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Students' Mental Health Needs: Problems and Responses,

edited by Nicky Stanley and Jill Manthorpe

Student life is a time of change and adjustment, and students' families as well as staff need resources to help them provide support for students experiencing mental health difficulties. Based on recent research findings and drawing on the experiences of professionals, academics and service users, this book explores how the needs of students can best be met by student and community mental health services. All of the contributors to this chapter have lost a son or daughter to suicide. Each of the stories is unique, as are the attempts to understand what led up to the child's death.

Margaret Harvey
Monday February 18, 2002

When Our Children Kill Themselves

Parental Perspectives Following Suicide

All of the contributors to this chapter have lost a son or daughter to suicide. Each of our stories is unique, as are our attempts to understand what led up to our child's death. Some of us feel that we can piece together a sequence of events, at least with hindsight, while for others it remains a shocking mystery. Probably we all accept that we can never know the full, true story. As parents, we recognise that the departure of a son or daughter to college or university marks a significant shift in the dynamics of our family. Our children are adults; they lead independent lives, and the family home becomes a place to visit, rather than to live. Some of us find it easier than others to adapt to this new 'equal adult' relationship than others; all of us still see ourselves as parents and our concern and wish to support our children continues, albeit in a different form. When our children take their own lives, we scour the past, unpicking their childhood in an attempt to understand, and we ask ourselves the question: 'how did it happen, when did it all begin?'

Our children's stories

Many of our children were high achievers who set themselves high standards and met with conspicuous success:

She was an extremely bright little girl with a voracious appetite for knowledge, life and people. Her career at school covered a wide spectrum of interests, both academic and in all other fields.

Some of us look back with hindsight and see shadows:

Most of the time Jim was happy and cheerful, always ready to get the most out of life, but he did have times of depression. At these times, he would become unmotivated and find it hard to complete his work on time. He would spend a lot of time sleeping. However, he could recover from these times very quickly and soon got back on track.

Even incidents remembered as markers are only defined as such with hindsight:

Our four-year-old, Ben, painted a totally black piece of paper and said it was 'his bedroom with the light off'; it was only recalled as a key to latent depression, rather than artistic awareness, when he had killed himself.

All of us who do look back and see shadows ask ourselves this question:

How does one judge if a teenager is being 'normal', keeping things to himself and not wanting to share everything with his parents and siblings? Isn't that what adolescence is about - becoming independent, knowing more about everything, sometimes feeling superior? He was popular, thriving, busy - a little self-contained and demanding. Had everything turned out well, I would not have remembered this.

All of our children died while at college or university or just afterwards. For some families, the late teenage years were a rollercoaster ride, knowing that our child was depressed, trying to help them find effective help, hoping that counselling or new medication would be the solution, but knowing that we could only go so far. Some of us watched helplessly, as treatments and medications were tried in turn, or in combinations, in an attempt to find something which was effective while still giving an acceptable quality of life. We discovered that our able and articulate children were not prepared to live a stupefied existence merely to stay alive, and they were often intolerant patients. We learnt that this was not something we could 'fix', like a plaster on a knee. Some of us had already had to support our child after a suicide attempt: 'At the age of fifteen Robert took an overdose of paracetamol. He would not see a GP or a counsellor after his first suicide attempt.'

Even at this age, when we are faced with refusal and it is our first real contact with depression, we are at a loss to know what to do for the best. We look back and remember these times. When our children are older, it is no easier to help:

I was aware that Guy was very miserable. We talked about this. He said something had happened a short while before but that he could not talk about it. I asked him if he needed

help and suggested he could have some counselling. This was met with a quizzical smile and a refusal. He was uncertain if he wanted to go back to college. I left the decision to him after discussing various possibilities. He seemed to have thought things through rationally.

Some of us, in the face of a polite refusal to let us help directly, agonised over what else we could do:

Two days before he died, I had such an uneasy feeling about him that I went to the phone to contact the polytechnic counselling service. I did not trust my instinct enough and felt that Ashley would be annoyed if I interfered in his life. Suicide never once entered my head. I just felt he was struggling and needed some expert help. I never made that call.

Other families found they could offer help that was accepted. Some of our children felt isolated and unhappy, for a wide variety of reasons: 'From a hall of residence, he had moved into a rented house with friends from his first year. None of them took his subject or had to work hard for exams during that year.'

Difficulties in communication can become real obstacles:

He did not have a phone in his Hall so had to go out to use a public phone box. He told me later that he really missed us after we left and felt homesick and unsettled for a while, although this was not evident to his friends or to the college.

It seems that for some of our children, it is regular contact with home that enables them to continue:

At home that Christmas she became very anxious about her 'writer's block', and all through the spring term would ring in tears about not being able to put the work on paper. Each call was agony, but by the end of spring she was calmer (perhaps on prozac again), and was awarded a scholarship for her first year's attainment as well as being voted vice-president of the Junior Common Room [college students' union] in charge of accommodation and welfare.

But even when quite openly asking for support, and clearly in deep distress, it is not always possible to get the help needed:

The first time we knew she was really ill ... she told us that she felt a 'compulsion' to wade into the reservoir near her flat. She broke down and we were completely devastated. She had wet clothing with her and we knew it was true ...I took her to the family GP next morning but stayed outside as she wanted privacy. I regret that I didn't go in as I later heard from him that she had presented a radiant smile and said her exams were a worry and he prescribed mild tranquillisers.

This highlights one key issue that comes through in so many of our stories: frequently our children employ a massive cover-up that may include friends, tutors and family - even health care professionals. Often we do not realise that this is going on, that even their closest friends perhaps do not know that they are depressed. Sometimes we only discover later, maybe by chance, that our child has been taking anti-depressants for years, that they

have made one or more suicide attempts of which we knew nothing. Even when we do know the seriousness of the problem, we find it almost impossible to approach the issue:

At this stage there had been no contact between us, the family, and the university... I didn't know what to do and felt the need to discuss things with a health care professional, but didn't know how I could do this without compromising Kate's need for confidentiality. I rang a local mental hospital to discuss the pros and cons of psychiatric help.

Some of us do feel that the university was constructive in supporting time out, keeping course enrollment open and giving our child time to recover from a severe episode of mental illness or breakdown. What seems to be missing from all our accounts is any real sense of partnership - of support services, tutors and parents being able to work together with a student in crisis.

When our child dies

The world changes for ever when we hear that our child is dead. For each of us, the circumstances are unique yet equally devastating; for some it is a totally unexpected shock, while others have lived in the shadow of suicide attempts, perhaps for years. Some families have had to endure a period when their child was missing, fearing the worst, but waiting weeks before a body was found. Even those of us who knew of earlier suicide attempts were never prepared for the reality when it came.

Our experiences of the police are varied in the extreme, but are not relevant here. Our first direct contact with college or university often only begins at this point, when it is too late to work together, when our child is dead. For some of us the contact was straightforward:

'Friends, neighbours, colleagues, tutors, the police - all were kind and supportive, as were his peers and friends. We had no struggle to get answers to questions.'

And some of us met great openness and a willingness to talk:

We wanted to meet his art tutors to see if they knew any reason why he had taken his life. They were stunned at the news and told us he had been doing very well at his course, had completed work on time and had a lot of friends.

Sometimes contact was maintained in an imaginative and thoughtful way:

Ashley's tutor wrote to say that his attendance and marks had been good, there had been no obvious problems. The student counselling service promised to review support services available to students on halls of residence. They prompted a friend to write to me, outlining Ashley's last movements.

For others, the communications and dialogue were less satisfactory:

After the announcement of my daughter's death, the university seemed to want to fade out of the picture. The doctor and therapist treating her in the last two months of her life were not forthcoming and I was the one who had to make the effort to investigate... We

received an official letter of condolence from the vice-chancellor 'on behalf of all the staff who knew Kate', but nothing more personal was ever written to us... When I look back, I find the 'wall of silence' extremely hurtful to the bereaved family. Equally, when I asked to meet a favourite tutor to talk about my daughter I was discouraged. None of her course work could be found anywhere when I asked. The university did not help the bereavement process. I now feel they were frightened of doing so by legal constraints.

This is not the only example where the family feel that anxiety about possible criticism of the care given to their child prevented the college or university giving them full information. Sometimes we are told that an enquiry will take place but, although we have asked specifically to be informed of the actions taken, we are told nothing. Sometimes, the university or college has been much more direct than the health care services:

A full independent inquiry was set up, the results and recommendations of which were sent to us. They now have in place a high-profile welfare policy and use the money from a fund set up in her name, to send students on welfare training courses.

Thus, in some instances, parents are able to make suggestions which result in specific help being made available, such as articles in student newspapers on stress and exam preparation. In one instance, volunteer examination 'advisors' were set up to help students under stress and help them to find the right support network. It seems clear from these few examples that dialogue with parents can be both supportive and fruitful.

With hindsight

All of us wish that our child's story had not ended in death by suicide, and all of us, as we unpick the past, can see times when things should have been handled differently. Some of these are personal to our family: the times we did not manage to say what was in our hearts, pick up the phone when we were worried, check whether someone was alright. Most of us, though not all, feel that our child's death represents a failure of parenting at some level:

We knew, we would always know, that the burden of guilt was ours, totally and completely. I, her mother, had not protected my child; I had not saved her from the black demons of despair and her despair was now mine for ever.

This feeling is not one grounded in logic, to be proved or disproved; it is simply a graphic statement of how we feel when our child takes his or her own life. But hindsight is more than guilt; it can teach us lessons that may be of practical importance to others.

All of us wish that we had known more about depression and other mental illnesses, and feel that such knowledge would have helped:

I regret that the possibility of suicide did not enter my thoughts, so I never asked him about suicidal feelings. I feel that to have helped my son I needed to be more aware.

There are two issues here: the need for better understanding and the need for openness, so that these matters can be discussed, both within and outside the family.

Why is it that depression is particularly a 'no-go area'? - ME and epilepsy are now understood and accepted by most people. Depression carries a sort of guilt with it, and a fear... Perhaps its name should change as it is too easily confused with having a low day 'so buy yourself a cream bun and have a relaxing bath'. Perhaps it should have a name like cancer of the mind, except that implies no cure.

This desire for greater awareness encompasses our children and their friends, not just ourselves as parents. For the young it clearly needs to begin at school, so that young people go on to higher education knowing that suicidal thoughts and dark depression are not unique to them, nor are they shameful. We know that this knowledge cannot of itself prevent tragedies occurring, anymore than knowing about depression stops an individual suffering from it. However, we do want our children to be able to help each other, to know what to look out for and to have some idea about how to help.

Similarly, we wish we could have been better equipped to help:

As parents we must find ways of keeping the lines of communication open with our adolescent children. If we do not, we may fail to recognise, or to respond appropriately, when things have reached crisis point. When our children go away to university we must find acceptable ways of supporting them and keeping in touch. Young men, in particular, may feel they should stand on their own feet and deal with problems of accommodation, finances, work and blending socially all on their own. Traditional role models do not encourage young men to reach out when problems arise.

Closely allied to this wish that we had been more successful in supporting our children, is the wish that we had better understood at the time the role concealment can play in mental illness. We all wanted to trust our children, to believe that they were in control of the decisions they were taking, to treat them as the equal adults that they were. But few of us realised to what extent the illness itself makes it impossible to seek the help needed. Even when we knew something of the severity of our children's problems, most of us did not feel able to contact tutors, health professionals, friends or student services against their wishes. We felt, at the time, that to do so would be to betray our children's trust, to step outside the perceived boundaries of our role as parents. Some of us wish with hindsight that we had acted differently.

Diagnosis of our child's illness is seen by some of us to have been inadequate: too little and too late. With hindsight, and sometimes after considerable research, we believe vital clues were missed. Sometimes this was because those we confided in were not sufficiently knowledgeable to pick up the clues and refer them to an appropriate source of help. For example: a persistent sense of being followed, together with other symptoms, can be an indicator of schizophrenia. Perhaps with more information, tutors, counsellors - even friends - might have been able to help.

Many of us also wish that the treatment our children received had been more effective, less fragmented, and more directly targeted at their needs. The bottom line is, of course, that we wish it had been able to keep them alive through the crises they experienced, that they had had time to recover. There often seems to have been a lack of co-ordination between the various sources of support available. When we try to unravel the course of

events, it seems that the communication between services at home and at university or college was often inadequate, sometimes even non-existent. As we try to understand what happened, there seems sometimes to have been a lack of communication between various agencies within the university.

This may well have been compounded by the concealment strategies mentioned above; when students do not say that they have already been receiving treatment for their problems from another source, then connections may not be made. But that does not negate the fact that many of us think that better exchange of information might have resulted in more effective care. This is especially true when judgements have to be made about the risks of self-harm and, ultimately, suicide. There is also an urgent need for some form of swift response when a crisis looms; an appointment in six months' time is of little help.

At the core of these problems is the issue of confidentiality. Many of us now feel that, had we known more, the outcome might have been different:

Far too much is made of confidentiality. It is like not putting a broken leg in plaster in case someone finds out it is broken! I wanted to go to the doctor with Simon but needed his permission, which he withdrew at the last moment. This was a life-threatening illness; confidentiality is pointless when things are really serious.

It seems that, if secrecy, isolation, and an inability to talk about the severity of a problem are part of the illness itself, then there is a Catch 22 situation. Health care professionals feel that their relationship with the patient must be based on trust, and that this involves not breaching a confidence without their explicit consent. But there is a real sense in which the illness itself impairs the ability to give consent.

The complexities of this issue need wider discussion, but most of us feel that the current balance does not always give the best outcome. Because our children were adults, that does not mean there was no positive role for us, had we known more. Some of us, ironically, learnt about self-harm - why some profoundly suicidal people view death as a friend rather than an enemy, and why cutting can seem to release insupportable mental tension - only after our child had died. It would have been more useful to have understood these things earlier. And many of us wish there had been support services available to us, when we were in a caring role, to advise on ways of living alongside and supporting a deeply depressed person.

When our children were hospitalised, sometimes after a failed suicide attempt, many of us wish that more recognition could have been given of their particular needs. To say this is not elitist, it merely recognises that there are differences:

We rang to find out why she had been released in a state of self-harm. We were told that she had appeared to them to be a borderline case and they dealt with many cases every day, applying the same criteria for everyone. But surely highly intelligent young people need to be judged by different criteria; they are used to words and ideas and are more adept at covering up their feelings?

Similarly, those of our children who were placed in a secure psychiatric ward found it an

impossible place to be: 'They are all mad here. I cannot talk to anybody'. The extremes of behaviour can be profoundly disturbing, especially to a young person in a fragile mental state who has never witnessed anything similar before. The care staff often appear to be in a custodial rather than a supportive role, and the ward is seen as a place to avoid returning to at all costs. This in turn creates more anxiety, and severe problems may be concealed from doctors when they attend for appointments and consultations. Anything, including death, is better than going back into hospital. We recognise that there is massive under-funding in this area, but it is another where, with hindsight, we feel our children were not given the help they needed, nor an appropriate place of safety in which to recover.

When our child died while in the care of the psychiatric services (perhaps having been in hospital and not wishing to return there), some of us were asked whether we wished with hindsight that they had been detained under the Mental Health Act. Our responses are varied and uniquely personal, though we all wish that our child had been able to stay alive and recover. For those of us who witnessed a long battle with a seemingly incurable and ultimately terminal depressive illness, our thoughts are complex. We respect our child's right to choose, and in that sense, see theirs as a 'complete' life, however tragically cut short and however deeply we wish that the outcome had been otherwise. Some of us have more than one perspective:

As a long-serving Samaritan, I believed that people have the right to take their own life. I still do, but - and this is a big but - I also believe that we should do everything possible to support the person in crisis. Some crises do pass and people can come through the other side. Samaritans cannot break their code of confidentiality, but they encourage people, by every means in their power, to explore those dark demons that make living seem so futile. No judgements are made and no stigma attached. One of the main debates I would like to see opened out is a willingness to talk about feelings of suicide. Many of us have them, but we have had to learn, painfully, to walk beside them without shame and guilt. The young do not always have the life experience to bring to bear on these things and they need to be nurtured, by every means possible, until they can manage.

The need for regular and frequent contact to be maintained at many different levels is also something we recognise more fully with hindsight. First year students, away from their familiar base for the first time, need to be supported; perhaps mobile phones should be seen as a necessary link and not a luxury. Gemma's account in the previous chapter testifies to the difficulty of relying on public phone boxes. Students need to be able to receive calls from family and friends in private so that they can talk freely. Students do feel isolated, especially when their place of residence is far from the campus and travel is difficult and expensive, when there are no obvious support services locally, and when they have yet to make new friends. These things are doubly true for those with depression. To put up a poster with a phone number is not enough, although it is better than nothing. There is a real need to be proactive, both with student support services and with health care. If an appointment is missed, it should not be assumed that the problem has resolved itself; rather, it should be seen as a cause for concern.

One issue lies at the heart of all these thoughts and is summed up by this parent:

The whole thing really comes down to lack of communication between all concerned - school, university, doctors, counsellors, friends and family ...and Simon, of course. In fact, it is the total impossibility of communication and the fact that it is virtually forbidden that is the problem. Simon's wishes had to be respected - but he was ill. That is why he saw suicide as the solution.

The way forward

Nothing is static and new initiatives are taking place all the time. However, there is still much to be done. From our experiences as parents of children who took their own lives, we offer these suggestions:

- 1.** Young people must be educated about mental illness so that they recognise the symptoms in themselves or in someone they know. Young people must know how to respond if someone they know is suffering, and there must be support services in place that are immediately and easily accessible. The discussion of these issues needs to begin at school. Time should be built into the national curriculum, and a proper delivery of study programmes should be supported by adequate funding and effective training for those teachers responsible. As well as tutor group sessions, personal, social and health education programmes and drama should be used as vehicles to explore these subjects. Discussion needs to cover both what it feels like to be depressed or suicidal oneself, and also how to support and get help for a friend who is troubled. Research has refuted the myth that we should not speak about suicide because then we 'put the thought into their heads'; there is ample evidence that it is there already (Pritchard 1995).
- 2.** When putting programmes and services into place in universities and colleges, it is vital to consult with the students themselves about appropriate courses of action. We need to understand their needs and fears, to listen to them when they tell us about the things they believe would work, and not to waste resources on schemes that will be of no use. By raising these issues, we are also taking a significant step in changing the climate of opinion and opening out discussion.
- 3.** There needs to be considerable support at the very beginning of a new student's life, even before they start their course. This should build on school education programmes, perhaps with shared conference sessions of sixth formers and current local students. Induction weeks should include information about support services available and how to access them. Written information needs to be backed up by personal contact. No one can guarantee that this will result in everyone getting all the help they need, but it does enlarge the safety net.
- 4.** There should be thorough, compulsory and properly funded training for all tutors who have a pastoral responsibility for students; it is not enough to leave it to people's good intentions. If there are clear requirements, for example that all first-year students should be contacted personally by their pastoral tutor in their first month at college, then there is at least a case to be made for funding this.
- 5.** In some areas there are concerns about the new student's contact with local health care provision. Perhaps all students should be required to register with either the student

health service or with a local GP, with formal notification of this so that each is aware of the other's existence.

6. If students are required to register with the student health service, then perhaps some strategy could be agreed to address issues of confidentiality and contact should a crisis occur. Some counselling centres ask clients to sign a 'personal safety' clause, giving permission for next of kin or other named person to be contacted if, in the doctor's opinion, they pose a threat to their own or another's safety. This would not guarantee such contact, but it would at least offer the possibility of discussion with family during a crisis.

7. Further to the central issue of confidentiality: there should be clearly defined protocols for the sharing of information between the various support services within the college or university. There are complex questions to be resolved about privacy and the rights of an individual. These need to be discussed widely, not least with the students themselves. If attitudes within society changed, if mental illness was no longer stigmatised, but became just another illness like diabetes, then it would become easier to move forward on these issues.

8. There is also a case for support systems at times of high stress, particularly during examinations. Trial schemes have provided specific help through exam 'advisors'. Students who leave examinations early are told of the help available to them, and there has been a good response to such a direct approach.

9. If we are to reach more students with problems, then there needs to be a wide range of services available, not all linked directly to health care, using a variety of approaches. The work of the Samaritans has pioneered the model of a confidential phone service combined with a drop-in contact point. Schemes such as '42nd Street' in Manchester offer services to meet recognised local needs that can be useful to students. Night-time phone support lines and internet chat rooms offer initial contact to an individual who feels unable to seek out face-to-face professional treatment.

10. Underlying all these above is the huge issue of education - both to raise the level of basic awareness, and to change the current climate of opinion about mental illness, including depression. This will be a long process, but schools and higher education institutions seem logical places to initiate new programmes and target funding. Awareness is growing all the time, but more needs to be done if future generations of students are to get the support services they need to survive in an increasingly pressured world.

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