Youth suicide and bereavement

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Suicide and deliberate self-harm are important causes of mortality and ill-health in adolescents. In the UK, suicide is the fourth most common cause of death amongst 15-19 year olds[1] and deliberate self-harm is commonplace. This article describes the suicidal behaviours seen in adolescents and looks at the role of bereavement and other losses as both long-term risk factors and as immediate triggers for self-harming behaviour.

Official suicide statistics are thought consistently to underestimate the true numbers for suicide[2] because coroners require unequivocal evidence of the intent of the deceased to die. Nevertheless, the yearly figures are a useful indicator of changes over time and show a gradual increase in the numbers of suicides in this age group over the last three decades[3]. In England and Wales, the 1997 figures for those aged between 15 and 19 years showed a total of 73 male and 19 female deaths as result of suicide or self-inflicted injury, while a further 153 male and 43 female deaths were recorded as cases of self-injury where it was not possible to to determine the young person's intentions. Statistics for deliberate self-harm are not collected centrally for these countries, but an estimate based on locally collected figures suggests that 18-19,000 young people aged between 10-19 years are referred to hospital each year as a result of self-harm[4].

OVERVIEW OF THE PROBLEM

Methods of deliberate self-harm

Methods of both suicide and deliberate self-harm vary widely between countries and cultures. In the UK the most common method of suicide amongst adolescent males is hanging; amongst females it is self-poisoning for both suicide and deliberate self-harm[1,4], with paracetamol being used in over half the reported cases because it is easily avaliable. In the USA, guns are used by over 50% of adolescent suicides[5]. Limiting the availability of lethal means of suicide can reduce deaths, for example there was a reduction in the suicide rate following the replacement of (poisonous) coal gas by natural gas and also following a reduction in the prescribing of barbiturates by family doctors. The reduced lethality of exhaust fumes from cars fitted with catalytic converters, restrictions on handgun ownership and limits on the quantity of paracetamol sold in a packet may have further benefits.

An important form of self-injury encountered among adolescents, especially girls, is wrist or forearm cutting[4], though the cuts made are often superficial and may not require stitches. It is rare for girls to cause a serious or life-threatening injury by cutting.

Assessing suicide intent

The closer an episode of self-harm resembles completed suicide the more serious it is[6]. Characteristically, successful suicides occur in circumstances in which discovery is unlikely. Preparations for death (such as writing a note or will) may have been made and help is not usually sought. After a failed suicide attempt patients are usually sorry to have recovered, say that they thought the method chosen was lethal, that they intended to die and had considered the act for some time beforehand. To an observer, it seems that without medical attention death would have been the likely result of the attempt. These characteristics can be used to measure the seriousness of episodes of deliberate self-harm and form the basis of risk assessment scales such as the Pierce Suicide Intent Score[7] (see Table 1, page 6)

Origins and meanings of suicide and self-harm

The meanings and motives of suicide are, of course, very difficult to ascertain with certainty. In his classic book *Suicide*[8], Durkheim postulated the idea of suicide as

EDITOR'S NOTE

One of the nightmares for counsellors is that they will miss signals given out by a suicidally-depressed client and feel devastated that, with more knowledge or skill, they might have averted a tragedy. All suicides are tragic, but none more so perhaps than that of a young person on the brink of adult life with all before them. Bereavement constitutes a risk factor for depression and suicide and Silva and Cotgrove's paper should aid us in recognising the danger signs. This is a useful complement to Parkes' paper delineating the signs indicating high suicidal risk in adults who have been bereaved*. Any counsellor who is worried about a young person's mental state should be able to consult swiftly with a mental health professional with special expertise in this age group, who will be able to advise on measures to be taken. In this country, medical primary care practices are obliged to offer a 24-hour service and so persuading a youngster to see his or her doctor should not be delayed. The problem arises with those who refuse to go or to allow you to speak to the doctor or parent. In such cases, counsellors should contact a senior member of their organisation who will advise. Whilst breaching confidentiality is a serious matter, and may lead to loss of the trust which enables counselling to take place, preventing a death by so doing is an ethical imperative which must have a higher priority.

*** Parkes CM. The risk of suicide after bereavement. *Bereavement Care* 1882; 1: 4-5.**

Table 1

Pierce Suicide Intent Score

Each of these factors is rated on a scale between 0 and 2 or 3.

Circumstances related to suicidal attempt

1. Isolation
2. Timing to avoid intervention
3. Precautions against discovery and/or intervention
4. Not acting to gain help during or after the attempt
5. Final acts in anticipation of death eg making a will
6. Writing a suicide note

Self-report

1. Patient's statement of lethality
2. Stated intent
3. Premeditation
4. Reaction to the act

Risk

1. Predictable outcome in terms of lethality of patient's act and circumstances known to him or her
2. Would death have occurred without medical treatment?

a result of various social pressures such as a breakdown of traditional structures in a society, or cultural pressures following an individual disgrace or poor links between society and the individual. Although social factors are still regarded as important, the role of mental illnesses and substance abuse are now considered to be of more relevance for individuals. The majority (90%) of adults who kill themselves are thought to have been suffering from mental illnesses, particularly depression[9]. For young people the percentage is probably less[10], with suicide often triggered by a culmination of long term difficulties. None the less, depression amongst adolescents does predispose to suicide, with almost one in 20 depressed adolescents found to have killed themselves at long-term follow-up[11].

Mood changes are common in adolescence, but a persistent low mood may be a sign of a depressive illness. The symptoms of depression can vary greatly depending on age, with older adolescents being more likely to have adult-type symptoms.

Common symptoms of depression in adolescents include: persistently low mood, loss of interest or enjoyment in normal activities, withdrawal, decreased energy levels, a change in sleep or appetite, school failure, low self-esteem and, importantly, thoughts of worthlessness and suicide[12]. Hopelessness is a particularly worrying symptom to find when assessing suicide intent[13]. Recently the importance of substance abuse, particularly the abuse of alcohol, has also been highlighted.

The meanings and motives for deliberate self-harm are similarly varied but easier to try to establish than those for suicide. Deliberate self-harm may, of course, represent a failed attempt at suicide and hopefully be recognised as such. Alternatively it may represent escape from an intolerable environment[10], a 'cry for help' or an expression of anger directed towards the self. As mentioned previously, cutting or scratching is often not associated with suicidal intent; instead it is often described by patients as a means of releasing feelings of inner tension.

Characteristics of those at high risk

The characteristics of adolescents who kill, and try to kill, themselves have been described[4, 5, 14]. Table 2 summarises the individual, family and environmental characteristics that have been found more frequently in completed suicide than in other adolescent populations, including psychiatric in-patients.

Immediate precipitants of suicide and deliberate self-harm are very similar to the predisposing factors listed in Table 2 and include interpersonal conflicts with family or friends, losses through bereavement or relationship breakdown, and external stresses such as legal difficulties, disciplinary problems, school problems, unemployment, abuse/neglect and bullying. Unfortunately, despite the apparent similarity of those adolescents who do kill themselves, their features are shared by many others that do not and attempts to predict those that will ultimately commit suicide fail, both by identifying a great excess of cases and also by missing the small proportion who do ultimately kill themselves[6].

THE ROLE OF BEREAVEMENT AND LOSS IN ADOLESCENT SUICIDE AND SELF-HARM

Losing a parent through bereavement or separation and divorce in early life has been shown to be a risk factor for both suicide and deliberate self-harm in young people[15] and for the development of depression in later life[16]. The mechanisms for this are uncertain, possibly indirect and certainly complicated. Children who have experienced early parental loss are also more likely to have experienced prolonged parental illness or disability, or alternatively inter-parental disharmony or even violence. Their subsequent care may have been adversely affected economically (by the loss of a wage earner) and may also be unsatisfactory in other ways, for example they may have been living in institutional care or receiving inadequate parenting from a grieving or abusive surviving family member. This risk may be mitigated if subsequent arrangements are adequate[17].

Bereavement and other loss, as well as predisposing individuals to suicidal behaviour, can also act as immediate triggering factors. In a study by Brent *et al*[5] of 38 adolescent suicides, the loss of an important relationship was found to be a common precipitating factor, most frequently the loss of friends, although it is reasonable to expect that the loss of parents can have the same consequences. In a study of adolescents taking overdoses in Oxford[4], bereavement was a precipitant in 7.9% of episodes, ahead of psychiatric disorders, drug and legal problems. Bereavement is likely to act as a precipitant in those adolescents with less resilience. Problems

Table 2

Characteristic features predisposing to completed adolescent suicide

Individual	Family	Environmental
Male sex	Loss of parent in early childhood	
Mental illness: – depressive disorders – conduct disorder – substance abuse	Bereavement – relative or friend	Life stresses – unemployment – financial difficulties – conflict with peers
Depressive symptoms – especially hopelessness	Abusive or alcoholic parents	
Physical illness eg epilepsy	Lack of parental support	Urban residence
Poor self esteem	Conflict with parents	
Help-rejecting attitude		
Immature psychological defence mechanisms		Availability of firearms
Exposure to suicide		
Legal/disciplinary problems	Family history of psychiatric illness or suicide	
School problems – academic failure – bullying		

with bereavement are particularly common in those who have ambivalent attitudes to the deceased.

Recently there has been increasing concern at the rising rates of suicide and self-harm in the general population and the scale of the problem amongst adolescent males is especially worrying. Whilst characteristic predisposing factors for completed adolescent suicide have been recognised, these are not specific and attempts at identifying those at particularly high risk, for example after an episode of self-harm, have been fraught with problems and generally unsuccessful.

Bereavement in early childhood is certainly one of the predisposing factors that has been associated with suicide in later life, along with a host of others that seem to have chaos as a common theme. Acts of self-harm in young people have also been shown to be triggered by bereavement[4] – the death of someone close is a traumatic event for people of any age. Bereavement can be a trigger for extremely serious suicidal behaviour in young people; those at most risk of suicide have a host of other family, individual and environmental difficulties. The case history which follows illustrates many of these problems.

Case history

Jane was just 13 years old when she was admitted to an in-patient adolescent psychiatric unit. She had first presented to mental health services several months previously, having taken an overdose of paracetamol. At that time she had expressed a wish to die so that she could join her mother who had died of cancer four years previously. However, within a couple of hours of taking the paracetamol she had told her father who immediately called for an ambulance. She was subsequently admitted to a paediatric ward in the local hospital.

Whilst on the ward, Jane disclosed that she had been sexually abused by visitors to her father's house. Social Services were involved and while these allegations were being investigated she was placed in temporary foster care. In the meantime, Jane's father denied the possibility that she could have experienced any form of abuse and accused her of lying. This compounded Jane's distress. In addition, it emerged that he had an alcohol problem and there were fears that he was not caring for her adequately.

After a week in foster care, Jane demanded to be reunited with her father. Social Services found no clear evidence to support her allegations of abuse and Jane's father was giving assurances that he would keep her safe in the future. However, within a couple of days of her returning home, she had taken yet another overdose.

At this point, Community Child and Adolescent Mental Health Services requested an admission for Jane to an in-patient adolescent psychiatric unit, to give her a chance to talk through some of her unresolved grief from the loss of her mother, to talk about her feelings following the alleged sexual abuse and to find strategies, other than self-harm, to deal with her distress.

During her admission she worked hard on the above issues. She was able to talk through the events leading up to her mother's death, including expressing anger that she had not been told that her mother's condition was fatal until after she had died. However, it was clear that Jane's self-harming behaviour, which now included superficial cutting, was not simply a result of her bereavement but had arisen out of a number of issues. These included feelings of guilt and self-blame following her sexual abuse and confused feelings of pity and anger towards her father who had not been able to parent her adequately.

By the time she was discharged her self-harming behaviour had reduced considerably and many of her confused and conflicting feelings were resolving. Whilst she was able to acknowledge openly her remaining love for her father, she accepted that it was not appropriate for her to parent him and agreed with our recommendation that she should live elsewhere. Unfortunately, Social Services were not able to find a foster family who were prepared to cope with the level of risk she presented because of her self-harming behaviour, and so she was placed in a therapeutic children's home which, fortunately, was able to offer her safety, commitment and containment.

MINIMISING THE RISKS

People caring for bereaved adolescents can do several things that may help prevent a tragic outcome.

An appropriate role in the family

Firstly, if the death of a loved one is anticipated, it is important to involve young people in preparing for it. This can prevent them from feeling excluded or rejected by the older members of the family, as well as giving them time to adjust to the impending loss. It is also important that the roles of the different family members remain appropriate, both before and after a loss. It can be very difficult for adolescents to take on a role normally filled by an adult, for example the emotional support for a distressed parent, household responsibilities or care of younger siblings, all to the neglect of their own needs.

Bereavement counselling

Secondly, bereavement counselling has been shown to reduce the number of mental health problems experienced by adults after a loss[18] and to have a positive impact on young people. Black and Urbanowicz[23] showed that using a family approach increased the psychological well-being of the young people they studied. Interestingly, they found that the children who cried in the sessions did best at follow-up, which suggests that the common reaction of adults – to conceal information from young people about losses, particularly the death of their parents – may be misguided. Similarly, counsellors should not fear that, by raising with young people the question of suicidal thoughs, they are 'putting thoughts into their heads'. If the answer is positive it is important to secure a mental health consultation.

Preventing further losses

Thirdly, to try to mitigate the effects of bereavement on adolescents, workers should ensure that one loss is not followed by a succession of further hardships. Workers should try to ensure that the subsequent care of an adolescent is maximised. This can be done by supporting the surviving family and, if the young person is then placed in Local Authority care, ensuring that consistent substitute parenting is arranged. Unfortunately, older adolescents almost inevitably have disruptions in their care when they reach 16, as Local Authorities no longer have responsibility for them. This can result in young adults with little or no family support having to move into independent accommodation, a change that is hard enough for those with a supportive family.

Bereavement counselling as a family intervention may also have a positive impact on the mental well-being of the surviving adult. This in turn should indirectly benefit the younger family members, and is thus an efficient use of resources.

Knowing the risk factors

Finally, workers should be familiar with the risk factors for self-harm and suicide amongst adolescents so that they can offer support where it is needed most. In addition, appreciation of the meaning of an episode of self-harm can help identify those who are actively suicidal, as well as highlighting the important problems for those who are not. Occasionally an unhelpful culture exists in institutions where self-harm is dismissed as being 'manipulative' or a deliberate attempt to annoy carers, and myths persist that young people cannot

suffer from depression or other mental illnesses. Appropriate supervision can reduce such problems, and can also be particularly useful when counsellors suspect that they may be dealing with somebody suffering from a mental illness.

The following checklist may be a useful *aide memoire* when trying to determine whether a young person is at risk of self-harm.

Pointers towards risk of self harm in (recently bereaved) adolescents

- Depressed mood
- Recent change in behaviour
- History of self-harm
- History of mental illness
- Threats of self-harm
- Substance abuse
- Impulsivity
- Hostility/help-rejecting attitude
- Deteriorating support
- Legal problems

After an incident of self-harm

Should self-harm occur it is important to actively listen to the young person's story, empathise with their feelings and offer further support. It is usually helpful to try and mobilise any forms of social support that may be available. In addition the adolescent and their family should be advised to consult their local doctor, who may refer to child and adolescent psychiatric services. Unfortunately, no single intervention has been shown to reduce the risk of ultimate suicide. Child and adolescent psychiatric services usually use an eclectic approach, including problem-solving, individual and family therapy. Some areas operate a 'green card' scheme[10] in which a card is given to young people who have harmed themselves, allowing them to be admitted, without question, to a paediatric ward without their having to self-harm. This facility is not abused and has been found to be useful.

Although the risk may not be large, bereavements can increase the likelihood of suicide and self-harm in adolescents. The key issue is to recognise that a problem exists and then to try to minimise the risk, while accepting that no single agency or strategy can provide a definitive solution. Essentially, workers worried by what they hear from a young person should not hesitate to contact a mental health professional for advice.

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LETTER TO THE EDITOR

Dear Editor

A number of issues raised in the review of my third book, *Critical Incident Debriefing*, (**17** [3]: 47), need to be addressed.

The reviewer comments that I 'do not make it clear what level of qualification is required to do what with whom.' In fact, the basic qualifications for debriefers are outlined in chapter 7, but I believe that some level of assessment about who should conduct particular debriefings is sometimes necessary.

The first 86 pages are included, not to educate the novice, but to give my understanding of how the debriefing model evolved from experiences of war, civilian disasters and crisis intervention theory, and also to counter criticism of the book as 'atheoretical'. The debriefing response to those in crisis – what has happened? (facts), how are you? (feelings), what can I/ we do to help and what do you need? (future) – is as old as humanity itself but, on pp 73-4, I do mention the similarities between debriefing and other familiar helping models.

Sensory reactions do need to be emphasised, as well as feelings and other reactions, because the core work of the debriefer is to help people make sense of an incident by placing them firmly in the event, which then enables them to restore a balance between their emotional reactions and cognitive processes.

Debriefing should be conducted within a wide context of response including training, education and preparation and the use of other techniques, such as defusing, as well as ongoing monitoring and supervision and, where necessary, referral. Bereavement counsellors are finding debriefing helpful when faced, for example, with a client who has accidentally killed someone. After attending a debriefing course, some said they had previously largely ignored such an incident as a formative and important event, but now realised that it was important first to use a shortened form of debriefing to deal with an incident before moving on to counselling. I would commend the debriefing model for consideration by bereavement counsellors because events and particular incidents or experiences can determine reactions and perceptions about self, life and others. Once the incident is addressed, counselling can more usefully follow.

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FORTHCOMING EVENTS

Aspects of Bereavement. 4th annual one-day conference; speakers: Jim Kuykendall, Carol Davies, Virginia Dunn, Sr Frances. 14 May 1999. Brighton, Sussex, UK. Further details from Dave Adamson or Elaine Chamberlain ☎ 01273 696955 ext 4971.

Bereavement Forum Workshops. Hampshire, UK. 13 September 1999: 'Shattered Dreams and Hope: A Hospice Challenge', led by Ted Bowman. Contact Marion MacGregor, The Rowans, Purbrook Heath Road, Purbrook. Waterlooville, Hamshire PO7 5RU, UK. ☎ 01705 250001