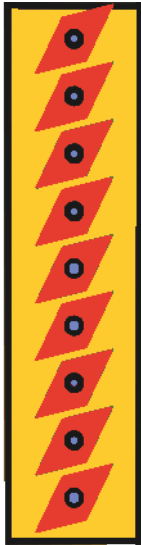
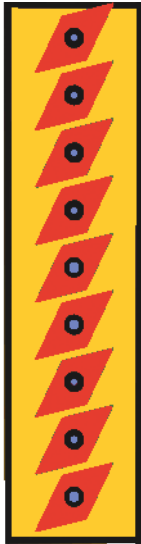




coping with grief after a suicide death



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Introduction

Someone you love has chosen to end their life and you are left to deal with the consequences: the pain of unbearable sadness; dismay and confusion; empty feelings of abandonment; anger; guilt; and the relentless persistence of unanswerable questions. You may have to bear the additional burden of trauma if you were the person to find your relative, friend or colleague after their death, or have witnessed the death occurring. You may be left with persistent memories of images, smells or sounds that make it difficult to concentrate on anything else, and make you long to remember the person who died, to remember them as they were.

At a time when you may be feeling as helpless as a child and vulnerable (the word 'regressed' describes these feelings) you are likely to be faced with necessary but unwelcome intrusions from the police and coronial system. For some, there may be resented, 'in your face' experiences with the media. How do you cope on a minute to minute, hour to hour basis, let alone for the rest of your life? What hope is there of ever leading a 'normal' life again? You may feel, in fact, what hope is there at all?

Perhaps fear has been added to emotions that may be unfamiliar in their passionate intensity – fear that coping with grief after a suicide is somehow worse than grief after death from other causes. The aftermath of suicide certainly has some distinguishing features, but grief is grief, and it is not possible to grieve with more than 100% of one's being. Research studies show the special features bereaved families are left to grapple with. However, they do not show a long term 'worseness factor' because of the suicide alone. The same factors which have the potential to complicate grief apply to any death. Families who have experienced the death by suicide of one of their members share many of the same reactions as other families experiencing sudden or violent death.

Family shame is one of the feelings often associated with suicide, but we don't often think of shame being associated with accidental death. For example, Bob and Elaine felt shame when their 19-year-old son died while drink driving and was found responsible for the deaths of a young family killed in the car he collided with. Jack and Barb felt shame when their 14-year-old daughter was found dead on their doorstep from an accidental overdose after trying drugs for the first time at a party. We will outline what is meant by 'risk factors' a little later.

This booklet is designed as a simple response to distress signals that you are likely to direct to family members, friends, your social support network, and others. Some people who care about you may have enough compassion, knowledge and sensitivity to meet your needs; others may 'mean well', and succeed in saying and doing all the wrong things.

Irrespective of the ability of family and friends to respond in a 'you centred' way, it can be helpful and empowering to have easy access to information that will help you to find and use other resources as needed.

Some initial reactions you may experience after a suicide

Grief is a chaotic emotional experience. While a wide range of reactions can be anticipated and are considered 'normal', each person's grief will be a unique expression of their personality, their pre-existing mental and physical health, their gender and culture, and most importantly, of their relationship with the person who has died.

You may initially:

- feel stunned and in disbelief, barely able to move
- feel confused
- behave in an agitated manner and have difficulty staying still
- experience a range of physical sensations including increased heart rate, difficulty breathing, nausea, sweats and a feeling of pressure in your head
- cry, show anger or appear super controlled.

Some immediate needs following a death by suicide

- simple, clear, truthful information
- an advocate – someone who knows you and your needs well, who will absorb information that may be overwhelming for you, and who will help you deal with the police, the Coroner's Court or the media. Ideally, this would be a friend or relative, but a sensitive social worker or other health professional may be good as well
- access to the person who has died
- love, sensitive understanding and support
- safety.

THE FIRST WEEK

If you are reading this booklet before the funeral takes place, there are several things that may help. You may still be feeling numb, particularly if the suicide was not anticipated, and you may not be able to think clearly. Your vulnerability may mean that you are easily confused by conflicting advice from well meaning friends and relatives.

With help, you may be able to slow down, to make decisions as you feel ready. After all, there is no rush, the crisis, in that sense, has already passed. Contrary to popular opinion, it is usually better in the long term for most people to have the funeral later rather than sooner. We have been socially conditioned to believe that the sooner the funeral is over, the sooner we can get on with life, as if it is the funeral that is the source of pain. Pain and distress exist because someone important to you has died. The funeral is an ideal opportunity to express grief in a public arena where it can be legitimised and supported by those who care.

In western society opportunities to spend intimate time with the person who has died are usually fairly limited, and active participation in preparation and conduct of the funeral and burial are traditionally discouraged, particularly for women. In these circumstances, five to seven days after the death is probably a more helpful time for a funeral service. In other words, delays caused by the coronial process can be positive rather than negative if seen from another perspective. If time is slowed down, you may be able to participate more in planning a funeral that fully expresses your relationship with the person who has died, and is an appropriate and creative acknowledgement of their life.

The funeral director will probably ask you if there will be a 'viewing'. You may initially reject the idea, particularly if the method used to end life has caused disfigurement. However, you could benefit from gentle encouragement to do so with support. Even if there is only part of a loved person's body that is recognisable and accessible, most people find it helpful in the long term to spend time with them, saying and doing whatever feels right. This will help you to acknowledge the reality of death and is something you will come back to over time.

As the experience becomes more familiar and perhaps less frightening, you may find it important to have time alone with the person who has died, secure in the knowledge that a supportive friend or relative is close by if needed.

SHOULD I TAKE A SEDATIVE TO HELP ME GET THROUGH THE FUNERAL?

As already mentioned, the funeral is meant to be a time when grief can be expressed openly. It is unfortunate that we live in a society that is so uncomfortable with intense feelings. Tranquillisers and sedatives may dull some of the pain, but they also dull memories of the experience that are important and you may later be left with regrets. Ask about what other help is available so that sedation is not necessary.

Even if you are not sedated to 'get through the funeral', you may find it difficult to recall details that later seem important to you. Many bereaved people appreciate being able to listen to an audiotape of the funeral, or watching a videotape of the ceremony with relatives or friends in the safety of their own home. You may wish to ensure that someone takes responsibility for taping the funeral and or burial/cremation so that it can become part of your collection of tangible memories.

SUMMARY OF NEEDS IN THE DAYS FOLLOWING THE SUICIDE

- Encouragement to slow down.
- Opportunities to spend meaningful time with the person who has died.
- Sensitive preparation before, support during, and support after the experience of 'viewing' (as it is referred to by the funeral workers).
- Time and opportunity to plan a funeral service which creatively acknowledges and honours the life of the person who has died.

Children

CHILDREN'S NEEDS

Children have many of the same needs as adults, yet they are often inappropriately protected from the reality of death, particularly suicide, through withholding information. While the desire to protect is understandable, in the long term children are rarely grateful and in fact may feel resentment from being excluded and disempowered.

When children ask questions and want access to information, it is often very confronting to adults who are not ready to deal with the starkness of a child's responses. If that is the case for you, ask someone to help. First ask about the child's understanding of what has occurred, then answer simply and directly in language that is familiar to them. They can be given access to truth sensitively and lovingly, and supported as they react.

No matter how hard we may try, it is usually difficult to conceal the nature of death indefinitely and a child is likely to experience more complex reactions when they eventually learn the truth from outsiders, perhaps in a publicly humiliating way. For example, Tom was six and his sister four when their father died from what they believed was a heart attack. Almost a year later they were told during a typical spat with neighbourhood children that 'anyway, your father hated you so much he had to kill himself to get away from you'. Their resulting anger was directed at their already vulnerable mother for some time until she was able to get professional help to deal with their reactions and needs.

WHAT IS THE RIGHT AGE TO TAKE CHILDREN TO A 'VIEWING' OR A FUNERAL SERVICE?

Whatever age the child is at the time. They need the same sensitive preparation before the experience as an adult, a supportive person to be there just for them, and opportunities to talk about their experience later. Very young children are more likely to 'debrief' by acting out their experience in play. They may use dolls, other toys or other children in a game which allows them to re-enact what they have seen, heard or felt.

At a 'viewing', children may want to investigate every detail. They may be fascinated with sutures (stitches), bruises and abrasions and want to touch them. This response is normal and natural and a child's way of integrating and making sense of their experience.

Most children want to be involved in preparing for the funeral and some children want to be involved in the funeral itself. They may wish to add drawings, letters, poems, toys or special gifts to the coffin, write (in their own hand) the order of service, or read something out loud during the funeral service.

SHOULD CHILDREN KEEP THINGS THAT BELONGED TO THE PERSON WHO DIED BY SUICIDE? IS THAT MORBID?

Children, like adults, want to retain a feeling of connection to the person who has died. They may appreciate a lock of hair, photos, or special belongings. Some families find comfort from jewellery that is made to include a lock of hair, or some of the ashes after a cremation.

Legal issues

AUTOPSIES AND POST MORTEMES

These are interchangeable terms. They refer to examinations required by law to determine the exact cause of death. While the cause may seem obvious it is still necessary for the coroner to act as an advocate for the deceased and rule out any other possibilities for example, murder, accident or misadventure. You may be, or may already have been, asked to 'identify the body' at the morgue prior to a post mortem examination. Sometimes it is possible to have the support of a social worker during this process so that it is possible to be prepared for the experience and debriefed afterwards. If not, it helps if you can be accompanied by a caring friend or relative.

You may have later opportunities to spend time with the person who has died; at the morgue in some circumstances, or perhaps at the funeral director's. Most people find it helpful in the long term to use opportunities provided by the funeral director to spend intimate time with the person who has died, usually in a less hurried or stressful setting. These opportunities can help to change, in a positive way, the images that may be in the foreground of your memory. You may feel anxious about seeing any disfigurement caused by the autopsy. Ask someone you trust to see them first, then explain to you what you might see, allowing your mind to rehearse. Most often, the reality is less distressing than what is imagined. However, many people find it helpful to 'block' and not focus too long on any details or images that are unnecessarily confronting.

When someone with AIDS or other communicable disease dies by suicide there may not be an opportunity for further intimate contact so it is advisable to spend as long as possible in their presence before the autopsy.

Whatever the setting in which the 'viewing' occurs, it is usually helpful to spend time afterwards talking about the experience. This can help integrate its meaning before being confronted with the harsh reality of life outside the hospital, morgue or funeral parlour.

THE CORONER'S REPORT

It may be some time before full details of the coroner's report are available to you. When that time comes it is usually helpful to read it in the presence of a sensitive and compassionate person; perhaps a friend or relative with some medical training. In some areas, social workers are employed by the Coroner's Court and may be available to sit with you and explain anything you don't understand. If the morgue in your area does not employ a social worker, you may be able to find (with the help of a friend or relative) a trained bereavement counsellor from another service who would be willing to do so. If the details are too distressing, read only as much as you can tolerate in any one sitting, and come back to it later when you feel ready.

You may of course, choose not to read it at all, and that's fine; having a real choice is important and empowering.

Grief may be inhibited to some extent until all legal processes are complete. It is as if some part of the self needs to be held back in order to deal with any new threat that might emerge. This 'holding back behaviour' seems to be part of a fairly large need to assure survival and safety before feeling safe enough to grieve with all of our being.

What are you going to say to other people?

It is not easy for most people to talk publicly about death, or about the feelings of grief they experience afterwards. Most of us fear being misunderstood, being 'diagnosed' as having something wrong (for example being seen as depressed or 'not coping'), or being avoided or rejected. Death is still not a socially accepted subject and some deaths appear to be less 'acceptable' than others. You may be tempted after a suicide to give other reasons for the death, to pass it off as an accident or a heart attack for example.

While it is understandable that you might want to do so, you may be left to deal with the added pressure of maintaining a secret, and secrets can complicate grief. It will be in your best interests in the long term to tell the truth. You may want to say something as simple as:

'He/she died by suicide, and that's all I want to say at the moment'.

or 'He died by suicide and I can't talk about it yet!'

or 'She killed herself/took her own life ... and I just can't talk about it ... yet!'

It may be too difficult in the beginning to add 'yet' or 'at the moment', but when you can, it's a way of acknowledging, even to yourself, that some time in the future you may want or need to talk about the details.

LATER REACTIONS TO THE SUICIDE

As you begin to absorb the full impact of the event that has irrevocably changed your life, you may feel as if everything is getting worse. Many people experience increasingly intense feelings of anguish and emptiness four to six weeks after the death has occurred. If this change has not been anticipated by you or those who care for you, it may be misinterpreted. Friends and relatives may have temporarily used up their available time and energy and need to redirect attention to work, home and family. While this is understandable and unavoidable, bereaved people sometimes feel abandoned.

In this situation EVERYONE may feel helpless and respond by encouraging you to seek medical help.

In a medical setting, symptoms of bereavement (difficulty eating and sleeping, crying, confusion, memory loss, lethargy, feelings of hopelessness and a range of physical sensations) can easily be misdiagnosed as depression. A busy GP may also feel helpless in the face of a bereaved patient's desperate and obvious pain, and respond prematurely and inappropriately with a chemical solution. Chemical solutions (antidepressants, tranquillisers and sleeping tablets) are often encouraged by pressure from family, friends, colleagues and the wider society to 'put it all behind you and get on with life'. 'Normal' grief is not an illness and should not be treated as such. A diagnosis of clinical depression should be carefully assessed by someone who is fully aware of the intensity and prolonged nature of grief responses, aware of other possible contributions to your current emotional state (such as consistent alcohol or other drug use) and conservative in their prescribing habits. In certain circumstances it may be necessary to have medication, but only after careful diagnosis.

Some bereaved people find it helpful to have a 'first aid kit' that contains tranquillisers for use in emergencies; for example when a public performance demands composure, fear of another sleepless night produces even more agitation, or when feelings of panic feel temporarily unmanageable in other ways. Consistent and prolonged use can be detrimental and may not only delay grief but may even contribute to the development of depression. For this reason, and because drug tolerance or dependence can develop fairly quickly in physically and emotionally vulnerable people, it is in your best interests to explore other options for managing grief responses before learning to rely on chemicals.

SUMMARY OF LATER REACTIONS

You may experience some or all of the following as initial numbness recedes:

- increased feelings of anxiety, occasionally as severe as panic
- difficulty sleeping, eating, concentrating, or remembering simple details
- yearning and pining for the person who has died, often experienced as a physical ache or a hollow feeling in the stomach
- anger at the deceased for the choice they made and its effect on you
- overwhelming feelings of helplessness
- questioning of previously held beliefs about the person who has died and the nature and strength of your relationship with them
- loss of confidence in your ability to 'read' signs of distress or to solve problems
- a crisis of faith
- shame and embarrassment
- loneliness and despair
- overwhelming tiredness
- desire to be with the person who has died, to be dead (or asleep) and free from pain coupled with a fear that in fact, you may die
- a feeling of being trapped in incessant circles of unanswerable questions
- inability to care deeply about anyone or anything, to give anything, especially to oneself
- fluctuating feelings of guilt or blame
- a sense of futility and meaninglessness
- if your relative/friend/lover/colleague had been suicidal for some time, you may experience initial relief, sometimes followed by guilt.

Your feelings may be more intense at particular times of the day or week, for example: the time of day at which you believe the death occurred; sunset, when most families are returning home; Sundays, often another family time; and special dates such as birthdays, anniversaries and significant celebratory occasions.

Long term needs of people bereaved through suicide

The needs of most bereaved people are fairly simple. There is not a right or wrong way to grieve. The only guideline that is really important is that expressions of grief should not cause harm to you, other people or your environment.

You will need access to a safe person or people; someone who is prepared to let you talk, or to be quiet; to hear your story and your pain as often as you need to tell it. Sometimes you will need to be distracted from your pain. Knowing when to distract you from your pain may sometimes be difficult for those who are supporting you and requires sensitivity, self awareness and knowledge of your coping style.

If you need more than friends are able or willing to give, you may need to find a suicide support group or the services of a competent bereavement counsellor. A list of resources can be found at the back of this booklet. You may know from the beginning that love and friendship will not be enough. For example, if you have ever suffered from clinical depression or been diagnosed with any other mental health problem, if you are currently (or have ever been) dependent on alcohol or any other mood altering drug, you may be vulnerable to complications that require professional help.

If the suicide death you are grieving is that of your child; if it was completely unexpected (and many are); if you believe you could/should have prevented the death; if the death occurred at a time when your life was already in crisis and your resources depleted; or if you found the body of the person who died, you may need a teamwork approach from the many resources available from your local community and perhaps elsewhere. Relatives and friends may be able to help you access these services and to supplement what they have to offer.

Alone or with others, you may find yourself asking many questions, struggling to make sense of your experience and your reactions. Some questions will be answered in this booklet, others will need to be asked of a range of people or answers found in books specifically written for people grieving a suicide death. Some questions may take time although there may be no ready answers.

Questions and answers about grief and the 'grieving process'

WHAT IS GRIEF?

Grief is a term used to describe a range of emotional responses we might experience about the loss of someone or something that has significant meaning in our lives. We may experience sadness, anger, anxiety and guilt, in no distinct order, and with varying intensity. While grief is a universal experience, family behaviour, gender, culture, age and other factors will influence the way these emotions are expressed in behaviour.

DOES EVERYONE GRIEVE?

Everyone can experience grief, except a rare group of people who appear to be incapable of emotional responses. Sadness, often expressed in crying, is one of the most obvious signs of grief. However, people grieve in different ways and at different times. Some people's grief may be experienced as a feeling in their body which may not show on the outside.

DOES EVERYBODY NEED TO CRY TO LET IT ALL OUT?

It's certainly important to be able to express grief, rather than 'bottling up' feelings. However, not everybody does so by crying. People who did not find it easy to cry before they were bereaved, will probably not find it easy now. They may express feelings in other behaviour such as vigorous physical activity. Others may do so through music, writing or other forms of creativity. For example, Billie grew up in a family where being in control was praised and nobody showed feelings very easily. When his mother died, he had difficulty telling anyone what he was feeling. His grief was expressed through the mournful tunes he played on his trumpet, often for hours and sometimes to the annoyance of his neighbours.

WHAT IS GRIEF WORK, OR 'THE GRIEF PROCESS' PEOPLE TALK ABOUT?

Grief work is the process in which people engage to resolve the disruptions caused by bereavement. When we are bereaved, our previously held assumptions (ideas and beliefs) about life are turned upside down. Initially we may feel like a passive victim of circumstances beyond our control, tossed around by chaotic emotions that feel frightening and unfamiliar. We may fear that we are going mad, or long for the oblivion of sleep or death. The help of a supportive other is invaluable – a simple and familiar source of security that can help us progress from passive to active participant in our own process. We don't 'recover' from grief as we might from some physical illness, but gradually learn to accommodate (adjust to) the absence of a loved 'other' as we develop a new identity in a new world.

The process of 'accommodation' (adjustment) will be influenced by factors already mentioned, and by life experience, previous loss history, coping style, personality and physical health. The way in which each individual engages in this process is unique and can include the whole spectrum of emotional responses – sadness, anger, fear and even joy. It seems that the more actively involved we become in our own grief process, ('do' things rather than just sitting waiting for 'time to heal'), the more likely we are to reach some point of accommodation. That is, we integrate the disruptive experience into our lives in such a way that we can make some sense out of what has happened and develop a new frame of reference, a new sense of meaning and purpose.

WHEN PEOPLE TALK ABOUT 'NORMAL' GRIEF, WHAT DO THEY MEAN?

If we compare bereaved people with non-bereaved people, most of their behaviour will appear abnormal for a time. Generally, we tend to grieve as we live, our grieving behaviour an intensified or exaggerated version of our usual way of being.

As previously mentioned, you may lose your appetite for a time, have difficulty sleeping or concentrating, experience some memory loss, feel restless, agitated or lethargic, experience a range of emotions from numbness to despair or anger, and a range of bodily symptoms. You may have strange and vivid dreams, imagine that you can hear, see or smell the person who has died, and fear that you are going mad. In addition to mood swings you may initially experience extreme sensitivity to sound, light, smell or touch, and be easily offended by people's verbal clumsiness.

DO PEOPLE EXPERIENCE THESE RESPONSES AT DIFFERENT 'STAGES' OF THE GRIEF PROCESS?

Grief doesn't occur in neat, sequential 'stages' and is usually different for each person. As already mentioned, the way each person grieves is usually an exaggerated version of the way they live, although some behaviour may seem surprising at times. The numbness of grief allows many people to disinhibit and say and do things they may only have thought of before. Although some grief responses can be anticipated, for the most part grief is a chaotic process which becomes less concerning as it becomes more familiar. The Greek word 'khaos' meaning gaping emptiness is a pretty apt description of a painful, universal experience.

Suicide grief

HOW DOES GRIEF AFTER SUICIDE DIFFER FROM GRIEF AFTER OTHER DEATHS?

There are more similarities than differences. The intensity and duration of grief after death from any cause is determined by what we might call 'risk factors' or conditions which have the potential to complicate the grief process. The existence of a number of these factors (mentioned earlier) may indicate a need for help additional to that which can be provided by family and friends. In summary, they are:

- sudden, unexpected death
- trauma – witnessing a scene that 'assaults the senses' – sight, smell, sound or touch may cause distress. People who find the body of the person who has died by suicide may experience trauma in this way
- death of a child
- death that may seem to have been preventable
- centrality (or importance of) the relationship to the bereaved person's everyday life
- ambivalence in the relationship (that is loving the person at times, almost hating them at others)
- concurrent crises (other distressing life events happening at the same time)
- decrease in roles (for example, the bereaved person loses a role, such as wife, mother, caregiver, that is central to their identity)
- lack of social support
- absence of reality (not being able to see the body of the person who has died)
- pre-existing difficulties (such as unresolved earlier losses, alcohol or other drug dependence, depression, personality disorder).

Families grieving after a suicide death probably have many of these factors to deal with. They may also benefit from individual counselling before participating in a support group. Individual counselling can help meet the intense needs before sharing your feelings in a group setting.

ARE THERE ANY DISTINCTIVE FEATURES OF GRIEF AFTER SUICIDE?

While it is inappropriate to describe grief after a suicide death as 'worse than' other grief (it is only possible to grieve with 100 percent of one's being), some aspects of grief may be more intense, prolonged or unsupported. Families often:

- feel embarrassed or ashamed of the manner of death and hesitate to tell people the truth for fear of judgment – they may feel as if their family is blemished in some way
- feel guilty about not being able to prevent the death
- lose confidence in their ability to 'read' signals of distress
- feel as if they are lacking in some way because the person who died was unable to ask them for help
- fear that thoughts of wishing they were dead too, or that they didn't have to wake up in the morning, might mean they will die by suicide too
- fear that suicidal behaviour is an inherited tendency
- feel abandoned, angry or inadequate because that person 'chose' to die and leave them
- get stuck in repetitive circles of questions, the often unanswerable 'why?'

WHY HAS THIS HAPPENED TO ME, TO OUR FAMILY? HOW CAN I FIND AN ANSWER?

Even if the 'why' question can be answered to some extent, for example in a suicide note, the answer is rarely satisfying.

The person bereaved through a suicide death needs the support of someone who can listen with understanding to the anguish of how it feels not to have a satisfactory answer, or any answer at all. Someone who can hear the loneliness caused by stigmatisation and shame; the pain of guilt and remorse; the fear of someone else close to them dying in the same way.

Sometimes it is possible to put pieces of information together to provide an explanation of why a decision was made to die by suicide. You may find it helpful to ask close friends, family members or colleagues what they knew or observed. Or you may be able to talk to a trusted person whose psychological knowledge or wisdom from living enables them to help you make sense of the death. But frequently, even rational explanations don't satisfy the heart space that continues to hold a 'why' question – 'But why couldn't they tell me/ask for help? Why didn't someone do something?' 'Why couldn't they see that there were other solutions?' 'Why couldn't I have seen something/done something?'

It is often in the lonely silence of early morning that we are likely to anguish over painful 'why' or 'what' questions. We may continually ask ourselves (and women are more likely to do so than men) 'What was wrong with our family? What could we have done differently? What didn't we do? Is it my fault? Is it because...?'

You may continue to ask yourself a version of these questions from time to time, forever, but with less frequency and less intensity. You will gradually learn (with compassionate support) to live with unanswerable questions. Sometimes it helps to structure the time you allow yourself to go round and round in unproductive circles. You may decide to limit yourself to five minutes at a time and no more before making yourself do something active that will distract you.

BUT WHY DIDN'T I SEE IT AND STOP IT?

As we have mentioned elsewhere, one of the distressing legacies of a suicide is loss of confidence. You may lose confidence in your ability to see or sense significant clues about people's feelings or potential behaviour, or in your ability to satisfy the needs of someone you love.

Sometimes a person contemplating suicide doesn't want anyone to 'see the signs', or the signs may be so subtle that even the most skilled professionals may miss them. In fact, studies have shown how difficult it is even for those who are very perceptive to predict in advance which people experiencing stress are likely to end their own lives.

I'M SCARED SOMEONE ELSE I CARE ABOUT WILL DIE, PERHAPS IN THE SAME WAY

It seems to be a fairly general reaction after the death of someone significant in their lives for bereaved people to become overprotective, usually temporarily, of everyone else they love.

When the death has occurred as a result of suicide, protectiveness may take the form of hypervigilance or being excessively alert to possible threat. We may watch closely for any possible sign of intended suicide. Prolonged crying, or the normal language of grief (the 'I wish I was dead' or 'I wish it was me who had died' statements) seem to take on more ominous meaning, and it is easy to rush in inappropriately to try and 'fix' the problem. Initially, family members may feel nurtured by protectiveness but later come to feel frustrated. They may resent being treated as if they are the same as the person who has died, and want to shout things like 'can't you see that I'm not like ... x ... I'm not going to kill myself, and I hate you watching me all the time'.

Sometimes vigilance is justified. For example, brothers and sisters may be more vulnerable after a suicide, and it can be difficult for grieving parents to walk the fine line between allowing children or young people to grieve in their own way, and knowing when to seek help. If in doubt, talk to your general practitioner, someone from Lifeline, your local crisis team or another trained professional.

HOW CAN I SURVIVE IF I'M GRIEVING ALL THE TIME?

Initially, grief may feel like a 24-hour-a-day, seven-days-a-week experience, affecting every level of your being – physical, emotional, intellectual and spiritual. As a grieving person you may long for respite and may keep asking others 'how long will it last?'

Despite the fact that you may have longed for respite, when that occurs, you may feel guilty or afraid, for as uncomfortable as grief might be, it is a connection with the person who has died, a constant reminder of the importance of that relationship. When pain eases, you may fear that the connection has been broken, or that your

love was not as strong as you had believed. You may also feel guilty if you find yourself laughing and actually enjoying something, even if only for a moment, when the person you love no longer has life.

HOW LONG WILL 'IT' LAST?

As long as it takes.

Gradually, almost imperceptibly at first, you will begin to develop a personal rhythm of contact and withdrawal from pain; the unique pattern of YOUR grief. You will spend time thinking about the suicide and its associated pain and distress, about the person who has died, and about your regrets and loneliness. As unbearable as this process is, it will give you a feeling of being 'connected to' the person who has died. When you have felt as much distress as you can tolerate for the moment, you will need to do something to take your mind off painful thoughts, to distract yourself. Both aspects (contact and withdrawal) are an important part of the process. As you become more familiar with your grief and receive support that is right for you, your thoughts will begin to include more memories of your life with the person who has died, bittersweet reminders of the significance of their life and the uniqueness of your relationship with them.

As we have mentioned elsewhere, you will initially do most things automatically. One of the first challenges of bereavement is to achieve a sense of relative safety and security; assurance, shaky at first, of your ability to survive what has seemed unsurvivable. The second challenge is what we might call 'a crisis of meaning'. Old beliefs and ideas may seem empty and useless now and need to be replaced with a new set of values and reasons for living. These will help you make sense of, and take something positive from, the life and death of someone you love. This step is necessary to help you reinvest in life.

You may choose to find new purpose and direction by contributing to some aspect of suicide prevention, or supporting families who are newer to the experience of suicide grief than you. Perhaps you will find direction from reading, religion or philosophy; a sense of release and fulfilment through writing or some other form of creativity. You may learn to express parts of yourself that you hardly knew before your bereavement; but don't be surprised if it takes you a long time (anywhere from two to five years) to REALLY FEEL as if life has meaning again.

WHAT IF I BECOME DEPRESSED?

We tend to use the word depression fairly loosely. Bereaved people feel depressed at times, and certainly show all the symptoms of depression such as frequent crying, sighing, loss of appetite, sleeplessness, lethargy and mood swings. A more accurate label might be 'passionate sadness'. It is unlikely, given a supportive environment, that a person who has never had a previous episode of clinical depression will do so now. Early childhood losses or abuse can increase vulnerability, but don't make depression an inevitable outcome.

Self medication with alcohol, or the prolonged use (more than two weeks) of tranquillisers or sedatives, all central nervous system depressants, often convert sadness to depression. If you are concerned about your drug use, or depression, tell someone who cares about you what is happening and ask them to go with you to your family general practitioner or another appropriate professional.

WHAT IF I FEEL SUICIDAL?

Most bereaved people at times use words that sound suicidal, that tend to frighten those who care for them. You may think and say things like 'I wish I was dead' or 'I'd end everything if it wasn't for...'; or, 'I can't go on/don't want to feel any more'. In most instances you will be trying to convey to others how bad you feel, and have no intention of taking active steps to end your own life. In fact it is rare for someone to kill themselves as a result of a bereavement, even if the bereavement was from suicide, if appropriate support and understanding has been provided. However, a small number of people ARE particularly vulnerable. If you are concerned about your own feelings of depression, or the apparent depression of a family member, consult your general practitioner as soon as possible. They should be able to refer you to a psychiatrist who is familiar with the difference between 'normal' grief reactions and clinical depression.

WHAT IF FEELINGS OF GUILT DON'T GO AWAY?

Guilt about all kinds of things is common in bereavement, whatever the cause of death, although these feelings might be intensified after a suicide death.

For example, you may wish you had said or done things that more clearly expressed your love and appreciation of the person who died, or wish that you had not said things that may have caused hurt. Inevitably you will wish you had been able to prevent that person's death, or the suffering that led to it. Sometimes feelings of guilt may be justified, but most often they are subjective reactions that are really expressions about caring; caring so much that there isn't anything you wouldn't have done in retrospect to have prevented the death. Having a caring person listen and understand is all that is usually required, but if guilt becomes intrusive and obsessive it is important to seek help from a professional counsellor.

Attempts to block out obsessive guilt feelings may include the use of alcohol and other drugs which then tend to make the problem worse.

Grief issues

IS THERE A DIFFERENCE IN THE WAY MEN AND WOMEN GRIEVE?

Yes, there is a difference, just as there is a difference in the way people from different cultures express their grief, or those of different ages, socio-economic backgrounds or with mental and physical health problems may respond. Internal feelings of grief appear to be pretty much the same but biology and social conditioning mean that outward expressions of those feelings may differ from person to person, family to family, culture to culture.

As a generalisation (and there are always exceptions) men are more likely than women to express anger as they grieve, and to be physically active; to search for problems that can be defined and solved. They may find benefit in reading books about how others have coped, and to search for people who can tell them what to do. They are more often attracted to information-giving seminars than to counselling. If it is a child who has died, men are frequently asked how their partner is coping, rarely about themselves. They may feel a social pressure to take care of their partner at a time when they have few resources, and in the process be denied the opportunity to express sadness and have someone care for them.

Bereaved men may find it easier to express their feelings to another man rather than a woman, and this may be surprising when in the past they have found it easier to talk to a woman about emotional things. Perhaps the intensity of passion associated with grief bypasses social conditioning and allows men to acknowledge their need for the strength of a father figure; or perhaps they are so familiar with a caretaking role with women that a female friend/relative/counsellor represents yet another woman they may have to protect.

Sometimes it is good for grieving men to go away for a weekend with a support group so they can 'do' things together, expressing the energy of their grief in very physical ways. They may also find it easier to express anger in this kind of setting without fear of being

misunderstood. In other circumstances people may say things like 'I don't mind his grief, it's his anger I can't cope with', unaware that his anger is his grief.

Again as a generalisation, women are more likely to exhibit care-eliciting behaviour than are men. Their grief may appear more passive than that displayed by men, particularly in the early days and weeks, and their vulnerability may be more obvious. Well meaning people may urge them to 'do' things at times when they have no energy, believing that staying still will allow them to become depressed.

Both biology and social conditioning probably contribute to women's tendency to turn inwards, to cocoon themselves in times of emotional pain, often retreating to the safety of their bedroom, and for men to turn outwards via some physical activity.

While many women may appear to be 'too' passive or withdrawn initially, and men 'too' agitated and physical, the right support should gradually allow each to achieve a point of balance that is right for them. If you are concerned that your own behaviour seems extreme, or remains extreme, talk to someone about your concerns and perhaps seek help from a professional.

However helpful it might be to have a rough understanding of the differences in male and female grief, it is important not to make assumptions. Each person is different, no matter what their gender, age, race, or physical condition, and we all long to have our particular needs understood by someone who really cares.

IS IT TRUE THAT SEXUALITY IS AFFECTED BY GRIEF?

For many people there is a change in sexual feeling and responsiveness as they grieve. For some, sexual feelings disappear altogether for a time, while for others these feelings are intensified. Men and women often respond differently, particularly when it is a child who has died. Mothers may find everything about sex off-putting, a source of potential pain. After all, if they hadn't had sex they wouldn't have had the child whose suicide death they are now grieving. Fathers on the other hand may need the comfort and reassurance of sexual contact

with their partners, and may feel abandoned yet again if they are rejected. Neither response is right or wrong, just different. If each partner is given loving support, their relationship will usually return to 'normal' in time. If it doesn't and you are feeling distressed about the distance that now seems to exist between you, talk to a counsellor.

Some people are confused and surprised by their own sexual reactions, particularly when they engage in behaviour that is uncharacteristic of them. For example, we now know that many people have a 'one off' sexual encounter when someone they love dies, and may be left with feelings of guilt.

The need for sexual contact may arise from a need to reassure yourself that you are alive, even though someone you love has died; or it may simply be a need to be held, to experience the reassurance of physical closeness and intimacy. If that has been your experience, try to understand what might have been happening for you, rather than judging yourself. You already have enough 'judgment' to contend with.

WHAT ABOUT ALCOHOL AND OTHER DRUGS?

Like many grieving people, you may find yourself drinking more alcohol, or beginning to drink when you haven't previously done so. You may smoke more cigarettes, take more painkillers, or ask your general practitioner for tranquillisers or sleeping tablets. You may even be inappropriately diagnosed as depressed and prescribed antidepressants when you are really feeling passionately sad. If sleeplessness creates intense anxiety or exhaustion, sleeping tablets for a couple of nights may help. However, it is important to remember that all drugs have side effects, and may create more problems than they cure.

It doesn't take long to become reliant on mood-altering drugs. The pain of grief you had hoped to avoid or diminish then has the potential to become a more complicated problem involving depression and physical as well as emotional dependence. We may be able to postpone grief but we can't avoid it in the long term unless we obliterate our ability to feel, and at that point we are not living, merely existing. That may seem like a desirable state at times, but eventually, with support, you will learn to live with the new self you have become.

ARE ANY TIMES MORE DIFFICULT OR SENSITIVE THAN OTHERS?

Most people find family times like sunset and Sundays, or anniversaries, birthdays and festive holidays particularly difficult, evoking bittersweet memories and highlighting aloneness and despair. The sight of couples or families together, the sounds of laughter and music, the smell of food associated with those times may stimulate overwhelming feelings of sadness that you will never again be able to share these occasions with the person who has died. And sometimes it is the weeks leading up to these events that are the worst, the day itself feeling like an anticlimax.

It is usually helpful to plan ahead. Think of a 'your sort of thing' to do on the day itself, building in the proviso that you can change your mind at the last moment. You may decide that you want to be alone, then suddenly find being alone too painful; or fear being alone and arrange to be with others only to find at the last moment that you can't face the thought of company. It is important to explain to friends so that they don't take your change of mind personally.

Many people find it helpful to do something different, to break with tradition on festive holidays. You may choose to be in a new place, change rituals, include new people, or just be with those with whom you feel most comfortable. Tell people how you want to be treated on these occasions. You may want them to be gentle and sympathetic, or a little more distant and cheerful to help you carry off the occasion without becoming too emotional. You may want them to talk about the person who has died, to help you find ways to include them as you create new memories, or you may want to avoid the subject because it is too painful, particularly the first time. Make it clear however, that you may want to change your mind at the last moment.

IS IT TRUE THAT SOME PEOPLE REJECT THOSE WHO HELP THEM, ONCE THE CRISIS HAS PASSED?

In all relationships we develop a rhythm of closeness and distance that is familiar and comfortable. The time we need to spend in the company of others and to have time alone will have been influenced by many people and events throughout our lives. When a painful and traumatic event such as bereavement occurs, our lives may be disrupted physically, emotionally, intellectually, spiritually and socially. Our vulnerability may be so pronounced and our needs so great that survival may be dependent on our ability to accept prolonged, intense and close contact with friends, family and colleagues; contact that is more constant than we could normally tolerate. Or perhaps the closeness we experience may awaken unfulfilled needs that we had previously denied. Either situation can produce anxiety.

On the one hand we may be appreciative of the care, attention and support we receive, yet on the other feel embarrassed by our neediness and resentful at the loss of independence our neediness creates. We may feel overwhelmed by the debt of gratitude we can't imagine ever being able to repay; feel irritated with friends who continue to be solicitous when we want to be treated as 'normal', yet feel abandoned and angry when they do so. Sometimes just seeing them reminds us of our pain, helplessness and dependence; or we may believe they exert some silent pressure for us to be the way we used to be when we know that it is not possible. We may long to meet new people who will accept the new 'self' we have become.

This can be a difficult period, often requiring re-negotiation of relationships. Above all, it requires honesty. If honesty, genuine desire to help, and understanding aren't enough to prevent a previously valued relationship from floundering, it may help to talk together to someone who doesn't have a vested interest in the outcome.

What helps?

Telling your story

Telling your grief story to people who care and will understand has many benefits. Each time you hear yourself going over the details that have produced such disruption in your life, a little of the shock effect is dissipated and the intensity of your emotions is decreased. Your body chemistry will change, as if healing balm were being poured over your wounds, which in turn produces further positive change. This is a gentle and natural process that allows the bereaved person to gradually accommodate incredibly traumatic and distressing experiences.

As you retell your story, you will gradually make the shift from your familiar, past relationship with the person who has died to a new, internal relationship. That is, from a relationship where you were able to see, hear and touch that person, to one where the relationship is a feeling in your heart. 'Seeing' and 'hearing' in this new relationship are the memories that pass across the screen of your mind.

YOU DO NOT NEED TO LET GO OR SAY GOODBYE.

Instead, you will learn to form a new attachment to the person who has died and that new attachment will help to shape the new 'self' you will become in a changed world.

Each time you are given an opportunity to tell your story, you may experience and express strong emotions. Unfortunately, it is often fear of stimulating emotions that may prevent people asking you questions that would be helpful in the long term. It isn't the TELLING of the story that causes upset, it is the story itself – the fact that someone you care about has died. You may appear to tell the same story over and over again, but when someone is really interested in listening, a little more detail may be added each time, or the story told from a different perspective.

If traumatic aspects of your story remain as a distressing and preoccupying foreground, it may be helpful to talk to someone who is experienced in effective trauma counselling. A competent bereavement counsellor can usually help.

DOES RELIGION HELP?

A strong religious belief can help at any time, as can a strong belief in some other philosophy of life if it helps you to understand and make sense of your experience, your pain. It seems that it is the strength of the belief that helps, and uncertainty that causes distress in times of crisis. Even more important than the belief itself for many people, is the loving support and fellowship of those who care about them. There may be an added dimension of connectedness when similar belief systems are shared. Shared feelings can cross all barriers.

Whether you are religious or not, you will have spiritual needs as well as those that are physical and emotional. Spirituality will have different meanings for different people, but for many it is likely to include definitions such as 'my inner self', 'essence', and 'sense of beingness'. Some people say that it is the point at which they feel connected to themselves, and to all life. Others describe it as the point of connectedness with God. This point of connectedness has both cognitive (thought) and emotional (feeling) dimensions that some may call 'soul', others 'life force' or an experience of knowing and being. However any of us describe this inner sanctum of the 'self', we may need times of stillness to listen to our 'inner voice'. Some people find prayer, meditation or music helps, while highly energetic people may find it easier to 'connect with themselves' and thence others, through physical activity like walking, running, gardening or swimming.

WHAT PRACTICAL THINGS CAN I DO TO HELP MYSELF?

Initially it will probably feel as though it takes all your energy just to keep breathing, to get yourself out of bed in the mornings, and to perform essential tasks automatically. You will go through the motions of daily living, particularly if you are responsible for the care of others, acting 'as if' you are involved and at times even enjoying yourself, but feeling inside as if you belong to another planet. Everyone else's 'normality' will seem to highlight your feelings of 'abnormality', of feeling like a distant observer of your own life.

You will probably be bombarded with advice, cliches and platitudes as others try to decrease your pain (consciously or unconsciously) so that they feel more comfortable. Suicide in your family may have stimulated fears of the same thing happening in theirs; or they may feel uncomfortable because they have never been able to acknowledge the potential they too have for suicide, as almost anyone has in some circumstances.

You may have been encouraged to find a replacement for the person who has died, to move house, find a new job, travel – anything that has the potential to ‘take your mind off your pain’. Ignore all advice except that which feels right for you, and where possible, avoid making any major decisions about your life until after the first anniversary of the death. At a time of such heightened vulnerability most of us lack the ability to make decisions that will be in our best interests in the long term.

There are, however, some simple things you may want to consider as part of your survival repertoire. For example:

Spend time

alone, to think, remember, pray, meditate, mourn.

Talk

to a trusted ‘other’ who will listen with understanding to your thoughts and feelings.

Develop

a resource list, phone numbers of people and places to contact when the going gets tough.

Find

distractions, to provide time out from the pain.

Collect

information, read simple books about surviving suicide, or about life enhancement, when you are ready.

Use

physical nurture, massage, spa baths, early nights, and get some fresh air by going for short walks.

Keep

treasures, a memory box, journal, photo album.

Have

a health check.

Eat

a healthy diet, frequent small amounts of nutritious, easily digested food.

Exercise

to use excess adrenaline.

Contact

a trained bereavement counsellor if the going gets too tough.

Prioritise

daily tasks, do only what is essential initially.

Use

an answering machine, choose who you will talk to.

Use

public transport if you are concerned about your ability to concentrate, to drive, or let others chauffeur you.

Walk

to ensure that you have plenty of fresh air.

Indulge

yourself from time to time as a reminder that life still holds some good things.

Write

notes to relatives and friends when you need to tell aspects of your story, or to express feelings.

Keep

a journal to record your thoughts and feelings, especially if you are unable to sleep.

Try

to recognise, acknowledge, and perhaps reward in some way, each step forward.

Some final thoughts about suicide bereavement

The suicide death of an important person in your life may be your first encounter with the impact of death (or other major losses) and your feelings of overwhelming helplessness in the face of uncontrollable circumstances. Perhaps your current grief has served as an unwelcome reminder of all the losses of your life, re-opening wounds you hoped had long healed.

You may question beliefs, relationships, career and priorities as you struggle to find new meaning in life, knowing that death is inevitable and grief is the price we all pay for attachment. You may grieve as you think of the pain that caused your loved person to end their life, and grieve for yourself as you are confronted with the stark reality of your current loss and the spectre of your own finiteness.

What happened to the illusions of childhood, where stories all had happy endings, and pain could be removed with one wave of a magic wand?

We grapple with loss from the moment of our birth, essentially alone, and all too often lonely because our society still discourages public examination of thoughts or expressions of feelings about one's own death. Whether we believe in life after death or not, most people fear death, or at least 'have a healthy respect for mortality', and rightly so. Yet the very fact of our finiteness and that of people who are important to us, has the power to enhance our appreciation of life, love and relationships. And each time we have the courage to mourn our own losses, we find more courage to discover meaning in our lives. For it is not so much death that creates fear in us, but life.

Right now it may seem as though life is not worth living. In your darkest moments, remind yourself that families since the beginning of time have learned, slowly and painfully, to live with the aftermath of suicide, and you too will eventually accommodate this experience into your life. Your greatest asset will be your ability to reach out for help when it is needed, to receive and use what help is available to you until you begin to re-experience some sense of control over your own life and destiny.

Progress may seem frustratingly slow at times; at others you may despair because you seem to be taking one step forward and two backwards. Try not to compare your progress with someone else's. Measure your progress in small steps. Initially it may be minutes between bouts of overwhelming grief, guilt or regrets; then hours, days, and, unbelievable as it may seem now, even weeks. Some part of every day will probably be spent remembering, but memories won't always be overwhelmingly painful. They will gradually become an important part of who you are; your unique link with the person who died.

NSW Mental Health Services

Information on Mental Health and other health services is available from your local Area Mental Health Service.

The following table lists 24-hour contact numbers in NSW Area Mental Health Services.

Health Service	Telephone number
Northern Sydney/Central Coast	
Northern Sydney area	1300 302 980
Central Coast area	(02) 4320 3500
South Eastern Sydney/Illawarra	
South Eastern Sydney area	1300 300 180
Illawarra area	1300 552 289
Sydney South West	
Central Sydney area	1800 636 825
South Western Sydney area	1300 787 799
Sydney West	
Western Sydney area	(02) 9840 3047
Wentworth area	1800 650 749
Greater Southern	
Western (former Greater Murray)	1800 800 944
Eastern (former Southern)	1800 677 114
Greater Western	
Central West area	1800 011 511
Far West area	1800 66 5066
Hunter/New England	
Hunter area	1800 655 085
New England area	(02) 6766 3400
North Coast	1300 369 968

For more information
about mental health services
or
bereavement support groups
or resources contact:

Mental Health Association NSW

Tel: 1300 794 991

Fax: (02) 9339 6066

Email: info@mentalhealth.asn.au

Community resources

National Association for Loss and Grief
(02) 9988 3376

National Centre for Childhood Grief (free service)
(02) 9869 3330

Institute of Forensic Medicine Grief Counsellors
Glebe Tel. (02) 9660 5977
Westmead Tel. (02) 9845 6907

Survivors of Suicide Support Group (Life Line MacArthur)
(02) 4648 2224

Bereaved by Suicide Support Group (Chatswood)
(02) 9419 8695

Compassionate Friends (for parents whose children have died)
(02) 9290 2355
Freecall 1800 671 621

Lifeline
131 114

Kids Help Line
Freecall 1800 55 1800

Reach Out!
www.reachout.asn.au

'Make a Noise'
<http://makeanoise.ysp.org.au>

Reading list

AFTER SUICIDE: Help for the Bereaved

Clark, Sheila

Hill of Content Publishing Company, Melbourne, Australia, 1995.

NO TIME FOR GOODBYES

Harris-Lord, Janice

Millennium, Sydney, Australia, 1993.

COPING WITH GRIEF

McKissock, Mal

Australian Broadcasting Corporation, Sydney, 1997.

IN MY OWN WAY: The Bereavement Journal

McKissock, Dianne and Mal

Australian Broadcasting Corporation, Sydney, 1996.

THE LAST TABOO: suicide among children and adolescents

Fabian, Suzane

Penguin Books, Ringwood, Victoria, 1986.

RELIEF WITHOUT DRUGS

Meares, Ainslie

Fontana-Collins, Glasgow, United Kingdom, 1970.

PICKING UP LIFE'S PIECES ... AFTER A SUICIDE

– A Hope and Help Handbook

Trezise, Eric and Lynn, Rodney

TEAKL Education Pty Ltd, Bonville, NSW, 1997.

SUICIDE BEREAVEMENT

Let's Live – Suicide Prevention Australia Newsletter

Volume 5, No 1 – September 1996.

