**Adapting to the New Challenges:**

**Attending to Depression and Suicidality in the Community**

**Bikur Cholim Conference**

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**Packet # 2**

Assembled by Rabbi Simkha Y. Weintraub, LCSW

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**Hearing the Voices of Two Jewish Parents Whose Children were Addicts**

My survival through my son's addiction and after his death

"Upon finding that my son was addicted to narcotics the shame and blame I felt was devastating. Every waking and sleeping hour the shame and fear I felt and the effort to hide that shame and fear from others was monumental. Then I found out about “Wit’s End” a support group for families and concerned loved ones of substance dependent children, founded in Vermont by a couple after the death of their 19-year-old daughter from a heroin overdose. The relief of finding out that I was not alone, that there were people who had the same experiences, who were willing to share, to listen and to be there for me was a huge relief."

*With that knowledge and the experience of sharing my story, I was able to confide in my Rabbi and a few friends.*

*Author Unknown*

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"I was able to learn Non-Violent compassionate communication skills for my own self-care. This also helped me to learn to love and connect with my son without shaming or blaming him. He is gone now, due to a heroin overdose after 5 years of slippery sobriety. I am able to carry on because I want to share the skills I learned, to be there for those who need someone to listen to them who will not judge or blame them. Through my life experience I understand the challenge, the sorrow as well as the joy, and the precious gift that comes from living with someone that is substance dependent.

*Sandy Marmar*

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[**10 Things Not to Say to a Suicidal Person**](https://www.speakingofsuicide.com/2015/03/03/what-not-to-say/)

***“I want to kill myself.”***

Those five words are a shock to hear, a dreadful pronouncement from a friend or family member you do not want to lose. You recoil at the thought. How could they want to die?

As unwelcome as those words are to your ears, your loved one has handed you a gift. He or she is letting you in. By telling you they want to die, they are giving you the opportunity to help.

What you say next is very important. It could lead to your friend or family member letting you in even more – or shutting the door. Understandably you are full of emotion, and you might have many thoughts, some helpful, some not.

Here are 10 common responses that can discourage the person from telling you more. First, a caveat: In general, these statements can convey judgment and foster alienation. But, depending on the context, some people might respond positively to at least some of these responses.

1. **“How could you think of suicide? Your life’s not that bad.”** Perhaps on the outside the suicidal person’s life does not seem “that bad.” The pain lies underneath. It can greatly help a suicidal person to feel understood. This sort of statement conveys disbelief and judgment, not understanding.
2. **“Don’t you know I would be devastated if you killed yourself? How could you think of hurting me like that?”** Your loved one already feels awful. Heaping guilt on top of that is not going to help them feel soothed, understood, or welcome to tell you more.
3. **“Suicide is selfish.”** This inspires more guilt. Two points are important here. One, many people who seriously consider suicide actually think they are burdening their family by staying alive. So, in their distressed, perhaps even mentally ill state of mind, they would be helping their loved ones by freeing them of this burden. Two, isn’t it a natural response to excruciating pain to think of escaping the torment? (I write more about this in my post, [“Is It Selfish to Die in a Tornado?”](https://www.speakingofsuicide.com/2015/10/28/is-it-selfish/))
4. **“Suicide is cowardly.”** This inspires shame. It also does not really make sense. Most people fear death. While I hesitate to call suicide brave or courageous, overcoming the fear of death does not strike me as cowardly, either.
5. **“You don’t mean that. You don’t really want to die.”** Often said out of anxiety or fear, this message is invalidating and dismissive. Presume that the person really does mean that they want to die. It does more harm to dismiss someone who is truly suicidal than it does to take someone seriously who is not suicidal, so why not just take everyone seriously?
6. **“You have so much to live for.”** In some contexts, this kind of statement might be a soothing reminder of abundance and hope. But for many people who think of suicide and do not at all feel they have much to live for, this remark can convey a profound lack of understanding.
7. **“Things could be worse.”** Yes, things could be worse, but that knowledge does not inspire joy or hope. I compare it to two people who are stabbed, one in the chest, one in the leg. It is far worse to be stabbed in the chest, but that does not make the pain go away for the person stabbed in the leg. It still hurts. A lot. So even if people who think of suicide have many good things going for them, even if their lives could be far worse, they still experience a seemingly intolerable situation that makes them want to die.
8. **“Other people have problems worse than you and they don’t want to die.”** True, and your loved one may well have already considered this with shame. People who want to die often compare themselves to others and come up wanting. They may even feel defective or broken. Comparing them to others who cope better, or who simply are lucky enough to never have suicidal thoughts, may only worsen their self-condemnation.
9. **“Suicide is a permanent solution to a temporary problem.”** I do know people, especially teens, for whom this statement was tremendously helpful. It spoke to them. But it also communicates that the person’s problems are temporary, when they might be anything but. In such a situation, a realistic goal for the person might be to learn to cope with problems and to live a meaningful life in spite of them. The other problem with this statement is it conveys that suicide is a solution – permanent, yes, and a solution. At a minimum, I recommend changing the word “solution” to “act” or “action,” simply to avoid reinforcing that suicide does indeed solve problems.
10. **“You will go to hell if you die by suicide.”** Your loved one has likely already thought of this possibility. Maybe they do not believe in hell. Maybe they believe the god they believe in will forgive their suicide. Regardless, their wish to die remains. Telling them they will go to hell can exacerbate feelings of alienation.

Again, any or all of the thoughts and emotions above may come to you. It doesn’t mean you are wrong or bad to have such reactions.

After all, you are human. You may feel angry, hurt, betrayed. You cannot control the thoughts and feelings that come to you. You can only control what you say or do in response to your thoughts and feelings.

When someone discloses suicidal thoughts to you, your words and actions can help the suicidal person to feel less alone and, as a result, hopeful. Good questions to ask yourself are, “How can what I want to say help this person? How can it do harm?”

Your answer may mean the difference between the person feeling judged and even more alone – or accepted and understood.

**What If You’ve Already Said the “Wrong” Thing to a Suicidal Person?**

I suspect that if I stopped this post here, I would receive frantic emails from people who already reacted in ways that were not especially helpful or understanding. Their fear and anxiety may have spilled out when they heard their friend or family member express a desire to die.

That fear and anxiety are understandable. So are the reactions above. But what to do when what has been said cannot be unsaid?

My advice? Try again. Go back to the person and say that you realize you did not respond helpfully, that you are frightened by the possibility of their dying by suicide, but you want to set aside your fears and understand better their wish to die so that [you can be a listening ear](https://www.speakingofsuicide.com/2013/06/06/how-would-you-listen-to-a-person-on-the-roof/), a partner in their struggle, an ally who helps them feel less alone and hopeless.

And then it can be helpful to ask some of the most important words of all, “How can I help?”

**UPDATE 10/3/2017: I just discovered another post, written before mine, with a list of 10 things to avoid saying to a suicidal person. It’s an excellent list, and I recommend reading it at**[**purplepersuasion.wordpress.com/2014/04/09/ten-things-not-to-say-to-a-suicidal-person/**](https://purplepersuasion.wordpress.com/2014/04/09/ten-things-not-to-say-to-a-suicidal-person/)**.**

Written by [Stacey Freedenthal, PhD, LCSW](https://www.speakingofsuicide.com/author/sfreedenthalgmail-com/) on March 3, 2015 in [All Posts](https://www.speakingofsuicide.com/category/all-posts/), [Friends and Family](https://www.speakingofsuicide.com/category/friends-family/), [Parents](https://www.speakingofsuicide.com/category/parents/), [Stigma](https://www.speakingofsuicide.com/category/stigma/), [Suicide](https://www.speakingofsuicide.com/category/suicide/), [Suicide Prevention](https://www.speakingofsuicide.com/category/suicide/suicide-prevention/) with [489 Comments](https://www.speakingofsuicide.com/2015/03/03/what-not-to-say/#comments)

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[**10 Things to Say to a Suicidal Person**](https://www.speakingofsuicide.com/2017/10/03/10-things-to-say/)

*Written by* [*Stacey Freedenthal, PhD, LCSW*](https://www.speakingofsuicide.com/author/sfreedenthalgmail-com/) *on October 3, 2017*

Many people desperately want to know what to say – and what not to say – to someone who is thinking of suicide. The article [*10 Things Not to Say to a Suicidal Person*](https://www.speakingofsuicide.com/2015/03/03/what-not-to-say/) is [SpeakingOfSuicide.com](https://www.speakingofsuicide.com/)’s most popular post. Almost a half-million people have viewed it in the last 2½ years. Several hundred have left comments.

Sometimes people complain to me that the post describes what *not* to say, but it doesn’t say enough about what *to* say. They’re right. So in this post, I provide 10 things to say to a suicidal person.

**First, Some Caveats**

Before starting, I want to make some things clear: I came up with this list based on my conversations with suicidal individuals in my work as a clinical social worker, my readings of both clinical literature and accounts by individuals who experienced suicidal crises, and [my own past experiences](https://www.speakingofsuicide.com/2017/05/16/why-i-came-out/) with suicidal thoughts. Nobody has actually researched systematically the most effective things for friends or family to say to a suicidal person, so opinion and experience are the best we’ve got for now. Results will vary according to different people’s needs and personalities.

I also want to make clear that this list of things to say is not intended to be a script. Instead, I illustrate ways that you can help a suicidal person continue to open up, rather than shutting the person down with a comment that minimizes, invalidates, or even denigrates the person’s experience.

And I want to add that what to say often isn’t nearly as important as how to listen. As I explain in my post “[How Would You Listen to a Person on the Roof](https://www.speakingofsuicide.com/2013/06/06/how-would-you-listen-to-a-person-on-the-roof/)?”, someone who is thinking of suicide needs to feel understood. Let the person tell their story. Refrain from immediately trying to fix the situation or make the person feel better. These efforts, however well intended, can halt the conversation.

So, with all that said, here are 10 things you can say to someone who tells you that they are considering suicide.

**1. “I’m so glad you told me that you’re thinking of suicide.**

When someone discloses suicidal thoughts, some parents, partners, friends and others react with anger (*“Don’t be stupid!”*), pain (*“How could you think of hurting me like that?”*), or disbelief (*“You can’t be serious.”*) Some “freak out.” A suicidal person might then feel a need to comfort the hurt person, provide a defense to the angry person, or retreat internally from the disbelieving person. The person might regret ever having shared in the first place that they were thinking of suicide.

By saying “I’m glad you told me” – or something similar – you convey that you welcome and encourage disclosure of suicidal thoughts, and that you can handle it.

**2. “I’m sad you’re hurting like this.”**

This simple expression of empathy can go a long way toward validating the person’s pain and soothing a sense of aloneness. There’s no “*Oh it’s not so bad,”* no *“You don’t really mean that,”* no *“But you have so much going for you,”* no other statement denying or minimizing the person’s pain.

**3. “What’s going on that makes you want to die?”**

This invitation to the suicidal person to tell their story can provide validation, engender a sense of connection, and show that you really want to understand. Ask the person to tell their story. And then, listen. [Really listen](https://www.speakingofsuicide.com/2013/06/06/how-would-you-listen-to-a-person-on-the-roof/). To deepen your understanding, follow up with more invitations to share, like “Tell me more.” Show empathy and understanding, too: “That sounds awful” or “I can see why that’s painful.”

**4. “When do you think you’ll act on your suicidal thoughts?”**

Even if you’re not a mental health professional, you still can ask some basic questions to help understand the person’s risk for suicide. Asking about timing will make the difference between whether you need to call someone immediately for help (for example, if the person says, “I have a gun in my backpack and I’m going to shoot myself during lunch”) or whether you can continue to have leisurely conversation with the person.

**5. “What ways do you think of killing yourself?”**

This is another risk-assessment question. The answer can help reveal the gravity of the situation. A person who has put a lot of time and thought into suicide methods might be in more danger than someone with a vague wish to be dead, for example.

Understanding the suicide methods that the person has considered also will help you in your efforts to keep the person safe. For example, if you’re a parent and your teenage child discloses suicidal thoughts, knowing that your teenager is considering overdosing on a painkiller alerts you to the need to lock up or throw away all potentially dangerous medications. (See [this information](https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_Suicide_Safe-guard-Home_Youth.pdf) from the Center for Youth for ways to make your home safer.)

**6. “Do you have access to a gun?”**

Even if you think the person doesn’t own a gun or can’t get a hold of one, this information is always important. If the answer is yes, ask the person to consider giving the gun (or a key piece of the gun) to someone, locking the gun up and giving someone the key, or doing something else to make the home gun-free until the danger of suicide goes down. For more information about firearm safety related to suicide risk, also see this [gun safety fact sheet](http://www.mass.gov/eohhs/docs/dph/com-health/injury/gun-safety-fact-sheet.pdf).

**7. “Help is available.”**

By telling the person about help that’s available, you can help them to not feel so alone, helpless, or hopeless. If you are in the U.S., you can give them the number to the [National Suicide Prevention Lifeline](https://suicidepreventionlifeline.org/) (800.273.8255) or the [Crisis Text Line](https://www.crisistextline.org/) (741-741). You also  can show them the SpeakingOfSuicide.com [Resources page](https://www.speakingofsuicide.com/resources/#immediatehelp), which lists other resources in the U.S. and worldwide to receive help by phone, email, text, or online chat. If the person who reveals suicidal thoughts to you is your child, take them to a mental health professional or an emergency room for an evaluation.

**8. “What can I do to help?”**

Definitely tell the person about resources for help, but also make clear that you are available, too, if you’re able to do so. That said, there’s only so much you can do, so if you are feeling solely responsible for keeping the person alive, it’s best to involve others, too.

**9. “I care about you, and I would be so sad if you died by suicide.”**

Be careful here. In my earlier post, one of the 10 things not to say is, “Don’t you know I would be devastated if you killed yourself? How could you think of hurting me like that?” As I note in that post, “Your loved one already feels awful. Heaping guilt on top of that is not going to help them feel soothed, understood, or welcome to tell you more.”

At the same time, a simple statement of how much you care about or love the person can help nurture a sense of connection, if your statement isn’t an attempt to stop the person from talking further about suicide.

**10. “I hope you’ll keep talking to me about your thoughts of suicide.”**

Just as you want the person to feel welcome for having shared their suicidal thoughts to you, it’s good to make clear that you would welcome further disclosures, as well. Often, someone who has suicidal thoughts senses from others an expectation to “get over it already.” By inviting the person to come to you again about their suicidal thoughts, you can help prevent isolation and secrecy.

**What Are Your Ideas about What to Say to a Suicidal Person?**

There are many other helpful responses besides those listed here. If you have thoughts of suicide, what do you wish someone would say to you if you told them? If you have ever helped a suicidal friend or family member, what responses from you seemed to foster sharing, connection, and safety? Please feel free to leave a comment below.

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**Teen Suicides: What Are the Risk Factors?**

***Temperament, family and community all play a role***

Nadine Kaslow, PhD

One of the myths about suicidal talk, and actual [suicide](https://childmind.org/topics/concerns/suicide-and-self-harm/) attempts, in young people is that they are just a bid for attention or “a cry for help.” Kids who talk or write about killing themselves are dismissed as overly dramatic—obviously they don’t mean it! But a threat of suicide should never be dismissed, even from a kid who cries “Wolf!” so many times it’s tempting to stop taking her seriously. It’s important to respond to threats and other warning signs in a serious and thoughtful manner. They don’t automatically mean that a child is going to attempt suicide. But it’s a chance you can’t take.

When thinking about this, it helps to understand what factors make a young person more or less likely to consider or attempt suicide. What do we know about young people who try to kill themselves, or who actually die by suicide? Let’s take a look at both the [risk factors](https://childmind.org/article/teen-suicides-what-are-the-warning-signs/)—things that increase the likelihood that a child will engage in suicidal behavior—and the protective factors, or things that reduce the risk.

If a child has a lot of risk factors and hardly any protective factors you need to be extremely concerned about him. On the other hand, if he has a fair number of risk factors but a lot of protective factors you may be somewhat less concerned, although you still, of course, need to be concerned.

**Here are some key suicide risk factors:**

* A recent or serious loss. This might include the death of a family member, a friend or a pet. The separation or a divorce of parents, or a breakup with a boyfriend or a girlfriend, can also be felt as a profound loss, along with a parent losing a job, or the family losing their home.
* A psychiatric disorder, particularly a mood disorder like [depression](https://childmind.org/topics/concerns/depression/), or a [trauma](https://childmind.org/topics/concerns/trauma-and-grief/)– and stress-related disorder.
* Prior suicide attempts increase risk for another suicide attempt.
* [Alcohol and other substance use disorders](http://childmind.org/article/parents-know-teens-drinking-drugs/), as well as getting into a lot of trouble, having disciplinary problems, engaging in a lot of high-risk behaviors.
* [Struggling with sexual orientation](https://childmind.org/article/lgbt-teens-bullying-and-suicide/) in an environment that is not respectful or accepting of that orientation. The issue is not whether a child is gay or lesbian, but whether he or she is struggling to come out in an unsupportive environment.
* A [family history of suicide](https://childmind.org/article/coping-with-a-parents-suicide/) is something that can be really significant and concerning, as is a history of domestic violence, child abuse or neglect.
* Lack of social support. A child who doesn’t feel support from significant adults in her life, as well as her friends, can become so isolated that suicide seems to present the only way out of her problems.
* [Bullying](https://childmind.org/topics/concerns/bullying/). We know that being a victim of bullying is a risk factor, but there’s also some evidence that [kids who are bullies](https://childmind.org/article/what-to-do-if-your-child-is-bullying/) may be at increased risk for suicidal behavior.
* Access to lethal means, like firearms and pills.
* Stigma associated with asking for help. One of the things we know is that the more hopeless and helpless people feel, the more likely they are to choose to hurt themselves or end their life. Similarly, if they feel a lot of guilt or shame, or if they feel worthless or have [low self-esteem](https://childmind.org/topics/concerns/confidence-self-esteem/).
* Barriers to accessing services: Difficulties in getting much-needed services include lack of bilingual service providers, unreliable transportation, and the financial cost of services.
* Cultural and religious beliefs that suicide is a noble way to resolve a personal dilemma.

But what about protective factors, things that can mitigate the risk of engaging in suicidal behavior?

Bottom of Form

**Here are some key protective factors:**

* Good problem-solving abilities. Kids who are able to [see a problem and figure out effective ways to manage it](https://childmind.org/article/how-to-help-kids-learn-to-fail/), to resolve conflicts in non-violent ways, are at lower risk.
* [Strong connections](https://childmind.org/article/12-tips-raising-confident-kids/). The stronger the connections kids have to their families, to their friends, and to people in the community, the less likely they are to harm themselves. Partly, that’s because they feel loved and supported, and partly because they have people to turn to when they’re struggling and feel really challenged.
* Restricted access to highly lethal means of suicide.
* Cultural and religious beliefs that discourage suicide and that support self-preservation.
* Relatively easy access to [appropriate clinical intervention](https://childmind.org/report/2016-childrens-mental-health-report/targeted-interventions/), whether that be psychotherapy, individual, group, family therapy, or medication if indicated.
* Effective care for mental, physical, and substance use disorders. Good medical and mental health care involves ongoing relationships, making kids feel connected to professionals who take care of them and are available to them.

So [what do you do if your child fits the profile](https://childmind.org/article/youre-worried-suicide/) of someone at risk for youth suicide? [Warning signs](https://childmind.org/article/teen-suicides-what-are-the-warning-signs/) of suicide to be alert to include changes in personality or behavior that might not be obviously related to suicide. When a teenager becomes sad, more withdrawn, more irritable, anxious, tired, or apathetic—things that used to be fun aren’t fun anymore—[you should be concerned](https://childmind.org/event/managing-teen-angst-depression/). Changes in [sleep patterns](https://childmind.org/article/happens-teenagers-dont-get-enough-sleep/) or eating habits can also be red flags.

[Acting erratically, or recklessly](https://childmind.org/article/teen-suicides-what-are-the-warning-signs/) is also a warning sign. If a teen starts making really poor judgments, or he starts doing things that are harmful to himself or other people, like bullying or fighting, it can be a sign that he is spinning out of control.

And, finally, if a child is talking about dying, you should always pay attention. “I wish I was dead.” “I just want to disappear.” “Maybe I should jump off that building.” “Maybe I should shoot myself.” “You’d all be better off if I wasn’t around.” When you hear this kind of talk, it’s important to take it seriously—even if you can’t imagine your child meaning it seriously.

What to do? The first thing to do is [talk.](https://childmind.org/article/talk-mental-health-issues/)

https://childmind.org/article/teen-suicides-risk-factors/

*For more information and resources on suicide, see* [*the APA’s suicide help page.*](http://www.apa.org/topics/suicide/index.aspx)

**Older Adults at Greatest Risk for Suicide**

**Poor health and isolation can increase suicide risk, experts say**

By Emily Gurnon/June 8, 2018

Credit: Thinkstock

(*Next Avenue has republished and updated this 2015 article as a service to readers who might need to seek help for themselves or for a loved one. We mourn the tragic deaths from apparent suicide of chef and TV host Anthony Bourdain and fashion innovator/entrepreneur Kate Spade*.)

Eastman Kodak founder George Eastman had accomplished much by the age of 77, having revolutionized photography and invented motion-picture film.

One day, he gathered together a group of friends to discuss how he planned to divide up his estate. After the meeting, he excused himself briefly and wrote them a note: “My work is done. Why wait?” He then shot himself in the heart.

But before we conclude that Eastman was making a sober, well-considered decision to end his days, Kimberly Van Orden, says, consider this: “If you look a little bit closer at George Eastman’s life, we learn that he suffered severe back pain, functional impairment in terms of mobility, had restricted social interactions and likely experienced depression… Suicide is not an expected response to the challenges of aging.”

**Suicide and Older Adults: More Common Than We Think**

Van Orden, an assistant professor in the Department of Psychiatry at the University of Rochester School of Medicine, took part in a webinar last month on older-adult suicide prevention.

In 2013, people ages 45 to 64 had the highest suicide rate, according to figures from the U.S. Centers for Disease Control.

— Kimberly Van Orden, University of Rochester

Many associate suicide with young people, like troubled teens or twentysomethings who never quite got their lives off the ground.

In fact, it is much more common among older adults. According to [new figures](https://www.washingtonpost.com/news/to-your-health/wp/2018/06/07/u-s-suicide-rates-rise-sharply-across-the-country-new-report-shows/) just released this week from the U.S. Centers for Disease Control, the highest rate of suicides in America is among people age 45 to 64. There were more than [232,000 suicides](https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a1.htm?s_cid=mm6722a1_w) in this age group from 1999 to 2016.

Other factors make suicide attempts more likely to be fatal among older people, Van Orden says.

“Older adults tend to die on their first attempt,” she says. Their frailty often makes them less likely to survive; their isolation makes them less likely to be rescued and “they tend to be more planful and determined in their suicidal behavior.”

**Sounding the Alarm**

The incidence of older adult suicide has not gone unnoticed by mental health professionals such as Van Orden. Yet they want to raise awareness of the problem among caregivers, family, friends and others who may be able to intervene.

When an older adult has one or more of the following risk factors, his or her loved ones should be especially cognizant of the danger of suicide, Van Orden says:

* Depression
* Prior suicide attempts
* Presence of other medical conditions
* Physical pain
* Social dependency or isolation
* Family discord or loss
* Inflexible or rigid personality
* Access to lethal means

One of the most important issues to confront is depression, she said. Health care providers should do routine screenings and, if depression is identified, get it treated.

“We know that depression treatment is effective,” at least in reducing thoughts of suicide and likely in reducing suicide itself, Van Orden says.

**Acute Risk – The Most Dangerous Time**

Warning signs of “acute risk” of suicide, Van Orden says, include:

* Threatening to hurt or kill herself or talking of wanting to kill herself
* Looking for ways to commit suicide by getting access to pills or weapons, for example
* Talking or writing about death or suicide when such actions are not typical

**Toward Prevention**

Fortunately, there are some “protective factors” that can reduce the risk of suicide, says Rosalyn Blogier, public health adviser with the Substance Abuse and Mental Health Services Administration. Blogier also took part in last month’s webinar, which was sponsored by the National Council on Aging. The protective factors include:

1. Assessment and care for physical and mental health issues
2. Social connectedness
3. Sense of purpose or meaning
4. Resilience during transitions

Those who work with older adults, including activity directors at senior living centers, have tried to educate residents by offering classes, but the tone of the approach made a difference, says Christine Miara of the Suicide Prevention Resource Center, who also joined the webinar. Stigma around mental health issues remains a very real problem.

“They found out that if they called it [the class] ‘Depression Awareness’ or ‘Reducing Suicide,’ they didn’t get many people to come, but when they gave it a title like, ‘Building Resilience’ or ‘Awakening to Joy’ or ‘No Regrets,’ the participation was much better,” she says.

If you or someone you know is in danger of taking their life, call the National Suicide Prevention Lifeline: 1-800-273-TALK.

Emily Gurnon is the former Senior Content Editor covering health and caregiving for Next Avenue. She previously spent 20 years as a newspaper reporter in the San Francisco Bay Area and St. Paul.[@EmilyGurnon](https://twitter.com/@EmilyGurnon)

https://www.nextavenue.org/older-adults-at-greatest-risk-for-suicide/

**Ten Common Tensions of Survivors of Suicide**

*Rabbi Simkha Y. Weintraub, LCSW © 2012*

**To Share or Not to Share**

Carrying an unbearable burden but risking avoidance, rejection or tyrannical sympathy

**Telling the Story and the Mystery, the Elusive Narrative**

Need to somehow understand and express what happened, but the authoritative storyteller is gone…

**The Very Real and Yet Disenfranchised Disease**

Society’s discounting, stigmatization, and moralization around depression, addiction, etc., so that the death is not understood in relation to disease

**The Focus on the Death but the Need to Reclaim the Life**

It is a major task to work through the nature of the death, and yet in grieving, one needs to be able to reclaim the whole life

**Compelling but Also Toxic (and sometimes Impossible) Secret-Keeping**

Protecting the survivors and the deceased – but expending great energy in what can be a futile and even harmful effort.

**Time Stands Still While Moving On**

Loved ones’ lives were ‘shattered’ and ‘frozen’ but family, friends, work, society marches on

**“I Need You” and “Leave Me Alone”**

There can be little healing without others, but so many don’t get it or unwittingly add insult to injury

**Idealization and Reality**

S/He was very special and unique – but not angelic or perfect….

**Being myself and taking on new roles**

The unsolicited task of becoming a “suicide parent/child/spouse/sibling etc.”

**The Dances of Guilt and Rage, Despair and Newfound Purpose/Priority, Grief and Gratitude…**

The journey is so complicated…

The Stigma of Suicide and How It Affects Survivors’ Healing

Written by [William Feigelman](https://www.opentohope.com/author/feigelw/) on Thursday, January 31, 2013

In this short paper, I condense an article that first appeared in the International Association of Suicide Prevention Postvention Taskforce Newsletter (Vol. 3. No. 5, Oct. 2008). Today analysts claim suicide stigma is subtle with blame being cast upon survivors and survivors being subjected to informal isolation and shunning. It is often noted that stigmatization promotes more grief difficulties and mental health problems for survivors. But, we were surprised to find no one has verified whether these assertions are supported with systematic evidence.

To investigate this, my co-investigators and I collected surveys from a sample of parents losing children to suicide (462 cases) and a contrast population of other parents who lost children to other traumatic deaths (e.g., auto accidents, drug overdoses, homicides, etc.) (89 cases) and natural deaths (24 cases). Our sample was drawn primarily from the ranks of members of suicide survivor support groups and from several chapters of The Compassionate Friends.

In addition to asking respondents various standardized diagnostic questions about their grief difficulties, depression and suicidality, we developed a new stigmatization measure consisting of 22 questions asking respondents whether, following the loss of their child, they experienced harmful (instead of helpful) responses from various kin and non-kin. Respondents were also asked whether relations with any of these groups had become more strained and to write onto their survey forms any hurtful things said and done to them following their loss.

Write-in questions yielded comments from over 80 % of respondents, the overwhelming majority (80%) giving either negative or mixed negative comments. We grouped the comments into one of seven types: a) Avoidance (expressed most frequently), e.g., “People avoided me,” “Friends or family didn’t call me afterwards.” b) Unhelpful advice (expressed by a majority), e.g., “It’s time to move on,” “Are you still going to that support group, now?” c) Absence of a caring interest (expressed by a majority), e.g., “No one asked me how I was feeling afterwards,” “If I started talking about my lost child, they quickly changed the subject.” d) Spiritual (expressed by a minority), e.g., “God called him,”;“He’s in a better place now,” “It was meant to be.” e) Blaming the victim (expressed by a minority), e.g., “That was a cowardly thing he did; ”He was selfish.” f) Blaming the parent (expressed by a minority), e.g., “Didn’t you see it coming?” “Why didn’t you get him into therapy?” g) Other negative (expressed by a minority), e.g., “Well at least he didn’t kill anyone else when he died,” or “At least you have other children.”

Our numeric measure of stigma showed 53% of survivors reported harmful responses from one or more family member group following loss and 32% reported harmful responses from at least one non-kin group. Also, about half of the respondents (55%) reported one or more strained family relationships and 47% reported one or more strained social relationships. These frequencies attest to the pervasiveness of stigma.

When we examined whether those gaining higher scores on our stigma scale had more grief difficulties, depression and suicidal thinking (compared to low scorers), our findings confirmed this.

A somewhat surprising result emerged when we compared stigma exposures among our three survivor subgroups: suicide, other traumatic deaths and natural deaths. Results showed suicide survivors much like other traumatic death survivors in experiencing stigma and both showed more stigma exposures than parents of a child’s natural death. This suggests most sudden deaths, whether by suicide, a fatal automobile accident or drug overdoses evoke similar fear-based avoidance responses. People think “it could have happened to us,” and often evade survivors in terror and dread, rarely offering comfort to those on the front lines of grief.

Concluding, these findings suggest that stigma experiences are unfortunately part of the everyday lives of traumatic death survivors. What makes these stigmatizing experiences so irksome is the expectations survivors have of gaining support and solace from these close family and social intimates. Who else should be able to readily understand their personal devastating tragedies? Thus, survivors need to carefully take stock of their social supports after a loss, avoiding some significant others in the interests of promoting their own mental health, or imposing a moratorium on association with others and may need to teach some of their significant others how to be more supportive.

William Feigelman, Ph.D.

**7 Synagogue “Interventions” towards Preventing Suicide**

It is a fact of life that challenges such as mental illness, substance misuse, trauma, abuse, etc. may well not be 100% curable, preventable, or manageable, at least not at this time in history. But synagogues, Jewish schools, Jewish community centers and organizations have their own unique resources to help “tilt the scales towards life,” to strengthen resilience and further connection, de-stigmatization, recovery, hope, and help.

Here are 7 possibilities for what synagogues can/might do:

1. **Normalize psychological/emotional challenges and encourage seeking professional support.**

Consider how to integrate these into Sermons and Divrei Torah; Anonymous First-Person Bulletin Narratives; Religious School and Adult Education Courses; Posters in Hallways; Promoting Resources and Community Programs on Website

* Name/Seek to address social alienation; anomie, spiritual emptiness; lack of meaning.
* Regularly feature “success stories” that inspire hope and underscore the value of every life.
* Host speakers from NAMI, JACS, AFSP, etc. (see # 5 below)

1. **Train Staff and Volunteers in Warning Signs, Intervention and Advocacy, Follow-Up**

* *K’lei Kodesh*/Clergy and Educators
* Front-Line Office Staff, Custodial Staff
* Board and Committee Leadership (and see # 4 below)
* Other volunteers, such as Greeters, Ushers, Bikur Cholim Visitors, etc.

1. **Weave psychological insights and perspectives into the study of stories such as:**

Expressions of Despair, Depression, or Deep Disappointment – as “Suicidal Ideation”:

Rachel in Genesis 30:1 Jonah in 4:3 and 4:9

Moses in Exodus 32:32 Job in 2:9, 3:11; 3:26; 10:10; 30:15-17

Jeremiah in 20:14, 18

“Successful Suicides” in the *TaNaKh*

King Avimelekh (Judges 9: 50-55) Samson (Judges 16:25-30)

King Saul and his Armor-Bearer (see I Samuel 31:3-5)

Ahitophel, Counselor to King David (II Samuel 17:23)

King Zimri (I Kings 16:15-20)

1. **Develop and sustain a Synagogue Crisis Consultation Committee**

Might include retired and active mental health professionals, “sturdy” survivors, teachers, guidance counselors, CASACs, chaplains, etc. -- a range of people who, respecting confidentiality, can be approached to be a safe and sensitive bridge to resources and an advocate/escort in an often-confusing and fragmented system.

1. **Develop and maintain connections with relevant local/communal and national agencies and organizations**, such as American Foundation for Suicide Prevention, Suicide Prevention Resource Center, Elijah’s Journey, The Trevor Project, The Jed Foundation, National Alliance on Mental Illness-NYC Chapter, JACS, the Samaritans, Met Council on Jewish Poverty, and so on.
2. **Enhance communication and relationships with other synagogues and houses of worship.** Many in distress may turn to several places while not being truly/effectively connected to any of them. Weaving a valuable safety net for these people might depend on these groups anonymously “sharing notes” and checking in with one another.
3. **Take care of the caregivers.** It is truly unwise, and often impossible, to carry the challenges of outreach and advocacy alone. Members of the community who are trying to help someone who is or has been suicidal need their own reliable and caring support, to be able to maintain their equilibrium, renew hope and return to their own lives without immobilizing guilt or overwhelming fear. And in those cases where a family member is caring for someone who is depressed, misusing substances, or otherwise at risk, remember that caring for these caregivers is an essential part of the picture.

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**Stories of Suicide in the TaNaKh**

**King Saul** – Because of defeat by the enemy and great fear after being wounded, Saul chose to end his life, rather than face abuse by his captors. When his armor-bearer refused to kill him at his request, he took his own life by falling on his sword. ([1 Samuel 31:3-5](http://www.biblestudytools.com/search/?t=niv&q=1sa+31:3-5))

**Armor-bearer to Saul** – Out of hopelessness and terror after seeing that Saul was dead, this assistant to the king impulsively took his life as well. ([1 Samuel 31:5](http://www.biblestudytools.com/search/?t=niv&q=1sa+31:5))

**King Avimelekh** – This king over Israel was ruthless and cruel. His evil knew no limits, and after killing many people, and even taking the lives of 69 of his 70 half-brothers, God allowed one woman to stop him. After she dropped a millstone on his head, he was so injured that his pride led him to command his young armor-bearer take his own life, so that no one could “say a woman killed him.” ([Judges 9:50-55](http://www.biblestudytools.com/search/?t=niv&q=jud+9:50-55))

**Samson** – In his great drive for revenge, Samson was willing to die when he killed the Philistines in the crowded temple that day. Braced between two pillars, he used his final strength to push them down, and take his own life along with his enemies. ([Judges 16:25-30](http://www.biblestudytools.com/search/?t=niv&q=jud+16:25-30))

**Ahithophel** – As a one-time close companion of David, and grandfather of Bat-Sheva, Ahithophel eventually took up the cause of Avshalom’s rise against him. But when he noticed that his advice had not been taken to lead to final defeat over David’s army, out of possible fear, rejection, or complete hopelessness, he chose to go home, “put his house in order, and then hanged himself.” ([II Samuel 17:23](http://www.biblestudytools.com/search/?t=niv&q=2sa+17:23))

**King Zimri** – As an evil king of Israel and facing utter defeat, Zimri saw no way out, except to take his own life. He set the palace on fire and died in it, rather than choose to face his enemy.

([I Kings 16:15-20](http://www.biblestudytools.com/search/?t=niv&q=1ki+16:15-20))

**Visiting Mourners When the Death is a Suicide**

*Making a* shiva *call is always difficult. You may not know what to say, or how to act with someone who has recently lost a loved one. When a family is sitting* shiva *after a suicide, visiting can be even more challenging because of stigma related to suicide and many misconceptions about suicide.*

*This fact sheet provides some insight into what families who have lost loved ones to suicide may be thinking and feeling, and some tips for being supportive in their time of need.*

Jewish burial and mourning practices are typically followed.

Jewish law has made space for compassion for someone who dies by suicide and for that person’s family. The complete set of Jewish burial and mourning practices are typically followed in the case of a death by suicide.

**What are the basics of *shiva*?**

 In many traditional communities, only family and close friends attend the first day of *shiva*. If you are un-sure about when to visit, try to ask someone organizing the *shiva* to see when would be most helpful (such as to make a minyan), or when not to go because there may already be too many people attending.

 Let families set the pace and tone for the *shiva*. If you’re invited to eat, eat. If there is a prayer service, take part. If the family is sitting quietly, join them. If they are laughing, laugh with them.

 Be respectful of the hours set for *shiva* and don’t stay more than an hour. You don’t want to make the family feel like they have to entertain guests.

**It’s okay (and sometimes recommended) not to speak.**

It may feel very uncomfortable to just sit and not say anything when paying a *shiva* call, but that can be exactly the right thing to do. Understand that there are no words that can lessen the pain of a loss to suicide.

Sometimes, what we think will be helpful can be unintentionally hurtful. Here are some things not to say:

*“They are in a better place now.”*

This kind of language implies that the loved one was in a bad place before his or her death.

*“I’m sure they loved you very much.”*

We don’t really know about other people’s relationships. While it may seem comforting to say something like the above statement to the mourner, it’s better to let the mourner take the lead in talking about his or her feelings. A death by suicide can contribute to feelings of guilt and anger.

*“You did everything you could.”*

Especially after losing a loved one to suicide, families would like to maintain hope that suicide is preventable. Strive not to do harm with your words. Saying, “You did everything you could” “There was nothing that could have been done,” or “Did you have any idea that this would happen?” places a lot of responsibility on the mourner.

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**Tips for things you can say to a mourner:**

If you do want to say something, try to acknowledge to the mourner that this loss is a tragedy, while at the same time offering your support:

 “I can’t imagine what you are going through, but I am here for you.”

 “I know there are no words that can heal your pain, but I want you to know that you are in my thoughts.”

 “I realize there is nothing I can do to lessen your pain, but please let me know if there is any way I can support you during this time.”

**Grief is different for everyone.**

Allow for those who are grieving to do so in their own ways. You may see dramatic expressions of grief at a *shiva* house. Some people grieve externally, expressing their thoughts and feelings out loud. Some people are silent. Some people may seem to be acting “normally.” Common responses to loss include anger, denial, sadness, or withdrawal. There is no right order to these responses, and different people within one family might experience different feelings at the same time.

**Don’t ask questions about the suicide.**

It may seem like common sense, but you should never ask about the circumstances of the suicide, such as if the person who died suffered from mental illness, or how the suicide happened. It may be painful for the family members to relive those moments by having to answer questions about it.

There may not be a clear “why” that family members can address. It sometimes feels like knowing “why” can help provide closure, but family members are often seeking the answer to that question without having clarity themselves.

**Paying a *shiva* call is about the mourners, not you.**

Of course it feels good to do a mitzvah like paying a *shiva* call, but remember that the *shiva* call is about the mourner, not you. Walking out of the *shiva* house feeling good about what you have done is not the most important thing in this situation.

Here are some suggestions for how to best lend support to the family in a time of tragedy:

 Focus on the life of the person who has died. Try your best to avoid talking about other people who have died, by suicide or by other causes, and focus on supporting the mourners.

 Don’t talk about your feelings or other experiences related to suicide. These conversations take the focus away from the life of the person you are mourning.

 Offer a positive memory of the person who you are there to grieve, so that the family can collect memories of their loved one.

**Mourning continues after *shiva*.**

After a *shiva*, the family’s grief will continue. There are so many things that can be helpful once many friends have left the *shiva* house. Offer to make a meal or go grocery shopping, or to visit. Many families still want friends and visitors even after the period of *shiva* as they navigate the mourning process.

Additional resources:

* www.elijahsjourney.net
* www.g-dcast.com/jewish-mourning/
* www.myjewishlearning.com/article/death-mourning/

This *shiva* guide was developed in partnership with Elijah’s Journey by

**Rella Kaplowitz**  **Elana Premack Sandler**  **Mia Simring**

This resource is dedicated in memory of our loved ones

**Eytan Kaplowitz**  **Joel Premack Noah Lior Simring**

***Guide for the Shiva of Someone Who Died of Suicide:***

<http://ritualwell.org/ritual/visiting-mourners-when-death-suicide>.

**Some Suicide Crisis Resources**

*Drawn from American Foundation for Suicide Prevention (ww.afsp.org)*

*Remember*: **If you or someone you know is in need of medical attention, please call 911.**

[**The National Suicide Prevention Lifeline – 1-800-273-TALK**](http://www.suicidepreventionlifeline.org/)

**Who runs it?** SAMHSA **When is it available?** 24/7, 365 days a year

**Who should use it?** Someone struggling or in crisis or the friend of someone who is struggling or in crisis

**What to expect:** You will be routed to a crisis center nearest to you. You will hear a message saying you have reached the National Suicide Prevention Lifeline and hold music while your call is being routed. The person you speak to will be a skilled, train crisis worker who will listen and tell you about mental health services in your area. Your call is confidential and free. Para español, 1-888-628-9454.

[**Veterans Crisis Line: 1-800-273-8255, Press 1**](https://www.veteranscrisisline.net/)

**Who runs it?** Department of Veterans Affairs, in partnership with National Suicide Prevention Lifeline

**When is it available?** 24/7 365 days a year

**Who should use it?** Veterans and service members, regardless of discharge status, who are struggling or in crisis. Family members or friends of a veteran or service member who is struggling/in crisis.

**What to expect:** Your call will be answered by a VA crisis responder. Some responders are veterans; all responders are trained to counsel veterans and service members specifically. If all responders are busy, you will be routed to counselors at the National Suicide Prevention Lifeline back-up center who are also trained to support veterans and service members. Responders can provide referrals for VA services and help fast-track appointments with a VA Suicide Prevention Coordinator. It is your choice how much or how little personal information to share.

[**Lifeline Crisis Chat**](http://www.crisischat.org/)

**Who runs it?** National Suicide Prevention Lifeline in partnership with CONTACT USA

**When is it available?** 2pm-2am EST, seven days a week

**Who should use it?** Veterans and service members, regardless of discharge status, who are struggling or in crisis. Family members or friends of a veteran or service member who is struggling/in crisis.

**What to expect:**  When you agree to the terms and conditions, you will be routed to a crisis center in the United States that has a chat specialist available to talk to you.  If all chat specialists are busy chatting with other visitors, please try again in 15 – 30 minutes. You might be asked non-identifying demographic information but this is only for data collection purposes. The chat specialist will also work collaboratively with you to create a safety plan, outlining some positive coping strategies and next steps, among other things.

[**Crisis Text Line- 741741**](http://www.crisistextline.org/)

**Who runs it?**  Crisis Text Line INC **When is it available?** 24/7, 365 days a year

**Who should use it?** Anyone in crisis, the friends or family of those in crisis

**What to expect:** When you send a text to the 741741, you’ll receive an automated text asking you what your crisis is. Within minutes, a live trained crisis counselor will answer your text. They will help you out of your moment of crisis and work with you to create a plan to continue to feel better.

[**Disaster Distress Helpline- 1-800-985-5990**](http://www.samhsa.gov/find-help/disaster-distress-helpline)

**Who runs it?** SAMHSA **When is it available?** 24/7, 365 days a year

**Who should use it?** Anyone struggling with emotional distress during or after natural or human-caused disasters, infectious disease outbreaks, and incidents of mass violence and their family or friends; first responders; rescue, recovery and relief workers; and clergy.

**What to expect:** The Disaster Distress Helpline is staffed by trained counselors from a network of crisis call centers located across the United States. They can provide crisis counseling, information on how to recognize distress, tips for healthy coping, and referrals to local crisis call centers for additional follow-up care and support. The counselor may ask you for some basic information at the end of the call, but these questions are optional and are intended to help SAMHSA keep track of the types of calls it receives.

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# SEVERAL OTHER HELPFUL HOT/HELPLINES:

# NAMI-NYC HELPLINE: 212-684-3264 [helpline@naminyc.org](mailto:helpline@naminyc.org)

[**SAMHSA Treatment Referral Hotline (Substance Abuse)**](https://www.samhsa.gov/find-help)[**1-800-662-HELP (4357)**](tel:+1-800-662-4357)

[**RAINN National Sexual Assault Hotline**](https://hotline.rainn.org/online/terms-of-service.jsp)[**1-800-656-HOPE (4673)**](tel:+1-800-656-4673)

[**National Teen Dating Abuse Helpline**](http://www.loveisrespect.org/)[**1-866-331-9474**](tel:+1-866-331-9474)

**Also you can visit your:**

* **Primary care provider**
* **Local psychiatric hospital**
* **Local walk-in clinic**
* **Local emergency department**
* **Local urgent care center**