

The aftermath of adolescent suicide : Clinical, Ethical and Spiritual Issues

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Mary, a 19 year old college student first consulted the Adolescent Medicine specialist when she was 15 years old for bulimia, depressed mood and cutting. Her primary physician felt overwhelmed by this and so the Adolescent Medicine consultant became her doctor. As years went by in spite of the efforts of an interdisciplinary team her depression worsened , she had two suicide attempts (overdose) , followed by two psychiatric hospitalizations . In spite of all this she was a good student and was accepted into a prestigious nearby college. Unexpectedly one morning, while visiting her parents during spring break, she committed suicide by bag asphyxiation . This coincided with her therapists vacation. Her psychiatrist had recently changed her from an SSRI to a different kind of antidepressant. By a twist of fate she had an appointment to see him on the afternoon of the day that would be her last. The adolescent medicine physician that had been taking care of her learned about it from the father. What can, what ought he to do next ?

INTRODUCTION

Suicide is an important contributor to the death rate, specially among young people and the elderly. Gender, culture and ethnic origin determine a distinct epidemiological pattern. Data from WHO show that in the year 2000 one million people committed suicide. (1) It has been estimated that at present 3000 persons every day kill themselves, which means one every 30 seconds. In the United States suicide is the second cause of death in adolescence, preceded only by accidents . During the course of our lifetime 85% of us will lose to suicide someone we care about. That means that there are millions of survivors that are trying to cope with this loss (2).

The goal for this chapter is to share with professionals how to:

- **be prepared for the aftermath of an adolescent's suicide**
- **help others when one is also in need to help oneself**

The objectives are to :

- **Analyze how death by suicide differs from all other experiences with death**
- **Recognize the magnitude of suicide survivors grief .**
- **Make recommendations to the health care team to prevent pathological grief and burnout**

This will be approached systematically by reviewing:

- Conceptualization of suicide
- A typology of suicide
- Physician's attitudes towards suicide,
- The aftermath of suicide (focusing on the suicide grievers)
- The impact of suicide on clinicians
- Research data
- The role of spirituality

- An outline of therapeutic interventions

We will conclude with the denouement of the vignette presented above.

Conceptualization of Suicide.

Research on suicide has embraced two conceptualizations, one looking at the individual as the object of analysis, the other looking at general data, such as for instance the suicide rate in cities, communities and countries.

The studies based on individual characteristics take into consideration personality types, attitudes, social functioning and physical and mental health. Those who utilize aggregates focus on sociological variables. This was already studied by Durkheim in the XIX century, when he stated that each society has its own social nature and hence its own aptitude for suicide. (3) Traditionally in the first view suicide is considered the domain of psychiatry. The second view, without diminishing the importance of mental health, concentrates on the ecology of suicide, thus recognizing that there are a multitude of contributing elements. (4) . Both views are not necessarily mutually incompatible and may eventually be integrated. Though this article is centered on the aftermath of suicide, the process culminating in the act of suicide needs to be considered in dealing with its aftermath effects on family and the social environment in which the adolescent lived.

Typology of suicide

A typology has been proposed intending to define the role of the involved clinician (5) . This classification distinguishes:

1. Unassisted suicide
2. Facilitated suicide
3. Assisted suicide

The **unassisted suicide** represents an action, that may take two forms. The first is when the victim completes suicide while not currently or recently in the care of a clinician. The second is when the victim was currently under care but not for a condition associated with suicidality.

The **facilitated suicide** is an involuntary event. It applies to when the victim completes suicide while currently or recently in the care of a clinician and where the following factors were present:

- A clinical or custodial relationship existed
- The clinician or provider had knowledge of the risk
- Means of prevention or intervention may have been available

This is the most devastating experience a professional may have in a lifetime and will be carefully addressed in this chapter.

The **assisted suicide**, is a voluntary event, where a clinician, with knowledge of the individual's wishes and consent, enables suicide completion by providing the lethal means and guidance to use. Assisted suicide is outside the scope of this paper.

Physician's attitudes towards suicide

Since their very early professional training doctors are taught that their mission is to help patients get well. Most professionals are not well prepared for the most radical rejection of their services implicitly or explicitly posed by suicide. This may be enhanced by the discrepancy between what the suicide was probably thinking and feeling at the time of his action, and how the members of the health professions normally think and act. (Or perhaps not entirely: every year the number of physicians that commit suicide is equivalent to a medical school class) . This leads to the post suicide emergence of ambivalent, critical and/or contradictory feelings that, by the way, family , close friends, and the (formerly) treating professionals may share. Certainly all those involved also bring their own subjective experience, their culture and tradition to bear on the experience.

When an adolescent suicide takes place, the patient being dead, an awkward situation arises that is different from what is part of the doctors everyday professional life. This usually involves working on prevention and treatment. on the handling of biologic and socio-psychological pathologies. Suicide often renders the physician impotent and confused. Nevertheless clinicians intuition is that most suicides follow a “process” and do not come out of the blue, even though the adolescent may never have shared *her* suicidal ideation . It is precisely the suspicion that this may be the case, that makes everybody feel so guilty. Feelings though are not necessarily markers for reality, and the more experienced health care workers understand that there is clearly a stretch between reflecting on what may have happened and considering that all those surrounding the suicide where guilty of *her* action

The aftermath of suicide.

There are some extraordinary issues involved in adolescent suicide. While loss and death are universal causes of grief, the death of an adolescent, the loss of future is an added cause of grief. Moreover death by suicide is a horrific death , which potentiates grief even more. Thus the survivors left behind can suffer extreme forms of grief including a sense of disbelief regarding the death, anger and bitterness over this death, intense yearnings for the deceased with *pangs* of painful emotions, preoccupations with thoughts about the loved one, avoidant behaviors (not cleaning out the room). More ominously it may lead to serious health problems such as alcoholism and even “reencounter suicide”. “ Suicide carries in its aftermath a level of confusion and devastation that is...beyond description” (6). The event shocks those that are close and rather similar emotional responses can be noticed, though the way in which they may be expressed may vary. A tumultuous number of ideas and feelings arise one after the other and intermix, such as fury, anger, depression, guilt, failure, disappointment, shame and hopelessness

It is true that death by itself has a tremendous impact on its witnesses. All human beings, starting around the age of four years old, acquire some understanding of death and rationally develop their consciousness about the end of life. Nevertheless it is very difficult to fully accept the fact of ones own personal death and be truly prepared for death. For most of us our primary survival instinct is present even at advanced stages of illness. Suicide is a different way of dying. . This is phenomenologically quite different

from the experience of losing somebody to an illness, as hard as that may be . Next we will address what happens to those left behind in the weeks and months following an adolescent suicide. **It is important to notice that the treating physician is also at risk.**

The suicide griever:

The definition for a suicide griever is an individual who has lost someone he/she cared for deeply to suicide. The victim may have been a parent, child, spouse, sibling, other relative, partner or friend. It is estimated that every suicide leaves 6-8 “survivors”. The 31000 reported suicides in the US annually cause 180000-250000 men, women, adolescents and children to become suicide griever every year. There may be up to 4 million grievers in the nation. Suicide , by its very nature, leaves in its wake a tremendous sense of confusion and displacement for those left behind .

The grief that suicide causes is intense and prolonged. In the National Strategy for Suicide Prevention this is poignantly described: “...*those who lose someone close as the result of suicide, experience an emotional trauma that may take leave, but never departs.*” (2) To make matters worse suicide is still stigmatized, this may result in suicide griever withdrawing from seeking support. Suicide griever may feel responsible for their loss. Those who witness the suicide or find the body may suffer post traumatic stress. Between the suicide griever the risk of suicide ranges from 1.5 to 5 times higher than the general population! Indeed one in four suicide attempters has a family history of suicide. Suicide griever who have consanguineous relationship to the victim may share neurobiological features that may increase that risk.(2)

The parents:

The American Foundation for Suicide Prevention in the resource and healing guide about the suicide loss (7) (www.afsp.org) stresses that suicide bereavement manifests through three broad areas of grief response:

- 1).- Survivors seem to struggle with questions of meaning-making around the death (“Why did they do it?”). They try to make sense of the motives and frame of mind of the deceased.
- 2).- Survivors show higher levels of guilt feelings, blame, and responsibility for the death than do other mourners (“Why didn’t I prevent it?”). Occasionally survivors feel that they directly cause the death through mistreatment or abandonment of the deceased. More frequently, they blame themselves for not anticipating and preventing the actual act of suicide.
- 3) Survivors also experience heightened feelings of rejection or abandonment by the loved one, along with anger toward the deceased (“How could they do this to me?”,) (6) They grieve for the very person that has taken their loved ones life.

After their son’s or daughter’s suicide some parents admitted thinking about committing suicide themselves, but they decided not to because they were all too familiar with the consequences for the bereaved. Nevertheless, caution is justified in the aftermath of suicide. The rate of suicide in families of suicide victims is twice as high as in families of comparison subjects, and a family history of suicide is a significant risk factor independent of severe mental disorder. (8)

The siblings:

While it is true that in general there is little support available to parents after their child's suicide, there is even less support for the younger or older siblings. Silence about the death and even hiding its cause may be the case for the very young brothers or sisters. Few adults, professionals or others have succeeded with involving children in sharing thoughts about the loss. (9) The "good bye letters" rarely clarify the deep motivations that led to suicide and are seldom helpful to the siblings, even though they declare love and ask for forgiveness or attempt an explanation: "I can't go on living like this". Some letters yielded instructions to pass on personal belongings to siblings, an uncomfortable inheritance for many of these. (10)

We must be aware that children express their feelings differently from adults, perhaps they want to play with their friends as usual or may appear to be unaffected; they must know that they don't have to feel sad all the time. Children express much of their grief through their behavior, rather than by words: they may become clingy, irritable, have problems concentrating, and play games involving death and violence. Many times they worry that someone else they love might die.

Often a question that arises for parents is "what should I tell my children about the suicide?". Many parents have had little experience talking with children about death, let alone suicide, and are worried about how their children will react and how the news will affect their child in the long term. The Children Bereaved by Suicide Project in South Western Sydney advises: "explain death as being when the body stops working, ask the child what they understand about what "being dead" means, It is not helpful to say that a person has gone away or there are just sleeping, one way to define suicide is to describe it as: "when someone makes their body stop working", because many times the word suicide is confusing so you must check out what they have understood. (11)

Most children experience difficulties that are not predominantly individual, but rather relational and social in nature, and largely contextually dependant.

The peers:

Consideration has been given to the "contagion effect" of suicide, particularly among teenagers and young adults. School-based strategies, peer helper programs and postvention (suicide prevention activities, such as crisis debriefing interventions, aimed at youth recently exposed to suicide) are strategies that are not supported by sufficient evidence to substantiate their widespread or unqualified use. (12) (13). Unfortunately the same is true about suicide awareness curricula used as part of school based suicide prevention strategies.

The physician and the medical team:

The theme of death and thinking about death has only recently made its way into Medical Schools and therefore many professionals' understanding of death is "self-made" as they progress throughout their professional life. This consists of "dying a little" with every patient that died under their care, a needed apprenticeship to endure the anxiety, the guilt and the sensation of failure, that such death can generate. However when death is not processed and becomes overwhelming it can lead to burnout, evasion from

responsibility, frustration, death anxiety, leading the professional to attend only his own needs rather than those of his patients. Indeed denial, distancing, mood changes are all defense mechanisms to ward off the anxiety and sadness evoked by the dying patient. (9).

Hence, paradoxically, aiming to incorporate death into one's own life results in an enriching experience that opens up the life of the physician. It is the knowledge that we have some time to live and that it is limited, thus we'll continue our doctoring confronting death calmly because we can admit that one day our own life will come to an end. Only that way can we really help our dying patients. (14)

The apperception however can be turned over by the adolescent who ends his own life. To the usual distress caused by death a completely different kind of suffering is added.. The suicide of a patient can be extremely distressing for front-line professionals. The exposure to such situations can undermine a professional's functioning and generate feelings of incompetence, cause them to question their professional standing and ultimately contributing further to burnout. Concerns for the bereaved family, feelings of responsibility for the death and having had a close therapeutic relationship with the deceased adolescent are key factors that influence the adjustment and coping of health professionals in the aftermath of the death of a client by suicide. (15)

The WHO has produced a manual on suicide prevention that includes advice for clinicians in the aftermath of suicide, recognizing that the professionals involved may themselves experience reactions such as anger, resentment, sadness and even post traumatic stress, strongly recommending the need for peer support. (16)

The impact of suicide attempts or completion on the medical team may vary, but it is worrisome that many health professionals are not adequately trained to provide proper assessment, treatment and management of suicidal patients, nor do they know how to refer clients properly for specialized assessment and treatment. Despite the increased awareness of suicide as a major public health problem, gaps remain in training programs for health professionals and others who often come into contact with adolescents in need of appropriate assessment techniques and treatment approaches. In addition, many health professionals also lack training in the recognition of risk factors often found in grieving family members of loved ones who have died by suicide (the suicide survivors).

Research

Long term studies and research about family reactions in the aftermath of suicide are lacking and clearly not easy to do. Approaching families and recruiting a large "n" is understandably quite difficult. Because of this, the data obtained are more qualitative than quantitative. A landmark Swedish study, two years after the adolescent's suicide had happened demonstrated the most important theme was still the search for the "why?". Almost all parents expressed anger at being deceived, and a deception that they had been denied the opportunity to provide parental support. Simultaneously, they felt remorse for being angry with someone who obviously had been so lonesome and desperate. Some relief was expressed by families that had been living with a troubled and difficult adolescent. This sense of relief was not easily admitted to.

The essential finding was that although a long time had passed since the suicide (2 years), the families were still struggling to move on, and those who had lost their only child appeared to have the greatest difficulty. Even though all of them had returned to the

routine activities of daily life, almost all the parents thought it impossible to ever return to “normality”. None had experienced one full day without thinking of the deceased. (9) There is still scant research on “the forgotten bereaved”; the children and adolescents who lose a sibling by suicide and are suffering from posttraumatic and grief reactions, depression and anxiety. (8)

The recent development of research addressing Post Traumatic Stress Disorder (PTSD) may be applicable to suicide griever. Engineers that had been involved in striking suicides that threw themselves under the train suffering from flashbacks and nightmares sustained a dramatic improvement of their symptomatology through Eye Movement Desensitization and Reprocessing(EMDR) (17) This is a form of psychotherapy that was developed to resolve symptoms resulting from disturbing and unresolved life experiences, using a structured approach to address past, present and future aspects of disturbing memories (18) (19). A 2007 meta-analysis of 38 randomized controlled trials for PTSD treatment suggested that the first-line psychological treatment for PTSD should be Trauma-Focused Cognitive Behavioral Therapy or EMDR. (20)

Spirituality in the aftermath of suicide

Suicide survivors often look for answers to the existential questions they are forced to explore within the framework of their traditions, their belief and their philosophy of life. Spirituality may be awakened or deadened during this process. The term spirituality comes from the Latin word “ spiritus” : the breath of life. It entails a way of being, of experiencing and acting that stems from the understanding of a transcendental dimension characterized by *values* that apply to oneself, others , nature and life itself. It may or may not include a Supreme Being, but it includes the perception that there is a transcendence, a sacredness to life that influences feelings , life goals and that nourishes the capacity to surmount life’s difficulties. Religion can be a particular case of spirituality, and it is characterized by being engaged in a particular faith, which implies a narrative, rituals, common activities, destined to communicate persons with the Deity.

There are as yet no longitudinal studies about the impact of the spiritual and religious on the grieving process in the aftermath of suicide Nevertheless there is currently a clear understanding that values and spirituality can be one of the pillars on which resiliency can get established. Resiliency eventually raises to the challenge posed by the suicide of a loved one and sometimes the survivor may emerge stronger than before. While adversity, physical or psychosocial , can annihilate a human being or can induce resistance and strength.

Resiliency can manifest in many ways and it emerges sometimes where least expected . it is like a vital energy , reminiscent of Henri Bergson’s “ Elan Vital”. From a spiritual perspective this constitutes the *vital center* of every human being and spirituality is about harnessing this energy to face adversity. (21)

Therapeutic interventions

Most of the acute symptomatology seen in suicide survivors in the aftermath of suicide diminish and disappear over time. However this may not be the case with the psychological distress. (22)To alleviate this every suicide griever needs immediate

support at the time of the loss. This is known as **postvention**. This may include facilitating the above mentioned spiritual endeavor. It may involve psychological interventions. EMDR falls under this category, as it may alleviate nightmares and flashbacks. (However it needs to be emphasized that this treatment is contraindicated for those individuals that are becoming suicidal.)

Another treatment approach can be done through groups. The New York State Office of Mental Health gives four reasons that support groups may be effective:

Normalization: One of the most significant and helpful realizations for a survivor of a suicide to have is that, given the situation, his feelings are normal,. In a group setting, it is reassuring to hear that others share their fears and their losses, and that it is not pathological to feel this way.

Understanding: This begins when the person starts to open up. By telling his/her story by verbalizing it – they can begin a process of organizing thoughts and feelings. This may be the first step in processing the “whys”, “what ifs”, and “why didn’t I?”

Monitoring: The third benefit is monitoring suicide risk. Given the link between the suicide of a family member and the increased risk for other family members, this is a critical benefit. Peer support groups may simultaneously provide healthy role models for grieving survivors while increasing social support.

Finally making sense of the suicide of a loved one is an emotional journey. Support groups provide educational resources to help educate survivors regarding the nature of suicide and suicide bereavement. Coming together to share and interact with other survivors may be their first step in the long journey towards healing. (23). For the members of a medical team that lost an adolescent patient to suicide there is nothing worse than silence,

Denouement

Mary’s suicide was devastating to her elderly parents, whose older son had long left home. They constantly repeated that if they would have returned home sooner from their shopping they would have found her, been able to remove the plastic bag from her head and save her. The experienced psychiatrist who had recently changed her medication was naturally very distraught and the therapist on vacation immediately responded to the Adolescent Medicine physician’s call, who then proceeded to invite the family to join the three members of the interdisciplinary team and they accepted gratefully. All together reflected about the vicissitudes in the young woman’s difficult life. We realized that we all had become, to different degrees, suicide survivors. The professionals then modeled for the parents, each in his own way, their sorrow, their disappointment, their angry frustration, their caring, their second guessing and their mourning for the young woman. The clinician asked the parents if it would be all right for him to call them to see how they were doing, and specially offered to see their adult son if he came back to town. (A few calls were exchanged). An important aspect in dealing with this tragedy was the exchange of thoughts between the team members and the ongoing support for each other. Neither this young woman, nor the team members’ compassionate effort of mutual support, will be forgotten as long as they live.

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