minal conditions; these include end stage renal and cardiac failure, which are important causes of death within ethnic communities.

We need proactive strategies to recruit staff from a diversity of backgrounds.[11] Our experiences show that multifaith hospital "chaplains" and ethnic outreach workers represent a particularly valuable resource in helping overcome language barriers, develop services, and promote partnership with local communities.

Health professionals are increasingly encouraged to focus on the idea of a good death. However, definitions have tended to emphasise physical and psychological support rather than religious perspectives. These often include control of symptoms and help with resolving unfinished business. Training in issues to do with faith—a subject so important to so many people during their last days—need to be incorporated into professional training. An estimated 65 medical schools in the United States now offer modules on spirituality and health, and these examples of good practice need to be emulated in Britain.[12]

But even the best training cannot cover all aspects of care nor deal with the myriad of ways in which values and norms interact and adapt before finally being enacted in the hospital, surgery, or home. We have, however, a relatively untapped potential for penetrating insights into how to shape the future agenda for the provision of palliative care: the doctors, nurses, and allied health professionals who, with their broad range of ethnic, religious, and cultural backgrounds, represent a most valuable learning resource. Understanding each other's narratives of what constitutes a good death offers us the possibility of improving the quality of care we deliver. The added benefit is that this helps us as individuals make better sense of questions we will encounter at some stage in our lives: How do I want to die?

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Helping people bereaved by suicide

Their needs may require special attention

For every suicide it is claimed that on average six people suffer intense grief.[1] With around 5000 suicides per year in England and Wales and at least 800 000 worldwide, the burden of suicide is immense. Those affected include parents, partners, children, siblings, friends, colleagues at work, and clinicians. The need for provision of care for this population is emphasised in the *National Suicide Prevention Strategy for England*.[2] This issue has also been highlighted by the recent publication of the *European Directory of Suicide Survivor Services* by the International Association for Suicide Prevention, which lists support services for people bereaved by suicide.[3] Here we review the specific issues faced by people who have lost someone through suicide, the nature of available help, and future needs in this area.

Does bereavement by suicide differ from the impact of other sudden death? Initial uncontrolled studies implied a particularly difficult grief process. More recent studies controlling for effects of loss in general have shown that bereavement after suicide is not necessarily more severe than other types of bereavement but that certain features or themes may be more prominent.[4–7] These factors may make coping with the loss particularly difficult.

Specific experiences that seem to be more common in people bereaved by suicide include stigmatisation, shame and guilt, and a sense of rejection.[1 6 7] Feelings of guilt and blame may be linked to a quest to understand why the suicide occurred. Bereaved people may blame themselves for contributing to the death. Failure to recognise mental illness or its severity may be an added factor. Guilt and shame are, understandably, likely to be particularly prominent where the suicide of a son or daughter has occurred.[5] Awareness of the generally negative reaction of the community to suicide compared with other types of death[8] may compound the sense of stigma. This is likely to undermine social support, increase the isolation of the bereaved person,[5] and make seeking

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help more difficult. The sense of rejection associated with bereavement by suicide may increase vulnerability.

Key additional factors likely to influence bereavement after suicide include the age of the deceased, the quality of the relationship, the attitude of the bereaved to the loss, and cultural beliefs. Fears for personal safety may be a feature for family members, especially when there is a family history of mental illness or suicide.

Official procedures necessitated by a possible suicide and media attention may also influence the experiences of bereaved people. Potentially distressing aspects of the coroner's inquest include the delay before the inquest, the courtroom atmosphere of many inquests, hearing details of the nature of the death and postmortem examination, and a sense that the only goal is to reach an official verdict.[6 9] Factually inaccurate or insensitive media reporting can also cause problems for bereaved people.[9]

The problems faced by many individuals bereaved by suicide indicate that help is often needed. What can be done? General practitioners will be an important source of care in many cases, particularly where they have known both the deceased and bereaved persons. Many people will, however, require more specialised help although their needs may vary greatly according to gender and age of the bereaved. Help may be provided through individual, group or family counselling or therapy. While there have been few methodologically sound evaluations of care, present evidence suggests positive benefits.[1 10 11] A controlled clinical trial in children who lost parents or siblings through suicide indicated greater improvements in depression and anxiety in those who entered group treatment than in those who did not.[12] The experimental treatment included education about death, suicide, and grief experiences, enhancement of coping skills, facilitation of expression of grief, and encouragement to develop new relationships. Surviving parents were offered similar help and advised on how to support their children in dealing with the loss.

Approximately a quarter of suicides occur in people in current or recent psychiatric care. In such instances the psychiatric service can often help, although this may be impeded if the bereaved feel that care was inadequate. Bereavement organisations such as CRUSE may provide individual counselling. Some bereaved people welcome the support of others who have had a similar experience. Several self help groups and organisations have developed to provide this, often initiated by people bereaved by suicide. Many of these are listed in the European directory.[3] In the United Kingdom, Survivors of Bereavement by Suicide (SOBS) and the Compassionate Friends (Shadow of Suicide) offer a network of support groups.

Some people may benefit from help and advice provided through reading material. Several useful books are now available on the topic, of which *A Special Scar* is particularly valuable in the UK context.[11] A *Bereavement Information Pack*, developed at the Centre for Suicide Research and published by the Royal College of Psychiatrists, provides information on experiences of bereavement from suicide, recommended reading, and contact details for sources of support.[13]

Contact details for support organisations:

The Compassionate Friends (Shadow of Suicide) (for parents who have lost a child, and siblings): www.tcf.org.uk

CRUSE Bereavement Care: www.crusebereavementcare.org.uk

PAPYRUS (committed to the prevention of youth suicide) will help bereaved parents and carers make contact with appropriate sources of support: www.papyrus-uk.org

Survivors of Bereavement by Suicide (SOBS): www.uk-sobs.org.uk

Winston's Wish supports bereaved children and their families, and produces a booklet, *Beyond the Rough Rock*, which is specifically designed for children bereaved by suicide: www.winstonswish.org.uk

Information and support are also available through many internet sites, which may be particularly useful to people who are geographically isolated or prefer anonymity.

Clearly much can be done to help people who are bereaved by suicide. Although clinical trials are not easy to conduct, given the special circumstances of suicide bereavement, they are none the less required to show whether specific types of care are effective. Other factors which might help reduce distress include specialised training for professionals who have contact with people bereaved by suicide, modifications to those aspects of coroners' inquest procedures that the bereaved report finding most stressful, and more sensitive media coverage of suicides.

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