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CLINICAL CHALLENGES FOLLOWING AN ADOLESCENT'S DEATH BY SUICIDE: BEREAVEMENT ISSUES FACED BY FAMILY, FRIENDS, SCHOOLS, AND CLINICIANS

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ABSTRACT: Given the increasing prevalence of adolescent deaths by suicide, social workers are increasingly likely to be called upon to respond to traumatically bereaved families, peers, and possibly professional colleagues following an adolescent's death by suicide. The authors discuss current trends in adolescent suicide. A stress diathesis model is applied to considering risk factors and their clinical implications following an adolescent's death by suicide. Using a case scenario, the authors discuss clinical issues of complex bereavement following suicide, along with some suggestions for effective clinical follow-up with surviving families, peers, and professionals.

KEY WORDS: adolescent death by suicide; bereavement; postvention; social workers; survivors.

BACKGROUND

The aftermath of a child's death by suicide typically extends to include a complex array of survivors, going beyond the family to

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include friends, teachers, and classmates as well as mental health and medical care providers. As such, the suicide may have something of a "ripple effect," touching the lives of an array of others with whom the child's family may not even be very familiar. Given that probability, combined with the increasing incidence of childhood and adolescent suicide deaths, social workers may well be called upon to work with survivors following suicide in a number of practice arenas, from hospital settings, to schools and mental health settings. While the existing psychosocial literature contains a considerable amount of material devoted to suicidal adolescents, less attention has been focused on the aftermath of adolescents' completed suicides. Based on their clinical work with adolescents and with families following suicide, the authors seek to address an existing gap in the literature related to working with those who are bereaved by an adolescent's death by suicide.

Cain (1972) coined the term "survivors" to apply to those who have been directly affected by a suicide loss. Estimates suggest that for the approximately 50,000 committed suicides substantiated each year in the US, a minimum range of 200,000–400,000 survivors are created yearly (Jobes et al., 2000; Shneidman, 2001). Most will face questions on some level regarding their own culpability in their loved one's decision to take their own life. In cases involving children and adolescents, that sense of culpability may be particularly bewildering. Survivors may find themselves repeatedly pondering missed warning signs and risk factors. Such questions may prove particularly poignant among family members and members of various helping professionals from whom the child sought help in the past.

CURRENT PATTERNS OF CHILD AND ADOLESCENT SUICIDE

- Quadrupled rates of suicide among adolescents since 1950.
- Increased rates of suicide among children 10–14.
- Greater rates of suicide completion among boys.
- Heightened risk associated with depression and substance abuse.
- Heightened risk associated with access to firearms.
- Heightened risk associated with prior attempts.
- Heightened risk associated with family histories of depression and suicidality.
- Heightened risks associated with recent psychosocial losses or disruptions.

REVIEW OF THE LITERATURE ON RISK FACTORS

Demographic Factors

Suicide ranks third among the leading causes of death for people between ages 15 and 24, after automobile accidents and homicides (Lawrence & Zittel-Palamara, 2002; Lipschitz, 2001; Mann, 2002). Meanwhile, deaths between ages 15–24 attributed to "unknown causes," the majority of which are believed or known to be self-inflicted, have doubled (Hawton, 1998). Estimates of suicide on which to base such rankings may be imprecise for a number of logistical, social, and legal reasons. Distinguishing covert suicides from accidents (including falls, car crashes, and shootings), particularly in cases involving deliberate recklessness, intoxication, and drug overdoses may be impossible. "Suicide by cop" is a phrase sometimes used to describe aggressively self-destructive behaviors. Covert or "indirect suicide" by way of refusing food or refusing necessary medications represents still another confounding variable (Diekstra et al., 1995). For such a variety of reasons, estimates of completed suicides are necessarily likely to be underestimates of the actual magnitude of the problem.

Among adolescents, the suicide rate has quadrupled since 1950, and now accounts for 11–12% of adolescent deaths (CDC, 1995; Sadock & Sadock, 2003). Among children ages 10–14, the suicide rates have increased by 120% since they began being reported in the US in 1970 (McKeown, et al., 1998; Stillion & McDowell, 1996). Between ages 15 and 19, the rate of suicide attempts is about 15 times greater than that of completions (Sadock & Sadock, 2003). Girls make about three times more attempts than boys, yet boys are about five times more likely to complete suicides (Zametkin et al., 2001). The rates of suicide among young males nearly doubled between the 1960s and 1980s (Hawton, 1998; Hollinger, 1989). While suicide remains more common among whites (McKeown et al., 1998), the suicide rate among African-American males, ages 15–19, increased by 165% between 1980 and 1992. African-American children and adolescents who completed suicides (and were reported as such) appear more likely to come from families with higher SES than the general African-American population (McKeown et al., 1998). Suicide rates among young African-American women doubled between 1992 and 1995 (Mann, 2002). Catholics and Muslims appear less likely than Protestants to die by suicide (Andreasen & Black, 1995).

Predisposing Mental Health Factors

Several psychiatric comorbidities are strongly related to childhood and adolescent suicide attempts and completions. Severe mood disor-

ders feature prominently among at-risk adolescents (DeWilde et al., 2001; Houston et al., 2001). For girls, depression alone appears a more serious risk factor for suicide, although suicidal boys tend to manifest more complex psychiatric symptoms, such as mania, thought disorders, substance abuse, and aggression (Shaffer et al., 1996; Zametkin et al., 2001). Among males with family histories of suicidality, their suicidal ideations and attempts began at a younger age than their female counterparts (Runeson, 1998).

Completed suicides by adolescents are strongly associated with histories of prior attempts having been made (Diekstra et al., 1995; Zametkin et al., 2001). Such attempts may have been more covert than overt, thus possibly "neutralizing" various high risk behaviors (Molin, 1986). Given that depression tends to be a cyclical disorder with multiple episodes (Garber & Flyyn, 2001; Pine et al., 1999), such patterns raise questions of ongoing or recurrent depressive disorders during childhood and adolescence.

Substance abuse follows prior attempts and depression as the third most important risk factor for childhood and adolescent suicide (Forman & Kalafat, 1998). It serves both as a risk factor and a method of completion (DeWilde et al., 2001) with intravenous substance use being particularly relevant among adolescent girls (Sadock & Sadock, 2003). Alcohol plays a crucial role relevant to suicidality among children and adolescents; as a central nervous system depressant, alcohol exacerbates the effects of both depression and anxiety; it also impairs judgment and serves to disinhibit drinkers engaged in potentially risky behaviors (Forman & Kalafat, 1998). Along with influencing a child's choice of peers, substance usage-related behaviors may also further obscure parental or professional recognition of mood disorders and related warning signs for impending suicidality (Forman & Kalafat, 1998). By potentially camouflaging depressive or suicidal warnings, substance abuse may easily distract parents and teachers. The relevance of the combined effects of depression and substance abuse, including efforts at self-medication, can create a complex legacy of grief for survivors following suicide.

Family Factors

Adolescents who die by suicide appear to come from an array of complex family backgrounds. Family disruption following divorce appears to be a clinically significant variable (Gould et al., 1996). Family histories of suicide among first degree relatives are strongly correlated with increased risk (Mann, 2002; Roy, Rylander & Scarchiapone, 1997; Runeson, 1998; Zametkin et al., 2001). Family histories of sub-

stance abuse, schizophrenia, bipolar disorder, and depression all figure prominently among studies of adolescent suicide risk factors (Runeson, 1998). While no single diagnosis appears sufficient in and of itself, all appear relevant to the consideration of risk factors for adolescent suicidality. Although no known genetic marker has provided conclusive, monozygotic twins have a higher concordance rate for suicide than dizygotic twins (Zametkin et al., 2001).

Stressors and Recent Precipitators

Impulsivity, availability of lethal methods, and histories of sexual trauma, along with exposure to family violence and family histories of suicide are all considered additional risk factors for adolescent suicide (Lawrence & Zittel-Palamara, 2002; Sadock & Sadock, 2003). Precipitating events associated with adolescent suicide include disrupted relationships through such events as rejection or humiliation by peers and romantic disappointments, stressors such as academic difficulties, relocation, and inadequate family support (Houston et al., 2001; Marttunen et al., 1994). Developmentally, adolescents experiencing such crises are more prone to seek support from peers than family members. Same-aged peers may be ill equipped to respond constructively in such crises (Forman & Kalafat, 1998). By either not recognizing suicidal risks or by responding in a dismissive manner, peers may potentially exacerbate suicidal adolescents' sense of despair.

The association between sexual orientation crises and adolescent suicidality represents a crucial clinical variable. The literature supports a strong association between sexual orientation crises and adolescent suicidality (D'Augelli et al., 2001; Morrison & L'Heurex, 2001; Remafedi, 1999; Russel & Joiner, 2001). Estimates range as high as a four times higher rate of serious suicide attempts among homosexual youth (Bagley & Tremblay, 2000). Given the combined perceived taboos of suicide and homosexuality, estimated correlations are likely underestimates as they are necessarily based on surviving families' open acknowledgement of their child's suicide as well as their sexual orientation.

Questions of hormonal and psychological development and sociocultural stressors further complicate the mosaic of adolescent suicide and demand clinical consideration. Girls appear more susceptible to depression following the transition to Tanner State III (mid-puberty) and later, while boys appear to be depressed prior to Tanner Stage III (Angold et al., 1998; Garber & Flyyn, 2001). For girls, the younger onset of puberty means the potential onset of menarche at around age 12 ½, rather than around age 16, which was the norm a century ago.

Simultaneously, however, psychological development does not appear to have accelerated accordingly. Thus, socio-cultural expectations during the past century have actually postponed the end of adolescence and socioeconomic independence until even later. Some researchers hypothesize that the disparities created by these disjointed physiological, psychological, and socio-cultural expectations may create a particularly overwhelming set of circumstances for some adolescent girls, thus influencing the higher level of suicidality among girls suffering from depression (DeWilde et al., 2001; Fombonne, 1995).

Finally, having access to firearms is a crucial risk factor for childhood and adolescent suicide (Brent et al., 1991a; Hawton, 1998). For those between ages 15 and 19, firearm-related suicides account for 81% of the increased suicide rate between 1980 and 1992 (CDC, 1995; Forman & Kalafat, 1998). The relationship between alcohol use and firearm-related suicide is particularly strong (Brent et al., 1987).

Methods

While the routes to suicide among adolescents vary greatly, some consistent patterns appear noteworthy. The means chosen for suicidal behaviors vary according to cultural and historical factors well as convenient access. While psychotropic drug overdoses are the most common method used in unsuccessful suicide attempts, firearms are the most common method of suicide completion by adolescents (Lawrence & Zittel-Palamara, 2002; Sadock & Sadock, 2003). Firearms are used in about two-thirds of boys' and half of girls' suicides, with hangings and toxic substances being the next most common methods (Brent et al., 1987, 1991; Diekstra et al., 1995).

Given the multifaceted aspects of psychiatric, environmental, and genetic factors, combined with developmental and socio-cultural stressors, a stress-diathesis model appears best suited to interpreting and responding to adolescents' risks for suicide. While no one factor appears consistently sufficient to predict suicide among adolescents, combinations of predisposing factors and adverse life events appear to have profound relevance for those at risk. Many adolescents with co-existing psychiatric disorders (depression, substance abuse and schizophrenia) may engage in the very behaviors that exacerbate various negative events associated with risks of suicide, such as school failure, social rejection and romantic disappointments, thus contributing to something of a chicken-or-egg dilemma.

CASE SCENARIO

"Patsy," aged 19, was a college sophomore, majoring in History. Patsy's relationships with her parents ("Bill and "Ruth") had grown increasingly contentious. Aside from arguments about her parents' growing disapproval of Patsy's choice of friends and her long-term boyfriend ("John"), bitter arguments erupted over Patsy's repeated assertions that either she or her younger (twin) brothers were adopted, as she insisted that they "couldn't possibly be related to each other by blood." Family arguments had accelerated to the point that the family had sought therapy during the summer prior to Patsy's freshman year. During counseling sessions, Patsy shruggingly dismissed her accusations, stating that her comments were simply reactions to frustration with being part of such a family of "nerdy brainiacs." She resisted any further exploration of her comments or the distress they had caused her brothers. Both parents are highly regarded professions (a research physicist in a local medical school and a law professor). Her twin brothers (age 14) are both enrolled in a program for gifted and talented children, and are both considered intellectually exceptional, especially in mathematics.

Between freshman and sophomore years, Patsy's parents became increasingly concerned over her general health and mental state. She was increasingly irritable toward them and her brothers. She found a job at the local mall, but resigned after 2 weeks, complaining that standing on her feet and being pleasant to customers was too exhausting. She slept for periods of 10−12 hours at a time. Her grooming became careless, which was out of character. Over the summer, she seemed to lose interest in food and lost 5 pounds. She seemed to wear only black clothing, and her choice of music and reading was increasingly death-related.

During the fall of sophomore year, Patsy made her first "C." Over Christmas, she refused to discuss any academic difficulties with her parents and became irate if they brought up any subject related to her school performance. During the break, they also became increasingly concerned about her drinking. Her boyfriend since high school ("John") was working as a bartender at a local club where Patsy spent as much time as possible. Her parents complained repeatedly when she came home intoxicated after having driven John home after he got off work.

During spring break, Ruth learned that patsy was frantically worried about failing a course in history because of multiple absences and assignments handed in late. When Ruth tried to discuss options such as withdrawing from the class, Patsy angrily commented that she could either "drop the class or just kill myself, whichever comes first." In response to this, Ruth insisted that patsy make an appointment to see a psychiatrist at the university's mental health center upon returning to school. Patsy made the appointment, but later cancelled it.

Patsy returned to school, but found attending classes impossible. She withdrew from the history class about which she had been so worried, but her other grades also dropped from what they had been. Patsy's roommate urged her to "talk to someone," as she had observed Patsy's general decline over recent weeks. Patsy spoke with a junior clinician at the university's mental health center on a Friday afternoon and was advised to return on Monday for a full assessment. The clinician was sufficiently concerned that she provided Patsy with various hotline numbers to use as she wished during the weekend. Her

roommate phoned patsy's parents that night to ask their advice. Patsy became irate about her roommate's "interference" in her life. Her parents drove to the campus and insisted that Patsy come home with them, promising to drive her back on Sunday.

During Saturday afternoon, Patsy had several quarrelsome telephone conversations with John. While her parents and brothers attended a school-related awards banquet on Saturday night, patsy raided her parents' liquor cabinet. Worried, her parents had carefully confiscated Patsy's car keys as they left. When they returned home, they found her very intoxicated and hard to rouse. After a belligerent discussion, during which she accused them of ruining her life by having her younger brothers at all, Patsy angrily went to her room and locked the door. Her parents tried to shield their two sons from hearing various hurtful remarks and to protect their excitement about the awards received earlier that evening. About an hour later, her parents heard what sounded to be an explosion. When they broke down her bedroom door, they found patsy dead of a self-inflicted gunshot wound to the head. Unbeknownst to them, Patsy had taken the gun from Bill's elaborately locked gun cabinet during their absence. She had bought the bullets the previous week while still at college. Her note to her parents and brothers was apologetic, insisting that she was doing them a favor by ending her life.

Following Patsy's death, her parents returned to their previous therapist. During subsequent sessions, Ruth sobbingly disclosed that patsy was indeed adopted. Ruth's younger sister ("Tricia") had become pregnant while in high school, much against family norms and expectations. The baby's father abandoned her prior to the birth. Ruth and Bob had provided all the emotional support they could, but were also keenly involved in their fledgling careers at the time. Following the birth, Tricia went into a severe postpartum depression. When patsy was 3-months old, Tricia died by suicide at age 18, by ingesting an overdose of aspirins. Both bereaved and guilt-ridden, Ruth and Bill had adopted patsy immediately and had agreed not to tell her about the adoption until she was "old enough to understand". They had never found a time that felt right to do so.

CLINICAL INTERVENTIONS

As noted in "Patsy's" case, the combined factors of genetic predisposition (*albeit* unknown to the adolescent), family history, age-related factors, academic stressors, and the combined effects of an untreated mood disorder along with evidence of substance abuse, formed a very complex clinical picture. Patsy's self-destructive behaviors accelerated despite clear social and intellectual advantages, parental concern, and a caring roommate's best efforts. The aftermath of her death entailed bewildered agony for two siblings, two parents, a distraught roommate, numerous friends, a guilt-ridden former boyfriend, and at least two mental health professionals who blamed themselves for having failed to recognize the severity of her depression and suicidality.

Schneidman (1972) coined the term "postventions" to refer to a set of strategies aimed at helping individual survivors following a suicide, comprising efforts that "reduce the aftereffects of a traumatic event in the lives of the survivors… to help the survivors live longer, more productively, and less stressfully than they are likely to do otherwise" (Shneidman, 1984, p. 413). The term postvention has come to be specifically associated with efforts intended to diminish the repercussions of a suicide.

For families, postventions ideally begin shortly after the death. Such clinical interventions, however, presume that the family is able and willing to address the death as a suicide, and are inclined to discuss their trauma with an outsider, which is not always the case (J. Tunkle, Unpublished).

Postventions may take various forms. While debriefings may be conducted for junior and high school students, similar outreach may or may not occur on a formal level on a college campus, where sometimes the size of the student body may preclude classmates' and faculty members' awareness of a suicide death until much later.

For mental health professionals, a client's death by suicide is clearly traumatic. Most completed suicides are preceded by visits to various helping professionals (physicians, psychiatrists, therapists) (Andreason & Black, 1995; Isometsa et al., 1995). Questions of missed signals, assessment errors, inadequate follow-up, failure to protect, and even legal liability arise. Ironically, few if any postventions for helping professionals are available on a formal basis. For various reasons, including issues of confidentiality, professionals have few opportunities to resolve the grief experienced upon a client's or patient's death by suicide. The topic of clients' completed suicides remains underaddressed in the clinical social work literature.

Working With Families

If the death of a child represents a parent's worst fear, then a child's death by suicide is that worst fear multiplied many times over. Family, friends, and other children's parents may find the death of a child impossible to discuss and something to be avoided or shunned. For parents, a child's suicide at any age is often seen as the ultimate failure and rejection for parents who were expected to raise, nurture, and protect their children (Calhoun & Allen, 1991; Calhoun et al., 1982; Rando, 1986; J. Tunkle, Unpublished). It also represents a compounded loss, with the tragedy of an avoidable youthful death, the loss of a future, and the stigmatized trauma of that death being self-inflicted (Ross, 1997). Four of the primary factors that distinguish the

complexities of suicide bereavement for families are related to stigma, questions of why, issues of remorse and guilt, and various logistical and legal factors unique to suicide that necessarily influence the events and processes following death.

The stigma associated with suicide is not a recent development. During the Victorian era, in which social respectability was a primary concern, suicide in a family resulted in social shame, tainted family reputations, lowered property values, and hasty funerals. Suicide was typically relegated to secrecy even within families and especially kept from children (Jobes et al., 2000; Minois, 1999). Despite increased social awareness, the social stigma closely associated with suicide across western cultures may be most keenly felt by surviving parents.

Beginning with who is informed of the cause of death, stigma and shame may pervade the aftermath of a child's death by suicide. Well-intentioned friends and loved ones may collude in determining who is allowed to know the cause of death. A "conspiracy of silence" (Lukas & Seiden, 1987) sometimes emerges following suicide, which may actually complicate bereavement even further. Death by suicide remains a topic more often whispered than spoken aloud. Such factors may be noted in such ways as the wording of obituaries, in which the term, "died unexpectedly" may function as a code word for suicide.

Such conspiracies may further compound some already-complex family dynamics. As in the case of "Patsy's" family, various family secrets may relate both to risk factors and subsequent grief work with the family. Certainly, in cases involving such potent secrets as Patsy's family held, issues of secrets play a powerful role in the healing for survivors. For example, including her younger brothers in discussions about her life and death would prove a starting point for avoiding further conspiracies of silence. Further questions of bonding between Patsy, Ruth, and Bob may well be explored along with attention being given to those aspects of success they had experienced with Patsy.

Decisions about whether funeral arrangements are open or kept private depend on family wishes. Decisions about telling the true cause of death need to be kept honest, including what children are told. While details about methods are not necessary information, acknowledging the cause of death precludes future deceptions (Clark & Goldney, 2000).

Further complicating the bereavement process, the family may actually find themselves avoided, if not shunned by friends, other parents, and even relatives following the suicide (Brent et al., 1996; Dunn & Morrish-Vidners, 1987; Rando, 1986). Whether such reactions stem from lacking the words to express sadness or from some fear of a contagion effect, the resulting sense of isolation can prove devastating for

surviving families following suicide. Problematic bereavement is considerably more likely in cases where family members consider themselves blamed by others for the suicide (Cleiren & Diekstra, 1995).

The stigma associated with suicide involves psychosocial, legal, and religious components. Historically, since suicide was viewed as a sin against God, punishment was considered necessary in the eyes of the Church (Minois, 1999). In some cases, death by suicide has precluded a religious funeral or burial in a church graveyard ("hallowed ground"), thus further complicating the observances and rituals following death from which the family could otherwise find comfort.

Given the pervasive sense of suicide as a preventable event, the question of "why?" often defines the grieving process and elicits idiosyncratic responses from survivors. Combined with factors of shock from the sudden, often violent nature of the death, questions of why are virtually unavoidable. In some cases, answers to questions of why may never be forthcoming or satisfactory. Survivors must nonetheless be allowed to pursue finding answers with which they can find solace. Such solace may take considerable time to evolve.

Survivors of suicide and other violent deaths may display a distinct need to discuss the death despite that need often being met with reluctance and evident discomfort on the part of others (Dunn & Morrish-Vidners, 1987; Lohan & Murphy, 2002). Such unmet needs can exacerbate the already complex bereavement issues of abandonment, punishment, stigma, and self-blame. Particularly among adolescent siblings who have shared close or even conflictual social relations, the need to articulate may prove a crucial factor in grief work (Roy, Segal, Sarchiapone, 1995). Siblings may be further subject to feelings of inadequacy to meet their parents' expectations for the deceased child (Brent et al., 1991b).

Issues of remorse and guilt are frequently complicated by a sense of failure to protect a child or to prevent the death. Unlike death from various causes, suicide remains a chosen, preventable death. Borrowing from The Compassionate Friends' (2000) guidelines, families may benefit from considering referring to their child's "death by suicide". By employing such a phrase, families may be empowered to move away from the more criminal implications of "committing suicide."

Issues of anger and ambivalence may further complicate the emotional toll taken by the suicide. Issues of anger regarding the suicide itself need to be addressed in ways that are safe and constructive. Ultimately, families are faced with the tasks of forgiving both themselves and their child for the suicide. Residual frustration and distress related to drug- or depression-related behaviors may need attention. Ongoing attention to indicators of acute trauma or post-traumatic stress is indi-

cated, especially if having found the body following a death by suicide complicates bereavement.

Particular attention needs to be paid to aspects of adolescent suicide that precluded recognition or prevention, in order to facilitate forgiveness. Discussion of mental illness in ways that serve to educate and diminish stigma and shame is likely to prove beneficial.

Given the strong family patterns of suicide, bereaved family members may be dealing not only with the trauma of a child's suicide, but also with multiple traumatic losses, (Mann, 2002; Roy et al., 1997; Runeson, 1998; Stelovich, 2001). In such cases, attention to mood disorders and substance abuse are critically important. Issues of family secrets (such as family histories of suicide) are also important to address. Clinicians need to pay close attention to unresolved traumatic bereavement issues as well as potential suicide risks among surviving family members. For example, in the case of Patsy and Ruth, in addition to the family's secrecy about adoption and suicide, attention to Ruth's issues of bereavement following her own sister's death would feasibly prove relevant. Questions of whether her bereavement was curtailed in order to nurture her newly adopted niece would likely need exploration in the interest of healing.

Especially during the early months after a suicide, doubt and then blame may serve some coping purposes, but often ultimately prove counterproductive (Dunn & Morrish-Vidners,1987). For example, in Patsy's case, her mother's immediate response was to blame Patsy's ex-boyfriend. She became quite bitter when he married the next year and his new wife had a baby girl. She resumed therapy and reluctantly joined a local group of survivors. Over time, "Ruth's" grief focused on her sister's and then Patsy's deaths by suicide. She agonized over her own participation in keeping the secret of Patsy's actual birth parents, blaming herself for having precluded Patsy's knowing of the existing risk factors for depression and suicide in ways that might have protected her. Over the next several years, Ruth and Bill became quietly but deeply involved with the survivors' group.

Although underutilized, support groups comprised of and facilitated by other survivors of suicide ("SOS") have proven to be effective means of lessening the impact of extended, unresolved, and complicated grief for suicide survivors (Campbell, 1997; Moore & Freedman, 1995; Renaud, 1995; J. Tunkle, Unpublished). Support groups can be of value when facilitated by other survivors or mental health professionals or both. Members appear to benefit from the process of responding to others suffering similar bereavement (J. Tunkle, Unpublished). Support groups for survivors tend to be comprised primarily of women.

This pattern may occur because more men than women complete suicide each year (Mann, 2002), leaving women more often bereaved by a partner's suicide than men are likely to be. Other possible reasons involve sociocultural norms that validate women's help seeking behaviors and overt expressions of emotions more readily than is often the norm for men (Doka, 1999; Tunkle, 2000).

Among other gender-related differences, fathers appear to be the 'least expressive following a child's suicide (Brent et al., 1993; J. Tunkle, Unpublished). Clinicians need to pay particular attention to the risks of fathers following adolescent suicides, especially for possibly somaticized symptoms of complicated bereavement. By paying particular attention to the inclusion of fathers in grief work and by acknowledging and respecting diverse ways of expressing grief, clinicians may find their work more effective.

While suicide has been referred to as a "victimless crime," because the victim and the perpetrator are one, the phrase "to commit suicide" necessarily implies a criminal act rather than death. In 18th-century English Coroners' Courts, posthumous trials were held to determine whether the suicide was the result of insanity, thus removing it from the realm of criminality (and into the realm of "non compos mentis"). Historically, surviving family members were expected to pay any fines or penalties following a suicide (Jobes et al., 2000). Such penalties included forfeiture of possessions as well as fines.

While economic sanctions are no longer imposed on families, the first thing that happens when the authorities are called to a suicide death now is that it becomes a "crime scene;' the people involved become "suspects" until proven otherwise. In some cases, the suicide note may be confiscated for forensic purposes, despite its tremendous importance to survivors (Clark & Goldney, 2000). Traumatized families may need explanations about the reasons for not touching or moving objects at the scene of the suicide for forensic purposes. Tactfully offered referrals for cleaning services may also be needed in the immediate aftermath of a child's death by suicide.

An additional traumatic factor following a death by suicide entails those who find the person or body following the event. When requested, social workers in emergency room or forensic settings may be in a position to facilitate an opportunity for families to spend unhurried time, preferably privately, prior to preparation for burial. Such opportunities appear beneficial in the process of acceptance of the reality of the death as well as in resolving unfinished business (Clarke & Goldney, 2000). Such viewings need to be arranged according to family preferences.

Working with Friends, Peers and Schools

In the aftermath of a youthful death by suicide, friends and peers are often in a state of shock that is compounded both by age-related inexperience and emotions and by feelings of guilt and bewilderment. Ideally, postventions with children following a peer's death by suicide need to start with their parents and include helping children observe genuine grief (Dunne-Maxim, Dunne, Hauser, 1987). Efforts to protect children by lying about the cause of death tend to be misguided, and appear to be associated with subsequent disturbances in reality testing and increased levels of self-doubt especiaIly when they know or suspect otherwise (Dunne-Maxim et al., 1987). Ignoring or doing nothing in response following a death by suicide may contribute to further harm by failing to recognize the seriousness of friends' and peers' distress. To the extent possible and appropriately respectful, friends and close peers should be encouraged to attend the funeral. That is not to say that schools should close for a funeral, which could actually represent a diminished level of support for some students in need (Lamb & Dunne-Maxim, 1987). Throughout the bereavement process, efforts are needed to keep communication and information about the death by suicide as accurate as possible and to avoid misrepresentations and misunderstandings among survivors.

Reactions of school communities have been likened to those of families following a death by suicide. Unlike families, however, schools' responses to a student's suicide should follow some pre-existing written school- or district-wide plan anticipating students' deaths from suicide and other causes. Ideally, schools may bring in an external consultant to facilitate postvention efforts. As an external professional, consultants can maintain a level of neutrality and emotional objectivity within an otherwise highly emotional process (Lamb & Dunne-Maxim,1987). Clinical social workers are ideally suited for this role and need to make themselves known to school administrators, who need to have such contact available *prior* to needing them. In filling such a role, clinical social workers also need to clarify their role as a consultant rather than an investigator especially when bereaved school staff and faculty may feel very vulnerable and blamed for missing signs.

Clinical considerations in a school setting include questions of how and when to inform other students of the death by suicide. School postventions should entail a prompt response, ideally within 24 hours of the suicide (King, 1999, 2001; Leenaars & Wenckstem, 1996). Attention to the child's closest friends needs to be prioritized. Specific staff should be designated for students to know an "open door" avenue exists

for purposes of discussion and processing following a suicide. While response to a peer's suicide is critical, that attention must be designed in such a way that suicide is neither glamorized nor romanticized (Callahan, 1997). Within the school system, school-based social workers who are already familiar with the students are ideally suited to working with survivors as they have already established a basis of trust and credibility.

In "Patsy's" situation, providing a structured postvention would be considerably complicated by the size of the campus and the diversity of her peers. Clinical attention to her roommate and boyfriend, however, would be imperative. Consultations with faculty members could also prove constructive to help minimize guilt as well as to provide information that could prove beneficial to their subsequent awareness of suicide risk factors among their students.

Because of the potential for "cluster" or "imitation" suicides (Tousignant, 1995), clinicians are compelled to pay particular attention to children and adolescents at risk especially during the early days after the death. Those at risk include close friends, roommates, and any students with known suicidal behaviors or histories (Lamb & Dunne-Maxim, 1987). An intrinsic outcome of effective postventions is the reduced likelihood of further suicides.

Following the initial shock and denial that are likely to result from learning of the suicide, friends and peers are likely to be subject to an array of intense emotional responses. Issues of profound grief, guilt, anger, impaired judgment, and cognitive distortions predominate in the aftermath of a student's death by suicide (Lamb & Dunne-Maxim, 1987). Issues of anger may be particularly complex as they may apply both to the deceased and the various others (parents, teachers, ex-romances) who may be perceived as having either exacerbated or failed to prevent the suicide. Issues of guilt may apply, particularly in cases where friends and peers were aware of suicidal threats or behaviors that were not disclosed to parents or teachers, or in cases involving rejections or shunning (Lamb & Dunne-Maxim, 1987; Morrison & L'Heureux, 2001). Careful attention is needed to balance the realities and complexities of suicide.

Particular care needs to be paid to cases involving homophobic issues. Both with families and peers, careful, respectful acknowledgement of issues of sexual orientation may prove important in the grieving process. Particularly in cases in which feelings of guilt about arguments about, or even rejection related to sexuality issues may prove significant with survivors, clinicians need to facilitate survivors' discussions relevant to the adolescent's sexual orientation in ways that avoid blame to the greatest extent possible.

Guidelines for appropriate observances at school, such as a memorial service, should be congruent with the precedents set by other types of tragedies. If memorial services or flags flown at half-mast occurred in the past for students following such tragedies as deaths from illness or accidents, then the same observances following a death by suicide appear in order. Thus suicide can be treated in the same way as other tragedies so as to provide a framework for consideration and discussion. Constructive discussions among students and faculty and professionals can follow (Lamb & Dunne-Maxim, 1987). Ultimately, survivors' memories of the deceased need to be focused on the life of the individual being mourned rather than on the manner of their death.

Particular attention needs to be focused on the emotional status of surviving peers who are at risk of depression (Brent et al., 1993; Forman & Kalafat, 1998). Examples of exaggerated and prolonged grieving may entail such disturbances as sleep and eating disturbances, self-medication through substance abuse, and school withdrawal and truancy. In such cases or in cases involving obsessive preoccupation with death, individual clinical attention needs to be focused on the child with particular attention to suicide prevention (Dunne-Maxim et al., 1987). Substance abuse issues must be addressed both as it relates to the suicide and to potential self-medication among bereaved survivors. Clinicians must employ compassionate yet clear guidelines regarding substance abuse issues and consequences. Issues of education and referral must take precedence over disapproval or inferred blame, but issues of risk must be clearly addressed. Other manifestations of cognitive disturbances among close friends include a foreshortened sense of future (not expecting to live longer than the deceased), and diminished academic performance (associated with concentration difficulties) (Dunne-Maxim et al., 1987).

Unlike adults, children and adolescents rarely utilize support groups for survivors of suicide (Rubey & Mclntosh, 1996). While bereavement group interventions have proven effective for children following the suicide of relatives (Pfeffer et al., 2002), such interventions do not appear to be replicated effectively among peers following suicide.

Perhaps ironically, the people most likely to be expected to provide support and facilitate ongoing postventions are the teachers, school social workers, and school administrators, who are also subject to intense feelings of grief, failure, and guilt following a suicide. Overtly or covertly, teachers' responses following a student's suicide often serve as models for students, regardless of the teacher's preparedness for such a role (Lamb & Dunne-Maxim, 1987). Teachers' responses to

students' suicides has received relatively little attention in the existing literature, but appears to parallel some of the family's reactions described earlier, including questions of guilt (missed cues, minimized interpretations of threats, harsh grading) and questions of why. Faculty and administration need support through their bereavement, which will necessitate additional faculty and staff meetings for purposes of support, debriefing, and discussion. Ideally, for the initial postvention faculty and staff meeting, the entire group needs to be in attendance. With general administrative support, this can typically be achieved (Lamb & Dunne-Maxim, 1987). Starting with educating the faculty and staff about the multiple factors that influence risks and completions of suicide, while simultaneously respecting the unique aspects of the situation at hand, social workers are ideally suited to address various contextual and psychosocial dimensions relevant to suicide and bereavement. Meanwhile, administrative decisions about clearing a locker, and returning personal belongings to the bereaved family need sensitive consideration and implementation (Lamb & Dunne-Maxim, 1987).

Following an adolescent's death by suicide, one of the most common factors is a need to blame someone for what has happened. Parents can blame the school; the school can blame the family; peers may blame both family and schools. Questions of "why?" may remain unanswered. By cutting through the blame and addressing the shared sorrow and bewilderment, facilitators of postventions are in a crucial position to guide survivors through to a more productive bereavement than would be possible by continuing to blame themselves or others (Lamb & Dunne-Maxim, 1987). Ultimately, issues of blame need to be avoided.

Working with Mental Health Professionals

While seeking professional help during the weeks or months prior to completing suicide appears a consistent pattern (Isometsa et al., 1995; Pirkis & Burgess, 1998), relatively scarce literature addresses the survivor status of clinicians following a patient's or client's death by suicide. Numerous estimates indicate that approximately 20–50% of mental health clinicians of various disciplines have or will experience a client's death by suicide (Valente, 1994; Jobes et al., 2000). In "Patty's" case, a junior clinician may be faced with a profound sense of guilt and failure for what proved to be an inadequate assessment on a Friday afternoon.

Despite cognitive awareness of the multifaceted aspects of suicide that preclude prediction and prevention, mental health. clinicians are

nonetheless subject to intense and emotionally difficult reactions following a client's death by suicide. Complex issues of grief, stigma, anger, and self-blame are commonly noted (Horn, 1994; Tanney, 1995). In some ways, the traumatic bereavement experienced by clinicians may most closely parallel that of family members, particularly when early responses pertain more to legal liabilities than to expressions of concern or sympathy (Jobes et al., 2000). As with family members' responses, clinicians' responses also appear to occur in phases, starting with shock and denial and moving toward anger, guilt and shame (Horn, 1994; Kleepsies et al., 1990). Fears of losing professional credibility and self-doubts about competence to treat potentially suicidal clients are also common (Jobes et al., 2000). Some form of debriefing may be in order. Some clinicians find the conducting of a psychological autopsy beneficial in understanding the hows and whys of the suicide (Tanney, 1995). Decisions about whether to attend the client's funeral may be difficult. Meeting with surviving family members may evoke a sense of blame or failure.

While support groups may prove unrealistic, clinicians may find it helpful to discuss their bereavement process with other mental health professionals who have also had clients or patients who died by suicide (Jobes et al., 2000). This may or may not entail the clinician's regular supervisor, depending on his or her circumstances and expertise. Such support may be indicated for up to a year following the suicide (Tanney, 1995). Because resolving bereavement issues following a client's suicide is so likely to influence future clinical practice, clinicians need to pursue support for their bereavement in a timely and effective manner. Ultimately, clinicians need to be prepared for the realistic probability that they will encounter potentially suicidal clients again in the future and that they need to be prepared to meet those clients' needs as effectively as possible without being impaired by unresolved bereavement.

CONCLUSIONS

Bereavement following suicide necessarily differs from bereavement following other causes of death (Dunn & Morrish-Vidners, 1987; Still ion & McDowell, 1996). Clinical interventions clearly need to be directed toward facilitating the bereavement process of survivors, who extend well beyond the immediate family. Attention must be paid to the subtle and not-so subtle issues of stigma, shame, and blame experienced by families, friends, teachers, and clinicians who survive a child's death by suicide. Through various clinical postventions following suicide, clinical social workers have a potential and viable means of inter-

vening effectively with survivors and achieving suicide deterrence or prevention among those at risk. Clinical social workers are ideally suited to function either as clinicians or as consultants for schools following a student's death by suicide. Efforts to address the ongoing societal stigma surrounding suicide that can exacerbate survivors' pain are also needed. While the ideal outcome is the diminished incidence of any suicide particularly among youth and thus the discontinuation of the need for clinical interventions, that ideal appears distant at present. Meanwhile, much more research is needed in the area of effective social work interventions with surviving family members, friends, teachers, and fellow mental health clinicians following an adolescent's death by suicide.

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