Suicide

Making Peace With Death

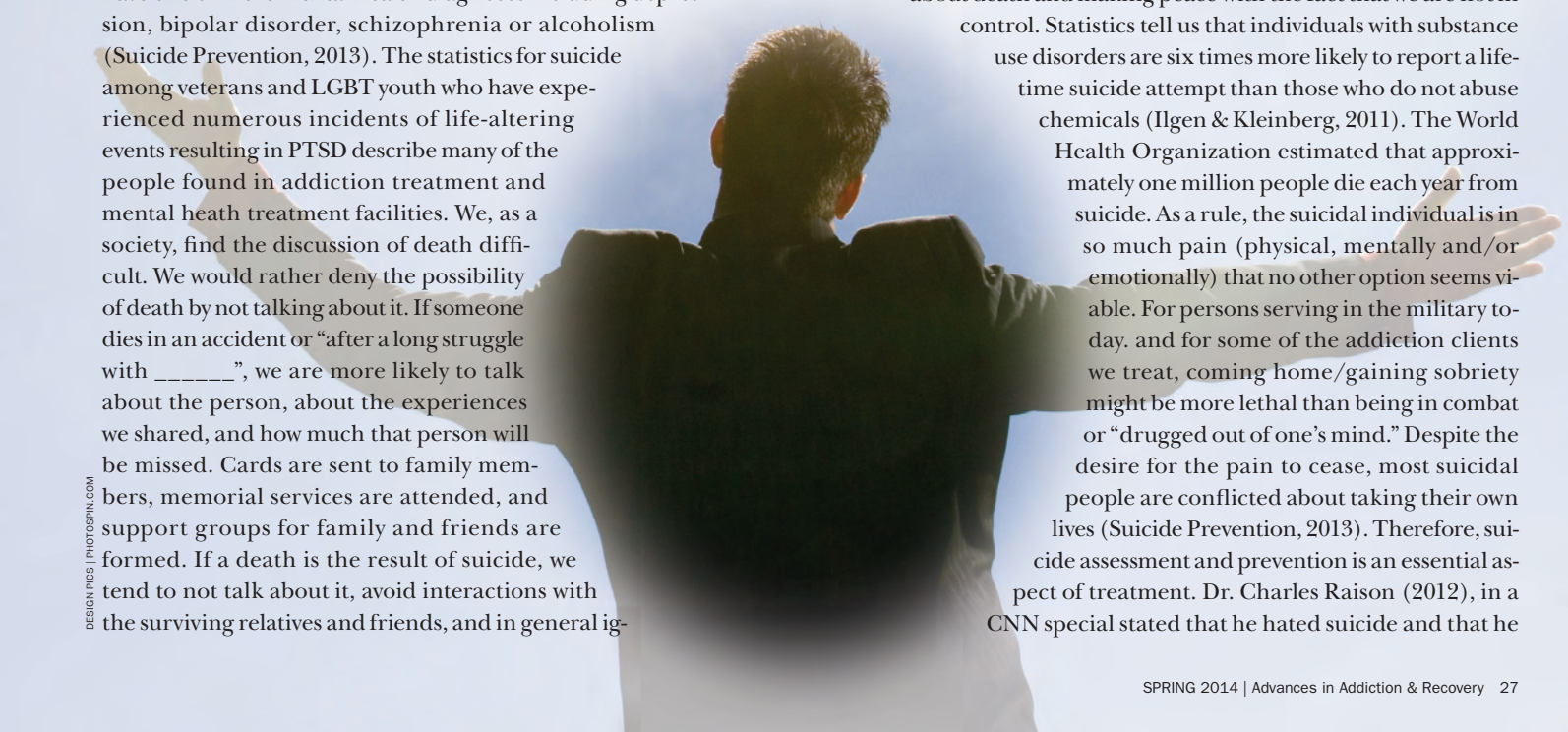
By Anne S. Hatcher, EdD, CACIII, NCACII

"Death has brought you face to face with your own mortality. You are looking at this irrational world with different eyes. You gain insights that had previously escaped you." (Grollman, p 110)

Brene Brown, in her book *Daring Greatly* (2012) described the attitude in our society as being one of "Viking or Victim." Surviving hardships and being able to share the story is rewarded and honored. Persons who were innocent victims are helped and often pitied. The stories of these individuals make up the content of news broadcasts and talk shows; donations are requested to help in their recovery. They are the subjects of numerous articles and books. For some people life ends in the middle of the story and as a result, no one knows how the story would have ended. In the U.S., we like to find resolution, to know how the story resolved itself and most of all we like happy (or at least logical) conclusions. Working with people who might choose to end their own lives does not fit the societal standard. When someone commits suicide, the potential story is interrupted; family and friends are left to wonder if they could have done something to prevent death in this situation.

Based on many years of observing human beings, some of us have come to the conclusion that dying is probably the hardest life task most people will ever face. The human body does not give up living easily; it has been programmed to maintain organ function and keep on living in spite of accidents, diseases, aging and chemical abuse. While there are any number of books and articles written about near death experiences, there is not one about someone who experienced death and then returned to teach others what to expect. This is truly the greatest unknown experience that no one can avoid. In addition, we cannot control the time and circumstances of death, except when suicide is the option chosen.

Some facts about suicide and attitudes towards it include the following. At least 90 percent of the persons who commit or attempt suicide have one or more mental health diagnoses including depression, bipolar disorder, schizophrenia or alcoholism (Suicide Prevention, 2013). The statistics for suicide among veterans and LGBT youth who have experienced numerous incidents of life-altering events resulting in PTSD describe many of the people found in addiction treatment and mental heath treatment facilities. We, as a society, find the discussion of death difficult. We would rather deny the possibility of death by not talking about it. If someone dies in an accident or "after a long struggle with _____", we are more likely to talk about the person, about the experiences we shared, and how much that person will be missed. Cards are sent to family members, memorial services are attended, and support groups for family and friends are formed. If a death is the result of suicide, we tend to not talk about it, avoid interactions with the surviving relatives and friends, and in general ignore the event (Brown, 2008). We, as clinicians seek to prevent suicide by clients because we don't want to experience our own pain of loss, anger, and grief as the result of death, especially one that could have been prevented. Clinically, we as addiction professionals think that we have failed if the client chooses suicide.



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In our profession, we focus on hope, life changes that lead to success and ability to make a difference in the lives of others. The suicidal client does not fit into this scenario. We often ignore the fact that we are working with people who, by their actions, are slowly killing themselves. One counselor observed that her work was in a hospice called detox. How many of us accept that reality and address it in the work with clients? We would do well to recognize that addiction is about control; the outcome of ingesting chemicals produces known effects that will last for a fairly predictable period of time. The symptoms of withdrawal are also known and a decision can be made to use more chemical or to "white knuckle" through the undesirable effects of not using it. In the same way, addiction professionals like control and predictability. The 12-Step programs as well as several other recovery support programs provide prescribed behaviors leading to discontinuing destructive behaviors and to finding a more desirable way of being in the world. When clients choose to not follow the treatment program, they might be described as being in denial or not having "reached bottom." Suicide is also about the client taking control by ending life and, in reality, the counselor cannot totally control the decision and the consequent actions. In other words, we cannot control what happens.

There is hope and joy along with frustration and the need to adapt to the client's reality in our day-to-day work. We have learned a lot about recovery and the new life that can be on the other side of addiction. When a client relapses, we support her/him in the process of giving up the drug of choice another time. If the client chooses suicide, we feel that we have failed; there should have been something we could have done. However, what we have not learned is how to talk about death and making peace with the fact that we are not in control. Statistics tell us that individuals with substance use disorders are six times more likely to report a lifetime suicide attempt than those who do not abuse chemicals (Ilgen & Kleinberg, 2011). The World Health Organization estimated that approximately one million people die each year from suicide. As a rule, the suicidal individual is in so much pain (physical, mentally and/or emotionally) that no other option seems viable. For persons serving in the military today. and for some of the addiction clients we treat, coming home/gaining sobriety might be more lethal than being in combat or "drugged out of one's mind." Despite the desire for the pain to cease, most suicidal people are conflicted about taking their own lives (Suicide Prevention, 2013). Therefore, suicide assessment and prevention is an essential aspect of treatment. Dr. Charles Raison (2012), in a CNN special stated that he hated suicide and that he

also understood it. He observed that some survivors of the person who committed suicide might defend the loved one's decision while others are angry and consider it a selfish act. Likerman (2010) noted that persons who have survived a suicide attempt have reported not so much a desire to die, but rather a desire to stop living. He stated that if there were an in-between state as an alternative to death, some of them might choose it. Another way of thinking about these observations is that many people fear the dying process because they do not know what to expect and how it will happen, but death (the end of life) is not feared. Perhaps the opportunity to talk openly about death and alternatives to suicide through finding a way to step back and help the client consider alternatives would be a means of addressing the needs of the person for whom suicide might be a choice.

It appears that addiction professionals would be well advised to recognize that our work involves working with people who are killing themselves by choosing to abuse substances that could cause death. Providing the option for clients to talk about death might be an opening to determine whether or not the client might consider suicide as a means of ending life sooner rather than later. Frank discussion of the circumstances that might lead to taking such an action would become an opportunity to assess a client's strengths, the options for changing life's circumstances, and for finding meaningful opportunities leading to growth and the ability to make a difference in the world rather than choosing a way out. In addition, making our own peace with death and its impact on our lives will provide an opportunity for personal and professional growth. In the opinion of this author, forming addiction counselor discussion groups in which we discuss the ideas presented here would enhance our work with clients.

The readings listed at the end of this article could be used to begin discussion groups. Many of the books and articles on death and the time leading up to it are based on grieving, learning about spirituality, and lessons from the end of life. Two books reviewed recently in the *New York Times Book Review* offer a different perspective (Williams, 2014). In the book, *Things I've Learned from Dying* by David R. Dow, the author observed that through sharing the experience of dying with another person, one learns about the boundaries of control. Questions addressed include: Who dies, how and when?" He states that the more important issue is, "How do we know when to let go when death is inevitable?" Another book reviewed is about a college course called Death in Perspective at Kean University in New Jersey. The instructor included classes ranging from end of life biology to the responsibilities of survivors and decisions essential to carrying on with life when the deceased is no longer physically present. The popularity of the course demonstrates a desire for understanding this unavoidable aspect of our lives; some students are on a three-year wait list before being able to enroll. Erika Hayasaki enrolled in the course and wrote *The Death Class: A True Story About Life,* a book about her experience. The reviewer noted that the course resulted in the instructor and her students doing "messy and necessary stuff" that enhances their experience of life.

In summary, and in support of encouraging discussion of this important topic, please consider thoughts from Forrest Church about his own impending death: "Death is not life's goal, only the end point. The goal is to live in a way that will make a life worth dying for. The one thing that cannot be taken from us as we reach the end of life is the love we give away … When facing death, we can take care of unfinished business, make peace with ourselves, reconcile where possible, and free ourselves to embrace the true meaning of life and relationships" (Church, 2008).

Readings from the following were helpful in writing this article:

Brown, B (2012). *Daring Greatly.* Gotham Books. NY. pp. 152–155.
Brown, B. (2008). *I thought it was just me (but it isn't).* Gortham Books. NY. pp. 148–149.
Church, F. (2008). *Love and death.* Beacon Press. Boston. pp. 94 and preface page x.
Flemons, D. (2013). Talking on the edge: assessing the risk of suicide. *Psychotherapy Networker.* Oct. pp. 19–20.
Grollman, E. A. (1995). *Living when a loved one has died.* Beacon Press. Boston. p. 110.
Ilgen, M & Kleinberg, F. (2011). The link between substance abuse, violence and suicide. *Psychiatric Times.* Retrieved from www.psychiatrictimes.com/substance-use-disorder on Feb. 3, 2014.
Johnson, J. (2012). *Keys for making peace with death.* Huffington post blog posted on Feb. 17. Retrieved from www.huffingtonpost.com on on Feb. 5, 2014.
Lickerman, A. (2010). *Six reasons people commit suicide.* Retrieved from www.kevinmd.com/blog/2010/06/6 on Feb. 3, 2014.
Meszler, Rabbi J. (2013). *How I made peace with death.* Huffington post blog posted on Jan. 29, 2013. Retrieved from www.huffingtonpost.com on Feb. 5, 2014.
Morris, V. (2001). *Talking about death.* Algonquin Books. Chapel Hill.
Simmons, P. (2002). *Learning to fall.* Bantam Books.
Suicide prevention, how to help someone who is suicidal. www.Help.org. Retrieved Oct. 26, 2013.
Williams, P. (2014). *Then we came to the end.* NY Times Book Review. Jan. 26. p. 21.

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