

# **SUICIDE: A CRISIS FOR THE WHOLE FAMILY; SHOULD SUICIDE SURVIVORS BE MANAGED DIFFERENTLY?**

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IN AUSTRALIA, OVER 2,000 PEOPLE WILL DIE FROM SUICIDE THIS YEAR ALONE. This figure is no doubt an underestimation of the reality. Whilst this is a tragedy in itself, the suicide survivors are far greater in number and could easily be estimated at over 10,000.

Indeed, it is known that over the last thirty years or so this country has seen a major increase in the number of suicides in those aged between 16 to 24. This shift represents a significant change in the profile of the surviving family (Baume 1988). It can, therefore, be assumed that in 1990 more parents will be burdened with this tragedy than was the case only a few years ago. Parents, however, are not the only ones who will feel the pain and guilt associated with the loss. Siblings, extended family members, as well as friends are also involved.

Whilst this paper is not about statistics, the numbers mentioned are an unhappy reminder of the tragedy Australia experiences each year and will continue to experience in the future. This paper focuses on the quality of life of survivors of suicide. It examines previous empirical reports and case studies and develops a framework for the management of those survivors.

The amount of research and literature on the subject of suicide is a testimony of a major effort by those interested in this field, to discover, give meaning to, predict and prevent self-destructive behaviours. It is apparent, however, that the focus has tended to be towards those who commit suicide rather than those who remain behind.

## Survivors of Suicide

Shneidman (1971) called those who remain behind, the survivors—and stressed that whilst suicide is one of the leading public health problems today, neither the prevention of suicide nor the management of those who attempt poses the major concern. Rather, it is the alleviation of the effects on the survivors whose lives are forever altered that should be considered.

When a suicide occurs, it is almost always the occasion of a crisis for survivors; children, spouse, parents, other relatives, friends, crisis counsellor, therapist, health professional or anyone closely associated with the person. The usual feelings associated with any serious loss are felt by most survivors of a suicide: sadness that the person ended life so tragically, and anger that the person is no longer a part of one's life.

The literature on this subject has been on the increase; whilst the majority of studies have discussed individual reactions to suicide, the impact of suicide on family system dynamics has been increasingly recognised as an essential factor mediating the crisis experienced by the bereaved individual (Calhoun, Selby & Selby 1982; Hajal 1977; Raphael 1983; Richman 1986). However, the few studies that have specifically examined the impact of suicide on family functioning have yielded conflicting results. Until recently, the majority of reports have suggested that the experience of a suicide survivor is an especially severe form of bereavement, and that the surviving family members are the most directly implicated in the aftermath of suicidal death.

These studies have indicated that consequences of suicidal death included many unique aspects, such as search for explanation, feeling of guilt, responsibility, shame, stigmatisation, and rejection, loss of social support, and self-destructive behaviour (Calhoun et al. 1982).

Barrett & Scott (1990) argue that many of these reports have been based, in part, on clinical observation, intellectual conjecture and theoretical speculation. Empirical attempts to compare suicide survivorship with other types of bereavement include studies by Sheskin & Wallace (1967); Cain (1972); Flesch (1977); Saunders (1981); Demi (1984).

Calhoun et al. (1982) and McNiel et al. (1988) have criticised the few existing empirical studies on a number of grounds. For example, authors have compared survivors of suicide with other populations in a post-hoc manner. The retrospective nature of the investigations, the lack of control groups, the use of specialised and non-standardised instruments, and the lack of operational definitions for the measured reactions and the limited size of samples have also been seen to be problematic in reducing the possibility of generalisation.

The survivors of suicide often experience much guilt and anxiety that may result from two main sources:

- the sense of responsibility that somehow one should have prevented the suicide. This is especially true when the survivors were very close to the person;
- the sense of relief that some survivors feel after a suicide. This happens when relationships were very strained or when the person attempted suicide many times and either could not or would not use available help (Hoff 1989).

A common tendency among survivors of suicide is to blame or scapegoat someone for the suicide. This reaction often arises from a survivor's sense of helplessness and guilt about not preventing the suicide. Deeply held beliefs about suicide also contribute to this response. Some survivors deny that the suicide ever took place. This seems to be the only way they can handle the crisis. Often, this takes the form of insisting that the death was an accident.

*For Example:*

A mother and father instructed their twelve-year-old daughter, who was a patient in the children's ward of a large public hospital, to tell the charge nurse that her older brother Tim had died in a car accident. The charge nurse of the ward happened to know that the family had been involved with the psychiatric unit of the hospital the previous year. At that time, the parents had insisted that Tim be discharged from the ward as soon as possible, even though he was highly suicidal and the psychiatrist in charge of the case had advised them against it. A week after his discharge Tim shot himself with his uncle's hunting rifle!

This case identifies clearly the denial which was taking place and the length to which the parents were going to hide what had actually happened.

*Reactions to suicide*

Barrett & Scott (1990) identified four types of reactions which suicide survivors experience.

- Grief reactions that are the normal result of losing a family member, including somatic symptoms, hopelessness, anger, guilt, loss of social support, and self-destructive behaviour which supports the Calhoun et al. study (1982).
- In addition, reactions that resulted from experiencing a death other than by natural causes and perceived as having been avoidable, including feeling stigmatised and shamed by the death, feeling abandoned by the spouse, and perceiving the death as preventable.
- A third type of reaction included grief reactions that resulted from the shock and pain of experiencing a sudden death, regardless of its cause, including searching for an acceptable explanation for the death.
- Finally, the fourth type of reaction seems to have resulted from additional trauma of dealing with the suicidal nature of the death, including feeling rejected by the deceased, feeling embarrassment over the mode of the death, wondering about the spouse's motivation for not living longer, feeling as if the deceased were somehow getting even with the survivor by dying, and concealing the mode of death by saying that it was something other than what it was.

This report supports studies by Cain (1972) and others that have documented many problems that can occur throughout survivors' lives if they do not have help at the time of the crisis of suicide.

Survivors consistently experience more grief reactions than other survivors, depression, serious personality disturbances, and obsession with suicide as the predestined fate for oneself, especially on the anniversary of the suicide or when the person reaches the same age (Hoff 1989).

Barrett & Scott (1990) highlight, however, that the course and quality of recovery from grief does not seem different from those of other survivors. They further argued that grief was not solely determined either by type of death experienced or by grief reactions occasioned by the death and that other factors besides the mode of death and concomitant grief reactions significantly influence both the course of bereavement and the quality of resolution.

The tragic effect of suicide is particularly striking in the case of young people after a parent's suicide. In studies of child survivors, some of the symptoms found were learning disabilities, sleep walking, delinquency, and arson (Cain & East 1972).

The findings of Barrett & Scott (1990) support a point of view expressed only by a few researchers: Shepherd & Barraclough (1974); Demi (1984); and McNeil et al. (1988). That is, that great differences did not exist between suicide survivors and other survivors. These writers are in agreement, however, with others who believe that suicide survivors undergo a major situational crisis and that the family functioning prior to the suicide should be studied further as this may affect the recovery rate of the suicide more so than the mode of death itself.

It is the opinion of the author that crisis counselling should, therefore, be available for all survivors of suicide.

### **'Postvention'**

Shneidman (1971) calls this 'postvention' an effort to reduce some of the possible harmful effects of suicide on the survivors. Making such support available, however, presents a special challenge.

Some people commit suicide while receiving therapy or counselling through a crisis centre, mental health agency or in private practice, or while receiving hospital care. In these cases, the counsellor, nurse or psychiatrist is in a natural strategic position to help survivors. Unfortunately, what often happens is that these professionals miss the opportunity for postvention because they may be struggling with the same feelings that beset the family (Baume 1988).

It is more effective to deal with the family immediately than wait for an impasse to develop, but if staff have not dealt with their own feelings, they may avoid approaching family survivors of suicide. A note of caution should, nevertheless, be made here in that survivors are not compelled to accept help, hence after making the decision to help, the counsellor has an even more daunting task.

The most useful preventive measure is for helpers to learn as much as they can about suicide and constructive ways of handling feelings one can have in working with self-destructive people. There will always be strong feelings following a suicide. However, a professional with a realistic concept of the limits of responsibility for another's suicide can help other survivors work through their feelings and reduce the scapegoating that often occurs.

In counselling in health care settings, health professionals should immediately seek consultation with others after a suicide occurs. Team debriefings are an important step in this process. They provide staff with an opportunity to air feelings and evaluate the total situation.

### *Debriefing*

Debriefing is a common way to structure reflection with groups and usually follows an experience. Simply to experience is not enough. Often helpers are so deeply involved in the experience itself that they are unable, or do not have the opportunity, to step back from it and reflect upon their actions in any critical way.

During the management of crises, debriefing provides an opportunity for staff to engage in reflection. Pearson & Smith (1985) have broadly structured it into three questions. What happened? How did you feel? What does this mean? It is essential that adequate time is given to staff for this reflection to be effective.

### *Journalling*

Another method of reflection which can be used in addition to debriefing is journalling. In the words of Holly (1984), keeping a journal is a humbling process. The person relies on his/her senses, impressions, and purposely records his/her experiences as vividly and creatively as they can. It is a learning process in which the writer is both student and teacher.

A journal is not just a description of impressions, it is impressions according to Holly (1984) plus descriptions of circumstances, others, the self, motives, thoughts and feelings. Taken further, it can be used as a tool for analysis and introspection. It is a chronicle of events as they happen, a dialogue with the facts and interpretations and perhaps most important, it is an awareness of the difference between facts and interpretations. A journal becomes a dialogue with oneself. Hence, to review journal entries is to return to events and their interpretation with the perspective of time. Time provides perspective and momentum and enables deeper levels of insight to take place.

In addition, self-examination and critical reflection after a suicide usually yield knowledge that can be applied on behalf of others (Hoff & Resing 1982; Hoff 1989).

### *Team meetings*

Team meetings also provide a forum to determine who is best able to make postvention contact with the family. If the helper who has worked most closely with the victim is too upset to deal with the family, another person should handle the matter, at least initially. In general hospitals or other health agencies where no-one has had training in basic suicide prevention and crisis counselling, outside consultation with a suicidologist or crisis counsellors should be obtained whenever possible.

### *Suicide survivors' grief groups*

Most suicides do not occur among people receiving help from a health or counselling agency. This is one reason why many survivors of suicide get so little help. In some communities, there are special bereavement counselling programs or self-help groups, such as widow-to-widow clubs, to help survivors of suicides. Ideally, every community should have an active out-reach program for suicide survivors as a basic part of comprehensive crisis services (Hoff & Miller 1987). Survivors are free to refuse an offer of support, but such support should be available.

A parent survivor, Adina Wroblewski (1982), has developed Suicide Survivors' Grief Groups since the suicide of her teenage daughter. Wroblewski's work is significant in two respects:

- following the suicide of her daughter, there were no peer support groups available to her and her husband;
- survivors of suicide do not necessarily need professional therapy as much as they need support from people who have experienced the same kind of loss.

This point has been illustrated by groups such as the Sudden Infant Death Syndrome Foundation and self-help groups for health and social problems, such as Alcoholics Anonymous and groups for mastectomy patients or for AIDS victims.

In the absence of these avenues of help, survivors of suicides can still be reached by police, clergy, and funeral directors, if such caretakers are sensitive to survivors' needs (Grollman 1977). These key people should take care not to increase guilt and denial, recognising how strong the suicide taboo and scapegoating tendency can be. The least one

can do is offer an understanding word and suggest where people might find an agency or person to help them through the crisis.

Techniques in helping survivors of suicide are essentially the same as those used in dealing with other situational crises. A survivor should be helped to:

- express feelings appropriate to the event;
- grasp the reality of the suicide;
- obtain and use the help necessary to work through the crisis (including sometimes his or her own suicide crisis);
- develop a forum for critical reflection;
- keep a journal.

### *Parent survivors*

When one deals with a parent survivor, certain variables affecting these survivors need to be kept in mind. A child's death leaves parents with feelings of guilt and powerlessness for their inability to have protected the child (Van Dongen 1988). Donnelly (1982) suggests that parents may never get over the pain of such a death, although time does help them to adjust. He further argues that the death of a child can also place extreme stress on a marriage and that, indeed in those families, separation and divorces are common.

A descriptive study by Hatton & Valente (1981), who conducted support groups for parents/survivors, found that the parents were overwhelmed with feelings of shame, guilt and self-doubt, confusion and isolation. Indeed, the research by Calhoun, Selby & Faulstick (1980) indicated that parents whose child committed suicide were rejected and blamed for the death by other adults. However useful, these studies did not have appropriate control groups and cannot, therefore, be used to generalise for all parent survivors.

Help for survivors of suicides has always been one of the goals of suicide prevention. Such work is important but difficult to carry out. Many people tend to cover up the reality of a suicide. The suicide taboo in modern times continues, despite a growing acceptance of the morality of suicide in certain instances (Battin & Mayo 1980; Hall & Cameron 1976).

### *The coroner's office*

One means of reaching a large number of survivors is through coroners' offices. It is there that every death is eventually reported and recorded. In Los Angeles County for example, all suicide deaths as well as equivocal deaths (those in which suicide is suspected but not certain) are followed up by staff from the Los Angeles Suicide Prevention Centre. Suicidologists then do a 'psychological autopsy' (Litman 1987). This is an intensive examination to determine whether the death was by suicide and, if it was, to define the probable causes of the suicide. Information for the psychological autopsy is obtained from survivors and from medical and/or psychiatric records.

Research is the primary purpose of the psychological autopsy; however, it is an excellent means of contacting the large number of survivors who are not in contact with a crisis centre, psychiatrist, or mental health agency (Sanborn & Sanborn 1976). Survivors are, of course, free to refuse participation in such postmortem examinations. Experience reveals, however, the majority of survivors do not refuse to be interviewed and welcome the opportunity to talk about the suicide. This is especially true if they are contacted within a few days of the suicide, when they are most troubled with their feelings. Many survivors use this occasion to obtain some help in answering their own questions and dealing with suicidal inclinations following a suicide. The 'official' interview situation is somehow a more acceptable circumstance for some people to open up about an otherwise taboo subject, and thus provides an ideal opportunity for the interviewer to suggest follow-up counselling

resources to the survivor. If weeks or months pass, survivors may resent the postmortem interview. By that time, they have had time to settle their feelings and questions on their own and in their own way, which may include denial and resentment. A delayed interview, however, may seem like unnecessary opening of an old wound.

## Conclusion

In conclusion, this paper has explored some of the aspects affecting suicide survivors and their postvention. In relation to the way parents may feel towards the loss of their child, data and studies that include control groups do not exist as yet to determine whether in fact these survivors go through the same type of grief as other suicide survivors. Further empirical evidence is therefore needed to make the case.

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