

Penetrating the Silence of Sorrow: Counselling those Bereaved by Suicide.

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the ‘*shock, of water encountering a rock*’ after suicide. Suicide is synonymous with silence. For years, it was the greatest taboo, with Ireland being “the last European country to decriminalize it” (Leenars, 2008). Thankfully, times have changed. With the enactment of the Criminal Law (Suicide) Act 1993, our country witnessed a growing willingness to confront the shadows of suicide. Anton Leenars (2008), in his seminal work on suicide around the world, finishes his review of Ireland stating:

“Ireland, indeed, may well be the best example where there is now a growing healthy balance between death and suicide, even while the country embraces a family/community approach to death and dying. Once more, in an appropriate way, Ireland is an exception” (Leenars, 2008).

Leenars (1995, p.54 as cited by O’Rourke, 2017b) asserts, “Suicide is best defined as an event with biological, psychological, interpersonal, situational, sociological, cultural and existential components.” Moreover, suicidologist Edwin Schneidman (1985) emphasised, ‘suicide is everyone’s business.’ Consequently, a deeper understanding of suicide is required. While it is not possible to explore each of Leenars’ suggested antecedents, the reader will be presented with a literature review of some aetiological factors.

Substance Abuse

“No one ever tells us to stop running away...the advice we usually get is to sweeten it up, smooth it over, take a pill,

bereaved “*break through the walls of silence surrounding*” them, without interrupting the grieving process. Ultimately, for healing to occur, we must trust the importance of just being present with the “inner spirit touching inner spirit” (Rogers, as cited by O’Rourke, 2017a).

The Psychology and Aetiology of Suicide

Therapists are taught that human beings possess a growth tendency, the drive to self-actualise, to become themselves to the fullest degree (Rogers, 2011). How then do we make sense of the suicidal, whose thoughts, feelings and behaviours appear antithetical to this? If, as Francis Bacon proclaimed, knowledge *itself* is power, then therapists would be well served in exploring the psychological and aetiological underpinnings to this *silent*, devastating killer. Furthermore, if we lack knowledge of this soul-destroying phenomenon, what support will we be to survivors – those coping with

Introduction

Suicidal people are *made*, not born. Suicide is less a decision than a reaction. I believed that if they could learn what is being reacted to, then we would have an opportunity to interrupt the suicidal impulse - Norman Farberow (as cited by Dovel, 2015, p. 661).

It has long been a valued consensus that we are pleasure-seeking creatures and will try to avoid pain at all costs. Freud (1922) suggested that all decision-making derives from these two drives. Sadly, for some, the ultimate price to pay to cease this pain is to see suicide as a feasible option. The purpose of this article is to present an overview of the psychology and aetiology of suicide and to examine what can be useful when therapists encounter someone who has been bereaved by suicide. Essentially, this article will consider how to best help the

or distract ourselves, but by all means make it go away.” (Chödrön, 2000, p.5).

If humans are pleasure-seeking creatures, then substance use is perhaps the epitome of hedonism. On the surface, the ingestion of mood-altering substances is an attempt to seek pleasure; however, it is unquestionably often an attempt to avoid pain. Substance use and suicide are inevitably linked. Theodora Fine (2008, p.11) informs us that 90% of individuals who complete suicide have a mental health or substance disorder. Fine (2008, p.12) argues, that substance use is second only to depression as a risk factor. When examining the literature, it becomes abundantly clear that substance use is an “Acute Risk Factor” for suicide (Schatzberg & Nemeroff, 2009, p.6). Substances of some kind have been found in the systems of those who have attempted or completed suicide (Arteine et al, 2015; Wong et al, 2013; Giesbrecht et al, 2015). If Laura Perls (1989, p.11) is correct that “death is the only feasible escape” from the torture of “guilt and worthlessness”, then maybe it becomes the person’s only escape when substances fail to ease their despair. Holmes & Holmes (2005, p.4) further claim that substance abuse itself may be a “form of slow suicide.”

Conceivably, an additional aetiological factor related to substance use is the impulsivity that goes hand-in-hand with drug and alcohol use. Yifrah Kaminer and Oscar Bukstein (2008) remind us that impulsivity is positively correlated to both suicide and substance use. This may be particularly true when considering risk in substance-using adolescents. Research (Allebeck et al, 1991; Bedford et al, 2006) tells us that one third of deaths in young males, especially adolescent males are due to suicide. Furthermore, “somewhere between one and two thirds of these

young men are intoxicated when they take their own lives, typically in very impulsive acts” (James, Kearns, Smyth & Campbell, 2014, p. 58). Adolescence is a tumultuous period, characterised by change, impulsivity and uncertainty (Meyerson, 2015). Additionally, today’s youth encounter added challenges, as they navigate the shadowy waters of virtual worlds, where “social networks” replace social interaction. Ironically, these digital “tablets” may have the same mood-altering, connection-impairing, addictive attributes of their chemical counterparts (Alter, 2017; Kardaras, 2016).

Social Media and Suicide

To pursue a goal, which is by definition unattainable, is to condemn one’s self to a state of perpetual unhappiness – (Durkheim as cited by Challenger, 1994, p.181).

While this landmark research is dated, it is still relevant to suicidality. Is history repeating itself? In Durkheim’s *Le Suicide* (1897) a notable term, “anomie”, refers to that lost societal connection and great psychological isolation that occurred during the Industrial Age. Undoubtedly, parallels exist in this modern age of social media, where there is an illusion of *thinking* we are connected, whilst *feeling* isolated. When considering the causes of suicide, it is worth contemplating what role social media might have on our psychological well-being. Mann (1983, p.12) refers to this when he states, “as a society becomes more anomic, the suicide rate increases.’ We must be mindful that there is a possibility of anomie present in today’s technological age. In *iDisorders*, Larry Rosen (2012, p.13) states that 62% of adolescents check their technologies every 15 minutes, with 51% experiencing anxiety if they cannot check it as often as they want to. The paradox of social media is that it makes us believe we are connected, while relationships are strained by silence,

as we stare into our screens. Do we connect with an online stranger before talking with our neighbour? Do we value ‘likes’ more than ‘hellos’, and ‘emojis’ more than ‘hugs’? Is it not better to be physically present with another, instead of offering a comment on Facebook?

Research into social media and suicide is new, but raises questions. A 2012 meta-analysis found that “there are several ways that social media can increase risk for prosuicide behaviour” (Luxton, June & Fairall, 2012, p.197). For example, there is a growing literature on links between cyberbullying and suicide (Hinduja & Patchin, 2010; Law et al, 2011) with documented cases of references to social media at inquests of completed suicides (Howard & Surtees, 2016). Studies (Schenk and Fremouw, 2012; Hindjua and Patchin, 2010) found links between online bullying and increased suicide risk and associations between suicidal ideation and online suicide searches (Katsumata et al, 2008; Hagihara, Miyazaki & Abe, 2011; Dunlop et al, 2011). Despite the benefits of social media and the internet, there are definite dangers and further study into potential correlations is warranted. Just as there may be adolescent specific aetiological factors, it is important to consider gender issues, as suicide rates greatly differ between the sexes.

The Changing Role of Men in Irish Society

Men are motivated and empowered when they feel needed....

Women are motivated and empowered when they feel cherished (Gray, 1992, p.43).

Although women attempt suicide more often, men complete suicide at a higher rate (Bilsker & White, 2011; Qin et al, 2000; Mergl et al, 2015; Lewinsohn et al, 2001; Vörös, Osvath & Fekete, 2004; Tatarelli et al, 2007). Recent times have seen

a shift in gender roles and there are potential links between these changes and rates of suicide. In Sue Sharpe's (1999) research, "*Just like a girl*", she challenged the patriarchal views of society. This study examined how primers influenced gender roles. Primers, in this context, are defined as the reading materials that young girls of the time engaged with, which had a hidden curriculum that socially constructed their role in society. O'Rourke (2017c, p.43) suggests that today it "is men who are seen as emotionally crippled and biologically redundant." Reversing Sharpe's research, would primers such as "Men & Motors" really equip men with the language and understanding of emotions? While anecdotally, we hear that women take their lives less than men because they express emotions more; the fact that more women attempt suicide is noteworthy. Nonetheless, the stark reality is that men are more likely to complete suicide. O'Rourke offers one possible explanation for this when he cites Kelleher:

"...with mental illness ... research has found that 80% of women had consulted their doctors and received treatment, whereas only about 20% of men were in treatment at the time of their death" (O'Rourke, 2017c, p.3).

Anthony Clare (2001, p.2) states, "men are renowned for their ability and inclination to be stoned, drunk, or sexually daring, appear terrified by the prospect of revealing that they can be – and often are – depressed, dependant and in need of help." Pollack (2006) calls this 'gender straitjacketing', where we are conditioned to believe emotional communication is less masculine. This is evident in colloquialisms like, "man-up", "big boys don't cry", and "man-flu" or the locker room banter of "drink a cup of cement and harden up." Fear of being mocked when we reach out, even when physically sick, is a common theme in male help-seeking literature.

Galdas et al (2005, p.616) found "a prominent theme ... implicates 'traditional masculine behaviour' as an explanation for delays in seeking help." Fekete, Osváth & Michel (2004, p.309) discovered, "consultation rates and help seeking patterns in men are consistently lower than in women in the case of emotional problems and depression." If help-seeking for medical issues is difficult, how challenging is it for men in terms of mental health? Hughes' findings (2012, p.6) mirrored earlier research, with males believing that seeking help for mental health is a "sign of weakness and failure."

While a woman needs a shoulder to cry on so too does a man, as feelings do not discriminate between the genders. Granted, we may think differently, but is this due to conditional or biological factors? Eli Newberger (1999, p.51) maintains, "We have diminished the emotional life of boys and men by defining crying so early and decisively as a weakness." This socialised reluctance to share our vulnerabilities may play into gender differences in suicide and into the methods with which men attempt suicide. Perhaps, our inability to express the more vulnerable emotions emerges in anger, and self-violence, leading to drastic and violent methods of suicide (Callanan & Davis, 2010). Newberger (1999, p.52) alludes to this by asserting,

"Eventually, the code against male crying asserts itself, so crying gets dropped from the combination of activities; from then on, the male who is boiling over with frustration will express his feelings either in violent language or in physical assault, or in both."

After all, what is suicide but the ultimate physical assault on oneself? If disassociation is a factor in male suicide, then learning to cry might be our greatest tool to combat life's difficulties. Judith Nelson (2005), in *Crying and Attachment*, notes, "Crying

in solitude contradicts the reason we cry: for connection." Therefore, as therapists, it is incumbent upon us to facilitate our clients in expressing emotions, as "there are many things that can only be seen through eyes that have cried" (Romero, as cited by O'Rourke, 2017c, p. 45).

Counselling Those Bereaved by Suicide

"I did not know how to reach him, how to catch up with him.... The land of tears is so mysterious" (de Saint-Exupéry, 1995, p.34).

Common words used to describe the suicidal include "lonely", "isolated", "helpless", and "hopeless." Arguably, those bereaved also experience a depth of aching emotion, knowing they were unable to reach their loved one. A duality is present in the helplessness, confusion and despair experienced by both parties. This may be agonisingly true in the case of parents' grief, as Euripides decrees, "what greater grief can there be for mortals than to see their children dead" (Didion, 2012, p.13). How then do therapists penetrate the silence of sorrow, so the client's grief can "melt into words that speak of pain and heartache"? Those grief-stricken can be left in a perpetual state of numbness, or as Didion (2007, p.32) eloquently put it, "I wake and feel the fell of dark, not day." Andriessen and Krysinka (2011, p.24) contend, "The metaphor of a stone thrown into a lake reflects well the wide-reaching impact of suicide. It causes many ripples which turbulently affect the water's surface." Unknowns, related to why their loved one did it and whether they could have prevented it, torment the bereaved. What must this endeavour of searching for an unattainable answer be like? Undoubtedly, grief work must explore unanswerable questions. There is healing in grieving, if it is honoured. Poignantly, Gibran (1923, p.40) reminds us, "the deeper the sorrow carves into your being; the more joy you can contain." For therapists, the Rogerian Core

Conditions are certainly a basis to facilitate grief work.

Elizabeth Kübler-Ross's Model of Grieving

When counselling the bereaved, it is important to have a theoretical foundation from which to start. One of the best-known frameworks is Elizabeth Kübler-Ross' Five Stage model. Grief and attachment are also inevitably intertwined (Kosminsky & Jordan, 2016). We do not mourn what we are not attached to, or as Colin Murray Parkes (2009, p.2) writes, "love and loss are two sides of the same coin". Alice Middleton and David Williams, (2001, p. 178) highlight the supposition "that some form of security is damaged by bereavement." Therefore, while giving due consideration to theories of grief, therapists must also consider attachment. Kübler-Ross and Kessler (2014, p.13) remind us that the stages model was 'never meant to help tuck messy emotions in neat packages.' Instead, "with the stages comes the knowledge of grief's terrain, making us better equipped to cope with life and loss." It is a model, but it is not necessarily linear. One can easily tumble into an earlier stage, in the moment-to-moment experiencing.

Denial:

"Your mind will believe comforting lies while also knowing the painful truths that make those lies necessary. And your mind will punish you for believing both." – Ness, From the Motion Picture *A Monster Calls*.

When referring to Denial, Kübler-Ross reminds us that it is not a denial of the death. Instead denial refers to the shock and numbness that is encountered. In suicide, this shock can be amplified. Denial can literally be the psyche's self-protection. As therapists, we should remember, "There is a period of avoidance that is psychologically therapeutic" (Humphrey & Zimpfer, 2008, p.149). In fact, some theorists (Stroebe, Stroebe & Hanson, 1993,

p.407) suggest interventions "offered to families immediately following a sudden death" can be counterproductive. Denial may be all that allows the client to cope. We should tread carefully, permitting clients to emerge from denial in their own time.

Anger:

Ann Smolin (1993, p.133) writes, "Anger is a normal response to being abandoned." Often the bereaved "experience themselves as the victim of a very savage assault" (Ainsworth-Smith & Speck, 1999, p.55). Loved ones may also exhibit anger towards helping professionals, wondering if perhaps 'something more might have been done' (Ainsworth-Smith & Peck, 1999, p.55). Jordan and McIntosh (2011, p.149) caution therapists to 'remember that anger is a reasonable, appropriate and understandable reaction to the suicide.' Kosminsky (2012, p.30) states, "feelings [like] anger are particularly elevated when losses occur through violent death such as suicide..." Kominsky further observes, "people who come to us after the loss of a loved one are bringing us a problem that we cannot solve." Anger will be present in the work and in the relationships the bereaved person has. William Worden (2009, p.69) calls this 'Angry Attachment' and encourages us to aid the person in expressing it.

Bargaining:

"...the *whys* and *what-ifs* of his death haunted my every thought. Why did he leave...What could I have done to save him? Did I do anything to bring about his decision to die?" (Fine, 2006, p.5).

Kubler-Ross and Kessler contend, "Bargaining can help our mind move from one state of loss to another" arguing that it "keeps suffering at a distance." Furthermore, they describe it as a thinking process, where thoughts bargain "with all the what ifs..." Possibly, the bargaining stage in survivors manifests in what

Smolin (1999, p.32) refers to as the "tortured refrain of 'We should have...', 'We could have...' and 'if only we had...'. There is a sense of magical thinking evident in these words, which echo the bargaining usually seen in grief. While CBT is not often considered a viable grief therapy, the one place it may be useful is when the person is ready to challenge distortions that lead to guilt. On its own, it "may not be efficacious for Complicated Grief Disorder among survivors of suicide" however, it can "lower dysfunctional grief symptoms and survivors' beliefs that they were blameworthy" (Parker, 2014, p.497). This suggests that an integrative approach is warranted.

Depression:

"Our concern must always be for the bereaved; that they may have the support to face, feel and express their pain in whatever way they choose" (Kenneally, 1999, p. 115).

Rita Robinson (2001, p.37) contends that depression "may be tougher on survivors of suicide." There is simply more conflict to deal with, and often a plethora of unanswerable questions. Those bereaved by suicide are at greater risk of developing complicated grief (Jordan, 2008; Prigerson et al, 2011). With complicated grief, comes a higher risk of a depressive disorder (Young et al, 2012). In a 2011 qualitative study of grief reactions in those bereaved by suicide, 71% of parents, spouses, children and close friends identified as depressed (Schneider, Grebner, Schnabel and Georgi, 2011). Unquestionably, therapists must ensure that interventions for managing depression are included.

Acceptance:

"It is from reaching beyond ourselves, beyond our sorrow, that we are transformed." (Tatellbaum, 1983, p.140, as cited by O'Rourke, 2017c, p.45)

Young et al (2012, p.178) maintain,

“the hallmarks of ‘healing’ from the death of a loved one are the abilities ... to recognise that they have grieved, to be able to think of the deceased with equanimity...and to be able to seek the companionship of others.” They go on to assert that from the bitterest of losses can emerge new meaning and wisdom. Teri Madura (2013, p.174) reminds us that “this does not mean that the pain goes away or that approval of the death is granted. Instead, there is acceptance of how one’s life has been changed by the loss.” Thus, acceptance is more than a word or a search for meaning, it is a way of truly living despite our losses.

The war on silence will end in defeat for every heart permitted to beat in the air that hearts make sweet” (Kennelly, 1990).

Conclusion

As therapists, it is vital that we recognise the grieving journey is unique to each client we encounter, and to the relationship dynamic that existed between the bereaved and the person they have lost. Grief in the aftermath of suicide is more likely to be complex, and the grieving process should not be rushed. In the therapeutic space, we must remember, “there is no typical response to loss as there is no typical loss. Our grief is as individual as our lives” (Kübler Ross & Kessler, 2014, p.14). Furthermore, as always, our role is to walk with the person, at their pace, facilitating a space for client to talk, as they navigate the changing seas of their grief.

“Give sorrow words. The grief that does not speak whispers the o’erfraught heart and bids it break.” (Shakespeare, Macbeth, Act 4, Scene 3)

In summation, if Farberow was correct that suicidal people are made and not born, it is plausible that Kübler-Ross would argue beautiful people are also *made*, not born. Was she alluding to this when she wrote

“The most beautiful people we

have known are those who have known defeat, known suffering, known struggle, known loss and have found their way out of the depths. These persons have an appreciation, sensitivity, and an understanding of life that fills them with compassion, gentleness and a deep loving concern. Beautiful people don’t just happen” (Kübler Ross, 1975, p. 96). ○

Note: All italicised quotations are taken directly from Brendan Kennelly’s poem, *May the Silence Break*.

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