themselves and relive what they know of the event constantly.

“Don’t blame friends and family members. Everyone is hurting. Nobody wanted this death. Getting into fights with your family about who is to blame or other details of the situation will only make you resentful of them. You do not need estrangement from your family at this time. You need to pull together.”

(Personal communication to the author by person wishing to remain anonymous)

With death by suicide there is also this added trauma – the “why” of it. When their relative first got sick with mental illness there was also the “why” of it. What did we do wrong? We should have done this. We should have done that. When a suicide occurs the “why” of it happens again. We ask: What could we have done? What didn’t we do? The family questioned themselves before, now they question themselves again, and as before, they often find no answers and must come to terms with that.

Grief Recovery and Suicide Bereavement for Families

The following extract comes from the website Console – Living with Suicide:

The loss of a loved one through suicide can bring intense feelings of grief and mourning. The responses and emotions experienced in bereavement following a suicide can differ from those felt after other types of death. The fact that a loved one's death appeared to involve an element of choice raises painful questions which may not arise if the death was natural or accidental. Bereavement by suicide can be prolonged. The grieving process is characterized by agonizing questions and a search for some explanation for what has happened. Research suggests that feelings associated with guilt, shame, rejection and stigmatization are often more pronounced than in other types of bereavement.

(<http://www.console.ie/index.aspx?content=articles&panel=bereavement>)

The following poem comes from a website entitled “Bereaved by Suicide”. The author is unknown.

If I had had five minutes more
Would the outcome have been the same
If I had had five minutes more
To sit you down and to explain
That if you were to take your life
My life would never be the same
That I would be left heart-broken
And in constant mental pain
Wondering
If I had had five minutes more
Would the outcome have been the same

What Bereaved Families Felt

- “My whole life had been swept away with the death of my husband.”
- “I felt I had died too. I had thoughts of joining him.”
- “I was completely numb for weeks afterwards.”
- “I didn't feel I could go on living with this overwhelming pain.”
- “It is terrible to say it, but the first thing I felt, after the horror of it all, was relief – relief from the constant worry, anguish, fear. At last it had happened – what we had feared for a long time. It wasn't till long after that I began to feel what people call normal grief.”
- “I went over and over what I had done, or hadn't done that would have made a difference.”
- (About her son) “The sight of a young person of the same age put me into a tail spin. I could not face answering the phone or meeting people on the street. You could say I hibernated. Speaking about it over and over again, to friends, neighbors, people I hardly knew, was too much for me.”
- “I couldn't cry at all at first; then the flood gates burst and I couldn't stop crying for many months.”

- “I felt weak and without energy. I had no taste for doing anything.”
- “I felt my life had no compass or purpose.”
- “Kind people suggested that I join a bereavement group but I just could not do it.”
- “A counselor told me to let out all my feelings. I wasn’t sure what she meant at first but then realized that there were all sorts of feelings inside that I hadn’t expressed, that were sort of bottled up. She helped me let them out and maybe this was the way to let all these feelings go.”

Recovering from Bereavement

Everyone grieves differently. In the same way, people approach the road to recovery differently. This is your intensely personal journey. There are few who can give you advice on what you should do, how you should act or what you should feel. But people will give you advice, even when they have no real knowledge to impart. How you respond is something you will work out for yourself.

This guide tries to avoid giving advice, but rather takes some words from those who have “been there” in the hope that they are helpful. Here are some of those words.

The greatest need of survivors is reassurance that what they are going through is normal. Some of what they go through may be slightly different than that caused by other forms of death, such as thoughts of their own suicide, but it has nothing to do with the length of time it takes to recover.

(Extract from Suicide Survivors: A Guide for Those Left Behind by Adina Wroblewski, quoted in Survivors Of Suicide by Rita Robinson)

What Other Survivors Want You to Know

- Know that you can survive. Though you may think or feel you cannot, you can
- The intense feelings of grief are overwhelming and frightening. This is normal. You are not “losing your mind” you are grieving
- You may feel extreme feelings of guilt, confusion, anger, or fear. These are common responses after a suicide
- You may have thoughts of suicide. This, too, is common. It doesn’t mean you will act on those thoughts
- Forgetfulness, is common, but a temporary problem. Grieving takes so much energy that other things will seem to fade in importance

(From Suicide – Coping with the loss of a friend or loved one. ©2009, SAVE. This is copyrighted material which has been reproduced with permission)

Stigma

Neighbors or other people you know may ask about your relative. Telling them can be difficult for you and difficult for the person you are telling. They may be truly upset and shocked or stunned by the news. A difficult silence may ensue, but try to keep the conversation going. They will likely have genuine interest in your family and you may value their contact.

People who discriminate against you and your relative because of mental illness, or because of suicide, are generally uninformed about the nature of mental illness and suicide. It is best to ignore unpleasant comments or behaviors. This is the time to call upon close friends to support and sustain you.

Approach those who would avoid you with dignity. Your grief may be such that you will not even notice the reactions of people around you at the beginning. Your turmoil of emotions may mean that you really cannot worry about what others think.

Appendix 1

EASY REFERENCE PAMPHLET

Warning Signs of Mental Illness, Managing a Crisis and the Risk of Suicide

Family members commonly reported that they knew at an early stage that something wasn't right with their relative. They sensed that their son or daughter, brother or sister, husband or wife was not merely going through a phase, was not in a temporary bad mood, was not reacting to the overuse of drugs or alcohol. Some parents, however, were taken completely by surprise. They assumed that what they were seeing was normal adolescent behavior. All who have been through this urged that people reading this should trust their instincts and seek help immediately if they become concerned. Remember that you know your relative best.

Social withdrawal was observed by everyone. Most commented that their relative had been a "good person, never causing any trouble". Seldom had the person been socially "outgoing" during the formative years.

Warning Signs of Mental Illness

Schizophrenia

Below is a list of warning signs that suggest the onset (or return) of schizophrenia. It was developed by families who have a member with schizophrenia. Some of the behavior is within the range of normal responses to situations. However, families felt that even with the mildest of symptoms there was a vague, yet distinct, awareness that the behavior was "unusual".

The unusual behaviors and symptoms described below will not be unusual to families whose relative has already experienced acute episodes of schizophrenia. For them, these symptoms may indicate the return of a more acute phase of the illness.

Here are examples of unusual behavior and symptoms that may indicate relapse or onset:

- Dropping out of activities (skipping classes)
- Decline in academic or athletic performance
- Social withdrawal, isolation
- Deterioration of social relationships
- Excessive fatigue and sleepiness or inability to sleep

- Staring, vagueness
- Apparent indifference, even in highly important situations
- Inability to express emotion
- Irrational statements
- Conversation that seems deep but is not logical or coherent
- Peculiar use of words or language structure
- Excessive writing without apparent meaning
- Inability to concentrate or cope with minor problems
- Forgetfulness
- Irritability
- Bizarre behavior
- Inappropriate laughter
- Deterioration of personal hygiene; eccentric dress
- Frequent moves, trips or long walks leading nowhere
- Undue preoccupation with spiritual or religious matters
- Strange posturing
- Unusual sensitivity to stimuli (noise, light)
- Drug or alcohol abuse

Many families noticed that there was no logical flow of ideas during conversation. Others noticed that their relative began speaking out loud to no one, and did not seem to hear other people speaking to them. One young man began researching all religions and cults. Another young man began turning off all radios because he believed that he was receiving messages from them. In some families, their relative destroyed bank books, birth certificates and photographs.

Signs of paranoia became apparent in many cases. A relative would begin talking about plots against him or her and had “evidence” that he or she was poisoned. One man said that his wife assumed that whenever she saw people talking, they were talking about her.

Siblings often felt that their brother or sister was merely lazy and shirking responsibility; children were embarrassed and confused by their parent acting so differently.

Eventually families reached a point they could not tolerate the behavior any longer. Many commented that there was much confusion in the home, with some resentment and anger toward the person behaving strangely.

Depression

The following is a list of symptoms of depression.

- Vaguely negative uncomfortable emotions—something's not right
- Fatigue or stress that they at first attribute to external demands
- Insomnia
- Anxiety
- Sadness, tearfulness
- Unexplained physical pain
- Decreased initiative
- Deterioration in personal relationships
- Impaired functioning at work/school through reduced ability to think straight or concentrate
- Absences from work or school
- Loss of appetite

All contributors stressed that you should not wait for tensions to reach such extreme levels. You should seek outside help from your family physician or a medical clinic.

With depressive symptoms in the household families begin to feel there is a cloud over everything. Parents disagreed on how to handle their child's problems; the stability of the marriage frequently suffered whether it was a child or a spouse that was showing these signs. Fewer family activities were undertaken. When it is not realized that this atmosphere is due to a mental disorder, resentments can make family life even more difficult.

Bipolar Disorder

Bipolar disorder is characterized by changes in mood from very highs – or mania – to very lows, or depression. Everyone experiences changes in mood. Sometimes we are happy and at other times sad, but in bipolar disorder people experience changes in mood that are more severe. The warning signs of depression are listed above. Below are the warning signs of high mood or mania.

- High energy
- Feeling great – euphoria
- Creativity
- Excited talking
- Hyperactivity
- Don't feel the need for sleep
- Impulsivity or recklessness
- Lacking in insight and judgment
- Quick temper

These early signs are critical. It is important to talk with trusted friends or family members and to consult a mental health professional to avoid what people have called “spiralling down” into severe depression.

None of the signs by themselves indicate the presence of mental illness. It is when many of these signs are present that families may be suspicious of onset or return of illness.

It is more difficult to act upon these signs when they are noticed for the first time. However, as indications of the return of acute symptoms it is important to act upon your suspicions and get medical treatment as soon as possible.

Managing a Crisis

Sooner or later, when a family member has schizophrenia or a major affective disorder, a serious crisis will occur. When this happens there are some actions you can take to reduce or avoid the potential for disaster. Ideally, you need to reverse any worsening of psychotic symptoms (psychotic means out of touch with reality) as well as to reduce delusional thinking (believing you have millions in the bank or that you have powers from God are two examples of delusional thinking). At this time you need to provide immediate protection and support to the ill person and to yourself and other family members. This pamphlet will help you manage a crisis and plan in case another one occurs (always a possibility and better dealt with if one is prepared.)

It is unusual for a person to suddenly lose total control of thoughts, feelings and behavior, without there being some warning signs that the person or his family members have recognized. There may be a variety of behaviors and symptoms that give rise to mounting concern. These can be:

- Sleeplessness
- Ritualistic preoccupation with certain activities
- Being suspicious
- Unpredictable outbursts
- Seeking quiet or isolation
- Changes in mood
- Demonstrating bizarre behavior

There may be other signs that are specific to the person rather than to the disorder itself that make the family knowledge of the person so important.

During these early stages a full blown crisis can sometimes be averted. Often the person has ceased taking medication s/he has taken regularly. If you suspect this, try to encourage a visit to the physician. If this is not successful (and the more psychotic or depressed the person, the less likely it is to be successful) you should contact the physician by telephone or by a note dropped off at his office in order to get advice.

You must also learn to trust your intuitive feelings. If you are truly frightened, the situation calls for immediate action. Remember, your primary task is to help the patient regain control. Do nothing to further agitate the scene.

It may help you to know that the person is probably terrified by their own feelings of loss of control over thoughts and feelings. Further, any “voices” may be giving life-threatening commands. In the person’s mind messages may be coming from light fixtures; the room may be filled with poisonous fumes; snakes may be crawling on the window. For those with depression a feeling of utter worthlessness and despair may overcome them.

We recognize that the severe mental illnesses are not alike in many respects. Thus we hope that this pamphlet will give useful information for the family in the case of each situation. Acute psychosis is common in schizophrenia and also occurs in the other serious disorders.

Acute Psychosis

Accept the fact that the person is in an “altered reality state”. In extreme situations the person with psychosis may “act out” hallucinations, e.g., shatter the window to destroy the snakes. It is imperative that you remain calm. It is also imperative that your relative get medical treatment. While waiting for medical help to arrive (or before attempting to take your relative to the hospital) the following suggestions may prove helpful:

- **Remember that you cannot reason with acute psychosis**
- **Do not express irritation or anger**
- **Don't threaten.** This may be interpreted as a power play and increase assaultive behavior by the person
- **Don't shout.** If the psychotic or depressed person seems not to be listening, it isn't because he or she cannot hear. They are probably experiencing traumatic internal feelings
- **Don't criticize.** It will only make matters worse; it cannot possibly make things better
- **Don't squabble** with other family members over “best strategies” or allocations of blame. This is no time to prove a point
- **Don't bait** the person into acting out wild threats; the consequences could be tragic
- **Don't stand** over the person if they are seated. Instead, seat yourself
- **Avoid** direct, continuous eye contact or touching the person
- **Comply** with requests that are neither endangering nor beyond reason. This provides the person with an opportunity to feel somewhat “in control”
- **Don't block the doorway.** However do try to keep yourself between your relative and an exit
- **Decrease** other distractions immediately – turn off the TV, radio
- **Express understanding** for what your friend or relative is going through
- **Speak quietly**, firmly and simply
- Should the psychotic episode involve violence, there may be no time for all the above strategies. **Do not hesitate to call the police.** When you call, tell them that your relative is psychotic. Explain what you are experiencing and that you need the help of the police to obtain medical treatment and to control the violent behavior. Instruct the police **not to brandish any weapon.** If you are alone, be sure to contact someone to come and stay with you until the police arrive. The doctor who has been involved with the care of your relative should be advised of the situation as soon as possible

Family Crisis Plan

Because a crisis often comes on very quickly, **a plan should be made before it happens**. If your police force is well developed and usually helpful call your local police station and speak to the community affairs officer. Advise them that your relative has schizophrenia/ bipolar disorder/ depression and can act in bizarre ways at times. Let close friends or neighbors know that you may call upon them for help if things get difficult. Then make a list of the names, addresses and telephone numbers of these special people and keep it handy. If a crisis arises, you will be prepared. (You will not have to worry about your pets, children, etc. if you have people to call upon.)

When you have weathered one crisis, your family may try to find the reasons it happened. It is normal for people to want explanations. It is important that the family does not blame itself, the person or anyone else for the ill person's behavior. Very little is understood about why crises occur and why violence can be so unpredictable. Continuous taking of medication considerably reduces the risk of relapse and possible crisis. The avoidance of alcohol can also significantly reduce violence.

Suicide Always the Risk

One in 10 persons suffering from schizophrenia commits suicide. Four in ten are known to have attempted suicide. Seventy percent of people who commit suicide suffer from depression. We are not telling our members anything new when we say that suicide is a serious problem – a problem that many family members have had to deal with and a problem that many families fear mightily. Yet, when we read statistics and listen to radio programs about who is most at risk we rarely hear about the large proportion of people with mental illnesses. One statistic that we did not expect is that only 2% of those with schizophrenia who commit suicide do so in response to command voices.

Young men and those with chronic illness are more at risk. A good educational background and high performance expectations are also risk factors. Some people are more aware of their illness than others and fear for the future and possible deterioration.

Suicide is more likely to happen in an upswing of illness, when the symptoms have abated a little and the person sees reality more clearly. Feelings of hopelessness may run high at this time.

People often keep their thoughts of suicide very private. Rarely do professionals know how they feel.

People are more likely to confide in family members, most naturally their mothers or close siblings, but some people confide in no one.

Talking about suicide should be taken seriously as it is often a plea for help.

Most people who commit suicide have a history of depression or depressive features. They have taken a bleak view of the future.

Risk Factors

In the general population indicators for suicide are:

- Death of a loved one
- Loss of employment
- Loss of a girlfriend/boyfriend
- Inability to work
- Feelings of worthlessness
- Divorce of family member or self may be too much to bear
- “Copycat” effect. Hearing about a suicide may prompt the action in the person. Family organizations have warned media not to publicize suicides to avoid this phenomenon
- Suicide may be precipitated by easy access to a means of killing one’s self, such as living high up in an apartment building
- Access to a weapon
- People often jump from bridges, throw themselves under a train or drown themselves; in rural areas, drinking pesticides is a common means
- An overdose of medications saved up by the patient is often a method to be aware of
- When a loved one is in hospital, be sure that staff issue day, evening, or weekend passes judiciously especially to young patients with chronic relapsing illness.
- Immediately following discharge from hospital people are very vulnerable. Quite often they are not yet stable. The incidence of suicide is high among people with mental illness at this time. Careful discharge plans should be made by the hospital team and the family. If the family is not sure when the patient is to be sent home, a family member should seek this information soon after admission. Sometimes families are not advised that the patient is to be discharged
- Feelings of being alone, not having family or other support may influence a person who is already troubled
- Suicide is more likely to happen when the family is away from home and leaves the ill person behind
- If the person lives in the family home, try not to leave him/her alone at home for long periods if s/he seems more withdrawn or disturbed than usual
- Persons living alone with few friends and very few visitors have a high incidence of suicide. If this is your situation, visit phone or mail postcards or greetings cards regularly to keep in touch. Access to the internet can be a source of social contact for people living alone
- Be particularly suspicious when someone’s previously gloomy mood suddenly changes to cheerfulness without sufficient reason. This may apply, but might be difficult to define in someone with bipolar disorder
- People sometimes write poems, notes or other material dwelling on death or suicide when they are contemplating these
- An informal study of local suicides prompted one group to suggest being especially vigilant and considerate of your relative during Spring or at family festival times. This may be because Spring is a symbol of renewal and at family festival times one experiences first hand the achievements of other family members. The person’s own feelings of unhappiness may become overwhelming

If the person lives at home, set up realistic rules for home life to help the family live as “smoothly” as possible. This may be helpful for your relative who is dealing with incredibly difficult symptoms.

Issues of suicide should be addressed directly. Acknowledge with empathy the patient’s view that death is one solution to the problem of the unbearable psychological pain.

Give your relative hope by speaking of the many advances in research and the better medications that will soon be available. Tell him/her that you want him/her to be around to benefit from these.

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Appendix 2

Books about Suicide and/or Containing Suicide Information:

Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies

White, J. & Jodoin, N. Centre for Suicide Prevention, Calgary, Alberta, 2003, 2004. Reprinted 2007. http://www.suicideinfo.ca/csp/assets/prom_stat_en.pdf

A very comprehensive book about suicide prevention.

Afrontando la Realidad del Suicidio – Orientaciones para su prevención

Confederacion Española de Grupaciones de Familiares y Personas con Enfermedad Mental (FEAFES, Spain) *In spanish*

After Suicide – A Ray of Hope for Those Left Behind

Ross, Eleanora B. Perseus Publishing, 1997, 2000.

Eleanora betsy ross runs support groups for american families who have had a relative die by suicide.

This is a comprehensive and useful book.

Behavioral Family Therapy for Psychiatric Disorders

Mueser, Kim T. & Glynn, Shirley M. New Harbinger. Second edition, 1999. pps 200-202.

– Crisis planning and BFT – Strategies for dealing with suicidal thoughts

Intended as a professional text book but useful for families.

Building Awareness – Reducing Risk: Mental Illness and Suicide

World Federation for Mental Health, 2008. Available upon request. www.wfmh.org

A monograph on suicide 2006.

The Complete Family Guide to Schizophrenia.

Mueser, Kim T. & Gingerich, Susan. Guilford, 2006. Page 215-218: Responding to Suicidal Thoughts or Attempts; Myths Prevention Guidelines; Crisis Prevention and Response Plan.

There are excerpts from this book in the guide. The book itself is a very useful source.

Death, Dying and Bereavement.

Rubel, Barbara, MA. 30-page section from this course book for nurses, from

www.griefworkcenter.com/grief-cr.htm

I Can't Stop Crying: It's So Hard When Someone You Love Dies

Martin, John D. & Ferris, Frank D. Key Porter Books, 1992.

Grieving for the death of a wife or husband; no reference to suicide.

If Your Adolescent Has Depression or Bipolar Disorder – An Essential Resource for Parents

Evans, D.L. & Andrews, L.W. Oxford University Press, 2005.

Monochrome Days – A first-hand account of one teenager's experience with depression

Irwin, C. The Annenberg Foundation Trust at Sunnylands Adolescent Mental Health Initiative, 2007.

Many indexed references to the suicidal experience.

SANE Guide to Staying Alive – Guide for People with a Mental Illness who have Suicidal Thoughts

SANE Australia, 2007. www.sane.org

Specific and useful. Order from the website.

Suicide – Coping with the loss of a friend or loved one

©2009, SAVE.

A pamphlet with several very useful passages.

Suicide Information for Teens – Health Tips about Suicide Causes and Prevention

Shannon, J.B. Omnigraphics, 2005.

Suicide Intervention Handbook

Ramsey, R.F., Tanney, B.L., Lang, W.A. & Kinsel, T. Living Works Inc. www.livingworks.net

Course manual for the Canadian Mental Health Association (CMHA) - assist suicide prevention program.

Suicide Prevention: Weaving a Strong Safety Net

Dixon, Bea. Care In Action Guidebook. www.careinaction.com

Available on the web as an ebook.

Suicide Survivors: A Guide for Those Left Behind

Wroblewski, Adina, 2002

Very helpful book for families; much concentration on depression.

Survivors of Suicide

Robinson, Rita. New Page Books, 2001. To order call 201.848.0310 or go to

www.newpagebooks.com

A helping guide for "family and friends left behind".

Thinking of or Attempting Suicide in Where there is No Psychiatrist

Patel, Vikram. Interview suggestions (66); Suicide as a crime (68); bereavement (152-154).

The Royal College of Psychiatrists (Gaskell), 2003.

Information for people in developing countries.

Books about Mental Illness

Grieving Mental Illness – A guide for Patients and Their Caregivers

Lafond, Virginia. University of Toronto Press, 2000.

Good resource for learning family issues and emotional trauma.

Surviving Manic Depression

Torrey, E. Fuller & Knable M.B. Basic Books, 2002. pp 253-7

Surviving Mental Illness – Stress, Coping and Adaptation

Hatfield, Agnes. Guildford Press, 1993. Chapter 10, The Interpersonal Environment.

General information on creating a caring environment for those with mental illness.

Surviving Schizophrenia: A Manual for Families, Patients and Providers

Torrey, E. Fuller. Harper Collins, Fifth Edition, © 2006.

A comprehensive, very useful book about schizophrenia in layman's language.

Articles about Suicide:

Suicide

[Special issue] (2001). European Psychiatry, 16 (7).

Articles about suicide for psychiatric professionals.

Suicide by Intentional Ingestion of Pesticides: A Continuing Tragedy in Developing Countries

Gunnell, D. & Eddleston, M. International Journal of Epidemiology. 32.5 Pp. 902-909 (Medical article)

Suicide: Get the Facts

Fact sheet of Schizophrenia Society of Ontario, Canada. www.schizophrenia.on.ca

This sheet – short check list – is specifically for families.

Risk Factors for Suicide in China

Phillips, Michael, et al. (Medical article) <http://www.ncbi.nlm.nih.gov/pubmed/12480425>

The End of My Son's Journey

Jackson Land, Sueann. Globe and Mail, Facts and Arguments

<http://www.theglobeandmail.com/servlet/story/RTGAM.20090130.wfacts30/BNStory/lifeMain/>

Sad suicide story – a true family experience.

Warning Signs of Mental Illness, Managing a Crisis and the Risk of Suicide

WFMH 2009.

This pamphlet appears as appendix 1 in this guide. It is intended as an easy reference.

Appendix 3

Useful Websites on Suicide for Family and Friends of People with Mental Illness:

All in the Mind

Transcript of meeting

<http://www.abc.net.au/rn/allinthemind/stories/2003/811522.htm>

American Association of Suicidology:

<http://www.suicidology.org/web/guest/home>

American Society for Suicide Prevention

<http://www.afsp.org/>

A Mother in India

<http://www.schizophrenia.com/indiam/archives/005256.html>

<http://www.papyrus-uk.org/for-you.html>

Articles on Suicide

RETHINK Mental Illness, UK.

http://www.rethink.org/applications/site_search/search.rm?term=suicide&searchreferer_id=6&submit.x=13&submit.y=14

Building Awareness – Reducing Risks: Suicide and Mental Illness

World Health Organization. World Mental Health Day 2006

<http://www.who.int/mediacentre/news/releases/2006/pr53/en/>

Care in Action – Guidebooks for families:

The essential skills you need when helping a mentally ill person

www.careinaction.com

Charles E. Kubly Foundation

<http://www.charlesekublyfoundation.org/projects.php>

Health - India; Public health strategies for suicide prevention

Jacob, K.S.

<http://spoonfeedin.blogspot.com/2008/12/health-indiapublic-health-strategies.html>

Help Guide – Suicide

http://www.helpguide.org/mental/suicide_prevention.htm

International Association for Suicide Prevention

<http://www.iasp.info/>

Intervention & Postvention Guidelines

Maine Youth Suicide Prevention Program, 2006

<http://www.maine.gov/suicide/>

Lifeline, Connect with Someone Who Cares

http://www.lifeline.org.au/find_help/suicide_prevention

The Living is for Everyone

The Living Is For Everyone (LIFE) website is a world-class suicide and self-harm prevention resource. Dedicated to providing the best available evidence and resources to guide activities aimed at reducing the rate at which people take their lives in Australia, the LIFE website is designed for people across the community who are involved in suicide and self-harm prevention activities.

<http://www.livingisforeveryone.com.au/>

NAMI (National Alliance for Mental Illness)

Need to be a member or to register in order to access information

<http://www.nami.org>

NAMI India

Nodal Association for the Mentally Ill

<http://www.namiindia.in/aboutus.htm>

Papyrus. Prevention of Young Suicide.

<http://www.papyrus-uk.org/for-parents.html>

Reducing Suicide – Protection Your Child’s Mental Health: What Parents Can Do.

The Jed Foundation

http://www.jedfoundation.org/assets/Programs/Program_downloads/parentsguide.pdf

Risk and Preventive Factors

Suicide Prevention Resource Center, Newton, Massachusetts

<http://www.sprc.org/>

<http://www.sprc.org/library/srisk.pdf>

Suicide Grief Work Center

<http://www.griefworkcenter.com/grief-cr.htm>

Suicide Sensitive Journalism Handbook

http://www.media-diversity.org/PDFS/suicide_report.pdf

Suicide and Mental Illness in the Philippines – A Mom blogger

<http://aboutmyrecovery.com/2006/10/05/suicide-and-mental-illness-myths-in-the-philippines/>

Suicide Prevention: The Urgent Need in Developing Countries

Lakshmi Vijayakumar

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1414701>

Teens’ Health: Suicide

http://kidshealth.org/teen/your_mind/mental_health/suicide.html

Understanding Depression and Suicide (Saskatchewan Govt. Canada)

<http://www.health.gov.sk.ca/understanding-depression-and-suicide>

Websites about Suicide and Suicide Prevention

http://www.simmons.edu/ssw/docs/Suicide_and_Suicide_Prevention_websites.pdf

What Can I do to Help Someone Who May Be Suicidal?

Metanoia

<http://www.metanoia.org/suicide/whattodo.htm>

Why Women Attempt Suicide

JECH Online

<http://jech.bmj.com/cgi/content/abstract/62/9/817>

1.2 lakh (100,000) Commit Suicide Every Year

The Times of India

<http://timesofindia.indiatimes.com/opinions/2443984.cms>

World Federation for Mental Health:

“Building Awareness-Reducing Risks: Mental Illness and Suicide”

A Monograph Summarizing the WFMH International Experts Forum on Mental Illness and Suicide, March 30-31, 2006

www.wfmh.org

Appendix 4

Programs to Help Prevent Suicide and Deliberate Self Harm

Many of the websites in Appendix 3 have associated programs that you can access on your computer. National mental health associations in many countries conduct programs/help lines, etc.

Crisis telephone numbers in a number of countries:

http://www.iasp.info/resources/Crisis_Centres/

Information about centers in

Africa

http://www.iasp.info/resources/Crisis_Centres/Africa/

Asia

http://www.iasp.info/resources/Crisis_Centres/Asia/

Europe

http://www.iasp.info/resources/Crisis_Centres/Europe/

North America

http://www.iasp.info/resources/Crisis_Centres/North_America/

Oceania

http://www.iasp.info/resources/Crisis_Centres/North_America/

South America

http://www.iasp.info/resources/Crisis_Centres/South_America/

<http://suicideandmentalhealthassociationinternational.org/Crisis.html>

<http://www.suicide.org/international-suicide-hotlines.html>

Programs in addition to the sources above:

Australia

Lifeline

http://www.lifeline.org.au/find_help/suicide_prevention/suicide_prevention_links_and_resources

The Samaritans

http://www.lifeline.org.au/find_help/suicide_prevention/suicide_prevention_links_and_resources

Canada

SPEAK (Suicide Prevention Education Awareness Knowledge)

Canadian Mental Health Association, MB Division
4 Fort Street, Suite 100, Winnipeg, MB R3C 1C4
Telephone: **204-953-2352** Fax: 204-775-3497

ASIST program, Applied Suicide Intervention Skills Training

Canadian Mental Health Association, Toronto Education and Training
700 Lawrence Avenue West, Suite 480, Toronto ON M6A 3B4
Telephone: **416-789-7957 ext. 295** Fax: 416-789-9079
Email: cbart@cmha-toronto.net
www.toronto.cmha.ca;

Courses are available in most Canadian provinces but these courses are for professionals who will come into contact with people and know what to do. They are not “counseling for persons considering suicide”.

India

SNEHA India. Suicide Programs.

#11, Park View Road, R.A. Puram, Chennai-600028, India.
Helpline Phone: **91-44-2464 0050**
Helpline Email: help@snehaindia.org
Admin E-mail: admin@snehaindia.org
<http://www.snehaindia.org/index.php>
<http://www.snehaindia.org/programs.php>

Excellent source of info about india.

United Kingdom

The Samaritans, U.K.: Managing Suicidal Contacts

Course: Sometimes work can bring us into contact with people who indicate they have suicidal feelings. This can raise our anxiety levels and leave us fearful of how to respond effectively. This course will show you how to respond and acknowledge difficult feelings and circumstances without taking on responsibility for the person's distress. This course has been designed for staff of all levels who wish to enhance their listening and questioning skills through e-mail. Learning Outcomes: By the end of the course you will be able to:

- Provide emotional first aid to people who feel suicidal
- Pick up on hidden messages
- Listen for feelings as well as meaning and respond appropriately
- Acknowledge suicidal feelings
- Make sensitive and effective referrals
- Use support effectively

Telephone: **+44 (0)20 8394 8370**

http://www.samaritans.org/your_emotional_health/workplace_training/managing_suicidal_contacts.aspx

South Africa

South African Depression and Anxiety Group

<http://www.anxiety.org.za/>

Zane Wilson, Founder

For counseling queries e-mail: zane1@hargray.com

To contact a counselor between 8am-8pm Monday to Sunday, call: **(011) 262-6396**

For a suicidal Emergency contact us on 0 800 567 567

United States

(United States) National Suicide Prevention Lifeline is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis.

If you need help, please dial **1-800-273-TALK (8255)**. You will be routed to the closest possible crisis center in your area. With more than 130 crisis centers across the country, our mission is to provide immediate assistance to anyone seeking mental health services. Call for yourself, or someone you care about. Your call is free and confidential.

<http://www.suicidepreventionlifeline.org/>

State Suicide prevention programs in the United States. See this website and click on a listed State:

<http://mentalhealth.samhsa.gov/suicideprevention/>



World Federation for Mental Health
12940 Harbor Drive, Suite 101
Woodbridge VA 22192, USA