The Post-Suicide Family and the Family Physician

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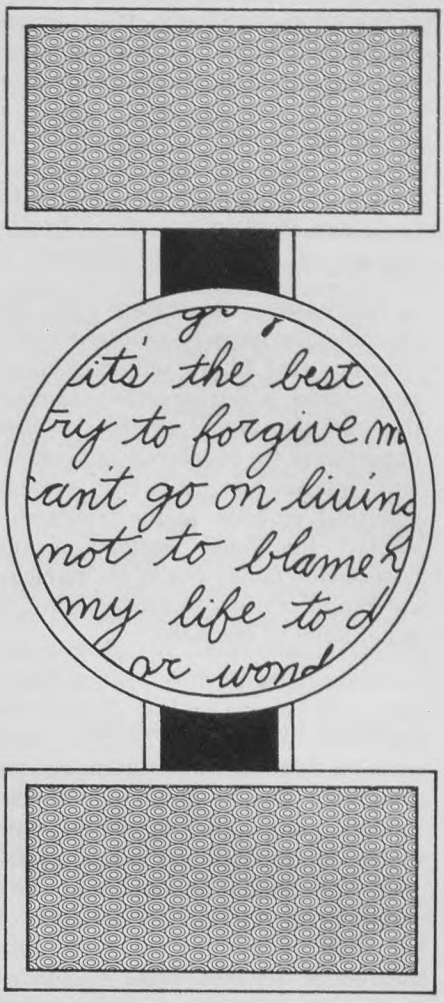

It is estimated that there are 750,000 people each year who are intimately affected by suicide. Prominent among these are the family survivors and their family physician.

This paper offers a time frame which divides the period following the suicide into three phases: Immediate (the first ten days after the suicide); Intermediate (after the first ten days through the first year); and Extended (from the first year until restitution occurs). It identifies the chief emotional reactions which occur in each phase, explores their psychodynamic origins, and proposes suggestions for appropriate management during each of the three periods.

The goal of this plan of management is to enable the family physician to function in a supportive, empathic, and restorative manner for the post-suicide family.

The subject of suicide, its risk factors, statistics, and prevention, has been extensively discussed in the medical literature. However, the topic of the care of the post-suicide family *by the family physician* has been virtually ignored. Family physicians are often a family's first contact following a tragedy, and they can provide extensive and compassionate care during such stressful periods. Consequently, it is essential for family physicians to consider carefully those emotions experienced by patients who suffer a loss by suicide, in order to deal competently and empathetically with these families.

Shneideman estimates that there are approximately 750,000 persons each year who are intimately affected by suicidal behavior.[1] At some time during his career, the family physician will be called upon to provide care for some of his families in the post-suicidal period. It is the purpose of this paper to provide insight, suggestions, and a structure and time frame for management of the family who are the survivors of a suicide. Armed with knowledge about the emotional reactions to the suicide and the phases in which they occur, and with an understanding of appropriate strategies for care and management during each phase, the family physician can provide the foundation of support for the bereaved family, and may also prevent the immediate or long-term emotional dysfunction which may follow suicide.

The structure proposed here offers a plan of care and a framework which is divided arbitrarily into three periods: Immediate (the first ten days after the suicide); Intermediate (from ten days after the suicide to the end of the first year); and Extended (after the first year and as long as support and counsel are required). The psychodynamic base of the feelings which the

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self-destructive act precipitates will be examined in order to facilitate comprehension of the profound emotional reactions which result from this kind of loss.

Immediate Period

The First Ten Days

Immediate observation of the psychological impact and interpersonal reactions that follow self-destruction, rather than a retrospective examination of the event, offers the best opportunity for concerned and competent intervention and may prevent abnormal sequelae in the family survivors.[1] Emotional reactions in the post-suicide family during the Immediate Period can be categorized into five major kinds of reactions.

1. Shock, horror, and disbelief.

In the immediate reaction to the completed suicide, feelings of shock, horror, and disbelief assume preeminence. Even though suicidal ideation and suicidal gestures may have been part of the behavioral pattern of the patient before the final self-destructive act, the awful finality of the suicide is a profoundly traumatic event for the family survivors.

The family physician, no less than the family, often shares some of the feelings of horror and shock. He may have recently seen the deceased patient, and now he is confronted by an unforgettable reminder of the frailty of life. He may entertain doubts about his therapeutic effectiveness.[2] Death strikes at the roots of his belief system and is a "cruel and recurrent reminder of the limit of our power – our power to save another or to save ourselves from the same fate."[3] Suicide has an indelible impact on his feelings. He is now faced with a flagrant outrage against his belief that to protect and preserve human life is his most important task.

For each of the feelings of shock, horror, and disbelief which the suicide has engendered, there are appropriate measures which the family physician can mobilize for the comfort of the bereaved family and for himself. He must recognize his own need for support at this stressful time. His support may come from a colleague, a professional counselor, his spouse, or a good friend in whom he may confide.

The adaptive process of denial is protective for the family in the immediate post-suicide period. An unconscious denial of what is consciously intolerable by a protective mechanism of non-awareness helps to absorb the terrible impact of suicide.[4] Anna Freud says that "the ability to deny unpleasant parts of reality is the counterpart of the hallucinatory wish fulfillment."[5] Reality testing usually puts an end to the employment of denial. Denial is an appropriate defense mechanism if it is not prolonged or unyielding to the reality of the situation. The family physician must exercise surveillance of the appropriate use of denial to prevent its being carried to extremes and to assist the family in getting on with the work of mourning.

The family physician himself cannot make use of denial because realistically and emphatically the fact of suicide is before his eyes and he must act in acknowledgement of this awareness. He must protect himself from being overcome by feelings of horror, shock, and disbelief and act in a rational, professional manner. Isolation, the process of splitting the effect (horror, shock, disbelief) from its expression, helps the family physician to deal with his emotions. The feelings are expressed as an idea but the emotional content is separated from this expression.

In his paper on Gross Stress Reactions, Tyhurst reported that during the Impact Phase 12 to 25 percent of people are "cool and collected." They are able to achieve this state by keeping busy in semi-automatic behavior and in helping to alleviate the distress of others. "It is well known that the reaction to stress can be contained and directed if there is effective leadership that organizes the group into some kind of purposeful activity and thus permits their organizational or adaptive capacities to reduce the anxiety."[6] This is the appropriate function of the family physician in the gross stress which follows suicide and it can be supportive to the entire family. This function is learned behavior on the part of the family physician, learned from the exemplary behavior of his mentors and from his own experiences in dealing with previous stress.

The family physician should be "a model of alertness, self-discipline and reduced anxiety."[6] The technique which he can use to direct and control the family group is to give simple matter-of-fact directions primarily to establish means of effective communication between himself and the survivors.[6] He will identify and mobilize the strengths of the family which remain functional and channel these into constructive action. He will assess and inform the family of the possibilities of present dangers (ie, rash acting-out behavior).

Certain specific tasks which the family physician must attend to in the immediate post-suicide period can demonstrate both his self-discipline and his ability to be in control of the situation:

A. The family physician should be aware of his medico-legal duties in regard to notification of proper authorities when he is called to a suicide. Such knowledge may obviate embarrassment that may arise out of ignorance or failure to comply with prescribed responsibilities.

B. The family physician may wish to be responsible for the onerous and emotionally stressful task of cleaning up the blood, viscera, etc, of a violent suicide. He may want to shield the family from the sight of this gruesome act.

C. The family physician may wish to prescribe a short period of psychotropic medication to distraught members of the family. This is not an attempt to produce a complete blunting of feelings, but acts only to partially alleviate the sharp pain and shock of this emotional crisis.

D. He may call others who may be supportive and comforting, such as other family members, clergy, and friends.

2. Guilt and Blame

The natural emotional reactions which follow the initial shock, horror, and disbelief are feelings of guilt and blame that may be manifested in verbal expressions such as "if only I had" – "believed him when he threatened to kill himself," "stayed with him," "gotten rid of those guns." This "if only I had" syndrome affects all those intimately involved with a suicide and is a manifestation of a wish to share the burden of guilt and to be

exculpated by another. Actually there is some use of projection in this situation (ie, perhaps the person may really mean "if only *he* had," eg, "not threatened to kill himself so often" or "given me that gun.")[7]

The family physician often reproaches himself for his patient's suicide. Will the family pass their own guilt and blame over to him? He may question his own clinical acumen. Will his peers be critical of his management, etc? He too may engage in the "if only I had" thinking.

Covert guilt has several psychodynamic causes at its origin. The guilty feeling of survivorship – of still being alive while the dead person "didn't make it" – is felt at the conscious level but is not usually verbalized.[7]

The ambivalent feelings of the survivors toward the deceased include irrational anger as well as the culturally approved expressions of "de mortuis nisi nil bonum" ("of the dead speak nothing but good"). "This conflict between feelings that an individual anticipated and can accept (ie, sadness at the loss of the loved object) and those he did not expect and cannot accept generates secondary emotional reactions. The bereaved person may find himself struggling to cope with a mixture of sorrow, yearning, and anger toward the loved and lost object. Unable to accept being angry with someone he loved who has been lost, he may experience shame and guilt. He must deal ultimately with the painful feelings of shame and guilt as well as the original feelings associated with this loss."[3]

Anger at the deceased in a suicide is often more intense than in a more normal death. While this hostility may seem irrational and unacceptable, it includes some quite rational feelings among which are disillusionment, abandonment, and withdrawal of gratification. It is conceivable in the case of a suicide that these angry feelings may be expressed by members of the family more readily than would be the case in a more normal death. Each surviving member of the family may have his own particular cause to be angry with the deceased. Instead of "de mortuis nisi nil bonum," "de mortuis nisi nil malum" ("of the dead speak nothing but evil") might become a possibility as this anger surfaces.

A more archaic source of covert guilt is anxiety about omnipotence of the death wish or fantasy directed against the deceased.[5] Death may be perceived as fulfillment of this wish and then would be an added source of guilt and fear.

The "if only I had" expressions can usually be dealt with by reassurance. Self-accusation is a normal part of the process of emotional withdrawal.[2] Perhaps all of us bear to some degree a portion of blame for the suicide of one close to us, and yet, no one of us is powerful enough to prevent all self-destructive acts. We may exercise vigilance and take every reasonable precaution against another's suicide. However, once the decision has been made, a person's determination for suicide is difficult, if not impossible, to deter, and this fact must be conveyed in a firm and unequivocal manner to the family group. This absolution of the family by their doctor also contains some positive reinforcement for him. Too often he considers himself as among those guilty of "sins of omission" toward the deceased.

The ambivalent love-hate feelings toward the deceased are usually weighted in favor of expressions of love in the Immediate Period of the Impact Phase. Angry feelings must ultimately find expression as part of the normal grieving process, but they usually surface later during the Intermediate Period.[3] After a suicide, the family physician may have to discourage premature and uninhibited angry feelings to prevent the family from being overwhelmed by additional guilt when they realize how hostile their expressions are. The family physician can serve as the monitor of the expression of these negative feelings.

It is doubtful that the guilt caused by the omnipotent death wish will find overt expression. The emphatic reassurance that suicide is difficult to prevent may be adequate to muffle this irrational source of guilt.

3. Fear

Ten to 25 percent of persons in the Impact Phase following a Gross Stress Reaction evidence "inappropriate responses, severe confusion or total loss of control of motor behavior."[6] The results of these emotional responses can include bizarre, aggressive, and irrational acts. Suicidal ideation is among the emotional reactions in normal grief and mourning. Because the grief reaction to suicide is intensified and because the helpless-hopeless attitude may be overwhelming, the tragedy of suicide may be compounded by another self-destructive act by a surviving family member.[1]

Fenichel states that the omnipotence of the death wish towards the deceased engenders fear in the survivor.[5] This primitive fear reasons that because one has invoked the wish for the death, one must now be punished. This punishment will be administered by the return of the deceased to wreak revenge. In *Totem and Taboo* Freud states that primitive peoples believe that the dead become demons, and that it is wise to take precautions to protect themselves against this evil.[7] Do remnants of these archaic fears still exist in the "collective unconscious" of which C. G. Jung speaks? If so, they may augment the more conscious awareness of the fear that someone among the survivors will become so distraught that he may react in an irrational fashion and further increase the tragic consequences of the suicide.

The function of the family physician in confronting the overt fear among the survivors is that of assessing their potential weaknesses as well as their strengths. By his ongoing relationships with this family, he has observed the manner in which each family member reacts to stress. He knows who may temporarily respond in an irrational and uncontrollable manner and he takes precautions against such behavior. Selective use of psychoactive drugs may help to prevent destructive acting-out behavior. Those in the family who have demonstrated strength and reasonable equanimity in times of previous stress are available to assist the family physician in providing direction, in facilitating communications so that feelings can be ventilated early, and in channeling the mourning process into a positive direction.

The mourning rituals provide the means of quieting primitive fears about the dead. The mechanism of substitution is part of the mourning process in the Immediate Period following death. The overwhelming stress of the feelings is alleviated in part by the mourners attaching or placing this feeling on someone or something outside the family in a socially acceptable

form, ie, the religious rituals of mourning.

4. Shame

Shame is a feeling closely akin to the reaction of guilt and blame. The psychoanalytic foundation of shame is, in fact, related to guilt feelings, and to feel ashamed means that the individual does not want to be seen. People who feel shame not only have a desire not to be seen by others, but they also close their eyes and refuse to look. "This is kind of a magical gesture arising from the magical belief that anyone who does not look cannot be looked at."[5]

The taking of one's own life is morally proscribed. In some states it is against the law. The suicide victim has quite obviously placed himself beyond the reaches of legal punishment but has burdened his family with society's stigma, perhaps for generations. The information about suicide taints the family tree and is not overlooked when the family history is surveyed.

Management of the shame reaction is difficult. The psychoanalytic basis for shame – the desire not to be seen and to close one's eyes – can be potentially disruptive to the grief work and may inhibit restitution of the entire family. The feelings of rejection or abandonment which the survivors sometimes experience in the case of a natural death are often magnified if the death occurred by self-destruction. Friends and others who might ordinarily comfort and support the bereaved family feel uneasy and inarticulate in the presence of suicide, and the mourners sense this as abandonment which may only intensify their feeling of shame.

The closing of one's eyes, but looking at the reality of the suicide, may lock the family into a distorted denial period. The family physician must tactfully and empathetically enable the family members to accept the reality of the suicide, to move forward in full awareness and acceptance of this fact. By bringing the entire family together in a warm and accepting atmosphere, feelings can be shared and past experiences forgiven and put aside. The mourners, aided by the skillful assistance of the family physician, can move ahead in a positive manner. A beginning can be made at this juncture. The family's pastor may be enlisted and certain friends may be encouraged to offer their support to overcome the feelings of rejection and shame. Mobilization of supportive people capable of realism tempered with understanding and compassion, is one of the tasks of the family physician in the immediate post-suicide family.

5. Relief

It is conceivable that individuals may feel relief following the suicide.[3] Surviving family members may have lived through the anxiety of previous suicidal threats, gestures, or even more serious suicidal attempts. They may have been "infected" by the deep and pervasive depression in the daily existence of the deceased. They may, therefore, have feelings of relief after the suicide but will not often verbalize them.

The family's physician may also share in the feeling of relief. He may have been called upon to deal with previous self-destructive threats or gestures. He may wish to express his feelings that death has finally brought a release for the deceased from his tortured existence.

It is not unusual, nor is it unacceptable, for family members or for their physician to verbalize their feelings of relief in the case of a lingering or painful death. Those concerned can realistically make such statements as "it's a blessing" or "he is finally at rest" in acceptance of the fact that death afforded deliverance for the deceased and relief to his family.

It may also be advisable to allow the family survivors to express similar feelings of relief if they were aware of the sufferings that the suicide victim endured. The family physician, if his insight and wisdom confirm the acceptability of such expressions, may wish to carefully facilitate this expression by the family survivors. He may even wish to gently lead the way by expressing his own feelings of relief about the death.

Intermediate Period

After the First Ten Days through the End of the First Year

During this period, the main task for the family, guided and supported by their physician, is to work through the grief process. Freud called this doing the work of mourning. The mourning process which follows the suicide of a family member may involve the family in more intense emotional stress than that which would have been encountered in the case of a more normal death. Feelings of guilt and fear may also occur during the Intermediate Period.

The feelings engendered by self-destruction have the potential to become distorted and more lasting. The family physician has an obligation to all the family survivors to assist them in moving through the mourning period and on their way to restoration. To enable himself to function in this very important role, he needs to understand the profound emotional impact of the loss and to observe the manner in which each family member deals with his feelings. He functions as the "participant observer," ie, he shares in the feelings with the family and is not emotionally aloof, but he does not allow his emotions to hamper his ability to exercise control and direction of the grief work. He should be alert for dysfunctional mourning and possess the skill not only to recognize such pathology but also to intervene swiftly and decisively if necessary. He must recognize his limitations and seek consultation if required.

1. Mourning: Loss and Sadness

In the Immediate Period which follows a suicide, the surviving family members are protected to some extent by the numbing effects of denial and by the psychological defense of isolation. The full impact of the loss of the loved one makes itself felt after this initial period, and each family member must confront and deal with his own particular feelings of loss and grief. Sharing of these feelings can be facilitated by gathering the family together and, under the skillful and sensitive guidance of the family doctor, permitting feelings to be expressed.

Grieving is work, requires time, and involves emotional strain. The remembrances of the lost loved object and the feelings about him are both pleasant and unpleasant. If the hostile and unpleasant emotions overshadow the feelings of love and the pleasant recollections, the guilt feelings of the survivors may be more intense, distorted and prolonged.

The family physician can assist the

post-suicide family in dealing with their feelings of loss and sadness by facilitating family sharing of feelings through open communication and giving permission to gradual expression of negative and hostile feelings about the deceased. These angry feelings may have to be teased out in small increments to prevent present guilt feelings from being increased.

The family physician should be alert for evidences of distorted mourning which may occur because of repressed or delayed expressions of painful emotional states. The hostile part of the ambivalent feelings toward the deceased may be directed at the mourner's own body in an effort both to expiate and to gratify the unacceptable wish. This may take the form of the use of sedative drugs, alcohol, and psychoactive medication which may be abused in an effort to gain relief from intolerable feelings. Compulsive activities, ritualistic behavior through such things as compulsive religious activities, visiting the cemetery daily, and ceaseless cleaning up, also help to deal with the feeling of loss. A certain degree of such behavior may be protective and restorative, but if it is the sole means of dealing with the emotional impact of suicide, it will eventually fail.

2. Guilt

The guilt feelings previously considered during our discussion of the Immediate Period are to be expected during the Intermediate Period and can often be resolved by adequate reassurance. However, there may also be guilt feelings which antedate the immediate feeling of loss of the love object through suicide. Long-standing, hostile feelings against the deceased are not relieved by quieting of the overt guilt expressed by "if only I had" words. The duration and intensity of the covert guilt can be magnified in the period of bereavement. Guilt may then be assuaged by ritualistic and compulsive behavior or other irrational behaviors.

3. Fear

There may be remnants of fear of an impulsive act or behavior by one of the family in the "recoil phase"[7] when the full realization of the suicidal act is acknowledged.

"Anniversary reactions," which may occur during delayed grief reaction in which the loss is reexperienced on an important date associated with the deceased, may engender a degree of fear and anxiety in the family and the physician.[1]

Ongoing supervision and contact with the family, alerting them to behavior which may signal trouble and the attempt to resolve delayed grief to prevent possible anniversary reactions, can be done by the family physician. Bizarre behavior, if more than temporary, may require psychiatric consultation.

Anxiety about the "inheritance factor" can be dealt with by reassurance that there is no evidence to support this concern.

The role of the family physician during the Intermediate Period is analogous to that described in the post-traumatic phase of Gross Stress Reaction. "Again the leader has to establish himself as a model of internal discipline, receptivity, and low anxiety. He encourages verbalization of the experience in a supportive environment, at the same time attempting to evoke from the victims whatever strengths and aspects of behavior tend to reconstitute the former self-esteem of the individual or group."[6]

Long-Term or Extended Period

The emotional reaction of *depression* is perhaps the most maladaptive behavior which can occur and recur during the extended period of management of the post-suicide family. Residual feelings of guilt, shame, rage, unmet yearning, and unresolved grief form the seedbed of depression. These feelings at times are so pervasive and overwhelming that their expression is prohibited because they are unacceptable to the depressed person.[3] He has literally swallowed his anger and this rage keeps gnawing at his guts.[5] The result of this intrapsychic process in the survivors, whose emotional reactions are immature and inadequate to cope with this distress, may be to cause them to suffer a reactive depression. This state is manifested by feelings of sadness, isolation, pessimism, lethargy, and a feeling of inability to cope with daily living.

Depression results from unresolved emotional reactions to the severe and profound stress that may envelop all the family survivors of a suicide of one of its members.

There are families and/or family members who may be "suicidogenic," ie, by their actions or attitudes, they may precipitate maladaptive, depressive, or self-destructive behavior in a chosen family member.[1] Blame-placing or scapegoating for the suicide focused on one of the surviving family members may engender a helpless-hopeless attitude on the part of the chosen "victim." The only avenue of escape which the scapegoat sees open to him is self-destruction. He will gain peace from the continued blame, and he will burden the survivors with punitive and enduring guilt.

Early intervention for all the surviving family members by their physician is perhaps the best preventive measure against the development of a prolonged or distorted mourning period. The gathering of the entire family for the purpose of sharing and expressing deep feelings and their significance about the loss, carried out under the leadership of the family physician, is a beginning toward the achievement of "good grief," and foreshadows restitution for the survivors. "Post-vention"[1] management implies ongoing care and appropriate surveillance of the emotional and behavioral aspects of the mourning period by the perceptive and concerned family physician. In this role, the family physician is challenged to show compassion, exercise a protective vigilance, act decisively and intervene if necessary to prevent abnormal and prolonged grief, and see the family through to the establishment of a new homeostasis.

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