THE ROLE OF THE 'BEREAVED THROUGH SUICIDE SUPPORT GROUP' IN THE CARE OF THE BEREAVED

Sheila Clark
Medical Practitioner
Department of Community Medicine
University of Adelaide
South Australia

'NOW, HERE, YOU SEE, IT TAKES ALL THE RUNNING YOU CAN DO TO KEEP IN THE same place. If you want to get somewhere else, you must run at least twice as fast as that,' said Red Queen to the exhausted Alice (Alice through the Looking Glass, Chapter 2). This is the feeling experienced by the majority of those who have been bereaved through suicide which precipitates their coming to the Bereaved Through Suicide Support Group (BTSSG). Bereaved people often describe grief as a bad dream from which they hope to wake. To experience the suicide of a friend or relative is one of the greatest hurts any person may endure. Grief following suicide is unique and so are the needs of the bereaved. It was to cater for these special needs that led two Adelaide bereavement educators: Harold Jones and Sister Veronia Honour to found BTSSG in April 1986. It is the work done in the group by these and others that will be presented here.

Composition of the Support Groups

The group into which a new member enters is composed of ten to twenty members who all have had the common experience of being bereaved through suicide. This is regarded as a safe house where feelings are accepted and confidentialities maintained. Group work is done in the large group and small subgroups under the guidance of a counsellor and trained support workers. Here, members have the opportunity of learning from the experiences of others. Alongside the program of group work is an informal educational program covering topics such as the legal procedural matters of suicide, grief, health, stress management and coping strategies utilising resources from within the group and outside speakers.

Recreational activities are arranged with a view to fostering friendships and helping the bereaved to rebuild their lives.

There are various tiers of support for the group: the support workers are members who themselves have been bereaved through suicide, who have healed in their grief and who have been through a grief management training program. Guidance is provided by the Professional Advisory Council. This is composed of a psychiatrist, a bereavement educator, a funeral director, a coroner's officer and a general medical practitioner.

Phases of Grief

Like Alice, the bereaved give the impression of being exhausted. They come to the group in desperation because they feel they are not coping with their grief and may regard themselves as failures. They come hoping to receive that support which they perceive to be lacking from their lives or of which they are running out. They often express their appreciation of the support they receive from the group. They also experience a sense of surprise and of relief: surprise that they are not the only ones to be experiencing such severe emotional turmoil and relief to find that these are quite normal experiences and that they are not going mad. To see that others have survived through their grief can be very uplifting for new members.

Following on these initial experiences is a period of understanding their own reactions, of creating order from the chaos, of learning to cope, and of coming to terms with the various issues involved in their loss. This brings about some experience of resolution of their grief which gives them a feeling of making progress.

From this follows a stage of healing: a time when self-esteem increases, new relationships are made and a new life is built. For many there follows, after a period of months or years, a phase of growth: a time of finding new meaning from their personal disaster and a time of creating a new dimension to their life.

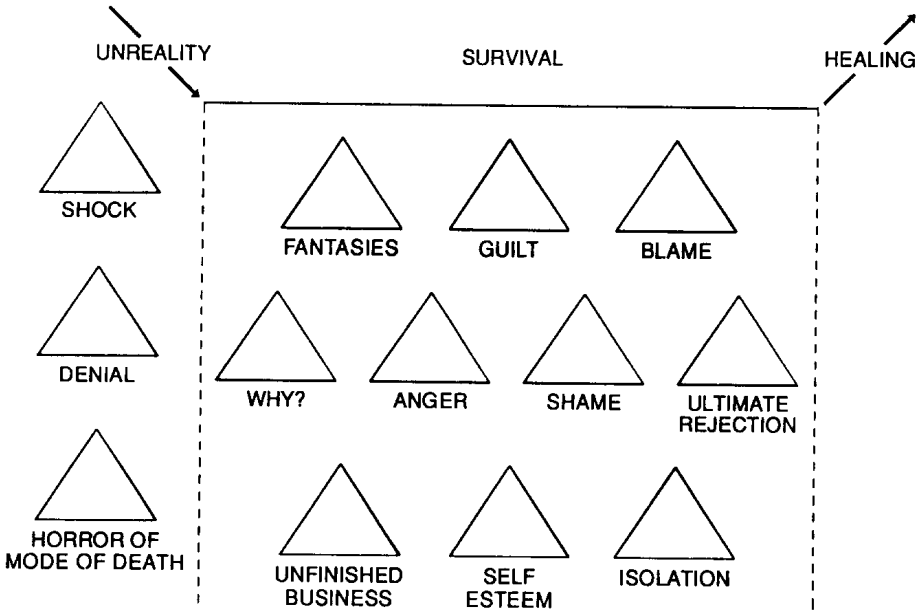
The work of the group is to permit the sharing of experiences and to guide and support through the normal oscillations of grief. Members are encouraged to express their feelings as they wish and they receive warmth and support back from the group members, which fosters cohesion of the group. Friendships may be made and maintained long after members have passed through the group.

Like dreams, every grief is different and yet suicide grief has a common story. This is the story of the emotional phases: some of the phases of suicide grief are unique in their nature and others are unique in their intensity. To the bereaved, these emotional phases are mountains. Like mountains, the ascent is steep and difficult and deceptive—one peak may hide another higher peak behind it. The mountain-climbing concept also helps the members to understand why they so frequently perceive themselves as not coping: they fail to take into account the affect of the steep incline of the mountain on their progress through grief. Only when viewed in 3-D can they comprehend what is happening to them.

The map of the mountains which are unique to suicide grief is shown in Figure 1. Figure 2 represents two groups of additions to the original diagram: the emotional phases of the survival stage and the healing stage which are common to all griefs. If the result is somewhat overwhelming for us, imagine how it may feel to the bereaved!

Figure 1

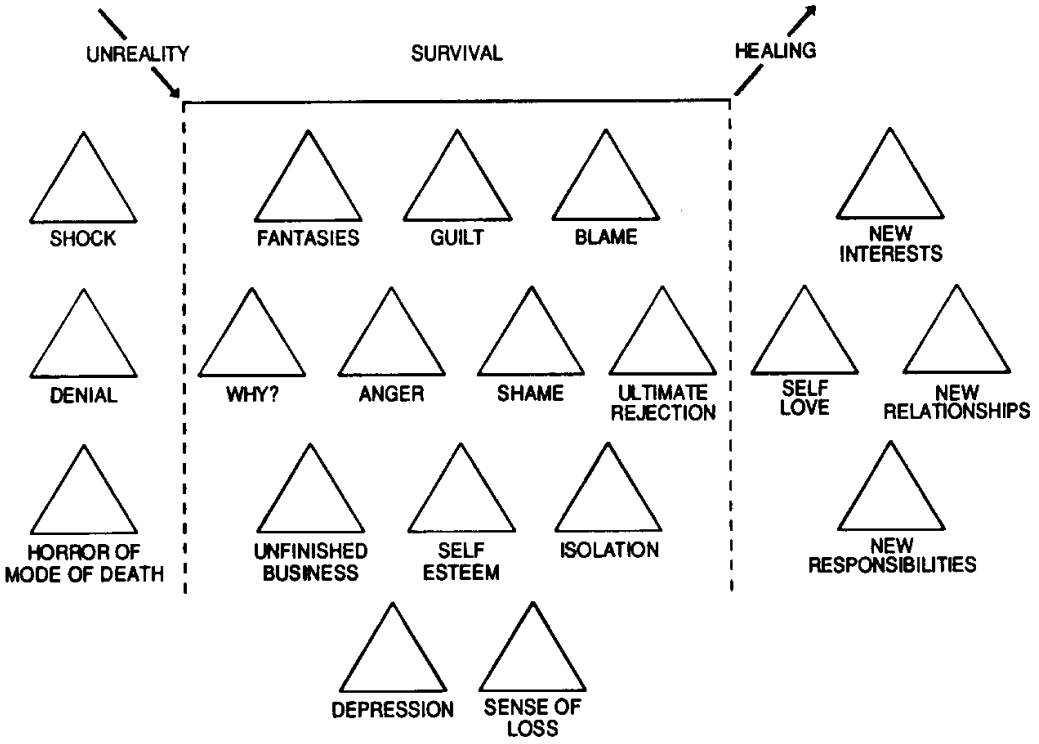
The Mountains Unique in Suicide Grief



The process of resolution of grief is particularly difficult following suicide. Because of its nature, the grief is difficult to resolve. There are many of the risk factors of an abnormal grief reaction associated with suicide (Parkes 1985). In addition, the effects of support which are so important in helping a person work through their grief (Maddison & Walker 1967) by facilitating the expression of grief, of experiencing supportiveness and of maintaining self-esteem may be lacking. There are several reasons for this. The load of guilt and subsequent fall of self-esteem may be so great that the bereaved cut themselves off from the support of others. They may be frightened to ventilate their feelings at home for fear of hurting their family. Or it may be that their friends have moved through the healing of their own grief following the suicide and expect the family to have done so at the same rate. So, in effect, the bereaved has to pretend that all is well when all the time they are hurting desperately inside as the reality of the death sinks in. This commonly occurs between three and six months following bereavement. For them their grief is becoming worse, whereas others perceive that they should be over it. In desperation, many people contact the group around this time. By the time they join the group, this 'conspiracy of silence' described by Cain & Fast (1966) is often well established. If this is maintained for long, the bereaved is left carrying an enormous emotional load. As a result a pathological grief reaction and significant illness may result (Raphael 1975).

Figure 2

Suicide Grief Map



One of the first aims of the support group is to break this conspiracy of silence by encouraging the verbalisation of feelings and rationalisation of emotions. In other words it encourages the process of grief work (Freud 1917).

Progress can be demonstrated by using the suicide grief map (Figure 2) at intervals. Members are encouraged to colour in each mountain to the height they perceive they have reached. Non progress over a period of a few months may be an indicator of the need for referral of the member for specialist help.

The group aims at aiding the resolution of some specific mountains. This will be illustrated by reference to selected examples.

Mountains

Guilt is one of the biggest mountains. This is the phase of the 'if only . . .'s. The parents of a teenager who suicides will feel guilty about not being able to prevent the suicide, about not identifying the suicidal behaviour before death, about their relationship with their child and about the upbringing of the child. They will feel a failure as a parent. Brothers and sisters have similar guilt and often regard themselves as unworthy siblings. Parents and siblings may feel guilt at being the survivors and yearn that they could replace their loved one in death. Most of the guilt will be imagined or be punitive self-blame or may be increased by blame laid on them by others. The task of rationalising their guilt will be more difficult if the suicide came on a background of family disruption. If the child has been causing disharmony at home, they may, in the heat of the moment, have fostered a death-wish for that child and when that was fulfilled be overcome with excessive guilt. If suicide followed on disharmony

or mental illness in the child, with repeated suicidal attempts, family members may experience guilt at the relief that the deed has finally been accomplished.

It often comes as a relief to family members to realise that all these types of guilt are common stories. Small group discussions help members to work through how much of their guilt is imagined or unrealistic. They may be helped by the results of suicide research: that nearly all of those who suicide are mentally ill (Robins et al. 1959) and that low levels of certain neurotransmitters have been implicated (Edmund & Asberg 1986). It seems that even the establishment of experienced crisis counselling centres seems to do little to reduce the suicide rate (Walk 1967). It seems that once someone has made up their mind to take their own life, there is very little that can be done to prevent them.

When the bereaved person is unable to see the body of the deceased, the mountains of denial (Brown & Stoudemire 1983) and fantasy are particularly prominent. It happens not infrequently that the body is not viewed by the bereaved because they may not wish to see the mutilation or is prevented by a well-meaning relative. Because of this, the reality of death cannot be established. An additional difficulty is that the bereaved has had no warning of the impending death and has not had the opportunity to pass through the preparatory anticipatory phase of grief. So there is difficulty in commencing the process of grief work. Fantasies regarding the extent of mutilation of the body also arise when the body is not viewed. These fantasies may cause revulsion, nightmares and preoccupation. The bereaved tell that it is easier to cope with the sight of the body or parts of the body (and funeral directors are very clever at making bodies presentable) than to cope with the imagined mutilations. If a member wishes, he or she can be referred to the coroner's office where the body may be kept. Support during the visit is offered by one of the trained support workers.

Why?

This is a question which may never be answered. There is a personal mental postmortem examination of the life and death of the deceased. The coroner's officer may be of considerable help here. He is willing to discuss with the bereaved the implications in the police reports, the coroner's report and the suicide note.

Self-Esteem and Health

By the time most bereaved join the group they are starting to rebuild their self-esteem. This plummets following suicide, sometimes to such an extent that the bereaved cut themselves off from their family, friends and offers of help even to the extent of isolating themselves within their home. There are several reasons for this fall, in addition to the normal fall experienced following any bereavement. Perceived guilt is usually the predominant factor. This is compounded with the blame put upon them from others regarding the death, shame because of the social stigma, rejection by the loved one who suicided and a sense of not coping through their own grief. Here the support group finds itself in a dilemma. If these reactions prevent the newly bereaved from seeking help, should the group be providing an outreach service? An attempt is made to meet these needs by providing a twenty-four hour telephone service and an individual counselling service.

Because the severe stress of grief may cause distress to the body and physical symptoms, a healthy lifestyle and stress management are encouraged. Issues such as diet, exercise and relaxation are discussed and include such topics as sleep and proper use or non-use of medications and alcohol. A common problem encountered is the belief that relations and enjoyment are prohibited following bereavement. If indulged in, these may

provoke guilt. People usually find that the forms of relaxation which they can undertake after bereavement are very different from those enjoyed beforehand. There is frequently difficulty in finding any form of relaxation which is acceptable. To give permission and to encourage enthusiasm for this, the group has compiled its own resource. They slowly come to realise that such activities as going to bed early with a good book, visiting a friend or taking themselves out to coffee are acceptable.

Identification of special problems which need referral elsewhere may occur, in which case the group would suggest appropriate referral—usually through that person's general practitioner. A common anxiety to many bereaved is which health problems are serious enough to take to their doctor. Because of the vulnerability of the bereaved to become sick, they are encouraged to make regular contact with their own general practitioner.

Many bereaved feel strong suicidal tendencies themselves, either wishing to join their loved one in death or feeling that life, following the bereavement, is not worth living. Shared group experiences are very helpful to those experiencing this and there is a certain normality in these feelings. However, the group seeks to identify and refer those at special risk.

Networks

Strategies for self-support and mutual support are encouraged. Some of the main areas concentrated on are those areas of self-esteem, coping abilities and of personal growth. Programs of individual and group exercises are used to enhance these.

Socialisation of the group is an important part of recovery. Many previous friendships may have been judgmentally rejected on the performance of their support. New friendships need to be fostered and are not infrequently made between group members who maintain contact and support between meetings and even after members have passed through the group. A social program of recreational activities is organised to encourage members to rebuild their lives. This is particularly important at difficult times of year such as Christmas and Mothers' Day.

In addition to working with the bereaved, the Support Group works to foster and develop liaisons with other groups helping those bereaved through suicide. The links between the group and the coroner's office and the medical profession have already been mentioned. In addition the group works with funeral directors, school counsellors, psychologists, crisis organisations and church and pastoral care workers. Many of these professionals will have the task of helping the bereaved at the same time as wearing the cap of their own grief if the deceased was one of their own clients.

Conclusion

One of the problems of working with those bereaved through suicide is the paucity of knowledge of grief following suicide both in the literature and in the community. In addition to encouraging and cooperating in research in this area, the group has also undertaken some educational projects. Last year, the group produced a video showing the experiences of those bereaved through suicide and staged its first public full-day seminar. The need for such was demonstrated by the attendance of 127 bereaved and professionals.

Unlike Alice, the bereaved cannot wake from their dream to the same Kitty and the same Great Arm Chair. For them the world is changed. The Bereaved Through Suicide Support Group is there to support them through their time of grief but also encourages the bereaved to pass through the group and on to a new life. Many members come through their grief with courage and fortitude and go on to add a fourth stage to that chart of grief—that fourth stage of growth. A deepening of personality, a new sense of caring for

others and a new meaning to life comes out of their grief. Or a new meaning may be found in religious beliefs. Some of our members who are from the caring professions have developed a deeper insight with their clients' problems which they might not otherwise have had and, as a result, have become more effective in their work. A number of artists amongst us have developed their art work in ways which had not previously seemed possible to them. It has been a great privilege to work with these people and to be able to learn from them. I thank them for sharing their stories with me and for entrusting me to present this paper.

References

Brown, J.T. & Stoudemire, G.A. 1983, *JAMA*, vol. 250, no. 3, p. 381.

Cain, A.C. & Fast, I. 1966, 'The Legacy of Suicide', *Psychiatry*, vol. 29, pp. 406-11.

Edmund, G. & Asberg, M. 1986, 'Skin conductance habituation & cerebrospinal fluid 5-hydroxyindolacetic acid in suicidal patients', *Archives of General Psychiatry*, vol. 43, pp. 586-92.

Freud, S. 1917, 'Mourning and melancholia', in *Collected Papers*, vol. IV, ch. 8, pp. 152-70.

Maddison, D.C. & Walker, W.L. 1967, 'Factors affecting the outcome of conjugal bereavement', *British Journal of Psychiatry*, vol. 113, p. 1057.

Parkes, C.M. 1985, 'Bereavement', *British Journal of Psychiatry*, vol. 146, pp. 11-17.

Raphael, B. 1975, 'The management of pathological grief', *Australian & New Zealand Journal of Psychiatry*, vol. 9, p. 173.

Robins, E. et al. 1959, 'Some clinical considerations in the prevention of suicide based on a study of 134 successful suicides', *American Journal of Public Health*, vol. 49, pp. 888-99.

Walk, D. 1967, 'Suicide and community care', *British Journal of Psychiatry*, vol. 113, pp. 1381-91.