

The Aftermath of Adolescent Suicide: Clinical, Ethical, and Spiritual Issues

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Suicide is an important contributor to the death rate, especially among young people and the elderly. Gender, culture, and ethnic origin determine a distinct epidemiological pattern. Data from the World Health Organization (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 1 every 30 seconds. In the United States suicide is the second leading cause of death in adolescence, preceded only by accidents. During the course of our lifetime 85% of us will lose someone we care about to suicide. That means that there are millions of survivors that are trying to cope with this loss.²

INTRODUCTION

The goal for this article 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

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The objectives are approached systematically by reviewing:

- Conceptualization of suicide
- A typology of suicide
- Physicians' attitudes toward suicide
- The aftermath of suicide (focusing on the suicide griever)
- The impact of suicide on clinicians
- Research data
- The role of spirituality
- An outline of therapeutic interventions

We conclude with the dénouement of the case presented at the beginning of the article.

Case: 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, 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 attempted suicides by 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 therapist's 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 who had been taking care of her learned about Mary's suicide from the father. What can and what ought he to do next?

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 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 that utilize aggregates focus on sociological variables. Durkheim³ studied sociological variables in the 19th Century, when he stated that each society has its own social nature and hence its own aptitude for suicide. 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 is a multitude of contributing elements.⁴ Both views are not necessarily mutually incompatible and may eventually be integrated. Although this article is centered on the aftermath of suicide, the pro-

cess culminating in the act of suicide needs to be considered in dealing with the effects on family and the social environment in which the adolescent lived.

TPOLOGY 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 the care of a clinician but not for a condition associated with suicidality.

The facilitated suicide is an involuntary event. It applies 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 is carefully addressed in this article.

The assisted suicide is a voluntary event, when 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.

PHYSICIANS' ATTITUDES TOWARD 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 that is implied by suicide. This may be enhanced by the discrepancy between what the individual was probably thinking and feeling at the time of his or her 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 the size of a medical school class). This leads to the postsuicide emergence of ambivalent, critical, and/or contradictory feelings that family, close friends, and the (formerly) treating professionals may share. Certainly all those involved also bring their own subjective experience, culture, and tradition to bear on the experience.

When an adolescent suicide takes place, an awkward situation arises that is different from what is part of the doctor's everyday professional life of treating patients. This usually involves working on prevention and treatment of biological and sociopsychological pathologies. Suicide is different: it often renders the physician impotent and confused. Nevertheless the clinician's 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 causes feelings of guilt that something could have been done to prevent the suicide. 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 responsibility for the actions of the suicide victim.

THE AFTERMATH OF SUICIDE

"Suicide carries in its aftermath a level of confusion and devastation that is . . . beyond description."⁶ The event shocks those that are close to the suicide victim, and similar emotional responses can be noticed among the grieving, although 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

There are some extraordinary issues involved in adolescent suicide. Although loss and death are universal causes of grief, the death of an adolescent and the loss of that 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, intense yearnings for the deceased, with pangs of painful emotions, preoccupations with thoughts about the loved one, and avoidant behaviors (eg, not cleaning out the room of the deceased). More ominously it may lead to serious health problems such as alcoholism and even "re-encounter suicide."

It is true that death by itself has a tremendous impact on its witnesses. All human beings, starting around the age of 4 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 one's 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 address in more detail 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 GRIEVERS

The definition of a *suicide griever* is an individual who has lost to suicide someone he/she cared for deeply. The victim may be a parent, child, spouse, sibling, other relative, partner, or friend. It is estimated that every suicide leaves 6 to 8 “survivors.” The 31,000 reported suicides in the US annually cause 180,000 to 250,000 men, women, adolescents, and children to become suicide griever every year. There may be up to 4 million griever 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, which 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 1 in 4 suicide attempters has a family history of suicide. Moreover, suicide griever who have consanguineous relationship to the victim may share neurobiological features that may increase that risk.²

The Parents

The resource and healing guide of The American Foundation for Suicide Prevention (www.afsp.org)⁷ stresses that suicide bereavement manifests in 3 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 caused 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. The best way of understanding this is by considering that in German the word for suicide is “selbst-mord,” meaning the murdering of the self.

After their son's or daughter's suicide some parents have indeed 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

Although 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 Suicide notes 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 such as, "I can't go on living like this." Some letters yield instructions to pass on personal belongings to siblings, an uncomfortable inheritance for many.¹⁰

We must be aware that children express their feelings differently from adults, and perhaps they may want to play with their friends as usual or may appear to be unaffected; they must know (be told) 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.

A question that often 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 Sydney, Australia, 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 they 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 dependent.

The Peers

Consideration has been given to the "contagion effect" of suicide, particularly among teenagers and young adults. School-based strategies, peer helper pro-

grams, and “postvention” (ie, 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.

Parents and loving adults giving emotional support are still the mainstay of protection.

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 for 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. An apprenticeship is needed to learn how to endure the anxiety, 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, and death anxiety, leading the professional to attend mostly to his own needs rather than those of his patients. Indeed denial, distancing, and mood changes can all be defense mechanisms to ward of the anxiety and sadness evoked by the death of a patient.⁹

Hence, paradoxically, aiming to incorporating death into one’s life results in an enriching experience that opens up the life of the physician. The knowledge and acceptance of one’s mortality allows the physician to continue to carry out his or her professional duties as a physician while confronting the death of his or her patients. Only that way can we really help our dying patients.¹⁴

However, the applecart can be turned over by the adolescent who ends his own life. A completely different kind of suffering is added to the usual distress caused by death. The suicide of a patient can be extremely distressing for frontline 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 a health professional in the aftermath of the death of a patient by suicide.¹⁵

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 patients properly for specialized assessment and treatment. Despite the increased awareness of suicide as a major public health prob-

lem, 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).

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

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 sample is understandably quite difficult. Because of this, the data obtained are more qualitative than quantitative. A landmark Swedish study, performed 2 years after the suicide of an adolescent, demonstrated the most important theme was still the search for the a reason why the adolescent had committed suicide. Almost all parents expressed anger at being deceived and 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.

The essential finding was that although 2 years had passed since the suicide, 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 post-traumatic and grief reactions, depression, and anxiety.⁸

The recent development of research addressing post-traumatic stress disorder (PTSD) may be applicable to suicide griever. Train conductors who have experienced striking individuals attempting to commit suicide by jumping in front of a train who suffer 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 dis-

turbing memories.^{18,19} A 2007 meta-analysis of 38 randomized controlled trials for PTSD treatment suggested that the firstline 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, beliefs, and 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 and 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 transcendence and a sacredness to life that influences feelings and 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, and common activities that connects persons with a deity.

There are as yet no longitudinal studies about the impact of spirituality and religion 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 be established. Resiliency eventually raises to the challenge posed by the suicide of a loved one and sometimes the survivor may emerge stronger than before. 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 *élan 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 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 previously 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 his or her fears and losses, and that it is not pathological to feel this way.

Understanding: This begins when the survivor starts to open up. By telling his/her story and 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 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.

DÉNOUEMENT

Mary’s suicide was devastating to her elderly parents, whose older son had long left home. They constantly repeated that if they had 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 3 members of the interdisciplinary team, and they accepted gratefully. All together, they reflected about the vicissitudes in the young woman’s difficult life. They realized that they had become, to different degrees, suicide survivors. The professionals then modeled for the parents, each in his own way, their sorrow, disappointment, angry frustration, caring, second guessing, and 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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