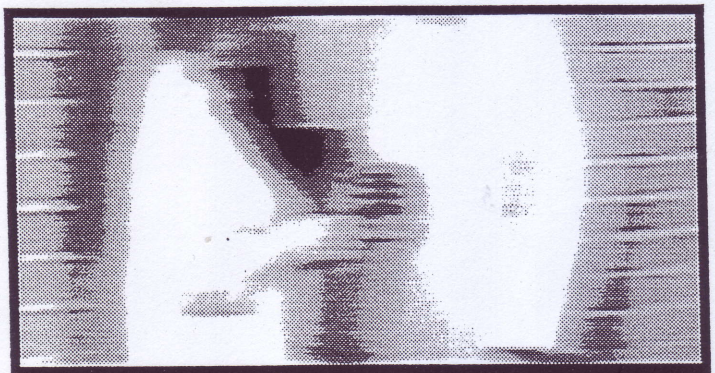
The suicide of young people and its impact on the family



A Training Manual

PRESENTED BY

Dr Heather A Feguson-Brown

& Professor Malcolm J Brown

University of Lincoln

THE SUICIDE OF YOUNG PEOPLE AND ITS IMPACT ON THE FAMILY

A TRAINING MANUAL

Presented by
Dr Heather Ferguson-Brown
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Distributed by
Concord Video and Film Council Ltd
Rosehill Centre, 22 Hines Road, Ipswich, Suffolk IP3 9BG

March 2002

ACKNOWLEDGEMENTS

The presenters are very grateful to the relatives who, having lost a family member through suicide, have so generously shared of their time, of their experiences and of themselves in the making of this training pack. The reason invariably given for so doing is the hope that their contributions will increase the understanding of the complex nature of the suicide of young people, may help to lessen the numbers of those taking their own lives and to heighten the understanding and skills of those professionals and volunteers working in this important field; both in relation to the young people at risk and to the families who are bereaved by the tragedy of the death of a loved one and the ensuing grief and pain. The presenters also wish to acknowledge the cooperation help given by voluntary agencies concerned with suicide and bereavement including The Compassionate Friends, Survivors of Bereavement by Suicide and Cruse Bereavement Care. Very special thanks go to Anna Brown of Papyrus (Prevention of Suicides) who has been particularly helpful throughout the production period; who has been very generous of her time, has assisted in many practical ways; and who has freely given of her wise counsel and advice.

On the technical side, Pete Mennell and Stephen Dyke of the University of Lincoln Learning Support Team have given excellent back-up and encouragement and many hours of sharing their knowledge and skill in the video editing studios. Their contribution to the production of this training pack is greatly appreciated.

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NOTICE TO TRAINERS

Trainers are free to make photocopies of any part, or all, of this training manual. It is anticipated one or two draft versions will be made available before the final issue is produced. These will be made available, without charge, to all purchasers of the training pack. Should a further videotape be produced as a consequence of a detected significant gap in the training pack, this will also be provided without charge.

Great efforts have been made to involve Asian and Black families where there has been a bereavement through the suicide of a young person. Over one hundred apparently relevant organisations have been approached but without success. Efforts are continuing with regard to this and any assistance to make meaningful contact would be appreciated.

Your experiences, comments and suggestions will be welcomed and will be considered prior to the next issue of the training manual. Please write to the presenters at: 7, The Crescent, Holywood, Co. Down, Northern Ireland BT18 9AY or e-mail to: Heather@ferguson-brown.freeserve.co.uk Please feel free to telephone if you wish: 028 9042 1324

When using the videotapes, we would just ask that you keep in mind and have regard for the fact that these are real people talking about the own circumstances and tragedies and using their own names. Thank You.

INTRODUCTION

Suicide

The World Health Organisation defines suicide as a "suicidal act with a fatal outcome" (WHO, 1968). It is an act of injury against the self that may reflect varying degrees of lethal intent (Jamison, 1999).

The death of a person by suicide undoubtedly follows great distress and unbearable psychological pain, possibly in the train of great disappointment and feelings of personal failure; physical illness and pain; in the face of an intolerable future or more commonly as an outcome of mental illness such as depression, schizophrenia or bipolar illness. Yet, those left behind may have had no inkling that their loved one was even considering suicide, and no doubt experience rejection and hurt that their partner, or sibling or parent could not find hope or pleasure in life with them, or feel able to turn to them for help or comfort. This experience becomes all the more acute when the person who has died is a young person, when a life with apparently great potential has been taken because life itself is, apparently, intolerable. Although, probably, the young person feels that his family will be relieved when the burden of their problems is lifted from them, the reality is that the trauma and shock of their death is barely surmountable. Yet, for so many families this is their burden - to continue life knowing that their son or daughter, their brother or sister has chosen death.

This training pack seeks to make a contribution in understanding the suicide of young people, and particularly its impact on the family of the young person who has died. This is achieved through videotaped interviews with relatives sharing their experiences, both good and bad, of the death itself and the services they have come in contact with before and following the death; their own understanding of the suicide and of their own lives as they try to adapt. This opportunity to learn about the impact of the suicide of a young person on the family is very special in that the narrative accounts, presented through one-to-one interviews, of the experiences of family members, mothers, fathers, brothers and sisters, have been freely shared. One of the tapes is an interview with Dr Colin Murray-Parkes giving an informed perspective as a psychiatrist specialising in bereavement.

Suicide is not a new phenomenon. Death by suicide is one that has caused great concern and disquiet to religions and to governments over the centuries. In the early church, both the Church of England and the Catholic Church denied a burial service/funeral rites to those who died by suicide. In Jewish custom no honour is bestowed on those who died by their own hand and in Islamic tradition suicide is a very grave crime. (Jamison, 1999; Field, Hockey and Small, 1997). In England and Wales the act of suicide was a crime until 1961. Suicide was never a felony in Scotland (Hill, 1995) creating a less stigmatised view of suicide. Nonetheless, the process of establishing whether such a death is a suicide, an accident or a homicide may be very traumatic for the families concerned. Suicide is associated with offending God, laying one's soul vulnerable to evil influence, and being a criminal. This legacy of association with grave sin and crime is ever present and permeates

religions and cultures, leaving families with both their own great sense of regret and the recriminations from their community. It is in this context of shame and embarrassment that families are grieving the loss of a son or daughter, a brother or sister, or a grandchild. Families, police and coroners may be more likely to suggest that death has been one of accident or misadventure than one of suicide. It is believed that the official suicide rates are far fewer than the actual numbers of people who kill themselves and that under reporting is most common in the cases of children and adolescents (Hill, 1995; Wertheimer, 2001). There are other more practical issues at stake that influence under reporting, such as property rights and life insurance policies (Jamison, 1999).

The Incidence of Suicide in Young People

The rate of suicide among fifteen to twenty four year-olds (both male and female) increased in UK by 110% between 1970 and 1990, while that of young men rose 160% (Hill, 1995). In 1998, 571 young men and 159 young women died in UK as a result of suicide (BBC news online 11/7/01). Young men are four times as likely to kill themselves as young women, and in suicide deaths of all ages, men are three times as likely to die from suicide as women, although women are two or three times more likely to attempt suicide than men (Jamison, 1999; Wertheimer, 2001). This may be partly explained by the fact that women are more likely to self poison (with significantly greater chances of recovery) while men more commonly die by hanging, jumping from a height, by cutting or by gunshot. Half of the female suicide deaths are from self-poisoning as compared to less than a quarter of male suicides (Wertheimer, 2001) and this is also the most common method of attempted suicide for females. There are many, many more suicide attempts annually than successful suicides. There may be discrete differences between the suicide attempt and the successful suicide in that a number of suicide attempts may be a 'cry for help' rather than a definite decision to commit suicide. Nonetheless, a suicide attempt is considered to be the 'best single predictor of suicide' (Jamison, 1999).

The suicide rates in Scotland and Northern Ireland are considered to be substantially higher than for the rest of the United Kingdom while in the Republic of Ireland, where suicide was a criminal offence until 1993, the suicide rates for the young adult males are thought to be the highest in the world, for countries where suicides are officially recorded.

Factors in the Suicide in Young People

Understanding the increased incidence of the suicide of young people may reflect many changes in our society and particularly the changes for young people. It may be that actual suicides are not increasing so much as it may appear and that some of the increase can be explained by changing patterns in the recording of cause of death (Wertheimer, 2001). Other explanations include the earlier onset of mental illnesses that affect young people (such as schizophrenia and bi-polar depression), increased pressure to be successful (Jamison, 1999; Hill 1995) and the changes in the family as a result of which:

> family leadership has been undermined, alliances broken or devalued and faith in the family as a source of love and security has been called into doubt (Murray-Parkes, 2001).

Young people are more likely to suffer from undiagnosed depression than in later adult life, and this may be associated with other factors such as alcohol and drug abuse, social stress factors, or other mental health disorders. These factors combine to contribute to the increased incidence of suicide in young people. (O'Connor and Sheehy, 2001)

Also affecting the decision of young people to take their own lives are alcohol and drug abuse, being held in custody, experience of physical or sexual abuse, parental unemployment, divorce, separation or death (O'Connor and Sheehy, 2001; Samaritans, 2000; and Wertheimer, 2001), a diagnosis of AIDS (Hawton, 1992), and a sense of hopelessness about the future (Aldridge, 1998). Any of these elements may also be a contributor to the onset of mental health problems. The picture is one of great stress and pressure socially, academically and in career choices in the context of decreasing family stability and support systems. Many young people experience great difficulty in personal and family relationships as well as hardship through lack of finance and employment. Considering these life changes and stressors for young people it becomes less surprising that young people do indeed seriously consider and frequently succeed in taking their own lives. Increased substance abuse in young people is likely to be a very significant factor in the upsurge in the suicide of young people (O'Connor and Sheehy, 2001) Bereavement, particularly of a parent within the last two years, increases the risk of suicide (O'Connor and Sheehy, 2001).

Murray Parkes, however, reminds us that for every person who commits suicide there are eight thousand who do not (Murray Parkes 2001).

Other Risk Factors

Sadly many young people die in psychiatric hospital wards and in prison or secure accommodation. The risk of death by suicide in such institutions is increased by three to fourfold. The very place where one might hope that a young person could be safely cared for and monitored may also be a place where he is most at risk. Both prisons and psychiatric hospitals have populations at high risk of suicide – those unemployed, homeless, or those abusing substances and those with poor prospects for the future who are at high risk of imprisonment (Liebling,1992) and those suffering from depression, schizophrenia, bipolar illnesses or other mental illness who are, as a consequence, at high risk of hospitalisation (Jamison, 1999). Schizophrenia and manic depression first manifest in the young and the risk of suicide is increased by eight and fifteen times that of the general population respectively (Jamison, 1999). Very often it is as people are making a recovery from depression that the risk of suicide becomes most serious. This may be explained as having new strength and energy to act upon suicidal feelings.

Young people in prison are particularly at risk, especially those on remand (Liebling;1992). Those isolated in single cell accommodation account for over a third of the young people in prison who commit suicide, while for others overcrowding is a factor (Dooley, 1990; Liebling, 1992). Only about 15% of young offenders who commit suicide have a history of psychiatric treatment (Liebling, 1992). In young people suicide is often an impulsive act with little planning or forethought and without serious thought about the consequences. Young people from ethnic minority

groups are more vulnerable to suicide, as are homosexual, and bisexual individuals (Jamison, 1999).

Suicide may have occurred in the family before this incidence, and for the family left behind suicide contemplation is not uncommon. A number of those interviewed have felt life is no longer worth living, or at least have felt this at some points of their bereavement journey. Where there is a history of suicide in the family the risk of suicide occurring again is thought to be at least doubled (Jamison, 1999).

A recurring theme of the interviews in this pack is of the creative and artistic talents of the young person who died. College students and high achievers are among those at risk of suicide, as are artists, writers, scientists and mathematicians (Jamison, 1999).

Service Providers

Those providing services to families whose young person has died from suspected suicide may be challenged by their role in relation to the suicide and the needs of the family. The police, for example, have to assess the evidence in order to determine the cause of death, whether natural or unnatural, whether homicide, accident or suicide. For families, what could be more distressing when a young person has been found dead in their home that for the area to be isolated in search of evidence and the body to be inaccessible? Naturally parents and siblings want to sit with their loved one and to hold them and talk to them. The last thing one would want is for the body to be 'out of bounds' and for the area to become the scene of a suspected crime. It has to be acknowledged that some procedures may be unavoidable but good practice requires that everything is carefully explained and that the family are helped through the experience in as supportive a way as possible. One thing that is clear from the video-taped interviews in this pack is that the skill of the service providers in working with the family and their ability to be supportive and understanding makes an enormous difference at a time when people are extraordinarily sensitive and in great psychological pain.

One area of difficulty is that the needs of the family may be assumed. Coroners and their staff and indeed many involved with suspected suicide may assume, for example, that a finding of 'death by suicide' would be more distressing than a finding of 'death by misadventure'. In trying to protect families from the possible embarrassment of suicide many families are denied the truth and the assurance that their own judgement in the circumstances has been correct. Others may assume that the family should not learn that the young person has been struggling with something, such as their sexuality, perhaps being gay, and that the suicide was connected to this and/or a relationship difficulty. It may seem that if the young person has kept this secret that this would be one way to respect that choice. Yet, families may spend many years trying desperately to piece together the events that could explain this sudden death by suicide. Issues of privacy are not irrelevant, but decisions about the needs of families need to be taken in the context of the wishes of each family member and should not be assumed. Similarly assumptions cannot be made about the appropriateness of viewing a corpse, but need to be made in the context of individuals and their needs and wants.

The process of grieving is affected by the trauma of the violent death, by the relationship with the deceased, by the support available, by the nature of suicide, and by the inquest. The inquest may occur as much as a year or more after the death, just when one would expect that some significant healing has begun. This healing may be inhibited by the fact that the inquest has not yet occurred nor made a ruling about the cause of death. In turn, the process of revisiting the detail of the evidence about the death and possibly learning some new information is very painful and, although necessary, may be a real set back in grieving and adapting to life without the dead person. For many family members the process of recovery and successfully grieving such a loss is likely to be slow and prolonged, so the stage of the inquest is still relatively early. From these tapes we learn that some are overwhelmed, even struck down by the death, and are unable to function for many months after which they start to recover, while for other it is a slow and uneven process, managing to complete every day life tasks, but living with great sorrow and depression. Some tell their story several years on from the death showing that many life changes have occurred but that healing has taken place.

Friends and Neighbours

Sadly, almost everyone who has lost a person by suicide has experienced the awkwardness, embarrassment and avoidance behaviour of friends, neighbours and acquaintances. Instead of comfort and support, people cross the road, leave the shop without making a purchase, or such like behaviour, when they see that the recently bereaved are approaching a face-to-face encounter. This behaviour is partly explained by the avoidance of death and talking about death, by the stigma of a death by suicide, by not knowing what to say, and by the assumption that the bereaved may also prefer to avoid those contacts that inevitably lead to discussion about the death. This, yet again, is an example of the inappropriateness of making assumptions about what people in difficult circumstances need and want. Relatives in these videotapes suggest that what people say is less important than the handshake or hug, thus acknowledging their deep loss and distress. The ineptness of the general public in dealing with death by suicide indicates a need for public education and social skill training in the area of death and bereavement by suicide.

Similarly, the difficulties of young people in knowing what to do when friends are showing signs of depression or other mental health problems, of abusing drugs and alcohol, and who are possibly even talking about death/and or suicide, could be tackled through schools and colleges and universities training young people in identifying risk factors and informing them of the resources available. Young people may also need help and support in facing the decisions they may have to take. Telling their friends' parents about the behaviour of their son or daughter may feel like betrayal, rather than an acknowledgement that the problem is very serious and that the family may be able to offer the very help and stability that their friend needs at this critical time.

Death and suicide in different cultures or ethnic groups

It has proved very difficult to find black or Asian families willing to contribute to this videotape series. This has not been through lack of effort by the presenters but that the many organisations engaged in bereavement, including a number of churches and pastors, which the presenters approached in different parts of England and in Ireland,

either did not know any such families where a young person had died by suicide, or did not feel able to ask the families if they would consider making a contribution to the videotapes. The explanation which was commonly given was that the organisation had been involved with young Asian and black people who had taken their own lives, but that they had not been able to support or help the families and had had no contact following the death. Such families may experience considerable support within their own extended families and communities, but they may also experience considerable isolation and stigma as a result of a death by suicide.

Families from a minority ethnic group, where a young person has died by suicide, are likely to be confronted by service providers, such as police or health and social service staff, who are of the majority, white culture in UK. While service providers have provided training and 'fact-file' information on different ethnic and religious practices to try to sensitise their staff to the needs of minority groups in difficult circumstances, this information is often anthropological in nature and does not take much account of the changing culture of black communities in Britain (Gunaratnam, 1997). Families may feel alienated if, for example, they followed traditional practices such as arranged marriages and this practice was in some way connected with the young person's death. They may feel that others will blame them even more than they blame themselves. If their young person died in prison they may feel alienated from any available help by concerns about racism. Young people from ethnic minorities are particularly at risk of suicide in prison (Leibling, 1992). Young Asian women are also at risk of suicide in Britain (Hill, 1995).

Reaching across a racial divide to offer help and support to families bereaved by suicide, is difficult but not impossible. It is particularly important to identify what difficulties people are experiencing and what help would be welcome. Helpers must not assume that the best thing to do is to 'back off and keep their distance'.

Death, gender and suicide

The prevalence of males in those young people who commit suicide raises issues of gender difference, some of which have been discussed earlier in the chapter. The vulnerability of young men to schizophrenia and bi-polar depression in their late teens and earlier twenties is a pre-disposing factor. The choice of method has also been highlighted as significant. Young women are most likely to overdose, leaving the question of judgement as to what constitutes a lethal dosage, and making it possible to be found in time for treatment and recovery, as compared to more violent methods such as hanging, jumping or cutting where death is likely to occur quickly and suddenly. However it is also probable that more men choose to die by suicide, particularly in this young age group, than women. Mourning and bereavement patterns have also been gendered, with women being more emotional and expressive about their grief than men (Walter, 1999; Hockey, 1997). Men on the other hand may be more likely to have physical reactions to the bereavement and become ill (Stroebe, 1998; Walter, 1999), to die early or commit suicide.

Sexuality is also a consideration in suicide. Suicide has been identified as the leading cause of death among gay, lesbian and bisexual youth in the United States and a large number of gay teenagers in London have attempted suicide (Hill, 1995).

Reaction of the family

Few experiences can be as traumatic or as disruptive for a family as the suicide of a member. The family may feel that the lost one has lacked the sense of security, love and belonging that one would expect from family life – that the family has failed to provide the safe haven from life's difficulties that their loved one needed. Amid the shock and horror and trauma of violent death, and the fact that their son, daughter brother, or sister made a choice to die by their own hand, is the feeling of having failed in some way – having failed to protect them from pain, having failed to give enough comfort, having failed to get the right professional help, having failed to notice the warning signs and so on. The shock, the deep loss and these deep seated almost inevitable regrets create a major hurdle for families to overcome in adjusting to life without the dead person. Not least for many families, particularly in the months following the death, is the effort they must make to piece the events leading up to the death together and to try to understand what has happened. When the dead person is young, possibly still a teenager, these feelings are particularly powerful.

While the shock of the death and the attempt to explain it may rip a family apart, the bereavement also has the potential to bind the remaining members together, at least in the first instance. However, as different family members deal with the bereavement in their own way and at their own pace, even the bereavement response has the potential to be divisive.

Murray Parkes, in this series of videotapes, emphasises the importance in bereavement of making sense of the death, of being able to explain it in some way and of becoming reconciled to the event of the death. He emphasises that in telling the story to counsellors the bereaved are in fact telling it to themselves and making progress in this process of making meaning of the death.

Conclusion

These videotapes allow the bereaved family members to describe their own experiences and to tell their own story of the impact of the loss of a family member, in England and Northern Ireland. This narrative makes these experiences real and poignant for the participant, and offers its own contribution to the education and training of people engaged with those who have lost a family member by suicide. The knowledge offered has value for those engaged in working with the circumstances of death by suicide, those in bereavement work, and for those in prevention. Only with the benefit of hindsight can helping professionals, friends and families become more skilled at preventing possible suicides in the future. Those who shared their experiences in this pack could hope for no better reward than that a family had been spared the anguish of a loss of a young person by suicide.

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CHARACTERISTICS/ELEMENTS DEMONSTRATED IN THE INTERVIEW VIDEOTAPES

	NUMBER OF VIDEOTAPE									
	1	2	3	4	5	6	7	8	9	10
Circumstances of death	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Previous attempts made									✓	
Anticipation of death								✓		✓
Death not anticipated	✓	✓	✓	✓	✓	✓	✓		✓	
Indications of depression								✓		✓
Indications of psychotic episodes	✓	✓						✓		
Significant alcohol issue	✓	✓								
Significant drug issue	✓	✓								✓
Suggestions of improvement prior to death								✓		
Attempts to get help for medical condition							✓			✓
Respect for decision to take own life	✓					✓		✓	✓	
Pride in prior behaviour/achievements	✓	✓	✓	✓				✓		
Attitudes towards medical services								✓		
Attitudes towards police services				✓	✓					
Attitudes towards Coroner's officers			✓	✓						
Anger towards relative taking own life					✓	✓			✓	✓
Anger towards other family member(s)										
Anger towards others			✓		✓		✓			✓
Strong desire to find reasons for death		✓	✓						✓	
Strong need to see, spend time with, body			✓		✓	✓				
Desired also to be dead					✓					

	1	2	3	4	5	6	7	8	9	10
Contemplated taking own life					✓					✓
Frequent visits to grave	✓		✓		✓				✓	
Strong feelings of guilt			✓		✓		✓			✓
No feelings of guilt								✓		
Strong emotional reaction	✓			✓	✓		✓			✓
Strong physical reaction	✓	✓		✓	✓		✓	✓	✓	
Retention of mementos					✓			✓		
Family members grieving and/or recovering in different ways	✓	✓		✓	✓	✓	✓	✓		✓
Blame within family members										✓
Family member(s) hurt by survivor's preoccupation with dead family member				✓		✓				
Belief that dead relative is influencing their lives								✓		✓
Factors found helpful/useful	✓	✓		✓			✓	✓		
Factors found hurtful/unhelpful	✓	✓								✓
Deterioration of self-image or loss of confidence	✓		✓	✓	✓				✓	✓
Tendency to avoid reality of existence of dead relative to outsiders										✓
Belief that own life will be permanently adversely affected			✓		✓				✓	✓
Acceptance of reality of death with resolution to strive to make the best of what life has to offer		✓				✓		✓	✓	

CHARACTERISTICS/ELEMENTS DEMONSTRATED IN THE INTERVIEW VIDEOTAPES

NUMBER OF VIDEOTAPE

	11	12	13	14	15	16	17	18	19	
Circumstances of death	✓	✓	✓	✓		✓		✓		
Previous attempts made	✓					✓				
Anticipation of death	✓									
Death not anticipated		✓		✓	✓	✓	✓	✓	✓	
Indications of depression	✓			✓	✓					
Indications of psychotic episodes	✓									
Significant alcohol issue	✓									
Significant drug issue	✓			✓	✓					
Suggestions of improvement prior to death	✓					✓				
Attempts to get help for medical condition	✓			✓		✓				
Respect for decision to take own life	✓				✓	✓	✓			
Pride in prior behaviour/achievements				✓						
Attitudes towards medical services	✓									
Attitudes towards police services				✓						
Attitudes towards Coroner's officers										
Anger towards relative taking own life	✓						✓	✓		
Anger towards other family member(s)										
Anger towards others	✓			✓		✓		✓		
Strong desire to find reasons for death										
Strong need to see, spend time with, body						✓		✓	✓	
Desired also to be dead		✓		✓		✓				
Contemplated taking own life		✓			✓					
Frequent visits to grave	✓			✓				✓		
Strong feelings of guilt								✓		
No feelings of guilt						✓	✓			
Strong emotional reaction	✓	✓		✓		✓				
Strong physical reaction				✓						

	11	12	13	14	15	16	17	18	19	
Retention of mementos					✓					
Family members grieving and/or recovering in different ways					✓		✓	✓	✓	
Blame within family members										
Fear for survival of other family member(s)				✓						
Belief that dead relative is influencing their lives	✓									
Factors found helpful/useful	✓				✓	✓				
Factors found hurtful/unhelpful	✓									
Deterioration of self-image or loss of confidence	✓	✓								
Tendency to avoid reality of existence of dead relative to outsiders	✓									
Belief that own life will be permanently adversely affected	✓	✓	✓	✓				✓		
Acceptance of reality of death with resolution to strive to make the best of what life has to offer						✓	✓			

SUGGESTIONS ON CONTENT OF COURSES

Trainers will be aware that with the very sensitive subject of the suicide of young people and its impact upon the family, it is possible that even very experienced workers can have a strong emotional reaction, may experience a fit of sobbing or may just wish to leave their group for a while. It order not to seriously disrupt the course, it may be advisable for an appropriate staff member, who has not been given a key role on the programme, to be available in order to be alongside such a course participant, should the need arise. Trainers may wish to make reference to the acceptability of leaving the group for a while in their opening remarks and perhaps refer to the availability of a suitable quiet room should there be one.

1. General Introduction to the subject of the suicide of young people and its impact on the family. Half-day session (three and a half hours)

Welcome, brief introduction to the course and its content.	10 minutes
Members break into groups of five or six, with seminar leader for each group. Members introduce themselves and share why they have come and what they hope to gain from the course.	10 minutes
Groups each watch a different video (selected by the trainer) and discuss in groups	60 minutes
Groups come together to share reactions to the videos and and what they consider they have gained from them	20 minutes
Coffee/tea break	20 minutes
Showing of Dr Colin Murray-Parkes's video and general discussion following	80 minutes
Verbal feedback on the course or completion of brief questionnaire	10 minutes

2. General introduction to the subject of suicide of young people and its impact on the family. Full-day session (7 hours)

Welcome, brief introduction to the course and its content	15 minutes
Members break into groups of five or six, with a seminar leader for each group. Members introduce themselves and share why they have come and what they hope to gain from the course.	15 minutes
Groups each watch a different video of a parent talking (selected by the trainer) and discuss in groups	60 minutes
Groups come together to share reactions to the videos and what they consider they have gained from them	20 minutes
Coffee/tea break	20 minutes
Groups each watch a different video of a sibling talking (selected by the trainer) and discuss in groups, including comparing and contrasting attitudes and feelings of parents with siblings (if any detected).	70 minutes
Lunch break	60 minutes
Showing of Dr Colin Murray-Parkes's video and general discussion including relating parents and siblings videos to that of Dr Murray-Parkes	90 minutes
Coffee/tea break	20 minutes
Working in groups, meaningful sharing of members reactions, thoughts and emotions in response to the death by suicide of young people and the impact that this has on remaining family members	25 minutes
Groups come together for a general rounding-off and course evaluation	25 minutes

3. Introductory course for Police Officers on the suicide of young people and its impact on the family.
Half-day session (3½ hours)

If the course membership includes inexperienced officers who will have had little or no experience of dealing with dead bodies, it is important that time be given to acknowledging legitimate anxieties and fears that are likely to be experienced when dealing with a suicide and that where these are paramount it will be much more difficult to be sensitive to the needs and feelings of family members.

Welcome, brief introduction to the course and to course content	20 minutes
Break into groups of five to six members with seminar leader to introduce themselves, what they expect to gain from the course and their thoughts and feelings about the suicide of young people and its impact upon families	20 minutes
Showing of Dr. Colin Murray-Parkes's video to whole Group with general discussion	80 minutes
Coffee/tea break	20 minutes
In groups watching different videos highlighting police involvement (selected by trainer) with discussion on how police should present themselves where there has been an unnatural death with likelihood of suicide	50 minutes
Whole group feedback, discussion and course evaluation	20 minutes

4. Introductory course for Police Officers on the suicide of young people and its impact on the family.
Full-day session (7 ½ hours)

If the course membership includes inexperienced officers who will have had little on no experience of dealing with dead bodies, it is important that time be given to acknowledging legitimate anxieties and fears that are likely to be experienced when dealing with a suicide and that where these are paramount it will be much more difficult to be sensitive to the needs and feelings of family members.

Welcome, brief introduction to the course and to course content	20 minutes
Break into groups of five to six members with seminar leader to introduce themselves, what they expect to gain from the course and their thoughts and feelings about the suicide of young people and its impact upon families	20 minutes
Showing of Dr. Colin Murray-Parkes's video to whole group with general discussion	80 minutes
Coffee/tea break	20 minutes
In groups watching videos of a family members reaction to the death of a family member (selected by trainer but excluding those with police involvement), followed by small group discussion.	60 minutes
Whole group feed back and discussion	20 minutes
Lunch break	60 minutes
In groups watching different videos highlighting families' reactions to police involvement (selected by trainer) with discussion n how police should present themselves where there has been an unnatural death with the likelihood of suicide.	60 minutes

Role play in small groups, two police officers called to house where adolescent boy found dead by hanging by parents and sister after they had returned from cinema at 10.0pm. Boy cut down by father. Ambulance had been called and family doctor who confirmed death (these need not be involved in role play. Family composition can vary according to role players available. Allow for two group observers. Give 15 minutes for family members to agree their respective parts and police officers to do likewise. Allow 25 minutes for role play and 20 minutes for discussion. 60 minutes

Coffee/tea break 20 minutes

Whole group, feedback, discussion and course evaluation 40 minutes

COMPILATION OF INDICATIONS OF CONTEMPLATION OF SUICIDE

Many organisations throughout the world concerned with suicide and its prevention, publish lists of the sorts of things those at risk say and do and which non-professional people can recognise. The following is a fairly comprehensive list drawn from a large number of such publications.

Cancelling credit cards
Casualness about appearance/hygiene
Giving things away
Joking about suicide
Loss of interest in things normally cared about
New and unexplained calmness
New and unexplained happiness
New interest in pictures, drawings, music about death
Preoccupation with death
Risk-taking behaviour- fast driving, dodging between moving traffic
Statements of worthlessness, hopelessness
Statements like, `You'd all be better off without me';
`I won't be here all the time.'
Talking about suicide
Telling people of their intention-often not believed, or passed off
Tidying up of affairs
Unexplained changes in behaviour: increased drinking or drug taking
Unexplained reduction in work/study performance
Unexplained increase in sexual activity
Unusual visiting of people (a saying, `Goodbye.')
Withdrawing from relationships

BRIEF RECOMMENDED BOOKLIST

Aldridge, D. (1998) *Suicide: the tragedy of hopelessness*. London. Jessica Kingsley.

Barraclough, B., (1987) *Suicide: clinical and epidemiological*. Croom Helm. New York.

Dickenson, D. and Johnson., M. eds. (1993) *Death, Dying & Bereavement*. London. Sage in association with the Open University

Field, D., Hockey, J., and Small. N. (1997) *Death, Gender and Ethnicity*. London. Routledge.

Hill, K. (1995) *The Long Sleep: young pe\ople and suicide*. London. Virago Press.

Jamison, K. R. (1999) *Night Falls Fast*. London. Picador.

Liebling, A. (1992) *Suicides in Prison*. London. Routledge.

Murray Parkes, C. M., and Weiss, R. S., (1983) *Recovery from Bereavement*. New York. Basic Books.

O'Connor, R and Sheehy, N. (2001) *Understanding Suicidal Behaviour*. Leicester. British Psychological Society.

Stroebe, M., Stroebe, W., and Hanson., R.O. eds (1993) *Handbook of Bereavement: theory, research and intervention*. Cambridge. Cambridge University Press.

Wertheimer, A. (2001) 2nd ed. *A Special Scar: the experiences of people bereaved by suicide. Hove, East Sussex*. Brunner Routledge.

World Health Organisation (1968) *Prevention of Suicide Paper No 35*. Geneva. WHO.

APPENDIX 1

Dr. Colin Murray -Parkes

Honorary Consultant Psychiatrist to St Christopher's Hospice, Sydenham and Consultant Psychiatrist to St Joseph's Hospice, Hackney; formerly Senior Lecturer in Psychiatry, The Royal London Hospital Medical College and member of research staff at The Tavistock Institute of Human Relations.

Author of:

Bereavement: Studies of Grief in Adult Life

With Robert Weiss, *Recovery from Bereavement*

With M. Relf and A. Couldrick, *Counselling in Terminal Care and Bereavement*

Also, numerous publications on psychological aspects of bereavement, amputation of a limb, terminal care and other life crises.

With Dora Black, Scientific Editor of *Bereavement Care,* the international journal for Bereavement Counsellors, and Advisory Editor on several journals concerned with hospice, palliative care and bereavement.

Formerly Chairman and now Life President of Cruse: Bereavement Care

He as acted as adviser and consultant following the disasters in Aberfan, Chedder/Axbridge Air Crash, Bradford Football Club Fire, Capsize of the Herald of Free Enterprise and Lockerbie disaster.

Recently work has focussed on traumatic bereavements (with special reference Rwanda where he helped UNICEF to set up their Trauma Recovery Program) and on the roots in the attachments of childhood of the psychiatric problems which can follow the loss of attachments in adult life.

Awards and Qualifications: OBE MD FRCPsych

Dr. Heather Ferguson-Brown

Heather Ferguson-Brown is from Northern Ireland where she worked as a social worker and social work manager in Social Services from 1969-1979 and from 1982-1985. A graduate of Queen's University Belfast, she subsequently completed her social work qualification and M Soc Sc (social work) at University College, Dublin. She also worked as a hospital social worker in St James' Hospital, Dublin 1981-1982 and it was there, in her work with oncology and haematology patients and their families, that she developed an interest in working with loss and bereavement. She later worked in this field in Northern Ireland in several hospitals and in voluntary work as a group supervisor with Cruse Bereavement Care. Since 1985 her work has been primarily in the field of social work education at Queen's University Belfast, University of Botswana, University of Transkei, South Africa, and the University of Lincoln. She completed her doctoral studies at the University of South Africa. Heather has also worked in a voluntary capacity with a number of non-government organisations in Transkei in developing services for children in need of care, street children, child abuse prevention, and domestic violence. She has published a number of journal articles, booklets, and conference papers across a number of cross cultural social work themes such as social development and domestic violence and worked with her partner, Malcolm, on several educational videotapes including 'Working with the Terminally Ill' which was originally published by Tavistock Publications and currently by Concord.

Prof. Malcolm J. Brown

After some years as a cinema operator, an RAF aircraftsman 2nd class, a Sainsbury's shop assistant, an electrician's mate and an electrician, Malcolm Brown joined the Metropolitan Police. In his nearly four years in the Service, the many human tragedies in which he became involved (many in the middle of the night) led him into the caring professions. After training at Swansea and Birmingham universities, he worked as a probation officer in Hertfordshire before leaving for Africa where he was employed as a social welfare officer in Zambia, a senior lecturer in the University of Zambia and a United Nations social welfare adviser in West Africa. Returning to the UK after eight years, he taught at the universities of Bradford and Birmingham and as professor of social administration and social work at the Queen's University, Belfast where he remained for 18 years before returning to Africa for a further eight years as professor of social work at the University of Transkei.

He returned to England in 2000 and is currently visiting professor at the University of Lincoln. He has written some 90 papers on social work and related matters and has produced over forty video training programmes on a range of social problems a number of which are on the interface of health and the social services. He has an MSW from the University of Pennsylvania and a Ph.D from Bradford University. He is a Listener for Crossline, a Christian telephone counselling service.

BRIEF SUMMARIES OF BACKGROUNDS AND VIDEO INTERVIEWS WITH FAMILY MEMBERS

Videotapes Nos 1 and 2

Joan and Mike were interviewed just over a year after their son Edward took his own life. They have one other younger son. Edward was a very artistic, creative young man who was enjoying his first year in residence at Hull University. Edward loved the social life and drank, smoked and took drugs. Friends noticed a significant and sudden change in his behaviour and he spoke of getting messages through his CD player and thinking that he was Jesus Christ. He bought a Sumari sword and used it to take his own life. It would seem that he was experiencing a form of schizophrenic episode.

Other than a strange telephone call a couple of hours before he died, Joan and Mike had been given no reason for thinking that Edward was contemplating taking his own life. Mike had a violent physical reaction and was off work for some six months. Joan went back to work much earlier but continues to have adverse physical symptoms and remains in a very distressed state. Mike, who has work which he finds very interesting and absorbing and which takes him around the world for much of the time, has thrown himself into his job. Joan is anxious when he is away and they both worry for one another and for the younger son. They both feel that their tragedy has aged them a lot and that life will never be the same again.

Videotapes Nos 3 and 4

Maxine is the mother and John, the 20-year of brother of Neil, an 18-year old who took his own life by hanging. Maxine lives with her husband and they have an elder daughter who is married with one child and lives fairly close-by. John lives close-by with him partner and they have a six-month baby girl. Maxine and John were interviewed some eight months after Neil's death. Neil was a very intelligent, talented young man who taught himself to play the keyboard and the clarinet. He was very keen on acting and had appeared in soaps and in TV adverts. He had been accepted by a college of music. His death was totally unexpected. Maxine (and indeed the whole family) are very angry with the police who kept them in the kitchen for four hours while they searched through the house and were escorted if they went to the toilet. They declined to allow anyone to be with or see the body nor allowed anyone to accompany Neil's body to the mortuary. All this apparently, without any explanation given at the time. Maxine is also angry with the Coroner's Officer and says that when he got to the house, he complained he should have been called first. It was four days before they were able to see Neil and then, only through glass. It was a week from the time of death, before the body was removed to a funeral chapel when they could be with Neil and visit as often as they wished. Subsequent explanations

have done little to lessen the bitterness. Maxine feels that her life is shattered that only her two remaining children and two new grandchildren are keeping her in this world. She carries a great deal of guilt and feels that she has no right to be working with children as an assistant at the near-by school. She likes to spend a lot of time in bed, not to sleep but it is only in bed that she feels safe.

John arrived at his parents' home just a few moments after his mother and his partner. His mother's screaming had him rushing up the stairs, to find his brother hanging in a top floor room. He could not get him down and ran down for a knife from the kitchen in order to do so. His subsequent physical reaction was quite severe with trembling and difficulty in breathing. He attempted to return to work too early and at the time of the interview had been off for two months. Feeling the need to keep strong for his partner put a great strain on the relationship and he believes that but for their new baby they would have broken-up – at least for a while. At least six months were a daze to him but he now is just starting to see glimmers of a life in the future.

Videotapes Nos 5, 6 and 7

Elaine is the mother, Kelly the elder sister and Gareth the 20-year old elder brother of Lewis, a 16-year old technical college student who took his own life by hanging, some 18-months prior to the interviews. Elaine was divorced some years ago and her ex-husband has re-married and had only limited contact with his previous family. Lewis had done very poorly in his GCSE examinations in the summer and had refused to show his results to any member of the family. He expressed interest in carpentry and with his mother's encouragement, signed on at the technical college for a carpentry course. Apparently he liked the practical work but not the theory and took to missing classes. In November, 1999, his brother rebuked him for taking and letting-off some of his fireworks. A few days later, his sister rebuked him for skipping classes and this led to a heated argument between them. Very shortly after this, Lewis took the cord from his sister's dressing gown and hanged himself on playground monkey bars fairly close by. The family had nicknamed him, Stormin' Norman because of his tendency to go off in a huff when things were not going in the way he wanted them to. Lewis's death was totally unexpected and came as a great shock to the whole family. However they tend not to talk to one another.

Elaine was in a frozen state for a long time and remains very distressed. She wanted to see Lewis's body to make the situation real for her. She is angry with him for taking his own life and carries a great deal of guilt. She feels undeserving and her self-image has taken a big knock. She worries for her other children, especially Gareth, yet resents others moving on. She tends to tell outsiders that she has two, not three, children and feels very guilty about doing this. It is not because she is ashamed of Lewis but because she cannot face the anticipated reactions. Elaine visits the grave regularly and prefers to go alone.

Gareth, 18 months on, remains in an extremely distress state and, as Lewis's big brother, carries a tremendous amount of guilt. He was off from work for many weeks, alone, and largely crying in his bedroom. He compares seeing his brother's body to being hit with a sledgehammer, has wanted the ground to eat him up and feels

like dying himself. He cannot talk about it to anybody, nothing else matters and he does not think that he will ever heal.

Kelly has shown herself to be the stronger member of the family. She needed four weeks off following Lewis' death but was able to prepare an address and present it at the funeral without breaking down. She is angry with her brother for taking his own life, does not think he was depressed and is puzzled about why he should give up on living before he has seriously started to live. She misses him as great deal, especially as she sees his friends turning into young men. Some days are much worse than others but she needs to keep strong for her family whom she sees at risk. Its hard to talk with her friends about Lewis and it will be hard to find a boyfriend who will be able to accept her times of sadness. She feels vulnerable but throws herself into her work and is very determined not to let her brother's death dominate her life.

Videotape No 8

Arthur talks of the death of his son Leon at the age of 25 years from carbon monoxide poisoning, nearly 10 years prior to the interview. Arthur had been divorced for about 12 years and was living alone at the time of Leon's death. He has one married daughter who was pregnant at the time of Leon's death. Leon had obtained a first class degree of which Arthur was justly proud. He was living about 30 miles away from his father and came up fairly regularly for week-ends. After graduation, he seemed to be in a world of his own, was remote and very difficult to relate to. Eventually, Arthur got him to a GP who said he needed to see a psychologist. There was a long waiting list. Visits to clinics, doctors and hospitals all failed to elicit help so Arthur took his son privately to a consultant in London. He said Leon needed to be in hospital. The consultant's call to Leon's GP got him into mental hospital within two days, where Arthur was told that Leon was manic-depressive and was suicidal. After a few days, Leon discharged himself and coming home from work the Friday, Arthur found his son dead in his car in Arthur's garage. Arthur met with his ex-wife and daughter that night but they could not talk positively to one another. The daughter was angry that a suicide note had been left for each of her parents but not for her. Arthur was in a state of deep shock and was in the mental hospital for a week This was followed by a very intensive weight and pain in his chest for about three months – a broken heart. His preoccupation with his son created a great gap between him and his daughter whom he had neglected. This took four to five years to heal. Arthur feels no guilt about Leon, is grateful for the help that his son allowed him to give him, understands why his son needed to take his own life, feels his son's presence in his life and is strengthened by it. He made a resolution to get on with his life and enjoy it.

Videotape No 9

Leisa is 28 years old, is married with two sons aged 4years and five weeks. Her only brother, Gareth, died four years ago at the age of twenty. He hanged himself in his bedroom and was found by his mother the next morning. At the time of his "A" level exams, he had taken some tablets when under great pressure but these did not have a

serious physical affect on him. He told his father what he had done, was very sorry and promised never to do such a thing again. His parents visiting the school and Gareth was seen by a psychologist. To all intents and purposes he was a very intelligent young man, very happy and outgoing, popular and with lots of friends. His relationship with a girl had just finished and Leisa thinks this may have been one of the things that led to his death. Leisa was very angry with him for doing it although now, four years on, says that she has forgiven him. Leisa remains very upset but does not normally like to talk about it, keeps things bottled up and pretends that everything is alright. She says that she does not like to keep crying all the time and is not very good at sharing her emotions. She is particularly worried about her one sister who was 11 years old at the time of Gareth's death. At the time she had been told that it was an accident. Now she knows the truth, says that she wants to hear about what happened but runs out of the room when parents or Leisa try to tell her about it. Leisa hopes that Gareth is at peace and with God. She feels vulnerable, sees herself as being less happy now and doubts that she will ever be anything like the person she was, again.

Videotape No 10

Sian's has an elder and younger brother. Carl, her younger brother was creative and artistic but not as intellectually bright as his two siblings which he always found difficult to cope with. Carl died some two and a half years ago by straddling a railway line. At the time of his death, he was working in London, apart from all of his family. Previously, he had often talked of suicide, would leave notes and wander off. The family spent a lot of time looking for him but until this time, he would always return. He would take a range of drugs and the family always thought it probable that he would take his own life. They had tried to get help for him but he did not seem to want this. Sian would get very frustrated and try to bully/chivvy him into seeing things differently and into behaving differently. She now bitterly regrets all the times she was horrible to him. She thinks of him daily and gets very depressed. She has thought of suicide herself and sees Carl has having set a precedent but thinks it is a shameful way to go and thinks she could not do that. She is angry with Carl for taking his own life and thinks that he has done an awful thing to his family. She gets very angry with people who complain about trivial things. In some ways she would like others to have had the same experience as herself so that they would know what it is like for her to grieve the way she does. She has nightmares about him suffering and dreams about him coming back. Her mother blames Sian for Carl's death and thinks she should have been nicer to Carl and given him more of her time. Sian does not want to have children herself in case they do the same thing as her brother. Sometimes friends can be helpful to her but their thinking and interests tend to move on and they do not want to keep hearing about Carl.

Videotape 11

Maggie talks about the death of her son Simon, three years ago at the age of 19 years. Simon took is own life by jumping off a bridge. He was the only child and his parents were divorced. About a year previously, he had become very anxious about

his work, started to drink heavily, fell out with his friends and was very rude to his mother. It is believed that he made two suicide attempts by overdosing during this time. He sought help from the G.P. and was put on Prozac. This was not very helpful and he asked to be admitted as a voluntary patient. He was in the mental hospital from July to October when he was discharged. It seems that he was asked to describe and discuss his feelings but when he drew a picture of the medical staff with decapitated heads, this resulted in a bawling out and a consequent discharge. This was not what he wanted and he talked a lot about needing help and taking his own life. He was depressed, very restless and possibly schizophrenic. He pleaded to his mother for help and she says that she was told by the GP that she would have to cope with things. He seemed to get a little better, started to apply for jobs and Maggie began to think that he might possibly be on the mend. On the night in question, he went to a pub with his friend and his father. He wanted to go on to a nightclub with his friend who said that plans had already been made for them to go the following night. His father left the pub first, then his friend. He tried to ring another friend who was not available; then his mother who found the voice so quiet that she did not recognise him (she wonders if he just wanted to hear her voice once more and not to engage in conversation). Fifteen minutes later and Simon had taken his life. Maggie's first reaction on hearing that Simon had died was, "Good for you, you're out of it now." She thought that he had been suffering a great deal and could see no way out and that he was heroic to hang on for as long as he had done. She went back to work after three weeks but on a part-time basis, went for healing sessions, and for counselling. Her GP gave her lots of time for a year. She would go to the bridge and to the cemetery on a daily basis for some months. Friends and neighbours are very kind and this helps. Three years on, she still lives very much on a day-by-day basis and does not think about the future. Maggie feels that Simon is with her, guiding and helping her. But she is alone, having no children or grandchildren. At times life seems very unfair and she believes that this is still very early days for her.

Videotape No 12

Denise talks about the death of her 18-year old son, Shane. Shane's parents were divorced several years ago and the father had remarried and had two sons by his second wife. Shane lived with his mother and three sisters, saw much less of his father and was jealous of his half-brothers. For some years, he has been very uneasy about spending time alone and even in daylight, on returning home, would not stay in on his own but would keep out until another member of the family arrived home. He had been previously involved with drugs, had taken to taking and driving away; and finally to encouraging police cars to chase him. At the time of his death by hanging, he was in prison and had been placed in solitary confinement for some disciplinary offence. Having only five week to go before release, a few days previously he had asked his mother for a set of new clothes to be bought for him for his coming out of prison. He had never given any indication of being depressed. Denise got the message about Shane's death from her ex-husband and went to the prison with her partner thinking there was some mistake. She had the news confirmed and just wanted to get home, in shock and disbelief. She had to go to the city mortuary: would have liked to have gone alone but the family went with her. Denise was distressed to see Shane with a purple cover with gold cross, on his body, through glass. Denise was given a letter Shane had written to her, she could not read this for a

week. Again, she wanted to be alone to do this. Denise wanted to see the cell where Shane died as she had been having nightmares about him being in a dungeon of some sort. She went with her partner and saw that it was not too bad but still has nightmares about him. For Denise, the worst part was seeing Shane in the coffin when they were placing the lid and knowing that she would never see him again on this earth. Life has little meaning for her now, she just wants to die and be with Shane. She treasures all items relating to him and spends a lot of time in his bedroom, which always seems cold. She just copes with life for her daughters and grandchildren. Sex with her partner has no significance for her now and she does not want to enjoy herself anymore. Shane said in his letter to her that he was going to a better world and she is just existing until that time when she can join him there.

Videotape No 13

Tommy talks about the death of his son Paul who had taken his own life by drowning nearly three years previously at the age of 25 years. About 18 months prior to his death, Paul, who had been on drugs, quite suddenly became very agitated, was always rubbing his hair, crying and following his mother around all day. He pleaded that he could not he left like that and asked that his parents help him to die. He thought that drug taking had damaged his brain. Tommy tried doctors, health centres and hospitals but it was over a year before he could get Paul admitted to a mental hospital. After two days, Paul left, cut his wrists and jumped in front of a car. After discharge from a general hospital he returned to the mental hospital but two days later the father was instructed to take him home otherwise the mental hospital would find a hostel place for him. The hospital stated that Paul was not suicidal. Tommy succeeded in getting Paul into a day centre where Paul responded very positively to Jimmy, an unqualified worker. He started shaving again, dressed smartly and put on weight. Jimmy had time off during his wife's pregnancy and Paul waited anxiously for his return. There were pregnancy complications and Jimmy did not return on the expected date. Paul took his own life by drowning. It took eight weeks for the police to find the body which was decomposed and identified by dental records.
The worst time for Tommy and his wife was waiting for Paul's body to be found. His wife wanted to die. Tommy froze his emotions in order to keep his window-cleaning business going and keep the family intact. Fifteen months later at a funeral service for the dead in the parish, Tommy broke down and was in bed three days crying all the time. Nearly three years on, the sparkle has gone out of his life, he gets by but will never be as happy as he used to be. He is always tired, fidgets all the time and sleeps badly. He spends a lot of his evenings in bed and wants to sleep all the time. He thought he was made of stronger stuff but now he is doubtful about this. He has just been to the doctor's and asked for some anti-depressant tablets although he has not taken any yet. He remains very angry with the psychiatrist who refused to help Paul and has no doubt in his own mind that Paul would still be alive he had been given the help he so desperately sought.

N.B. Craic (pronounced "crack") is a social event, a party or enjoyable gathering of some sort. Gutties are gym shoes or trainers.

Videotapes Nos 14 and 15

Linda is the mother of Caitlin who took her own life at the age of 18 years, three years previously. Sean is Caitlin's elder brother and the only other sibling, who was 29 years of age at the time of Caitlin's death. Linda and her husband had been divorced for about 10 years at the time Caitlin died and were living some 150 miles apart. The divorce had been quite acrimonious. Sean had been living apart from his family since he was 17 years old. Caitlin had been living with her mother and a close female, family friend. She was a very intelligent girl, vivacious and full of life.
Linda relates that her daughter had become unhappy following that break-up of a relationship which had been very significant for her. When someone suggested that not only would Prozac make you feel good but would also cause you to lose weight. Caitlin insisted on going on it despite her mother's pleadings. The normal expectation is that it takes at least a couple of weeks before there is any noticeable difference. With Caitlin it seemed there was a somewhat manic and acting-out reaction, with Caitlin behaving in an unusual and uncharacteristic manner from the first tablet. This is borne out by Sean who saw more of his sister at this time as she had gone to live with her father for a few weeks who was in the same locality as Sean, although normally saw very little of him. Sean saw Caitlin as being very happy during these weeks with her doing things that normally she would never have done. There did seem to be a manic edge to much of this behaviour however which caused him some concern. Linda does not share her inner feelings easily. Three years on, she continues to grieve for her daughter and does not see the situation getting any better for her. Sean believes that there were other reasons for his sister to take her own life although considers that the taking of Prozac could have pushed her over the edge. Sean is a somewhat troubled young man who believes that he has made a mess if his life. At various times he has been heavy into drink and non-prescribed drugs. Caitlin's death has certainly adversely affected his life, which he considers he has yet to try and get sorted out.

N.B. The "Kate" that Sean refers to in the interview is not his sister but one of his Partners. Rufus is one of his children.

Videotape No 16

Susannah talks about the death of her brother Paul, aged 21 years, who took his own life two years ago by hanging. He had made previous attempts, by hanging, wrist cutting and overdosing. A year previously, when in hospital after an overdose he acknowledged to his family has he had been sexually abused from the ages of seven years to fourteen years, by a member of the church where he had been an altar boy. The offender had only just been convicted and given two years imprisonment and Paul said he wanted to die. After this event he was given psychiatric help, was watched closely at home and seemed to be getting better. He mother had bought him a puppy two weeks previously and he hanged himself in his bedroom with the dog lead. Three brothers were asleep in the room but his mother entered early in the morning, found him and called his father who cut him down. The man who had sexually abused him had been released from prison a couple of weeks previously and Paul had seen him in the street. Susannah was called from her own home, by her

sister. She lay beside Paul for a while, talking to him and stroking his hair. The police were very good and understanding and gave everyone as much time as they wanted to be with Paul before taking him away. Susannah wanted to die too. She could not kill herself but prayed to God that she would die in her sleep. She was off work for three months. For the first two months she wanted to be alone, after this she wanted to spend time with her family. Friends were very supportive and she could ring them in the middle of the night and they would listen to her saying the same things over and over again. She feels no anger towards Paul, only to the man who abused him. She thinks of and prays for Paul every day. Two years on, she still gets bad nights but gets comfort from listening to the music he liked and watching a video that was made of him when he was happy and laughing. At funerals and watching sad films, she cries for Paul. Her partner at the time and the father of her son could not cope with her grieving and they separated. Her new partner can be along side her in her sadness. There will always be times of tears and sadness but Susannah is determined to make the best of her life and live it to the full.

Videotape No 17, 18, and 19

Michelle is the sister of, and Anita and Mike the parents of, Richard who died two years ago at the age of 16 years. At that time, Michelle was 13 years old. Richard had been due to go on a skiing with his school that day. He had partially packed his things but was subsequently found by his mother in the garage having taken his own life. Michelle misses him a great deal as they were very close but is angry reasoning that Richard either did it on the spur of the moment without thinking or talking about what was troubling him or else lied to her in saying that he would see her in her school pantomime on his return when he has no intention of so doing. Either of these alternatives make her cross with him. She resented not being seen by people around her as Michelle has had been the case, but as the girl whose brother had killed himself. She is also very upset that she will never be an aunty now. She believes that she was less upset by Richard's death than her parents but worries about them, especially her mother, and does not like to be away from them. She is doing well at school and while more vulnerable than previously seems to have made a good adjustment to Richard's death.

Richard's mother, Anita, was devastated by her son's death, had no idea that anything was wrong and carries a great deal of guilt for what happened. One big regret is that she never actually told Richard that she loved him and wonders if he knew that she did. She is hurt that a police officer was heard to comment that clearly he did not want to go on the school trip. This may have been the case but he had been twice before and appeared to want to go again. Anita wondered if there was any bullying involved. The headmaster rather pooh-poohed this idea but apparently insisted on being present when the boys were interviewed by police on their return from the skiing trip - which would certainly have made any whistle blowing more difficult. Anita comments that after a holiday, the return to work brings questions about how the holiday had been. A return to work after a longer absence dealing with the death of a child brings no questions. She makes the plea that friends, neighbours and colleagues should speak about the death even if it brings tears. Ignoring the death is much more hurtful. Both parents were upset that the police had left Richard's watch

etc lying on the side in the kitchen. The unexpected hourly chime was distressing but poignant for them.

Mike was told by the police at work. They drove him to his sister-in-law's house where his wife and daughter were waiting. They hugged each other and both parents simultaneously told Michelle never to do anything like that. Mike made great efforts to make everything right for the funeral, kept busy with that and felt very low once there was little else to do. He carries some guilt that as a consequence of Richard's death his employers put him in a different job in which he is much happier. He returned to work part-time in the first instance and worked in something of a daze initially. It seemed as if he could fairly quickly switch off, as he puts it, and think about other things. This is in contrast to his wife who would like to spend more time talking about Richard than would Mike, although the great love that each held for their son is not in question. Mike is a committed Christian and has no doubt that that Richard is in Heaven and that they will all be together again one day. In the meantime they grieve in their different ways. Both parents have some concern for Michelle but are relieved that she is much more outgoing than her brother and that her life and future gives reason and meaning to their owns lives.