# BEREAVEMENT BY SUICIDE

by

**Dr. Susan Henley**

**BSc. PhD, ABPsS**

## The effect of a suicidal death upon surviving relatives

This is a summary of a literature search on behalf of Cruse's research sub-committee to help it decide the next major research project

There have been surprisingly few systematic investigations of the effects of a suicidal death upon surviving relatives. However, the evidence available—most of it from clinical case studies—is consistent with the view expressed by a number of writers [1, 2, 8, 11, 14, 17, 18, 19, 20] that bereavement following suicide is more devastating than that following other forms of death.

### Effect of Suicide Upon a Spouse

Spouses bereaved by suicide encounter numerous difficulties over and above those normally associated with natural or accidental death [4].

A major source of problems is the widespread assumption that if an individual commits suicide someone must be 'to blame'. This attitude is manifested in negative social reactions—towards surviving relatives in general, and spouses in particular—which range from a failure to offer emotional support and practical assistance, through active avoidance, to downright hostility, accusations and ostracism [4, 6, 7, 14, 17, 22, 24, 25, 26, 27].

The most serious consequence of this lack of social support and actual or anticipated blame appears to be massive avoidance of communication regarding the suicide. Quite apart from the negative effects it may have upon surviving children (see below), this virtually prevents the working through of mourning by the spouse, not least because it limits opportunities for dealing with and eventually resolving, the intense and irrational guilts to which spouses bereaved by suicide seem particularly prone [4, 27].

Evidence of increased pathology [4, 13] among spouses bereaved by suicide becomes even less remarkable when, in addition to difficulties associated with the actual death, account is taken of the continuous, often prolonged stress to which many of them have been exposed as a result of the abnormal aspects of their partners' pre-death behaviour and psychological and physical functioning. (The husbands of one supposedly random sample of 12 suicide widows included a heroin addict, alcoholics, a polio cripple, a stroke victim, victims of work 'accidents' and a twice would-be suicide). Under such circumstances signs of disturbance are perhaps predictable.

Among recurrent patterns of disturbance observed in surviving spouses by Cain and Fast (1966) were:

(a) attempts to undo and repair the past, either by remarriage to a 'damaged object' (in several cases new spouses were either chronically ill, grossly physically handicapped, or handicapped in some other way) or, in the case of professional people, by means of elaborate, only marginally conceivable 'world rescue' plans, pursued with a near fanaticism often to the detriment of the person's other interests, responsibilities, and professional reputation.

(b) openly self destructive impulses and behaviours.

(c) projection on to a new partner of the complaints, grievances and accusations—real or imagined—of the person's previous partner against him.

(d) 'repetition compulsion', or what appeared to be an unconscious attraction to other suicidal persons.

Self destructive behaviours among spouses of suicides have also been reported by Wallace (1973).

However, Hindley [10] claimed to have found that, after a year some widows of suicides showed less disturbance than the normally bereaved. As Parkes has pointed out (personal communication, 1983), this could be interpreted as evidence that, while the effects of a suicide upon survivors may be disastrous in many cases, there are some philanthropic suicides which may be an overall blessing to the survivors.

### Effects of a Parent Suicide upon Surviving Children

Consistent with what one might expect, high rates of psychological morbidity have been found among children bereaved of a parent by suicide [23].

In a study of 45 **disturbed** children, one of whose parents had committed suicide, Cain and Fast (1966) found the full gamut of symptom pictures. Many of the observed pathological reactions appeared to derive from three main

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**Postbag,** *continued*

of warmth and sympathy into what is for many bereaved people a desperately bleak day. This has been a particularly happy and rewarding enterprise and our Sunday afternoons have a genuine family feel about them, with a glowing Calor Gas fire, home-made scones, cakes, etc. It has also given the opportunity to those who feel that they no longer had a reason to do the traditional North East weekend bake to take it up again and share with others. Incidentally, it is 'Eddie', one of our widowers, who is our star cake maker—**not** such a North Eastern tradition!

Another valuable extension of the 'Drop In' is a weekly swimming session at a local leisure centre. This has now become known as the 'Plop In'. The idea was formed when 'Kathy', who has suffered from chronic depression since her husband died eight years ago, happened to say that the only thing she had ever been any good at was swimming. She was immediately appointed the 'expert' and a few weeks later the 'Plop In' was launched amidst shrieks of laughter, and considerable courage on the part of those of us worried about our shape, size and dignity! The result has been that Kathy, for the first time in many years, finds herself in a dominant role and there have been therapeutic benefits for all of us in terms of exercise, laughter and self acceptance.

We hope that this is just the beginning of a series of activities revolving around the 'Drop In' which will foster the growth of the 'rebuilding' skills which many bereaved people need so much.

sources—guilt, avoidance of communication or distortions of the truth on the part of the surviving parent and other adults, and identification with the dead parent.

Intense guilt was manifested both directly, in self recriminatory statements, and less directly in a variety of pathological forms including depressions, rampant self destructiveness and 'undoing behaviours'.

Other disturbances, such as learning difficulties, speech problems, and distrust in the reality of their senses, seemed to be related more to misguided efforts on the part of the surviving parent and other adults to distort the facts. For example, in many cases the child had actually witnessed some aspect of the suicide, only to be told by the surviving parent that the death was not a suicide but the result of illness or an accident, that he had confused it all with a bad dream or television programme. Further confusion was often created by differing adults giving differing, often contradictory accounts of the death.

Arguably the most severe of pathological reactions among these children—suicidal behaviour on their part—was attributed to identification with the lost parent.

Cain and Fast also observed what they referred to as 'part identifications' among children of suicides which consisted of symptoms inexplicable other than in terms of perceived characteristics of the dying suicidal parent: for example, the smell of a rotting flesh-like smell about himself experienced by a patient who had found the rotting body of his father; choking sensations in another who had found his mother hanging in a barn, the desperate deep breathing and gasping of a boy whose mother had died in a gas filled kitchen.

## Effects of a Suicide upon Other Family Members

Parents' reactions to the suicidal death of an adolescent son or daughter (according to Schaffer [16] few children under the age of 12 actually commit suicide) are very similar to those of spouses and children of suicides: intense, often overwhelming guilt; denial that the death was a suicide coupled with hostility towards persons designating it as such; avoidance of communication; depression [9, 29].

The effects upon siblings appear to have been almost totally neglected as an area for research, and clearly warrant investigation.

## Conclusions

The available evidence suggests that in terms of a number of factors believed to influence the outcome of grief (see Parkes, 1972) those bereaved by suicide are a vulnerable population: the suicide is likely to be only the latest in a series of stressful life events; the relationship with the deceased is likely to have been marked by ambivalence; the death is untimely; the cultural taboos on suicide in our society are likely to inhibit expressions of grief and lead to additional stresses for the bereaved; social support is likely to be lacking. In consequence bereavement following suicide may, as has been suggested, be more difficult than that following other forms of loss, with greater proneness to guilt; feelings of rejection, abandonment and worthlessness; depression, self destructiveness and other manifestations of pathology; and incomplete mourning.

Priorities for future research should be not only to establish the 'facts' concerning bereavement following suicide, and to identify those most at risk regarding pathogenic disturbances, but more importantly, to discover the 'postventive methods' (Schneidman's [21] term for interventions aimed at reducing the distress of the bereaved) which would be most helpful in the prevention of pathological outcome.

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