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Effective Communication With Bereaved Child Survivors of Suicide

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Abstract

TOPIC—While bereavement is considered by many to be among the most stressful life events, it becomes even more distressing when it is related to the suicide of a loved one. Further, the death of a parent is traumatic for anyone, but it may be especially intensified for young children. This points to a strong need for the recognition and treatment of psychiatric and social problems associated with childhood bereavement.

PURPOSE AND SOURCES—The purpose of this paper is to review the literature and present a synopsis of the psychosocial outcomes of childhood suicide survivor bereavement and outline communication issues that emerge when talking with young suicide survivors.

CONCLUSIONS—A case is made to develop and test interventions designed to meet the mental health needs of this important group of individuals.

Search terms

bereavement; child; communication; survivors of suicide

Scope of the Problem

In the year 2000, suicide was the 11th leading cause of death in the United States, with nearly 30,000 suicides occurring annually (American Association of Suicidology, 2001; U.S. Bureau of the Census, 1998). Estimates suggest that each year, approximately 60,000 children must deal with the death of a relative to suicide (Pfeffer et al., 1997). While the death of a parent is a traumatic event for anyone, it may be especially intensified for younger children. Studies suggest that when the death is due to suicide, the impact can be associated with more long-term problems in comparison to nonsuicidal deaths (Cerel, Fristad, Weller, & Weller, 1999).

Characteristics of Child Survivors of Suicide

Of children who are bereaved by the death of a parent, one in five may manifest a wide range of emotional and behavioral symptoms at a level sufficient to justify referral to a specialist service. These symptoms may include anxiety and/or depressive symptoms, fears, angry outbursts, and regression in developmental milestones (Dowdney et al., 1999). Yet, children who are survivors of parental suicide tend to experience even higher rates of anxiety, depression, poor school performance, and decreased social adjustment than children whose parents died of natural causes. Child survivors of parental suicide are left with the challenge of not only trying to understand why their parent died by suicide but also of coping with the stigma that society places upon a suicide death (Cerel et al., 1999).

As with cognitive development, children's emotional development is likewise different from that of adults. Some common feelings experienced by bereaved children are sadness, anxiety, anger, shame, guilt, acceptance, and relief; the negative emotions are exacerbated among children mourning a suicide, and their effect becomes more apparent around 6 months after the death (Cerel et al., 1999). For example, in a comparative study of bereaved children, Pfeffer, Jiang, Kakuma, Hwang, and Metsch (2002) found that all bereaved children in their sample experienced increased anxiety, aggression, and withdrawal in the weeks following the death, and children who were suicide-bereaved tended to experience more anxiety, anger, and shame along with depressive symptoms than their non-suicide-bereaved peers.

In another study comparing children bereaved both through suicide and nonsuicide deaths, Pfeffer and associates found that children bereaved by parental suicide were more likely than children not bereaved by parental suicide to experience anxiety immediately after the death followed by anger at 6 months and shame by 1 year after the death. Within 18 months of parental death, children bereaved by suicide reported significantly more severe depressive symptoms (Pfeffer et al., 1997). This suggests that children who must cope with the loss of a parent to suicide are more likely to experience problems with long-term psychological and social adjustment. Therefore, early identification and therapeutic intervention is crucial to prevent the development of negative health outcomes with these children.

As part of a longitudinal study that continued their investigation of suicide-bereaved children, Cerel, Fristad, Weller, and Weller (2000) assessed family histories of psychopathology and family environment before and after the death of a parent. Twenty-six suicide-bereaved children, ages 5 to 17 years, along with their surviving parents, were compared with 332 children and their surviving parents who had experienced a nonsuicide parental death. Comparisons were made through the use of structured and semistructured interviews conducted at intervals of 1, 6, 13, and 25 months after the death of the parent. Results indicated that suicide-bereaved children exhibited greater evidence of psychopathology than those whose parents died from other causes. These families exhibited less stability, and relationships with the deceased parent prior to the suicide had been less satisfying. However, the surviving parents in the suicide-bereaved group had no more evidence of psychiatric disorders than the nonsuicide group, and there were no differences found between the groups related to the children's relationships with the surviving parents. The study was limited by a small sample size, but results indicated that suicide-bereaved children appear to be more vulnerable to psychopathology than their surviving parents, and that the surviving parents may have a positive effect upon their children's ability to deal with the suicide (Cerel et al., 2000).

Similarly, in a controlled comparison study of child and adolescent survivors of a family suicide with an age-matched group of children bereaved by family death due to illness, Sethi

and Bhargava (2003) assessed both groups for psychiatric symptoms and social adjustment 6 to 24 months following a family member's suicide. The sample was comprised of 20 Hindu families in urban India with a total of 26 children, ages 6 to 16 years, who were compared with an age-matched group control group of 26 children with no history of family suicide. Both groups participated in a structured psychiatric interview designed to identify the presence of psychiatric disorders. The children were also assessed for social adjustment and symptoms of posttraumatic stress disorder through the use of separate semi-structured interview tools. Their findings indicate that child and adolescent survivors of suicide were at an increased risk for major depressive, posttraumatic stress, and panic disorders, as well as difficulties with social adjustment. The study points out that losing a family member to suicide is associated with immediate and ongoing repercussions, resulting from the emotional and physical absence of deceased and grieving parents, the disruption of the family unit, and factors such as financial instability, social isolation, and stigma. Limitations of this study include a small sample size and a wide age range of subjects, as well as differences in the time period of assessment following the suicide of a family member. However, it is one of the few studies examining the effects of suicide in an immediate family member on children, and in particular psychosocial functioning and psychiatric symptoms.

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Another serious concern in the treatment of the suicide-bereaved child is whether child suicide survivors are more likely to commit suicide themselves. Lester notes, "few studies have focused on suicide just in parents, and the answer, therefore, is uncertain ... in either case, counseling is critically important for the survivors of suicide" (1989, p. 36). There is the need for recognition and treatment of psychiatric disorders and social problems in this group of children in order to address the immediate impact of the death and reduce risks of long-term maladjustment.

Toward a New Understanding of Bereavement

Child survivors of parental suicide, like others bereaved by the loss of a loved one, have traditionally been understood from within a conceptual model for dealing with loss that has its origins in early psychodynamic thinking, which emphasized the transfer of psychic energy away from a lost object. Early psychodynamic models were then gradually expanded into a bereavement theory that included what were thought to be universal phases that needed to be negotiated in order to "resolve" grief (Neimeyer, 2001). For most of the twentieth century bereavement was understood "as a process of 'letting go' of one's attachment to the deceased person, 'moving on' with one's life, and gradually 'recovering' from the depression occasioned by the loss so as to permit a return to 'normal' behavior" (p. 2). The limitations of this model have gradually been recognized by increasing numbers of researchers and clinicians, and a new model of bereavement theory is emerging that illuminates the role of loss within an individual person's experience. Hagman (2001) offers a new approach to bereavement, mourning, and loss that emphasizes the strengthening of relations with others and the reestablishing of meaning. Bereavement results in a crisis of meaning that threatens the structure and substance of a person's life.

Hagman (2001) states that mourning refers to the individual's varied psychological responses to the loss of an important other. This includes a "transformation of the meaning" associated with one's relationship to the deceased with the goal of permitting one's survival

without the other, while also ensuring an experience of continued relationship to the deceased. Further, the work of mourning is rarely done in isolation, and more often involves an active participation with other mourners or survivors. Mourning involves a reorganization of the survivor's sense of self, which is a key function of the whole process (Hagman).

With this changed model of bereavement, grief is no longer seen as a private experience, but rather an outward-directed effort to communicate. The purpose of this communication is the preservation and/or restoration of interpersonal connections. Neimeyer (2001) also postulates that the central process in grieving is the reconstruction of meaning in response to a loss. These emerging concepts of grief, bereavement, and mourning can provide a foundation for our efforts to understand the experience of child survivors of suicide and how we may best begin to assist them.

Defining new concepts of grief and bereavement must take into consideration children's ability to understand death. Cuddy-Casey and Orvaschel (1997) identified age, cognitive development, and exposure to death as factors most often reported to influence a child's ability to understand death. They also identified several key concepts central to a mature, functional understanding of death that were seldom included in the explanations given to children about death: awareness that all living things eventually die (universality), that once dead, a being cannot become alive again (irreversibility), that all life functions will stop at the time of death (nonfunctionality), and finally, that living things will die as a result of biological causes (causality). Further, Cuddy-Casey and Orvaschel note that empirical assessment of children's understanding of death has been slowed by the nature of the nonstandardized interviews and measures (such as drawings) often used in work with children. While such measures are necessary to accommodate children's developmental levels, they are subject to bias and problems with interrater reliability.

Based on their review of the literature, Cuddy-Casey and Orvaschel (1997) found that available evidence suggests that children appear to develop a complete understanding of the concept of death only after the chronological or mental age of 9 years. The concepts of universality and irreversibility tend to develop first and appear to be necessary for the development of the other concepts. Most children under age 7 do not see death as inevitable, and those that do tend to view it as something that can be reversed. The concepts associated with death seem to develop in a similar way and sequence for most children.

In addition to the effect of age upon children's understanding of death, level of cognitive development is also important to their ability to understand the concept of death. Most research studies have concluded that children begin to develop an understanding of death only after reaching the stage of concrete operational thought, between the ages of 7 and 12 years. Overall, most studies indicate that children's understanding of the concept of death is a function of age, verbal ability, and cognitive development.

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Communication Issues With Young Bereaved Suicide Survivors

Communication about suicide is difficult for adults who grieve, the professionals who counsel them, and the researchers who study them. Shneidman has commented that suicide is a "dirty word" and that some languages have no word for suicide (Shneidman, 1966, p. 39; 1998). Such barriers to the discussion of suicide may result in the construction of family myths to conceal the true cause of death in order to hide the shame and guilt often associated

with a death by suicide. This in turn compounds grief reactions (Nelson & Frantz, 1996). Suicide may challenge a family's entire belief system, including their own sense of themselves as a unit. Nelson and Frantz note that secrecy about the death and lack of open communication may result in interminable mourning.

Walsh, McGoldrick, and Jordan (as cited in Gilbert, 1996) identify three steps that are needed to resolve grief in families: recognition, reorganization, and reinvestment. The first task, recognition, is especially crucial to a child's grieving process, requiring professional counselors and family members to use a variety of communicative and symbolic tools to promote the grieving process. Only after recognition can suicide survivors attempt to reorganize the family following the loss. Reinvestment is the process by which the family moves forward without "leaving the deceased behind," often through the use of ceremonies and rituals.

In order for children to adjust to the death of a parent, they must have a realistic and coherent understanding of what has happened. Effective communication serves to reassure children that someone will take care of their physical and emotional needs. This is a fundamental emotional need that is often overlooked by those caring for bereaved children (Rando, 1988). If children feel supported and secure, they may be more open to understanding the concept of suicide and the circumstances surrounding the death. This in turn enables them to grieve, an important process in promoting mental health and preventing the development of future psychiatric problems (Antai-Otong, 2003).

Unrealistic communication about death, however well-intentioned, may be harmful to the child. If children are not provided with an adequate and realistic explanation surrounding a parent's death, they may construct erroneous and fantastic accounts of the troublesome events that may be worse than the facts surrounding the suicide. Furthermore, the desire to protect children from the truth by avoiding discussions about death denies children the opportunity to express themselves and deal with their emotions. Children who are unable to mourn therapeutically may be forced to suppress their emotions to avoid becoming overwhelmed and risk living their lives with a constant sadness (Rando, 1984). One way to effectively deal with this issue is to consciously use the word "suicide." Even if the child is too young to understand the connotative and denotative meanings of the word, its matter-of-fact use can desensitize the child to the social stigma the term often evokes, and can provide a basis for future discussion.

Considerations Concerning Language Use

One of the main concerns in helping children understand parental suicide death is to assure accurate comprehension of what they are being told. However, Fairbairn (1995) posits that the language in which suicide is discussed is very sparse. Nonetheless, the language we possess and use can make a difference in the way we think and in the way we act. Children do not possess the intellectual maturity or the life experience that adults bring to the understanding of death (Rando, 1988).

When discussing suicide with children, it is important not to use euphemistic or metaphoric words that the child may misunderstand. For example, it is important for the child to understand that his or her parent is dead and has not just "gone somewhere." Such understanding will reinforce the fact that his or her parent will not be returning to the family home. If the permanency of the parents' death is not made clear, children could misinterpret that the parent is lost somewhere and may be found at a later time. It is also inappropriate to use the word "sleep" when describing the concept of death (and suicide) with children. Using such language may lead the child to believe his or her parent could eventually wake

up from their sleep. For these reasons, it is essential that communication with children about the cause of death as suicide be as clear and honest as possible.

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The use of analogies is another linguistic tool that often helps children comprehend the suicide death of their parents. A useful analogy may be comparing their parents' death to a broken toy, explaining that "the deceased parent does not function any more, and although we would like to fix it, he or she will not work again" (Rando, 1988, p. 213). It is also valuable to assure children that their parent no longer experiences pain or emotion in order to prevent them from worrying that their parent is sad or hurt.

Lastly, it is important for clinicians to understand that children continue to grieve at subsequent stages of their cognitive and linguistic development. As a result, a child may explore and suppress his or her feelings at irregular intervals. Children often express their grief intermittently for many years after the death of parent because of their difficulty in articulating their feelings and thoughts at younger ages (Rando, 1988). This suggests that as children grow and their intellectual abilities increase, they will need new information and new ways to express their feelings about the death (Rando, 1984). Despite attempts to provide age-appropriate explanations, children may continue to ask questions repeatedly. This is not necessarily for the purpose of gaining new or different information, but for the reassurance that the death really did occur and that nothing else has changed. As a general principle, being as specific as possible in communicating with the child can help to eliminate misunderstandings and enhance children's ability to grasp the concept of death as best as they can during each episode of grieving.

Conclusion

Despite the results of studies indicating an increased risk for psychiatric disorders and social maladjustment in children grieving the loss of a parent due to suicide (Cerel et al., 1999; Pfeffer et al., 1997; Sethi & Bhargava, 2003), there is a dearth of studies which focus on the effects of psychotherapeutic interventions to help child survivors of parental suicide to cope with their loss. As a starting point, therapeutic interventions must begin with realistic and accurate communication so these children can effectively grieve the loss of their parents. Using the communication techniques discussed above, clinicians will enable children to express their feelings while developing the skills necessary to cope with their grief. Through effective communication and support, children may better be able to understand the concepts of death and suicide. Such understanding will help equip the children to develop effective coping skills as they grieve the death of their parent.

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