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Do Current Suicide Prevention Policies Neglect Suicide Survivors?

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Abstract

The emphasis placed on mental illness by policy makers and researchers to explain suicide in order to prevent it is both unwise and leads to adverse outcomes. For example, the flaws of conventional suicide prevention policies include incorrect and misleading suicide statistics such as the repudiated and discredited claims that 80%-90% of suicides had depression, the majority of suicide cases had mental illness, and that talking about suicide will lead to more suicide. Such false claims lead to erroneous decisions such restricting reporting and public discussion of suicide, and the sharp increase in anti-depressant prescription, e.g. in New Zealand anti-depressants prescriptions quadrupled between 2001 and 2012 with no impacts on suicide trends over the same period. There has been very little or no public conversation around suicide and its prevention, making suicide taboo. Therefore, there is a lack of confidence and experience in the population to deal with suicidal behaviour. As a result, there is an absence of public engagement with suicide survivors (family and friends of the suicide case). This paper reports on the experiences of a group of suicide survivors (parents and siblings) following the suicide of a loved one which has led to isolation, the internalization of grief and hindered the healing process.

Keywords: Suicide; New Zealand; Anti-depressants; Suicidal behaviour

Introduction

The biggest flaw with suicide research is the sources of bias allowed in by researchers but not acknowledged and accounted for. The main problem from the outset is that researchers and health authorities through the media perpetuate the belief that mental illness and in particular depression are the main causes of suicide.

A policy of keeping suicide discussions out of the public domain has had a number of adverse effects on suicide rates as a well as preventing progress in suicide prevention development [1]. Because of the lack of public discussion about suicide, a number of myths have flourished, e.g. suicide is caused by mental illness, and talking about suicide causes more suicide. New Zealand's main suicide prevention policy since 2006 has seen a massive drive to tackle depression which receives a lot of air time (e.g. TV, radio, billboard) and reinforces the public perception of a link between mental illness and suicide.

Added complexities due to bias arise when a study design is based on a medical model which means that survey tools are biased towards mental illness, inevitably the survey questions will lead the respondent towards a desired response, and so on [2].

Hjelmeland and colleagues [2] provide a comprehensive review of psychological autopsies and discuss the problems in adopting this type methodology which renders them useless in informing the process of policy formation.

Furthermore, such studies become even more complex when methodologies employed for data collection and data analysis fail to account for sources of bias leading to erroneous results and mis-conclusion [1,3] as is the current belief that mental illness causes suicide.

The adverse effects of insisting on a medical model that promotes secrecy around suicide assume that mental health services are the answer to their loss and grief. The answer could lie in suicide prevention strategies that are community based [4-6] because these strategies target suicide prevention at grassroots, i.e. not just potential suicide victims but also their family and friends before the event of suicide [3].

Methodology

Compared with other forms of bereavement (e.g. fatalities due to accidents, disease, murder), the literature agrees, on average, that bereavement is complex and prolonged for this group of suicide survivors [7,8] and suggest the utilization of mental health services to help survivors through these difficult times. By the same token, others [9,10] suggest that despite the elevated risk for psycho-somatic complications very little research has focused on the empirical evaluation of clinical intervention for suicide survivors. This is a simplistic view of the grieving process.

The policy of secrecy around suicide has helped to maintain the taboo status of suicide in the public mindset and may, at least in part, explain why over two-thirds of suicide cases do not come into contact with mental health services [11-13]. On the other hand, mental health services do not guarantee successful intervention in the other one-third who did come into contact with psychiatric services but completed suicide. Ironically, it appears that the policy of secrecy is in direct conflict with the current campaign to change the public mindset in order to make mental illness less tabooed and more acceptable within the mainstream. The approach to suicide prevention, through a

policy of secrecy has been to effectively silence the survivors and to isolate them to care for themselves.

The implication of continuing with a flawed policy for suicide survivors and society as a whole is 'more of the same' but at much higher cost each year in lives lost and financial terms. A lack of understanding of suicide, together with a mental illness model for suicide intervention and a policy of secrecy does not explain to suicide survivors why they lost their loved one to suicide nor does it support them through the healing process. In this paper, suicide and suicide prevention and intervention are discussed through the experiences and stories of suicide survivors who have lost a loved one to suicide, who want to shatter the silence and contribute to the public discussion of suicide.

Methods

In November 2010 and 2011 a number of youth suicide prevention workshops were organized and delivered in the Waikato District Health Region, New Zealand [14]. The workshops were well attended by frontline service providers, teachers, counselors, community police, health promotion officers, as well as the general public and suicide survivors. The workshops, amongst other things, exposed a high level of frustration by the survivors and the general public about two main issues. First, the policy of secrecy around suicide has prevented any public discussion of suicide, and second, being ignored by policy makers and academics. Ironically, the survivors, those who have experienced suicide first hand, have the credentials to inform the development of suicide prevention policy more than academics or health authorities. Furthermore, suicide survivors can provide first-hand information and experience of suicide, as well as appropriateness of support services.

An invitation to participate in a free format study where participants could freely tell their stories was distributed through community liaisons and public health coordinators in the Waikato Region, North Island, New Zealand. Participation was absolutely voluntary and the emphasis was on telling stories rather than being questioned.

In this pilot study nine stories were recorded from seven families: consisting of a sibling, a grandparent, and five mothers.

The tool for collecting stories was free-format but guided by several themes including coping processes, formal and informal support processes. We called the sessions with suicide survivors a 'korero' (conversation) rather than interviews where the subject was free to talk about the effects on their lives of losing a loved one to suicide.

The story (korero) sessions were interviewer administered. In order to maintain the project's cultural sensitivity a bilingual interviewer of Maori descent, and was well versed with Maori culture was employed.

The story sessions were transcribed and were subjected to textual analysis by two researchers. The researchers looked for patterns in the stories of attitudes, perceptions, emotions, and experiences, e.g. anger or inappropriate services. The results were compared for agreement/disagreement. Any inconsistencies between the researchers' findings were subjected to further analysis until a consensus was reached. However, the latter situation did not arise.

Results

The survivors' stories highlighted a number of areas of concern regarding suicide intervention, prevention and postvention policies. The length of time of bereavement by suicide in the sample ranged from less than six months to over 10 years. Perhaps the most startling and important result of the pilot study was the reported reaction of suicide survivors when visited by the interviewer:

- "This is the first time someone has talked to us about suicide....."
- The stories also illustrated the feelings and emotions experienced by suicide survivors ranging from not knowing why their loved one took their own life, as well as anger and denial, to social stigma, lack of information and lack of support which had adverse effects on the 'healing' (grieving) process.
- Reaction to suicide is not the same for all family members and friends. In our sample mothers were concerned about the impact of suicide on the rest of the family and took a central role in order to keep the family together. On the other hand, fathers tended to withdraw and grieve in isolation. Siblings tended to be more expressive in the range of emotions exhibiting denial followed by anger.
- The story tellers were mainly mothers but also included a sibling, a father and a grandfather. Some of the main findings are summarized here.
- Lack of support: One of the most startling findings was the appreciation shown by survivors that our interviewer was the first person to ask them about suicide and their loss, and the first person to listen to their stories since the suicide-this came as a shock to the research team since some of the suicides had occurred ten years earlier. the following quote summarizes the lack of support and long delays in responding to requests for help:
- "But we were getting people who started offering us papers to fill in for services like prevention courses that were coming to our community but I didn't want to do those anymore coz we had asked for that to come to our community last year, when it was all happening. It wasn't till after my son died and then now they bring it. That really pissed me off."
- Not knowing why and guilt: the following quotes typify the search for an answer to explain why a loved one had committed suicide and the complex internalization of guilt and anger:
- "Oh traumatic totally traumatic, I mean it happened umm almost eight and a half years ago but that feeling will that maimai tangaroa is staying (keroto) aye will always be inside, um and I think the biggest thing for me was um the big question is why?"
  "…saying um oh why would you do that? What did I do to you?"
- "… Yeah, to me it's a natural thing you know, yeah so I left there light as a feather even now people ask me why' and I wouldn't have a clue but before I use to cry when people ask me those questions like cry and feel guilty and you know all of that but the guilt has gone but even though I still can't answer the question the guilt is gone…"
- "… just from what I've noticed, it's just but why? It's probably more hurtful. I don't know, just from what I've seen, it seems to do their head in more trying to figure out why, and then that's when the blame, oh I should have, would have, could have but I didn't…"
- "… People were asking 'why did he do it? … how am I gonna answer this? Why am I gonna answer? I don't know, but I wanted to have an answer I really did wonna have not THE answer but an understanding to give across at the same time it was his choice and

only his, it wasn't anybody's fault this is what he wanted, just not a good way out but reckon it's a quick way out…"

- Denial and anger: grieving for a suicide victim is quite a complex emotion-as described above it has its source at not knowing the reason why, guilt, and lack of information and support. Thus, anger at the suicide case is a natural strong emotion to take over the grieving person. The emotions produced by anger and denial in the sample can be best summarized by the following quote from a sibling:
- "…Mm they asked me to go dress him and stuff, I went No! I just stayed back home and everything I was sour as like nothing happened but as soon as I seen him, I just dropped with tears and really believed it that it really did happen, it was like a whole lot of wave of things just 'Yep it's all happened he's did it he's rested you asshole you c**t and piker all that kind of stuff…'"
- Lack of information: there are several main issues with information.
- Firstly, we have no insight about suicide and therefore suicide is poorly explained by mental illness
- Secondly, public information and understanding of adolescence and adolescent development is scant and practically invisible in our parenting, education, justice, etc.
- Thirdly, the heavy emphasis on mental illness as the cause of suicide has contributed to and sustained the taboo status of suicide
- Fourthly, the New Zealand's Government's policy of silence around suicide has exacerbated the situation by confining it to a single discipline, removed it from the public domain, and mystified it. The lack of an open and public discussion of suicide prevents the development of crucial lifesaving skills within the population. Whilst the public in general is concerned and sympathetic towards suicidal behaviour and suicide survivors, yet the public is not skilled enough to communicate with someone showing suicidal behaviour or someone who has lost a loved one to suicide.
- The adverse effects of a lack of relevant information may be best summarized by the following quote from a mother:
- Yeah, and then I noticed probably when X was about 17 there was these changes, but I just thought they were teenagers, growing up, I just thought they were those issues."
- Life-events: most participants were able to provide historical information and life-events at an individual, family, and social level
- Doubt about mental illness as a cause: mental illness was present in only 2 of the cases and participants freely talked about doubting mental illness as the main cause of suicide by highlighting the failure of the psychiatric services to save their loved one. The survivors viewed psychiatric and mental health services as inappropriate and ineffective as an intervention to stop suicide, as can be seen from the quotes below:
- "I feel mental health services let me down because first of all, every single time X had an attempt they said A) X wouldn't do it again, even though X did do it again, every single time they were proved wrong, and B) every single time X saw a different person, and that to me was the biggest failing. Because there was no continuity…"
- "And every single time they were saying X was fixed, you won't do it again, and every single time X did it again the message X was getting was well you're wrong, you're lying to me and you don't know what you're talking about because I did do it again, I did feel like that again. They were saying to X you won't feel like this again, you won't, next time you'll be able to cope, but X wasn't able to cope. As far as I'm concerned the only message mental health services were giving X was that we really don't know how to help you."
- "It was pretty much for us to make a decision with the medication, people were saying don't give X the medication, karakia, and water, and stuff like that, but it just wasn't working. But then sometimes the medication would go so far but we knew X didn't like taking that medicine and X always used to say to us, even from the beginning, it's not working…"
- "… But for X, used to say it's not going to work. It's not working mum, X used to tell me, my medicine's not working... And then after a while, even with the doctors giving different medication X was just yeah it's working but it wasn't, X was still hearing things."
- "I found it disheartening that a service which had been charged with supporting X with mental wellness responded so casually and without caution in a potential 'crisis' situation."
- There were also references in the conversations to problems which arose from the stigma of suicide, isolation and the healing process. From the points raised above it can be deduced that the healing process is very complex. Perhaps the biggest stumbling block in the healing process is wondering 'why' a loved one would want to end their life, and a lack of appropriate and relevant suicide information. The process of discovering why someone killed themselves is impractical because the person who could provide the answer is no longer alive. Even in cases where there is a suicide letter, this only provides some information about the state of the case's mind at the time of suicide NOT of the process that led to the decision to commit suicide.

Discussion

The results in part have been reported elsewhere [15-17], however, this paper aims to explore what can be learnt from suicide survivors about suicide. They have quite a bit to advise us about how relevant and appropriate services for survivors beyond a limited number of counseling sessions and being placed on a waiting list for psychiatric services.

- No one had asked the survivors about their stories: several issues: (secrecy) people in general no idea of how to deal with suicide and suicide victims, therefore, don't know what question to ask and even if we assume the medical model they don't know how to identify and look for symptoms; assumption that survivors receive help or talk to experts (this says something about the services); isolation leading to chronic health issues; etc
- Gender differences in reactions to suicide means that the grieving process for the mothers is delayed and they often miss out the opportunity to properly go through a grieving process. Similarly, fathers who withdraw and suffer in isolation may develop similar health outcomes, e.g. chronic mental and physical ill-health due to not coming to terms with their loss, which in turn leads to a poor quality of life.

In this study, the survivors had tried all treatment options open to them for their loved one who had problems with visions and voices; including psychiatric help, counseling, traditional counseling, and traditional healing. Cultural differences aside it appears that New Zealand is insensitive to suicide. Survivors from different backgrounds expressed their dissatisfaction with the response from insensitive police procedures to a lack of and inappropriate mental health and social services. There was also concern about the victim support services:

"… They did put me in touch with victim support. I know the drill I told them the first time victim support contact me I told them to let me know where my girls could go for Counselling, it never happened…"

Concluding Comments

Allowing suicide survivors to tell their stories, without the use of a preconceived mental illness-based questionnaire, could be mined to inform gaps in an understanding of the process of life changing decision making.

In 2010 a number of workshops on adolescent health and behaviour were piloted in the Waikato Region, New Zealand. In 2011 and 2013, these were expanded and offered to the wider community [3]. The workshops provided strategies for communicating and supporting young people through their adolescence, not just for their parents but for education, health and justice systems. Following the workshops a number of suicide survivors made the comment:

"Had we known what we know now our loved one would probably be alive?"

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