AGUS
Angehörige um Suizid

Martina Kommescher-Dittloff
Jörg Schmidt

Grief after suicide

(not) a grief like any other

AGUS publication series: Helps in grief after suicide

Contents

AOK-Bundesverband
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Authors: Martina Kommescher-Dittloff & Jörg Schmidt

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Preface

August 7, 2007 changed my life and that of my family overnight. The ground we stood on, which we thought was solid and safe, was swept away from beneath our feet, and old certainties seemed no longer to apply. Our son took his life in the early morning hours of a summer day that was supposed to be warm and bright, at just the age of 26. The suddenness of this terrible event hit us real hard, for we had anticipated nothing of the sort. We were utterly unprepared. There was no single indication of this approaching disaster. – But then again, looking back on it, we certainly realize a good many clues, indications of an impending doom about to befall our son and us.

The apparent certainty of having failed as parents to save our child from this terrible incident scarred the next stage of our life, together with the immense pain and the deep grief. Feelings of guilt and the blame we shouldered sapped the life out of us. In that situation we felt lonely in our pain, in our grief, and while we believed the world stopped turning, life just went on around us. We couldn't understand the world anymore and at the same time felt not understood. We needed help.

A terrible situation, but actually, not one that we alone had to endure, even if it seemed so to us at first. Only later on we realized that many people underwent it, almost every person who was bereaved by suicide. And that means a good deal of people, given almost 9.000 suicide cases annually in Germany alone.

This brochure is a new edition of the same-titled previous publication from 2020 and aims to aid the bereaved that grieve upon a suicide. It is composed of two major sections.

In section one, Jörg Schmidt, Director of the AGUS Head Office, elaborates on the peculiarities of the grief that follows a suicide, together with the reasons why people are very often hit real hard and the grievers experience the death of their loved ones as an "absolute catastrophe".

Among other things, he demonstrates how scientific models that try to clarify the development of suicide and the conditions leading to it help to understand the death of a beloved person better, but cannot really manage to clarify the

burning question of “why?”. Ultimately, the deceased takes this secret to their grave.

The statistical classification of suicide makes it clear to us that the problem has social dimensions, that the frequency is gender-specific, and that it happens much more often than we commonly assume because the topic is talked about so little and because broaching the subject it is still observed a taboo. And we learn that the suicide rate varies by federal state in Germany.

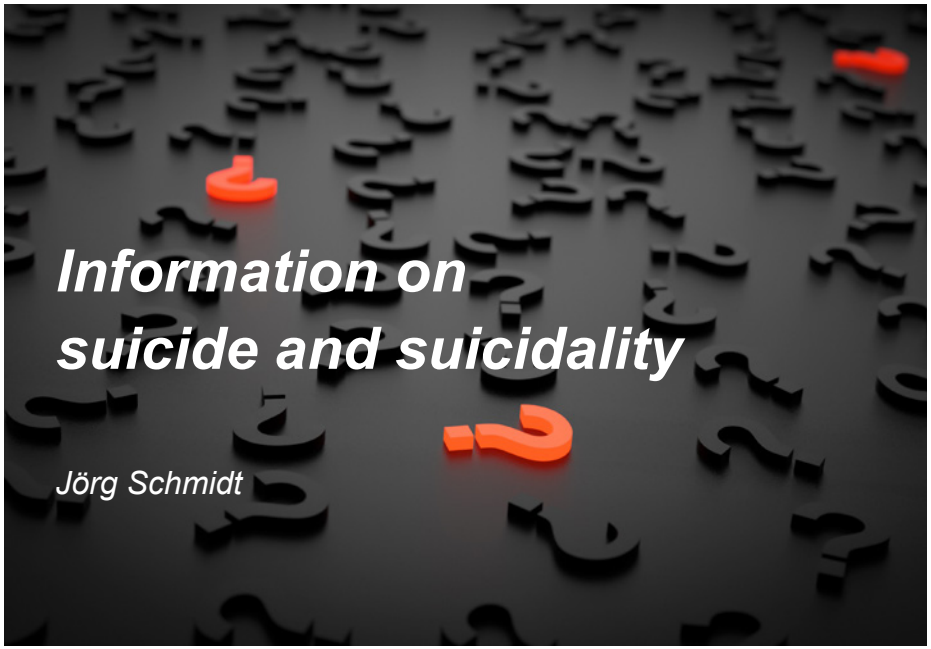
At the end of his text, Jörg Schmidt shows how important participation in an AGUS support group is for a successful grieving process. And it is indeed not surprising how a survey of the bereaved – as part of a study by the University Hospital of Hamburg – reveals that a large majority of them no longer feel abandoned to their fate, that they not only talk everything over, but also learn from the experiences of others and can thus cope with their situation better.

The second part of the brochure comes from Martina Kommescher-Dittloff, a grief counselor – a bereaved wife herself – who leads AGUS weekend seminars for the bereaved. Based on this experience, she describes the grieving process of the bereaved, depicting the problems they face. She addresses here, among other things, senses of guilt and shame, the importance of the nagging question of why, as well as horrific scenes and fantasies, particularly in the lack of clear communication.

As a special focus, she refers in detail to Chris Paul‘s grieving concept, which the author bases her work on. She points to the relevance of the six grief tasks in the grief process and the things a grief counselor should be mindful of in their work. Her elaborate remarks can prove an essential help to bereaved readers in coping with their own grieving process. And at the end she highlights once again how important the support provided by AGUS support groups is for those who are grieving.

If my family and I had found our way to AGUS back in 2007 following our family catastrophe and if the information provided abundantly in this brochure had been in our possession back then, we would not have been spared all of the painful paths of our grief, but they would have probably come more easily. And I can only emphasize that the AGUS support group, which we managed to join after three years of grief, was invaluable in helping us cope with our grief process.

Burkhard Möcklinghoff
(Member of the Executive Team, AGUS Group Dorsten)



Suicide is…

… sudden, tabooed and associated with violence

A suicide always afflicts family members, relatives and friends out of the blue. Notwithstanding possible signs or even attempts in the past, nobody is ever prepared for such news. That someone took their life is inexplicable. We suppose that every person is life-oriented, that is to say, they want to live. We therefore hope in the course of a social or medical crisis that things will get better for the person concerned – either through the stabilizing effect of contacts or adequate medical care – perhaps even both. Usually, before a suicide, a deceptive atmosphere of calm prevails. The person concerned seems to have overcome the crisis or at least be on the way to recovery. The departed has arranged to meet friends in the coming days, wanted to undergo a rehab, etc. Only in hindsight can you interpret a certain situation from that particular day in a different light: “I wondered indeed why he gave me such a long hug when he said goodbye this morning. He’d never done that. Now I know why he did that.”

Everyone is acquainted with crises in a relationship, the family and at work. When a family member takes their life in such a situation, you are confronted with an absolute catastrophe. All hopes, wishes and perhaps courses of action developed together are wiped out at a single blow. A person has taken their life and at this point all that remains for the bereaved is to come to terms with this new life situation.

Notwithstanding the apparent improvement in the society‘s stance on suicides and their family members in the last decades, people still find it difficult to talk about this matter, intimidated by the reactions of the environment. Sufferers are confronted immediately after the suicide with the question of whether they would say it was actually a suicide or rather an accident. This is a completely different situation than after a death by natural causes.

It is not only your own world that changes upon the death of someone dear, though. Friends, neighbors and colleagues, too, have got to face up to a new life situation and find their bearings. Many people stand there helpless before a griever for fear of saying something wrong. Following a suicide, curiosity and prejudices might crop up. Therefore still many family members must often watch friends and acquaintances pull back without saying a word, and that in the middle of the hardest time of their lives. It is all the more important to keep an eye on those who prove supportive and affectionate in this hard time, too.

Aside from suddenness, a suicide is always attended with a violence impact, too. Depending on the form of the suicide, the body might turn out to be quite disfigured. Asking themselves how the suicide felt in the last moments of their life and whether they suffered great pain is agonizing for the family members. They usually associate horrible phantasies with the incident. Yet, it appears that many suicides see a solution to their problems and agonies in taking their lives. We know this from people who have survived a suicide attempt: they say they had a clear and totally peaceful mind at that moment.

Suicide is a way of dying

Suicide is a genuine human act. For at the end of the day, the subject of this deed is the human as a free, reasonable, self-confident, unique, responsible entity that has command of the inner and outer form of their life. That is to say, a person with their specific human capabilities, although these are manifold blocked, overlain and hence considerably restricted by the typical pre-suicidal factors of consciousness at the time of the decision to commit suicide.

Drawing merely on medical-pathological knowledge will not suffice to facilitate our comprehension of suicide or handling of suicidal persons, their family or the bereaved. Just like one is permanently exposed to a multitude of factors, there are in this context, too, various dimensions that we've got to take into consideration, such as the religious, the ethical-philosophical and the social aspects.

The interpretations range between endorsement or tolerance and disapproval or condemnation since ancient times. Whereas Plato referred to suicide as „sloth and unmanly cowardice“[1] in the 4th century BC, the Stoic school prized some three centuries later the quality of life above quantity.

Suicides (acts and people) were never condemned in the Bible; neither in the Old Testament nor in the New. The theologian Augustinus appears to be the first to refer to suicide as murder in general, in the 5th century AD. Moreover, suicide denoted the denial of redemption opportunities like the confession for instance. This antagonistic stance prevailed for many centuries (even among such philosophers as Kant). It was the French sociologist Émile Durkheim that introduced a new approach through his epochal work Le suicide (Suicide) in 1897. In his lifetime at the turn of the 20th century, the suicide rates were quite high, and he interpreted it as a social problem. Therefore, it's not attributable merely to individual and psychological factors; external factors can just as well make you suicidal. In recent times, notably Jean Améry's book On Suicide: A Discourse on Voluntary Death (1976) appears to occupy a prominent place. He denounces any heteronomy with regard to one's own death.

However, in all historical and social developments, the following two extremes should be avoided: on one hand the pathologizing that boils suicide down to a disease alone, and on the other hand the idealizing that talks suicide up as a

calculated act of freedom, decided and performed upon careful consideration. Neither lives up to the issue in its totality with manifold dimensions. Labeling suicide grievers automatically as traumatized people in need of psychotherapy applies just as little. Suicide is a way of dying.

Self-murder, free death and other expressions

You can't have a value neutral opinion about a suicide, it appears. It is way too much associated with existential issues and the recesses of a person's mind, for that. Nonetheless, in use of language it is advisable to beware of certain terms that might be laden with subliminal judgment.

The term self-murder implies an act of murder and therefore an offence. For centuries, suicides have been regarded as culprits, not victims and they were penalized for that, too: On the part of the church, suicides have been interred outside a cemetery in the absence of a priest and suicide was often portrayed to the outside world as a sudden, incurable illness. Such was the case for the German actor Hape Kerkeling, whose mother took her life in 1973, when he was eight years old. She was declared to have died of a stroke.[2]

Particularly, following Améry's claim for the right to one's own death, the term free death has emerged. Yet, in this context as well, it is necessary to observe with a critical eye whether the person was genuinely free or willed in the suicidal situation. In that sense, the term free death does not live up to the psychological reality of the suicide, which is contingent in most cases upon despair, the feeling of having reached a dead end, the inability to objectively comprehend values, and the constriction of emotional and intellectual perceptive faculties. Usually, these are accompanied by the feeling of a stifling inner compulsion.

Instead of the terms self-murder or free death, which imply either a negative-preachy approach or a glorification, AGUS recommends the use of suicide or self-killing, for a rather value neutral terminology. The term suicide comes from the Latin expression “sui cadere”, which literally translates cutting oneself down. Indeed, this term might sound alien or affected to many in ordinary everyday language. That's why you often hear other expressions like topping

yourself or taking your own life, which might just imply that there's a certain self-restraint involved in facing up to the incident.

AGUS founder Emmy Meixner-Wülker was keen to take action against the term self murder back then, too. Following the suicide of her husband in 1963, people referring to the suicide of her husband as self murder made her feel like she's the relative of a murderer. To this day, that's how the bereaved feel. And this terminology appears again and again, be it on television (especially on "Tatort"), on the radio, in newspapers or, above all, on the Internet. The non-bereaved often use the term self murder offhand, not considering the impact it has on the bereaved and the additional stamp they are to bear. They are already troubled, maybe even trying to avoid the imputation of blame for the suicide of a beloved person. A further condemnation as being connected to a murderer is less than helpful here indeed. Hence the commitment of AGUS to the omission of such terminology as self murder from common German usage as much as possible.

Especially when you are communicating to children the suicide of someone dear you must refrain from expressions like fallen asleep or gone, or else they could be confused. Here's an example: Imagine a mother, who tries to avoid communicating to her child the suicide of his father using the suitable vocabulary and prefers instead the expression he fell asleep, has sleep disorders someday and tells her child off-the-cuff: "I just can't sleep". What shall the six-year-old possibly think?

A person kills themselves, because …

People would give their eye teeth to be able to complete this sentence in order to understand why their partner, child, parent, sibling, relative or friend took their life. Alas, at the end of the day, the issue remains unresolved.

In spite of intensive research in the last years and decades, not even scientific studies could find a comprehensive explanation as to why someone takes their life. There are models assuming various perspectives:

Developmental models
Developmental models focus on the course of the process from the very first suicidal thoughts up to the suicidal act. Possible causes or triggering factors behind this development are disregarded here. The best-known among these are the models of Austrian psychiatrists Walter Pöldinger and Erwin Ringel.

Pöldinger delineates three phases: the contemplation stage, the ambivalence stage and the decision stage. Death wishes first appear at the initial stage. At the second stage, you face up more intensively to the question of whether you want to live further. At this stage, appeals for help are not uncommon. "These signs are unfortunately often pretty much encoded, hardly discernible and in many cases only post-hoc, that is, following an already committed suicidal act, decipherable." At the following decision stage the suicide appears calm on the outside. This is often interpreted as an improvement of their situation, attended by the hope that things will take a turn for better. However, this is a deceptive calm, for the suicide has made their decision already. But even that is almost impossible to discern.

Erwin Ringel introduced additionally the term constriction. The field of vision regarding the help opportunities in the environment and your own capabilities gets smaller and smaller. The suicide withdraws from the outside world more and more, relations are broken off, all interests are lost. You can compare it to peripheral vision. Normally a person has a field of vision of 180 degrees. At least out of the corner of your eye you can see what is happening to your left and right. In the course of a suicidal trend, the field of vision becomes smaller and smaller (almost as if you were wearing blinders). As a result, you no longer

recognize possible offers of help. In the end, all that remains is the small light at the end of the tunnel, observed by the suicidal person as the only way out: taking their life.

Formational models
The question of what puts people into such a process described by Pöldinger and Ringel yields two possible causes: crises and illness.

Crisis implies a situation which seems to be insoluble at some point in time like financial woes, relationship difficulties / lovesickness, falling down on the job or studies. Such a situation can have various outcomes: the first possibility is constructive and thereby life-sustaining (crisis as an opportunity), whereas the second one is destructive, and in the case of a suicidal crisis, life-destroying (crisis as a threat).

The establishment of a certain affinity between suicidality and mental illness dates back to the 17th century. The prevalent explanations on the part of the church before that were beliefs of demonic possession or a committed sin. The attribution to medicine aspires to sympathize better with suicidal people, and bring the fact into focus that suicidality is subject to certain laws, just like any illness. Alongside the high incidence of depressive disorders you often encounter manic-depressive disorders, schizophrenic disorders and psychoses, borderline disorders and long-term addiction in this context.

Of course, you cannot generalize. The vast majority of the cases involve very different influences and experiences, which contribute over a certain period of time to the decision of a person to take their life. Acting on the basis of a rash decision without any discernible sign of a crisis or mental illness is very rare.

Yet, besides these factors that promote suicidality, there are protective factors, too, like partnership, family ties, social and religious norms and values.

A person takes their life every 52 minutes in Germany

In Germany, just over nine thousand people die due to suicide every year. That means, one in a hundred deaths in Germany is by suicide. That's more than three times as many as the victims of traffic accidents. Suicide has thereby become one of the most common death causes for years now, and even the second most common death cause among young people between fifteen and twenty-four years of age after traffic accidents. The number of suicides committed worldwide annually is estimated to be around one million. That means, on the average, somebody takes their life every forty seconds around the world.

People who commit suicide are between ten and over ninety years of age. Numerically, the most frequent suicide cases happen between forty and sixty years of age. A good deal more men take their lives than women: about seventy-five percent of all suicides are committed by men. Due to the aging population, the frequency of suicides among those aged seventy and over is getting higher and higher. Table 1 on page 14 shows the age distribution of suicides in Germany based on the 2021 figures.

Aside from these figures on deaths by suicide there's also the so-called suicide rate. This depicts the number of people who have taken their lives per 100,000 population. North Rhine-Westphalia had the lowest suicide rate nationwide in 2021 at 7.4. This means that, statistically speaking, 7.4 people per 100,000 inhabitants took their own lives. The highest suicide rates in 2021 were seen in Thuringia at 15.5 and Saxony at 16.1; Bavaria had 12.1. High suicide rates are not only seen in the (eastern) new states of Germany. The suicide rate for the whole of Germany appeared to be 11.1 in 2021.

The number of deaths by suicide is in decline within the last several decades. In 1981 it was almost 19,000, but it decreased to about 14,000 in 1991. Since 2017, the annual figures (in Germany) are around 9,000. The World Health Organization (WHO) estimates that at least six loved ones are affected by a suicide. If you include other family members, relatives, friends, acquaintances and colleagues, the number of people affected might as well exceed 20.

Table 1:

Number of suicides by age group (2021)

Age group	Male	Female	Total	Proportion
under 14	12	15	27	0,29%
15 to 19	118	44	162	1,72%
20 to 24	223	83	306	3,26%
25 to 29	268	58	326	3,47%
30 to 34	308	81	389	4,14%
35 to 39	355	90	445	4,74%
40 to 44	358	99	457	4,86%
45 to 49	390	133	523	5,57%
50 to 54	605	218	823	8,76%
55 to 59	710	300	1010	10,75%
60 to 64	633	197	830	8,83%
65 to 69	516	192	708	7,54%
70 to 74	475	194	669	7,12%
75 to 79	480	193	673	7,16%
80 to 84	679	249	928	9,88%
85 and older	675	264	939	9,99%
Total	**6805**	**2410**	**9215**	**100%**

Source: Federal Statistical Office: www.destatis.de (retrieved on 13.07.2023)

Support within the grief process

Notwithstanding the empathy of their social environment (friends, neighbors or colleagues), the suicide bereaved come up against a gulf between sympathy and understanding. Talking to people who have had a similar experience and have to endure similar pain can be of great help. A basic understanding of the situation of the other person is present and you do not have to justify yourself for your often diverse feelings: “No one shakes their head over heartache, it’s familiar to everyone.” The conversations often yield new approaches to one’s own situation and perspectives on the life ahead. AGUS sprang from this conception. The initiator Emmy Meixner-Wülker couldn’t imagine being the only victim of such a fate notwithstanding all the taboo and stigma, and she managed to put the issue of suicide on the social agenda through newspaper interviews, TV reports and lots of other activities. This made other sufferers aware that they are not alone in this fate and the first meeting as a support group was held in Bayreuth in 1989. There are currently more than 100 AGUS support groups in Germany, and counting. A list of these support groups is available on the AGUS website. You can enter your place of residence there to find out the AGUS support group closest to you.

The keynotes of the support group have remained unchanged to this day:

- Intercourse and mutual support within the group in a sheltered environ-ment
- Eligibility for participation is totally irrespective of religion and ideology.
- Participation is on a voluntary and non-binding basis, i.e. no one is obli-gated to show up for a certain number of meetings. A membership in AGUS is just as little required.
- The support groups are no substitute for medical or therapeutic care, but rather an essential complement.
- Everyone joins the group due to their own difficulties and everyone is in charge of themselves.

The participants of the support groups often meld their own experience with the experience and knowledge of others to develop a sufferer's competence, sometimes even a nontrivial expertise, which proves to be of great help to them in dealing with their own life situation. And they pass it on to others as well. People who have recently been bereaved by suicide find this extremely helpful. The motto: Take the good in und pass it on.

The feedback from a mother who lost her daughter to suicide was for instance such after visiting an AGUS weekend seminar for bereaved parents: „I was so guilt-ridden about my daughter taking her life. But when I heard other parents' stories in the round of introductions, who were just as guilt-ridden, I thought to myself, they're not to blame. And that put my view into perspective."

In a study by the University Medical Center Hamburg3 just over 3,000 people were asked what support groups mean to them personally. The most common answers were:

- I have the feeling I'm not alone (96%)
- I can talk openly about my problems (92%)
- I benefit from the experiences of others (90%)
- I learn to cope better with the situation (80 %)
- My participation is positive for the family / relationship (60%)
- I am less burdened by the situation (56%)

Self-help through support groups have social impacts, too. Indeed, the second major goal of AGUS is removing the taboo surrounding the issue of suicide and promoting the alleviation of prejudices against suicides and their bereaved relatives. In our view, every person actively engaged in self-help is contributing substantially not only to the solution of personal problems, but also to social integration and to social intercourse and involvement. They constitute thereby a fundamental pillar of civil engagement in Germany.

Support within the grief process

Among the goals that the German Association of Support Groups sets for support groups in general, the following can be transferred to grief:

- Open conversations about problems and challenges with your own grief
- Emotional support and confidence in difficult situations
- Boosting self-esteem and cohesion
- Relaying the "competence of the bereaved" from experienced members to the new ones
- Enabling the handling of grief better in everyday life
- Averting social isolation by meeting regularly with the group

These are enriched by the following points due to AGUS' many years of experience:

- Adjusting to the changed life situation
- Finding new perspectives on life
- Development of personal skills to deal with what has been experienced
- Ability to determine one's own general social standing and health situation, and improve these **(health promotion)**
- Avoiding secondary illnesses due to severe grief and maintaining the ability to work **(prevention)**

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[1] Bauer u.a. (2011): S. 78
[2] Hape Kerkeling (2014)
[3] Universitätsklinikum Hamburg-Eppendorf u.a. (2018): S. 6

About the author

Jörg Schmidt (born in 1981) studied in Bayreuth (B.A. in Cultural Studies, majoring Religion) and in Bamberg (M.A. in Adult Education). He is the Director of the AGUS e.V. Head Office in Bayreuth, Germany since 2017.

Grief after suicide

Chris Paul put it down into words in an article for the magazine Psychotherapie & Seelsorge (Eng. Psychotherapy & Pastoral Care) back in 2010: *„In the first instance, the focus of attention is on the grieving person with all their diverse feelings, thoughts and experiences. Next, our attention turns to the person who has died, with their whole life and their whole personality. The manner of death is only interesting in the third place.“*

Given the vast number of the bereaved, it is quite possible to come across one such person in all sorts of social contexts. At that point, it is important to be able to react, listen and speak to them, and stand them by. **For the bereaved the opportunity of resource-oriented and empathetic counseling lies in being able to find a healing path through the grieving process.** AGUS plays a big part there. Support groups, which are active throughout Germany, together with various seminars – like „Vertrauen wagen“ (Eng. restoring confidence) or hiking

weekends – are just a selection of the diverse range of support services.

I am not only a freelance grief counselor (within BVT, German Association of Grief Counseling), speaker and seminar facilitator, but also a bereaved person myself. This text was written against a background of my own grieving process and on the basis of my many years of work and experience as a grief counselor.

The implications for the bereaved

Death by suicide is not only unexpected and overwhelming like other sudden deaths, but also the most tabooed way of dying in our society. The manner of death of the suicide is still often not discussed openly among bereaved groups of people. A construct of lies makes the death seem like a mystery constantly. The manner of death then becomes a family secret that might as well endure over years and generations. The lack of communication stokes insecurity and a progressive loss of trust within the social system.

Even if there is open communication about it within the bereaved group, there often arise in minds horrible images associated with the actual suicide as to the suffering and presumed despair of the deceased, as to their pain and as to the appearance of the corpse, too. These horrible images remain unspoken – often due to the supposed protection of the other bereaved – and cannot be resolved. Conjectures of others stoke these horrible images.

The bereaved are usually accompanied over a long period of time by shame and, particularly, burdensome thoughts and feelings of guilt. Blame can be put on the bereaved from outside. Most of the bereaved are in search of moments inside themselves from which the supposed guilt could be derived anyway. The case is further aggravated by the way the authorities approach the bereaved: Criminal investigators turn up at their home, possibly treating them initially as witnesses, if not suspects. The body is seized for medical examination, causing naturally a lot of ambiguity and uncertainty among the bereaved in the first days. And then there’s the stimulated imagination of the neighborhood, col-

leagues and/or friends with all possible opinions and judgments. To top it all, the media permanently employs the term “self murder”, making it not easier to handle the apportioned blame.

The questions of „Why?“ and „What did I miss, at what point could I have acted differently to be able to prevent the suicide?“ are decisive for the bereaved upon a suicide in their close environment.

Also, when it comes to death by suicide, the focus is often more on the manner of death than on the loss of someone close. At the same time, the manner of death evokes fear and is extremely unsettling. The associated feelings are often more intense and longer lasting than after other (sudden) forms of death.

Counseling grieving people upon a suicide in their close environment

In counseling grieving people upon a case of suicide in their close environment, the primary concerns are perceiving the bereaved with their individual grieving process, recognizing in a resource-oriented manner the earlier strategies for dealing with the loss, and supporting people in their own stimuli positively.

The different aspects of the life and personality of the deceased are appreciated and put together for the purpose of perceiving the overall personality.

The actual suicidal act often plays a subordinate role in counseling, in spite of the obviously higher importance attached to it by the social environment (e.g. through probing questions as to the days before the suicide or as to how exactly it happened).

In grief counseling I am guided by a concept that encompasses a variety of tasks in the grieving process: In her “Kaleidoscope of Grief” Chris Paul emphasizes the simultaneous presence of all tasks of grieving, or, the way she puts

it down in her concept, all facets; there’s always a different facet is in the foreground of the grieving process. “Like in a kaleidoscope, all facets of the grief path are permanently present together – though they are not equally visible. They mix in a flexible manner to form ever new, mutually hindering or supporting structures.” (www.chrispaul.de/trauerkaleidoskop). In counseling grievers, it is particularly essential to me that the kaleidoscope of grief includes the approach of one’s own creative possibilities in the processing of the facets. It is therefore not about phases that are experienced, but rather about tasks that can be processed. The focus is on your own scope of action.

Surviving usually refers at first to existential aspects such as eating, breathing and sleeping – these are the vital things that must be ensured. Sometimes you just cannot afford more than that in the context of the grieving task of surviving. Functioning is often equated with survival, but in reality it goes beyond that and implies the necessity to take care of issues that are immediately at hand.

That could be children in need of care and attention. It could be for instance the communication with the criminal investigators or the organization of the

funeral with everything that goes with it. It is important for the bereaved to be stabilized by their counselors in this task and supported in all due duties. The bereaved usually feel completely powerless and at the mercy of the situation. This makes it all the more important to increase your awareness of your own options for action.

At the same time, grief counselors should deliberate on any wishes to follow the deceased into death and should definitely take heed of any possible statements by the bereaved in this direction and be watchful.

The news of my husband's death was brought to me by two young police officers on a hot May evening; one of them knew my husband personally. I was reading Pippi Longstocking to our daughters, who were five and seven years old at the time, as an evening ritual.

My first reaction that I can remember was: How are you supposed to live with that? I wasn't really surprised; All of a sudden, statements I hadn't really taken seriously became real and understandable. I couldn't doubt for a moment the truth of the news.

When the policemen went up to the apartment with me, I closed the bedroom door. I don't remember anything else in that regard. My daughters must have fallen asleep alone that evening –without knowing then why I didn't come back to them.

Luckily we were able to reach my parents, who came to me right away and truly stood by me and us during this difficult time.

But despite this support, I felt like I had to be strong – at first for the two officers, who were noticeably overwhelmed by the situation; and then of course for my children, for my parents, my mother-in-law. I took care of everything almost all by myself. I remember choosing cards and discussing the funeral with the undertaker who was appointed by the police. I found him terrible. I didn't know back then that I could have opted for another funeral home.

While I was searching for the gravesite, I burst into tears and that was certainly

a challenge for the cemetery workers there. I also clearly remember a detective recommending that my husband remains in my memory like I used to know him – and also the feeling that this can't be right. Nevertheless, I couldn't manage to admit this feeling and insist on bidding farewell to my husband or to inquire about the possibility of restoring the injured body or parts of the body.

I have no memories of a good many things from that time – When I once said to a good acquaintance years ago that I was so sorry I hadn't offered colleagues and distant friends a funeral repast (reception after the funeral with coffee and cake) and thus an opportunity to say goodbye, she said with surprise that they did attend a reception at my place indeed. The challenge, the urge to survive and function had simply impaired my perception and memory performance. The only thing that mattered was to somehow make it through another day and let the children have as carefree and "normal" an everyday life as possible.

When grief counselors speak about the necessity of grasping **death as reality**, what they refer to is that death by suicide often feels unreal at first. The taboo of suicide and the perceived stigmatization lead to an atmosphere of unreality. If a deceased person can no longer be viewed or touched, this can under certain circumstances increase the feeling of unreality. For this reason, it is essential that counselors provide information about what can be done after a death by suicide; e.g. that the deceased can actually be brought home and laid out there, or that you can opt for a funeral home that is able and willing to prepare the dead body in such a manner that at least parts of it can be viewed and possibly touched as well. This way, the bereaved can literally grasp that their loved one is dead and gone.

Also, the uncertainty about the final hours and the suicide process often leads to fantasies that are full of horror and violence. Fantasy images often replace the real images of the deceased and lead the bereaved into associating every memory of them with unbearable horror. Therefore, it can be helpful to use all available sources of information about the days before the suicide, the suicide itself and all subsequent actions (access to records, questioning of individuals

involved, conversations with other relatives and friends, conversations with the criminal investigators regarding confiscation, possibly autopsy, release, etc.).

If necessary, referral to pertinent specialist centers who are familiar with trauma-related disorders is recommended.

In counseling, it is crucial to continually offer respectful and forbearing support when decisions are being made and implemented. This could be the case, for example, in the immediate farewell to the deceased or the request to access to records or the release of personal belongings at the criminal investigation office. Every decision made by the grieving person deserves support, for it also leads them from powerlessness to awareness of their own options for action.

What remains of the unfulfilled farewell is that, even years later, there are (now rare) moments in which I think: "Who can tell whether he really lies in this grave? In the end I never saw him again." At the same time, I know that my husband is dead and was buried in the spot where I can still visit the grave today. And yet, a spark of unreality lingers.

I received no counseling back then; I didn't even know something like that was provided at all – apart from priests, to whom I felt quite distant at first. However, the funeral and the pastor's well-considered words brought me a little closer to the church and the community.

Not being able to talk about it was also difficult for me. Nobody asked me about it in kindergarten. The primary school teacher did actually come to the funeral, which I've given her credit for. There had been no guided conversations in the classroom and/or kindergarten back then, or at least not in the institutions my daughters attended.

Ten years after the suicide, I was ready and knew of the opportunities to contact the criminal investigation office. I had conversations with the victim protection officer, which I remember as very beneficial and even a little healing. They have shed some light on my husband's final moments.

And I was able to talk to him about the training of young detectives, for example: How are they prepared today to deliver news of death?

Unfortunately, so much time had passed that archived evidence could no longer be handed over to me. This is possible up to ten years after a death by applying to the public prosecutor's office through a lawyer.

The **variety of feelings** that the bereaved experience and endure keeps them doubting again and again that they can maintain their mental health. „I felt like I was going crazy", is a statement often made. The relief is often great when you can convey to the bereaved that the rapid change in intense feelings such as longing, grief, powerlessness, despair or love is appropriate to the occasion and is normal for this extraordinary situation. It is not the bereaved going crazy, but rather the safe and familiar world that they had known until then seems to have gone crazy due to the suicide.

The feeling of being abandoned is often at the forefront of the attention of the suicide bereaved. A loved one took their own life, leaving the bereaved alone with their pain. "Was our life together really genuine? Wherein might he/she has been deceiving and lying to me and us all this time? What can I actually believe about the past and what might this suicide call into question fundamentally?" The self-esteem and basic confidence in life are massively shaken by a suicide. Taking your life is perceived by the people in your life as the harshest form of rejection and separation, generating a profound feeling of abandonment among them.

Therefore, for counselors, honesty and reliability are crucial in their intercourse with the grievers; keeping agreements and absolutely avoiding any additional breach of trust in general. Treating the grieving person with respect definitely takes precedence over excessive care. It's always about the impulses that the bereaved person provides themselves, not about unsolicited advice.

I myself never had the feeling of being abandoned. I've believed all along that my husband died from the adversities of life. He came from a difficult family background, so he has never been able to develop any real sense of basic trust in life – at least not in the way I experienced it.

I think I understand how he came to this step. And yet there are so many people who have similarly difficult or more difficult life circumstances, but still manage

to make other decisions. Therefore the question of the actual why still remains unsolved.

Despite all the consideration and perhaps even understanding for his desperate decision, I still had feelings of longing, powerlessness and anger; and of not being able to grasp – especially when I look at our wonderful daughters. How could he deprive himself of sharing in their life? How could he expect them to live with such a life story? There will never be an answer to these questions for me.

It should be noted that the diverse emotional experiences may as well include anger and relief. These are among the taboo emotions in this context. “How can I be angry at my loved one who was obviously so desperate and hopeless that he/she could no longer see any other option than suicide?” These are cognitive considerations that are not necessarily reflected in emotional life. This is where anger emerges – perhaps again and again in the rest of one’s life: There are so many situations in which the deceased is missing, where you experience their loss once again painfully and possibly with anger.

Such is also the case with the feeling of relief. Many of the bereaved might have already been living a life between hope and fear prior to the suicide – in times of mental illness such as depression (possibly with past suicide announcements and/or attempts). What the bereaved possibly feel there is: “Finally, it is over. No more waiting all night long, no more consultations with the doctor, no more worrying about early discharges from closed psychiatric wards.”

It is not easy talking about these taboo feelings. You don’t want to burden other bereaved people any further than they already are. It is not any easier to open up to outsiders and talk about these emotions either. For most people, it is even difficult to perceive and accept these feelings in themselves at all.

Within the approach of accepting and resource-oriented grief counseling there is room for this; anger and relief are also accepted, discussed and experienced as appropriate feelings.

I am not angry with my husband, but I can understand when other people speak of anger and relief, too.

I myself am always annoyed every time I come across incidents in my own life where I miss him, where I wish he could be at my daughters’ side. Then, for a moment I don’t understand anything anymore again, and I’m sad and thinking “You idiot, how could you!?” Such was the case at the birth of our first grandchild and the wedding of our older daughter, as well as at the high school graduation and training qualification of my younger daughter. There are so many moments like this and there will be many more in my life and the lives of our daughters.

The search for why is the main focus for many bereaved people. A good many explanations are adduced: What crises were there in the life of the deceased? The suicide is seen as a victim of adverse circumstances, a victim of life crises. However, all the causes for a deep life crisis discovered cannot ultimately answer the question of why suicide was the only solution for this person. The search for answers often leads to accusations – against yourself or other people. One or more of the bereaved may just as well be blamed by people from outside (There must have been something wrong in this family). Guilt is often the issue upon a death by suicide.

In counseling, in the beginning it is important to hear the accusations and accept them. There is no rationality in the accusations and they cannot be explained away. Assertions like “You are not to blame because it was entirely someone else’s decision” do not help the bereaved. Usually, they feel misunderstood and are left all alone with their self-accusations, giving vent to them no more in the future. These thoughts can become all the more distressing and often lead to self-punishment in the form of massive reductions in one’s own quality of life. Examples of such inner convictions are: “I must no longer be cheerful, I must no longer feel myself easy.”

In grief counseling, developing an understanding of the functionality of blame can help relieve feelings of guilt.

A reality check might also help the bereaved get a different perspective on their supposed guilt. Questions like “Could you have acted differently at the crucial

moment?" and "Could you have known something better?" as well as "Did you act like you did intentionally, perfectly aware of the consequences?" often help people take a new look at the issue of guilt.

What also could help to free the bereaved a bit from thoughts of guilt is pointing out the possibility that the deceased might have wished that their thoughts and needs are not noticed by the bereaved, determined to do everything possible to protect these people.

Of course, I'm familiar with thoughts like: "What would have happened if I had called him that Tuesday afternoon?" or "Could I have understood the hints that I only understood in retrospect earlier, too?" Anyone who has had to experience a case of suicide in their close environment will be familiar with such thoughts.

Statements like: "I don't blame you either" may have been well-intentioned, but they immediately led to the perception that I was exactly the one to blame.

The fact that hardly anyone spoke to me or us about the suicide, and that as a result, the event seemed to remain unreal for us underpinned our own thoughts of guilt and, above all, our suspicions about what others might think about us, our life together and our families.

I too have blamed others and I still carry these thoughts with me to the present day. And that although I am aware that theoretically my husband could have found other options for action. Nobody is responsible for what happened. And yet probably everyone's heavily burdened with these thoughts all the time.

What weighs most heavily on me is probably the certainty that I have carried with me since we've met: I was his anchor. At the age of 17, I had the youthful conviction that I could and above all wanted to show this person that life could be good indeed; that I would be there for him. At the age of 36, I left him. Despite all that knowledge about suicide and grief after such a loss, I still catch myself thinking about this every now and then. The gaps have gotten longer, but even now, as I write these memories, I notice that it "gets" me emotionally.

I'm not suffering from these thoughts of guilt, I must emphasize that. But they

accompany me throughout my life, as do the longing, incomprehension, anger, love.

Adapting to a changed environment involves various aspects. First of all, it's a matter of your own understanding of your role. How do I define myself?

Another aspect is perception from outside. "How are other people experiencing me, how are they handling me? Are they bearing my grief and going along with it, or turning away and avoiding contact with me – because they're ashamed, or overwhelmed? Are they possibly blaming me for what happened?"

And a third aspect relates to one's own spirituality. For people who make much of spirituality, the question "Why did this happen?" is supplemented by "Why did God let this happen?". Whereas some people lose their faith over it, others find strength in faith. Margot Käßmann emphasized in her sermon in 2009 on the occasion of the funeral service for the footballer Robert Enke: "God walks with us in the darkest hours of our lives." And Hartmut Schott puts down in his autobiographical book "God watched my son commit suicide": "It is a knowing and expectant watch over a work of Creation that he sent out and is now coming home again, and He has the responsible task of providing the bereaved with everything they need."

I separated from my husband three years before his suicide. In my opinion, we had grown apart, each of us developing different convictions and perspectives on life.

It took many years before I could speak and write of him as "my husband" again. After all, it was I who ended the marriage; how could I still be his wife and he my husband? It took time, therapy and inner work to understand that even after the separation we had remained close and familiar with each other. We knew each other since we were 17. He took his life at the age of 39.

For a long time I've been able to say that I am widowed, that my husband took his life.

Spiritually I am socialized as a Catholic. However, as a family we lived far from church and faith. The suicide changed that; the pastor who buried my husband was open-minded and made it clear that the "church" today approaches people who have taken their lives differently than it did many years ago. This alleviated a major concern for my parents. My husband could be buried in the cemetery and not "dumped into a pit" outside.

The words the pastor found in the funeral mass revealed what had happened. I had told many people that it was an accidental death – apparently nobody who had experienced him in the last few years quite believed me. The sermon, the way he handled me and the family, and perhaps the fact that I was urgently looking for a secure footing for my children, brought me closer to the community again. For many years my daughters were active in children and youth work, were baptized and received communion. I could back all of their decisions.

Today each of us lives their faith differently, some more attached to the church, others more distant. I have the feeling, though, that all three of us have found stability through faith in divine guidance in life as well – each in her own way.

Another task in the grieving process concerns **remaining attached**. Grieving people still relate being given the advice to "let go" and "look forward", for "life goes on". These are advices resulting from the helplessness of the interlocutors who want to see the grievers as they were before the event, wishing them more easiness and less sadness. Such recommendations might also result from the social environment's need for less heaviness in everyday life and in contact with the grievers. In that regard, the bereaved are not only confronted with their own emotional world, but must also face the expectations of the people around them. Here it is important to counsel them delicately, in such a manner that they focus their attention on their own needs.

In grief counseling, the bereaved are supported in (re-)establishing their positive contact with the deceased. The memory of the shared life story, the peculiarities and character traits of the deceased are gradually given a broader scope again, so that the grievers can perhaps also recognize what sort of seeds, so to speak, the deceased person sow in their mind and what of it may flourish and grow in their future lives. In this way, an attachment to the complete

personality of the deceased remains or can be (re-)established – so it is not a matter of letting go, but rather of remaining attached.

I managed to find an inner attachment to my late husband early on. Maybe I have elevated him a little in my memory and attachment as well. Especially in the first years after his death, changes in things that he had constructed were not allowed or only allowed upon a great deal of persuasion by friends.

I do not exhibit such character traits as thoughtfulness and deliberation; but I can experience them as beneficial – for my daughters and other people as well. And I often remember how serenely and full of inner conviction my husband considered, decided and implemented what was to get done practically.

He could be spontaneous and cheerful at the same time – I clearly remember moments when we danced in the kitchen arm in arm and assured each other: "The team needs you!" We didn't feel alone, we had each other. We were there for one another for a long time.

Those are a few aspects and memories that attach me to him beyond his death – just as do the memories of unhappy days and arguments and ultimately the circumstances surrounding his suicide.

Just as the deceased should be conceived in their entirety, the life of the griever should also be observed in its entirety. Not focusing exclusively on the drastic experience of suicide is an aspect of the grieving task of pinning down. When you look back on your life later on, the incident can perhaps be re-embedded at some point. What is initially and often over a long period of time perceived merely as a catastrophe, might just as well lead to a new task over the course of your life, for example. The suicide can then take on a new meaning for the bereaved living on.

My husband's name is Ludger. His suicide has introduced me professionally to endeavors, which I was certainly always open to, but would probably not have devoted myself to the extent I do today. I was always open to and interested in life stories and as a teenager I was often told to be a good listener.

For a grief counselor, this is a skill of great value – listening between the lines, discerning unspoken thoughts and feelings as well.

I'm grateful to Ludger for the years we spent together. Every now and then I get sad, angry, hurt and full of incomprehension for a moment – but then in the next moment, the grateful memory of his joy of life and happiness, of his openness towards other people and of his easiness in approaching even perfect strangers prevails back again. I remember at times; it's as if this memory gives me a little push to embody more and more of his easiness and openness in my life.

Support opportunities through AGUS

Referring to AGUS support groups can be helpful for the suicide bereaved – the communication with bereaved others is beneficial and makes it clear that no one is alone in what they have experienced. The support groups feature trained executives who are invariably bereaved themselves, and a composition of participants, who are all grieving a loss through suicide, without exception.

The "Vertrauen wagen" (Eng. restoring confidence) seminars, that have been offered and conducted by AGUS with alternate speakers for over 20 years are characterized by the usually prompt mutual trust and instant opening up to each other. Here, too, the speakers are invariably bereaved by suicide in their close environment. A distinguishing characteristic of these weekend seminars is the homogeneous composition of the target group – there are services for parents, siblings, children and partners. What they have in common is the experience of loss through suicide.

Both opportunities are underpinned by the experience-based competence of the bereaved. The exchange of experiences and the individual handling of the loss through suicide is not only enriching but also motivational in the context of one's own grieving process.

Based on personal experience and professional practice as a grief counselor, at this point I would like to underline certain special aspects of coming to terms with a loss, depending on the pertinent family relationship. Children who have lost a parent or sibling to suicide experience different aspects in their grieving process than parents whose child has taken their life. People whose life partner has died by suicide experience the loss and grief in yet another way. Every loss must be viewed individually, and approached and handled uniquely depending on the relationship structure and the age of the bereaved.

In the AGUS publications series there are brochures relating to the respective loss that help the bereaved understand their grief better:

- Upon the loss of the life partner
- Upon the loss of an adult sibling
- Upon the loss of a child
- Upon the loss of a parent

Concluding remarks

Relationship work is the decisive requirement for a trusting atmosphere between the counselor and the griever – as in any other counseling situation. Only with a stable bond characterized by reliability, a safe environment and respect can the grieving person develop trust in the counselor and open up about their individual thoughts and feelings.

The most crucial requirement is that the counselor is aware of their own stance on suicide, so that this type of death does not come between the counselor and the griever. In order to prevent retraumatization, it is also helpful to have basic knowledge about traumas and their consequences, and access to a competent specialist (department) to refer the griever to as and when the need arises.

Successful grief work does not mean never feeling any sadness and longing again. The grieving process helps to continually find a new balance – between looking at the past, looking at life with the deceased, the grief over them, the questions surrounding their decision and an affirmative look at the present and future life of the bereaved. It's about a stabilizing balance.

About the author

Martina Kommescher-Dittloff, born in the Ruhr region in 1962. I am the mother of two adult daughters and the grandmother of two grandchildren.

In the year 2001, my husband, the father of my children took his life. In the first moment of shock, the question of how I, how we can continue to live with this was at the forefront of our minds.

Rendered powerless and yet impelled to take action, the first thing I did was to survive, look after our children, try to keep providing them with care and warmth – and at the same time I tried to understand what had happened to us.

A long path of grief lay ahead of me, which led me to completing my training as a grief counselor in 2011. Since then I have been active for AGUS as a seminar facilitator and author within the scope of the publication series. In addition to that, I work in individual and group settings as a freelance grief counselor, and am available as a speaker on grief topics; in all my activities, removing the taboo surrounding the topic of suicide is a matter close to my heart.

My daughters and I have learned to live with the loss of their father and my husband; we have evolved – each in her own unique way – and found our ways and means of dealing with this. From my personal experience and as a grief counselor, I often underscore: life will be good again, good in a different way.

AGUS e. V. – Support after suicide

AGUS stands for „Angehörige um Suizid (Eng. the suicide bereaved)“ and was founded as an association in Bayreuth in 1995. Five years before that, it was also there that the first meeting ever of a support group for the bereaved in Germany took place. The initiator was Emmy Meixner-Wülker, who lost her husband to suicide in 1963.

The suicide bereaved are provided with counseling and care opportunities at the AGUS Head Office as well as at the more than 100 support groups all over Germany. Likewise, the internet forum on the website as well as the Facebook grief group lets them exchange knowledge, experiences and opinions among themselves. There is a travelling exhibition on the themes of suicide and suicide grief, which has already been hosted by numerous cities in Germany. To supplement the support groups, AGUS offers weekend seminars for suicide grievers.

Further information is available at the website www.agus-selbsthilfe.de

Thematic brochures

The thematic brochures take up issues that engage the attention of the bereaved time and again. To date, the following brochures have come out and are obtainable from the AGUS Head Office:

1. Suizidtrauer bei Kindern und Jugendlichen angstfrei unterstützen (Chris Paul)
2. Erklärungsmodelle – die Zeit vor dem Suizid (Prof. Manfred Wolfersdorf)
3. Schuld – im Trauerprozess nach Suizid (Chris Paul)
4. Trauer nach Suizid (Martina Kommescher-Dittloff und Jörg Schmidt)
5. Suizid und Recht (Lutz Weiberle)
6. Zwischen klagend schrein und getröstet sein. Hilfe durch den Glauben in der Trauer nach einem Suizid (Dr. Andrea Schmolke)
7. AGUS-Selbsthilfegruppen aufbauen und leiten (Chris Paul)
8. Trauer braucht Zeit (Jörg Schmidt)
9. AGUS – wie alles begann (Emmy Meixner-Wülker, G. Lindner, E. Brockmann) – vergriffen
10. Frauen trauern – Männer arbeiten. Ein Klischee? (Dr. David Althaus)
11. Vergebung nach einem Suizid (Dr. Jens-Uwe Martens)
12. Von der Angst verlassen zu werden (Annette Félix)
13. Symbolhandlungen und Rituale für Hinterbliebene nach einem Suizid (Christian Randegger)
14. Mein Trauertagebuch (Renate Salzbrenner)
15. AGUS ist für mich... 25 Menschen für 25 Jahre AGUS
16. Unterstützungsangebote nach Suizid im beruflichen Umfeld (Dr. Fanciska Illes)
17. Wolle, Paul und Papas Stern (Marianne Loibl)
18. Nicht jede Trauer ist ein Trauma (Sybille Jatzko)
19. Resilienz in der Trauer nach Suizid (Dr. Jens-Uwe Martens)
20. Bis dass der Tod uns scheidet? (Martina Kommescher-Dittloff und andere)
21. Unzertrennlich? (Stefanie Leister und andere)
22. Die Liebe bleibt (Christiane Engelhardt und andere)
23. Suizid im schulischen Kontext (Ulrike Brunner, Gisela Faßbender, Jörg Schmidt, Cordula Tomberger)
24. Lebensthema (Cordula Tomberger, Dr. Nathalie Oexle)

It's like someone kicked my puzzle.
At the moment I can't find all the pieces,
and I don't know, whether I should sort by colors or edges.

Peter Engels
(a bereaved father)

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Obtainable from AGUS e.V.
Telephone: 0921/1500380
E-Mail: kontakt@agus-selbsthilfe.de
Internet: www.agus-selbsthilfe.de