Young people bereaved by suicide: what hinders and what helps

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IF YOU WERE TO LIST THE RISK FACTORS that might be unhelpful to a bereaved young person, being bereaved by suicide often has them all. Research indicates that, compared to children bereaved by non-suicide deaths, children bereaved by suicide have greater anxiety, anger and shame in the year following the death[1], and more symptoms of depression 18 months after the death[2]. This article considers what is so bad about suicide for young people and how they can be helped.

It may be difficult to understand or make sense of any death. Even for an adult, a death may undermine some basic beliefs about the world, beliefs that have come to be relied upon and considered truths[3]. Children's understanding, however, may be impeded by their limited ideas about the meaning of death itself. Over time children's grasp of the concept of death and their ability to deal with it develops, depending on their cognitive ability and their experiences. This is well described in Atle Dyregrov's excellent book, *Grief in Children*[4].

However, in general, it is best *not* to assume that children will know that:

- death is irreversible
- the body is no longer working, feeling or moving
- precisely what caused the death
- the body will decompose
- death is universal
- 'bad' things may happen to 'good' people

What makes it particularly difficult for a young person to grieve after a suicide?

Meaning

A death by suicide is likely to be particularly difficult to understand. Answering the question 'why?' may prove to be impossible and learning to live with not knowing may be the best outcome possible. In an attempt to try and explain the suicide, children (and adults) may assume that it was their fault in some way or that they could have done something to prevent it. This can lead to extreme guilt. This guilt can be even more severe in children if they have been involved in some way in the suicide and, as noted earlier, research shows how children bereaved by suicide experience more shame than other bereaved children[2]. They may also assume that the deceased's rejection of life is in some way also a rejection of them, which may lead to depression.

Stigma and concealment

One of the ways in which people make sense of many of their experiences is to talk them through with those around them. However, there continues to be a particular stigma attached to suicide so it is less talked about than other deaths. This absence of discussion means that children are sometimes denied opportunities to make sense of the event. They may not even be told how the person died.

Cain and Fast[5] found that in their sample of children bereaved by suicide, many who had actually witnessed the suicide of their parent were told by their surviving parent that the death was due to an accident or illness. Although this is an old study and hopefully things have changed, children continue to be denied information by adults, in the hope of protecting them.

EDITOR'S NOTE

Much has been written about the needs of adults bereaved by suicide and several papers have been published on this important topic in Bereavement Care *(see below). The impact of such a traumatic event on surviving children has, however, received little attention. The parents, on whom the child relies for support, are likely to be confused and distressed and may be quite unable to respond appropriately; they will often turn to bereavement services for support. In this paper David Trickey highlights the problems and indicates how we can give the help that is needed.*

How does one explain suicide to a child? Adapting our adult language to their age and stage of development, we can help children understand what led to their parent believing that everyone would be better off without him or her. We have to remember that young children's thinking is egocentric and animistic, that is, they see everything as emanating from themselves and being caused by them. So, if they said they hated dad and then he killed himself, for them it must mean that they caused his death. We, as adults, have to prove to children in this situation that they are not all-powerful – a tall order, but achievable. CMP and DB

*Hawton K, Simkin S. Helping people bereaved by suicide. 2003; **22**(3): 41-42.*
*Wrobleski A. Mutual help groups for those bereaved by suicide. 1987; **6**(1): 2-3.*
*Henley S. Bereavement by suicide. 1983; **2**(2): 6-7.*
*Parkes CM. The risk of suicide after bereavement. 1982; **1**(1): 4-5.*

If the account given to them does not tally with their knowledge of events, or what they overhear or are told in the playground, this may cause substantial problems for children. They may be left to form their own account of what happened in an attempt to make sense of the death. This made-up version of events may include the idea that it was the child's fault or that the dead person did not love them. At a time when they really need the adults around them to be trustworthy, so that at least something in life is dependable, they may be told lies.

If children are given an untrue account initally, then it may cause problems later as other adults may not know how to answer questions. Furthermore, if the adults in their lives have different ideas of what they should be told, there may be splits and friction instead of the stability and peace the child so badly needs. As time passes it may become more difficult to tell the truth, not easier.

The stigma attached to suicide can mean that children are not offered sources of support available to other bereaved children. People sometimes feel that they do not know what to do or say, and therefore prefer to offer nothing. Families may feel that they have been failed by their general practitioner (GP) and the mental health services, who in their view 'allowed' the person to die. They may therefore be reluctant to ask these services to help a bereaved young person. Children may worry that they themselves may be prone to suicide.

Police, procedures and press

Suicide leads to the involvement of many strangers, such as police officers, coroners and press. A family's private grief may suddenly become a very public affair. Rather than having the people they are close to around them, young people may find themselves surrounded by complete strangers. If the suicide took place at home, it may suddenly become a 'crime scene' and may lack its previous comforting ambience. Possessions can be removed by the police, including any suicide note.

The procedures surrounding a suicide sometimes lead to a delay in the release of the body, which will postpone the rituals that so often assist people with their grief.

'At a time when young people really need the adults around them to be trustworthy, so that at least something in life is dependable, they may be told lies'

Delayed reaction

The sudden nature of suicide means that there is no opportunity to say goodbye, and this can prolong a feeling of disbelief in the death. There is an increased risk of drugs and alcohol misuse following bereavement by suicide and these substances also have a numbing effect. This can mean that by the time that the person does react, everyone has assumed that they are doing fine and support is no longer available.

Memory

We commonly make sense of experiences, including bereavements, by thinking things through. However, suicides are often violent deaths which can traumatise people, especially if they directly witness the event or its aftermath. Shepherd and Barraclough[6] found that, of their sample of children, almost half was nearby at the time of the suicide. This traumatisation 'trips up' the usual grieving process because each time the bereaved brings the deceased to mind, the graphic, vivid image of the death takes precedence over any other softer more pleasant memories[7]. The child may dread thinking about the deceased person and avoid it wherever possible. This makes grieving very difficult.

What can help?

Helping young people to 'get their heads around it'

Children and young people do not need to know every detail of a suicide immediately, but they may read accounts of the death in the paper or overhear conversations. It is less damaging for them to be told a truthful account of what happened by someone whom they already know and trust, who can tell the truths in a way that takes into account their age and maturity and who enables them to ask questions. Nonetheless, this may be very distressing or shocking for the child. They may not take it all in the first time so information may need to be repeated. Children need the opportunity to talk and to ask questions, but no pressure to do so.

The child may also need help to weave the information into a 'story' that makes sense to them. Being in an environment where it is acceptable to talk of the deceased and how they died will assist with this process, and a coherent story that explains the facts will facilitate their grief. The story should also enable the child or young person to explain to curious peers what has happened, and protect them to a certain extent from the taunts of the unkind. If a number of siblings have been bereaved the story should be one that is shared, although older siblings may have a fuller and more mature understanding.

A possible story that might be told to young children bereaved by suicide, first suggested by Erna Furman[9], is that the deceased had a 'mind-sickness'. Given that it is estimated that 90% of adults who kill themselves are thought to have been suffering from mental illness[8], this is not an unreasonable explanation. Children understand that when they are sick something in their body is not working properly, so the idea that the person's mind was not working properly may help to explain their actions. The story can go on to explain that because of the mind-sickness, the person thought, mistakenly, that it would be better if they were dead. So they hurt themselves so badly that the doctors could not make them better and they died.

As they mature, young people may require more information and may be able to handle more details. The story may need elaborating to incorporate these and take account of their growing understanding. Explaining a death that is as traumatic as suicide is likely to be a process rather than an event. Adult family members may need help in doing this with children and young people, and clinicians can offer appropriate support before, during and after, as required. On some occasions the clinician may be the best adult to actually tell the child or young person what happened and answer their questions, but generally it is better if someone that the child already knows is able to do this.

Problem solving

There may be little that can be done to minimise the impact of police, procedures and press, although sometimes just the process of listening to the family's difficulties decreases their distress or enables them to begin to solve problems more effectively. One mother with whom I worked was suddenly unable to make simple decisions concerning her children. My role here was not to make the decisions for her, but to reassure her that she was as good a parent this week as she had been last week, and to help her to think things through and make the decisions herself.

Rituals

There are many rituals which people now employ to help them with the grieving process as well as funerals and grave visiting, such as laying flowers in other special places, writing messages and keeping photographs in memory books or boxes, and so on. These are concrete ways of expressing complex and intense feelings and, as such, may be particularly helpful for children. However, sometimes children or young people are denied access to such rituals when they are probably the people who would most benefit from such a concrete expression of emotion. There is much written about children's involvement in rituals; again, Atle Dyregrov's book is one of the most readable and comprehensive[4].

One-to-one support

Although the environment around children and young people has a great deal to offer in terms of assisting with their grief, individual support from a professional or volunteer may also be useful. It can offer the person the opportunity to express any thoughts or ideas they may have that would be unbearable, even for the most supportive of families. Counsellors are able to tolerate and contain the young person's distress in a way that other adults in the person's life may not be able to, possibly because they are also shocked and distressed. Talking things through can provide the young person with opportunities to think about ways to deal with their distress more effectively than by following the example of the deceased.

A professional, judgement-free environment can allow the client to express all their feelings, including relief and feeling guilty about not feeling guilty. However, guilt is such a common feeling following a suicide, that practitioners should specifically ask the child or young person what they think may have led the person to kill themselves. This allows the practitioner to assess whether the young person feels responsible and opens up conversations which can help the young person to re-evaluate the unhelpful beliefs which lead to feelings of guilt.

There is an understandable concern that someone bereaved by suicide may be more likely to commit suicide. The research is somewhat mixed in this area, but there is some evidence of an increased risk[4] so practitioners should, therefore, be more aware of their client's potential for suicidal tendencies. With adolescents, particularly, they should ask specifically how bad their clients have felt and enquire if they have had any suicidal thoughts. Silva and Cotgrove examined suicide in bereaved youths, and suggested that those working with young people should be aware of the risk factors (listed below) for adolescent self-harm and suicide[10].

If a practitioner considers that a young person is at risk of suicide, they should contact the client's GP or seek a mental health consultation. In Parkes' important article[11], the advice is clear: 'it is the responsibility of the counsellor to do his or her best to prevent suicide even if this necessitates a breach of the confidential relationship between counsellor and client'.

Timing

Making contact with a child or young person and possibly their family at an early stage enables the practitioner to give information about the help that is available, and may make it easier for the young person to make contact later when they may feel that they need it.

Risk factors for adolescent self-harm and suicide

- Depressed mood
- Recent change in behaviour
- History of self-harm
- History of mental illness
- Threats of self-harm
- Substance abuse
- Impulsivity, hostility
- Deteriorating support
- Legal problems

My involvement with traumatically bereaved families often has a number of phases. Initially, in the immediate aftermath, I may be involved with the family, sometimes just the adults, helping them to create the most therapeutic environment around the child or young person. I may then fade into the background and allow the family to move on together without my interference, knowing that they can contact me if they would like to in the future. Then, sometimes six months later, there is some problem which leads the family to consider that the young person is still struggling with their grief and they approach me for some further help. This may take the form of some individual work with the young person. Then, at some much later stage, an event may trigger further feelings and difficulties, and the family find it easy to approach me again, because they feel that I know them already and they will not have to explain the whole situation from scratch to a stranger.

Group peer interventions

Group therapy can be particularly helpful for children and young people who are traumatised by suicide. Just the process of hearing other people's stories immediately makes the young person realise that they are not alone in their wretchedness[12]. Peers who had similar experiences sometimes make for much more potent therapists than adults, who may be perceived by the young person as being out of touch.

Pfeffer and colleagues have developed a group intervention and manual for children bereaved by suicide. The intervention encourages discussion of death and its permanence, assists children to identify feeling of grief, facilitates discussion of suicide and suicide prevention and enhances problem solving. There is a parallel parental component to the intervention. It has been shown to decrease symptoms of anxiety and depression[13].

Road for You (www.RD4U.org.uk) is the Cruse Bereavement Care Youth Involvement Project website designed for bereaved young people by young

people where peers can swap stories and offer one another support, as well as play games and have fun.

Other resources

There are many other resources and voluntary organisations offering help to traumatically bereaved young people, a number of which have been reviewed in previous issues. Children of all ages (and their families) should be encouraged to seek out this help rather than hide in shame. The UK voluntary organisation, Winston's Wish, is particularly recommended: it offers phone advice, guidance and support on 0845 20 30 405. Its website (www.winstonswish.org.uk) includes an area specifically for young people and its booklet on suicide, *Beyond the Rough Rock*, offers excellent practical advice to families.

SOBS (Survivors Of Bereavement by Suicide) is a UK voluntary self-help organisation offering support through telephone contacts, bereavement packs, group meetings (in a number of locations), one-day conferences, residential events and information relating to practical issues and problems. The website is www.uk-sobs.org.uk/about.htm and the phone number is 0870 241 3337.

Conclusion

Research has not consistently demonstrated that a young person's bereavement after a suicide is particularly different in *quality* to other bereavements[14]. The actual effects are similar, but stronger and more long-lasting, and there are particular elements of such a death that may act as obstacles to grief. Therefore, what a young person needs is the same as any other bereaved young person, but probably just more of it – some additional support to get over the obstacles. ●

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EVENTS IN 2005

Loss in schools – time to listen. 3rd International conference of the Hull Learning and Culture School Support Services. 29 June. **Lost for words.** Training event 28 June. Hull, UK. Contact Alison Moore. alison.moore@hullcc.gov.uk or www.hullcc.gov.uk/education/lostforwords.php

Abrupt death? unexpected loss and bereavement support. 4th annual conference of Cruse Bereavement Care Tees Valley Area. Speakers include Gordon Riches, David Trickey, Rose Dixon. Darlington, Lancs, UK. 20 May. Contact Angie. Tel 01325 252777; Tvcbc@aol.com

Bridges over troubled waters: living with loss in the community. NALAG (NZ) national conference. 24-25 Sept. Christchurch, New Zealand. For more information contact Lynne Barron +64 [0] 3 3799920 or nalag@paradise.net.nz

St Christopher's Hospice courses: Young people facing bereavement, 27 June; **Complicated grief** (Colin Murray Parkes), 7 July; **Young people facing bereavement (advanced)**, 16 Sept; **Working with children facing loss and bereavement**, 4 Oct; **Schools and bereavement**, 2 Dec. London, UK. Apply to David Oliviere. Tel 020 8768 4656; education@stchristophers.org.uk

Loss, grief and bereavement. Two-day courses in Scotland, UK. 1-2 June, Inverness; 16-17 June, Edinburgh; 15-16 Sept, Glasgow. Contact Marie Curie Cancer Care. Tel 0131 456 3710; educationscotland@mariecurie.org.uk

Traumatic incident reduction training. Three-day certified training course. London, UK. 10-12 June. Contact Henry Whitfield. Tel 0800 849 6723. www.tir.org.uk

Bereavement workshops. Counselling skills for multiprofessionals. Apply to Amy Pearman. 27 May, 5, 9 Dec. Birmingham, UK Tel 0121 472 1191; amy.pearman@st-marys-hospice.org.uk