

## Touched by Suicide: Bridging The Perspectives of Survivors and Clinicians

MICHAEL F. MYERS, MD, AND CARLA FINE, MS

This article is a revised version of an invited plenary address given at the 39th Annual Conference of the American Association of Suicidology. The authors, a psychiatrist and a writer survivor, outline and summarize the different ways in which professionals and survivors come to an understanding of suicide. They explain how each group often exists independently and separate from the other—by cognitive and emotional dissonance, by private language, by psychological defenses and miscommunication—and call for dialog. They argue that both perspectives are essential to advance the science of suicidology and to give hope and meaning to those bereaved by suicide.

**[MFM]:** Professionals and survivors use a different lens to gather information. I use the term *professionals* in a very general way to include all people working in the field of suicide research and all people caring for individuals whose lives have been touched by suicide. The operative word here is *work* or *job*. Even *calling*, if you like. But professionals learn about suicide from study, reading, the teaching of their professors and supervisors, and conducting original research; for those on the front lines, they learn by listening and bearing witness to the stories told to them by suicidal individuals and those they leave behind.

Researchers use their brains and minds to gather and synthesize information, weighing through scientific articles and books, analyzing statistics, and generating hypotheses for new research. Their work requires use of

one's intellect and rational thought. They collaborate with each other through meetings like this [AAS annual conference], presenting data, and preparing their findings for publication and wider dissemination. This cognitive focus is essential to advance our science.

The work of clinicians is a bit different. These professionals have the responsibility of helping people to feel better. To understand why they are feeling despairing and suicidal. To stop them from harming themselves. To help bereaved individuals who have lost a loved one to suicide. This work melds their minds and hearts. In my field of psychiatry we call it practicing both the art and science of medicine.

Carla will speak about the lens of survivors, but I will say one thing in order to draw a contrast with professionals. Professionals come into the field of suicide voluntarily. It is a choice, free will. I have never met a survivor who chose to become a survivor. This state is thrust upon them with a fury. They are catapulted into the world of suicide. It is sudden, unwanted, and unwelcome.

We must never forget that some professionals are also survivors of suicide—

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MICHAEL MYERS is Clinical Professor, Department of Psychiatry, University of British Columbia; and CARLA FINE is a writer who lives in New York City.

Address correspondence to Michael F. Myers, MD, St. Paul's Hospital, Department of Psychiatry, 1081 Burrard Street, Vancouver, BC V6Z 1Y6; E-mail: myers@telus.net

indeed, becoming and being a survivor has in part informed their decision to study to become a professional in the field. Likewise, some professionals were already working in the mental health field as researchers or clinicians when they lost a loved one to suicide. To quote a psychiatrist colleague of mine after her son, struggling with an eating disorder and depression, hanged himself in his college dorm, “When Ken died, the loss was colossal. I lost my boy, my only child, and I lost my career. I wasn’t able to practice medicine, Emergency Psychiatry, for almost two years. My confidence was in tatters.”

Whatever the lens, cognitive or experiential, thinking or feeling, separate or integrated, wanted or unwanted, our field needs both. Both are essential to advance our understanding and preventive efforts in suicide. The experience that Carla and I have in reaching out to one group of people, physicians, has supported our belief that survivors and professionals working together can have an impact (Myers & Fine, 2003).

This hit home to me a few years ago when we gave our first presentation together to an audience of doctors. The subject was physician suicide. I began with a brief power point presentation on what the research tells us about risk factors in doctors, how to assess for suicide, when to hospitalize a doctor and when not to, and what to do if a physician kills himself or kills herself. Carla then told her story of losing her physician husband, Dr. Harry Reiss, to suicide. But she brought him into the room. Where he went to medical school. Where he did his residency. His research at New York University. His publications. That he loved being a doctor. She put a human face to the subject. She spoke from her heart, a widow struggling to make sense of her husband’s decision to die. I watched the doctors in the audience. They were galvanized by her words. She concluded by reaching out to them, telling them to take care of themselves. The silence was deafening.

This moment was pivotal for me and reinforced something that I had always known—that some audiences seem to need

the “science” (which appeals to their intellectual side) and the “story” (which appeals to their soul). I realized the importance of clinicians and survivors working together, bridging their differing perspectives for a common goal.

**[CF]:** As Mike mentioned, this feels like perfect synergy to be speaking here today, with Jim Rogers as the Conference chair and the theme of the conference one of collaboration and understanding. During our presentation at the AAS conference in Santa Fe (Fine & Rogers, 2003), Jim and I emphasized the importance of creating a shared knowledge and language between scientist and survivor in order to discover new insights and information about suicide. Mike and I were inspired by this simple but elegant concept in the writing of our book *Touched by Suicide: Hope and Healing After Loss* (Myers & Fine, 2006), and we are grateful to Jim not only for inviting us to talk but also for helping to pave the way in improving communications among researchers, mental health professionals, clinicians, first responders, advocates, crisis center workers, and those of us who have lost someone we love and cherish to suicide.

The idea of writing a prescriptive book about suicide from the dual perspectives of a mental health professional and survivor—a practical, step-by-step guidebook combining medical and psychological information as well as first-hand observations and advice from survivors on the front lines—came about as the result of another AAS conference. This one was in Miami in 2004 where I was asked to speak about practical steps for healing at the “Healing After Suicide” luncheon. My first reaction was surprise at being asked to address the topic. After all, I was a survivor, not a professional, and all I could offer would be my personal observations from both my own experience and the shared stories of the many other survivors I had met and spoken with over the years. This would be fine, I was reassured, and reluctantly and with many caveats, I outlined a series of specific steps that I and other survivors have found to comfort and ease the pain after suicide touches your life.

The response was immediate and positive. There were, after all, ways to feel better; we weren't as powerless as we seemed. Survivors, myself included, want a path to follow; each of us looks to establish some kind of order in the terrible chaos that follows the suicide of someone we love. It helps to know that our feelings have a name; our road to healing follows a rocky but prescribed route; and our emotions and reactions are not random like the death of our loved one.

The reaction from the professional and scientific communities in the audience was humbling. "You have opened up your private world to us," I was told. "Survivors have their own language and we are not often invited to be part of their conversation. This will help us in our work."

What became obvious to me was that we all share a common goal even though, as Mike points out, we may view suicide through our own particular personal or professional lens. Our goal, then, is to bridge the gap between survivors and professionals, or as Jim Rogers puts it, to find a common ground. Together, we are looking for answers in the "Canyon of Why," Frank Campbell's eloquent metaphor for our mutual search to make sense of suicide as well as the title of his brilliant and important book-in-progress. We all want to unlock the mystery of suicide, to prevent more suicides from happening, to lower the risk factors of suicide, and to ease the pain and suffering of those who have lost a loved one to suicide.

When my husband, Harry Reiss, killed himself in 1989 at the age of 43 after 21 years of marriage, I thought I was the only one who had experienced such a loss (Fine, 1999). I thought I would never recover, that I was the only person in the world that this had happened to, that no one could ever possibly understand what I was going through. In an instant, I entered a different realm of existence from anything I had ever known before. I didn't know where to turn, what to do, what to expect, or what to believe in.

Knowing that I was not alone, that there were others who had also "been there," gradually helped me to begin to regain my

shaky balance. As I met other survivors and exchanged the often gory details of our stories as well as our similar fears of going crazy, our terror and bewilderment about our loss, our guilt and anguish about what happened, and, our all-consuming unbearable heartache, I slowly began to resume breathing. Then living, then functioning, then forgiving both my husband and myself, then creating—or recreating—a new life without Harry but one that honored and paid tribute to his memory.

The lens of a survivor is anecdotal and subjective. Yet, we are the witnesses, the information gatherers, the first-hand observers who have lived with or known intimately the person who has died by suicide. We have shared our loved one's last months, days, and even hours and minutes. We can inform the work of researchers and clinicians by describing behavior that, in the wake of suicide, are now considered symptoms. We can recount details of our loved one's demeanor that may shed new light on the decision or process one goes through before ending his or her life.

I have had 16½ years to try to figure out why Harry killed himself one cold and dark December afternoon. I have tried out different sound bites over the years. "He lost both his parents in one year and never got over it." "He was suffering inconsolable grief." "He was suffering from undiagnosed and untreated depression." "He was screwed up and out of his mind." Maybe all of these reasons are true. But Harry took the answers with him when he gave himself an intravenous injection of ten times the dosage of the anesthetic Thiopental. Sadly, maybe Harry didn't have the answers either. But I will never know.

For most survivors, suicide is something we know nothing about until someone we care for ends his or her life. Suicide is not in our vocabulary and we have no time to prepare for it. From the minute we walk into the room or receive the phone call, our lives are split apart, creating a frozen "before" and a permanent "after." It takes a while to understand that suicide and death are two separate entities, that first we have to

go through the suicide before we can mourn the death.

At the beginning, survivors don't have the language, the knowledge, the context, or the resources to understand what has happened. We know our loved one is dead. We know that he or she died purposefully. We are consumed with the details of what happened, obsessively recounting the final minutes and hours, even days and months, as if trying to find the missing clue that will explain everything. We don't know where to turn or who we can trust. We reach out to other survivors with suggestions, tips, advice, and comfort for making sense of suicide. We muddle through as best we can.

But, instinctively, we know that we cannot get through this experience alone. Although shared anecdotes and stories with other survivors help ease our grief, we also search for hard facts and advice from clinicians and researchers. We look for scientific and medical information to help us understand the complexities of the human mind, the causes and treatment of mental illness, and the most recent psychological and biochemical research related to suicide. We seek out professional guidance on ways to keep ourselves together, to keep our families together, and to maintain our physical health, our faith, and our sanity.

We want to know: "How can I tell if I am handling this right?" "What is the normal grieving time after a suicide?" "Is suicide genetic?" "Is thinking about killing yourself ever normal?" "Why did I miss the signs that my daughter was planning to kill herself?" "Why didn't my mother leave a note?" "Is it wrong to be angry at my husband?" "Why did my father shoot himself in front of the family?" "Can antidepressant medications cause suicide?" "When should I go for help?" "How do I tell my children?"

All of these questions—and hundreds more—swirl around your mind after a suicide. And, initially, most survivors, myself included, do not know how to articulate our thoughts or describe our emotions. By opening up the dialog between professionals and survivors at conferences such as this, we can

begin to explore and ultimately find some of the answers that concern those of us whose lives are touched by suicide.

For example, in our book, Mike and I write about the emotional symptoms of stress. Although survivors have suffered a trauma of great proportion, we are usually not aware of its power and reach. Many of us describe feeling as if we have entered an alternative universe where nothing seems quite real. We feel detached, and may even fear that we are losing our minds.

So, when Mike names this not untypical reaction to suicide as "dissociation," it gives us a definition we can hold on to and brings clarity to our confusion and fear. Not only do we discover that dissociation is a splitting off of our emotions from our thoughts because they are too intense and overwhelming to experience, but we also learn that as odd or frightening as this may feel, dissociation is almost always temporary. As a matter of fact, dissociation is usually benign and self-protective because the pain we're experiencing is just too much to bear in full force. We start to calm down. We're okay.

And if we can't remember who attended our son's funeral or forget the directions to our home or even our sister's name, we begin to understand that we are not suffering from a sudden onset of Alzheimer's or have become permanently brain damaged—we are having "memory lapses" that are probably shielding us in some way from the full impact of our loved one's suicide. Or if we hear our loved ones speaking to us a couple of days after they have killed themselves or see them sitting on the living room couch, hey, we may not be truly insane but are instead suffering from temporary "sensory disturbances."

In the chaos and turmoil that follow suicide, most of us don't know any of this. And many of us are afraid to tell mental health professionals and others how we are feeling because we assume they won't take us seriously. Or think us crazy or even try to commit us to a psychiatric facility.

Establishing a common language brings

about great trust. Jargon among clinicians and scientists excludes survivors; buzz words and private verbal codes among survivors distance professionals. Listening to and respecting each other's points of view sharpens our own unique lens and helps to make the overall picture clearer and more comprehensive.

It gives me great hope to be speaking to an audience of both professionals and survivors, and to be part of a dialog that includes so many people who are committed to better understanding suicide and its impact on every person it touches.

**[MFM]:** We professionals regularly use scientific and technical language to convey our observations and findings to each other in both oral and written form. We learn this language in our course work, usually at a postgraduate level, as we train to become psychologists, clinical social workers, psychiatric nurses, family physicians, and psychiatrists. This language facilitates communication, gives momentum to our discoveries, enhances our clinical competence, and ultimately, we hope, helps our patients and their families. The downside is that our language can be distancing, highly intellectual, and devoid of feeling. And it can become closed to outsiders, what I like to call somewhat tongue in cheek, club language. At its worst, some professionals will even become competitive and challenging with their language.

An example: In 1998 I produced a videotape called *When Physicians Die by Suicide: Reflections of Those They Leave Behind* (Myers, 1998). The stories of the survivors on the tape are powerful, evocative, and emotionally engaging. After showing part of this tape at a psychiatric grand rounds, the instant that the lights were turned back up, a hand shot up from a man in the audience. He said "Well, Dr. Myers, this show is all very interesting but hardly empirical. Never mind. I have a question arising from something you completely neglected to address in your earlier power point presentation. I'm not sure why you omitted what permeates the suicide literature, both the general corpus of knowledge and the focal nucleus. I'm referring of course

to epidemiology. Does the well-known, very high suicide rate in Hungary also apply to their doctors?" How did I respond to this question? I said something like: "I intentionally did not mention suicide in Hungarian physicians. Because this subject is so close to home—our brothers and sisters in medicine are killing themselves—I deliberately wanted to touch your hearts so that as psychiatrists we might do a better job in looking after our own."

This brings me to my next point, which is our defensive use of technical language. We use it to protect ourselves. Whether you are a neuroscientist dissecting brains of suicide victims, a sociologist studying suicide in African American adolescent males, a cardiac surgeon trying to save a man who has just shot himself in the chest, or a therapist listening to her patient describe a detailed plan to leap from a downtown office building after work today, we erect protective armor to shield ourselves from the full impact of what we're studying, hearing, or doing.

We cannot labor for long in the world of suicide without personal safeguards. We risk burnout, cynicism, exhaustion, and detachment. It's also called compassion fatigue (Figley, 1995) or vicarious trauma (Nelson, 1996). If our defenses fail us, we feel our patients' pain with such force that we become emotionally overwhelmed, break down, and become paralyzed. Not only are we not helpful to our patients but we may frighten them and heighten their anxiety. Even worse, they begin to worry about us and this is not appropriate in a professional relationship.

As a further example of bridging the perspectives of professionals and survivors, Carla and I included a section in our book on the impact of suicide on professionals. This is intended to be informative for not just our professional readers but for survivors too. There is an ever increasing scientific literature on how a therapist is affected when he or she loses a patient to suicide, but this information is recorded primarily in professional journals (Gitlin, 1999; Hendin, Lipschitz, Maltsberger, Pollinger Haas, &

Wynecoop, 2000; Ruskin, Sakinofsky, Bagby, Dickens, & Sousa, 2004). It is not readily accessible to the general public. We made the decision to distill and translate key findings into *Touched by Suicide* so that survivors and others would have a window into the hearts and minds of therapists. It is this humanness and vulnerability that we hope explains why some clinicians behave in confusing or defensive ways with families of their patients.

Dr. Ted Rynearson is a Seattle psychiatrist and international expert in bereavement attached to violent death (Rynearson, 2001; Rynearson, 2006). After his wife Julie killed herself in the midst of a severe postpartum depression, he had a visit with his wife's psychiatrist. He has written about this experience and how this man talked to him as if he were talking to a colleague who had lost a patient to suicide (Rynearson, 1981). Dr. Rynearson was not approached as the grief-stricken widowed man that he was, and this was perplexing and jarring. Was Julie's psychiatrist struggling with his patient's death and his grief affected his ability to be empathic? Was he afraid to show feelings fearing that Dr. Rynearson might think he had been medically negligent and sue him? We can only speculate but what is clear is that Dr. Rynearson's first person account of his loss is eloquent and heartfelt. Let me share a few sentences to you from his journal article.

As he began a detailed clinical presentation of her illness, I became uncomfortable. Only later was I able to appreciate the inappropriateness of his candid formulation when I wrote, "I realize now that I unconsciously needed to incorporate my dead wife's healer to continue what was unfinished. Not to 'magically' heal or explain what was already lost but to help as a supportive ally with whom I could identify in caring for her image; an image he knew well and had cared for himself. He represented a curative intermediary between my annihilated self and myself that still lived. I am sure he did not recognize it either. If he had, he might have been more giving of his own feelings, his own grief, his own confusion, and he cer-

tainly would have been less cadaverous in discussing my dead wife who was still part of me."

We have learned a lot about language from survivors and continue to learn. We know now that certain expressions used by professionals rankle some, not all, survivors. The survivor community, and I use "community" in a diverse not unitary sense, is divided on the use of the term *committed suicide*. For some, the word *committed* has a criminal ring (i.e., that he committed a crime by hanging himself) or a religiously transgressive ring (i.e., that she committed a sin by overdosing). Another expression is the word *succeed*: "After three failed suicide attempts, the patient finally succeeded. She was found dead by the police last night. Divers found her body floating in a river near her home." Since succeeding at something can mean doing something well, thriving, accomplishing a hard fought goal, you can see why this kind of language can be seen as insensitive and hurtful, when this is not what the clinician intended at all.

We professionals can take a lesson on language from survivors. Whether we are writing for a lay audience, lecturing in a public forum, being interviewed on TV or the radio, we must be very attuned to language. What is everyday parlance in our professional worlds, can be obfuscating and indecipherable to the audience we're trying to reach. Likewise with our tone. If our language is academic and our manner is stiff and stultifying, we will not connect.

Most survivors bring enormous passion to the world of suicide prevention. Their loved one has died alone. It has been an untimely death, a tragic death, a death that does not make sense. Most survivors make statements that they do not want their son or mother to be forgotten or to have died in vain. They volunteer enormous amounts of their time to make a difference. Professionals can be grateful that these individuals and families share a common vision with them.

Many survivors reach out to each

other. As a clinician I am thankful for this. If my patient is open to talking with another parent whose daughter killed herself, I am relieved to know that I can contact someone near or far for my patient to talk to. This person can help my patient in ways that I cannot and that is very comforting. In fact, it could be life-saving. One of the painful realities of being a clinician, is that our efforts are not absolute, never 100 percent effective. No matter how much I practice cutting edge medicine, how experienced and current I am in my treatment methods, no matter how empathic I am, I cannot always help a survivor to regain faith and continue living after losing their dear loved one. But I know that another survivor may assist in restoring my patient's hope. That if she can talk to another single parent whose son killed himself and who herself was dangerously suicidal for weeks or months after his death, then I am reassured, at least in part, that my patient may hold on.

Survivors have many, many questions that we professionals have not addressed. Carla hears this constantly from survivors. This is the nidus of our book, that there has been a huge hiatus out there. Families of suicidal individuals and survivors have taught us that we have to be more responsive to them—both while their loved one was alive and after their death.

[CF]: Mike mentions that survivors have many, many questions for professionals. Some of our questions have answers: What is the definition of bipolar illness? How do antidepressant medications work? What are the signs of suicidal thinking? Some of our questions have solutions: There are crisis centers and crisis workers we can turn to for advice and help. There are mental health professionals and therapists we can speak to about our pain and ask for help to lead us through our confusion. There is our faith and religion and spiritual beliefs that can offer some relief and comfort.

Yet, some of our questions do not have any answers, at least not at this time. So survivors look to the research of scientists, the

studies of mental health professionals, the hands-on experiences of first-responders. We wait for new findings and welcome new theories about the complex nature of the human mind and the unique intricacies of human behavior. Knowing that there are so many people out there seeking an answer, an explanation, a deeper understanding of suicide makes it easier for us to withstand our own very personal pain. We know we are not alone, that there are others who are also searching for answers along with us. And we are grateful.

One of the most significant developments for survivors over the years is that our voices are now part of the quest to understand and prevent suicide. We are no longer sidelined or dismissed; we feel included in the larger community of kindred spirits looking to, if not solve, at least shed light on the “why” and mystery of suicide. Our contribution to the dialog not only gives context to our loss but also helps us stay connected to our loved ones.

Mike also talks about how professionals can help survivors regain faith and meaning in their lives after suicide. Yet, isn't that why we're all here today, why we've all devoted our energies and, yes, hearts and souls, to deciphering the great puzzle of suicide? I've come to believe that the researchers and clinicians in the field of suicide are not just interested in the absolute yes/no of an exact science. How can they be? Everyone touched by suicide becomes a poet and philosopher, despite ourselves.

Each person in this room and at this conference is bound together in a mission to understand the reason why although most people choose to live, others choose to die. Understanding suicide is not a grim subject. This is what I say to those people who react with a gasp when I tell them what I write about. “My books are not depressing,” I tell them. “The subject is difficult but the stories are uplifting. This is real life, about people who embrace the glory of life and use their knowledge or pain or both to help others.”

Suicide transforms us in profoundly different ways. I have come to believe that every person in this field is a survivor—and ex-

pert—in one way or the other. Although we know we cannot undo past mistakes or misconceptions nor bring our loved ones or patients and clients back, we continue to search for meaning and answers. If this isn't optimistic and life-affirming, I don't know what is.

In our book, Mike and I quote the great Dr. Edwin Shneidman from an interview he gave to the *Los Angeles Times* in 2004 (Curen, 2004). Dr. Shneidman tells the reporter that after studying and writing about

suicide for 50 years, if he had to do it all over again, he would probably study love. But I believe that Dr. Shneidman—and the rest of us, survivors and professionals alike—are studying “love” of some sort. At the very least, we are studying “hope.” By joining forces in collaboration and understanding, we both save lives and honor those who have died. Bridging the gap between us can only give our work greater depth and meaning.

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