PROJECT CHAI

CRISIS, TRAUMA, SUPPORT

A Project of Chai Lifeline

INTENTIONAL DEATH: FACING THE AFTERMATH OF SUICIDE

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Self-harm, especially the ultimate harm of talking one's own life, marks one of the most severe and most painful human experiences imaginable. Whether driven by despair, by peer pressure, by shame, by sadness, or by compulsion, a person initiating self-destruction is in a mental state of profound distress.

It is no surprise that our Torah tradition traces the prohibition of forbidden suicide back to the earliest years following the Creation of the Universe, and the Torah connects suicide to the prohibition of spilling blood, or homicide. There is no doubt that the act is prohibited by the Torah. Yet, our tradition – both in the Written Torah and in our Oral Torah - includes situations, incidents, where persons under duress, in fear, in misery, or facing the threat of humiliation and torture, have taken their own lives. There are also instances wherein ending one's own life may be regarded as an act of necessary martyrdom, when the only other option is to commit a heinous act of interpersonal or spiritual iniquity.

Whereas the above framework is an essential one for all of those who are allegiant to halacha, and all of those who follow and adhere to the Ways of Torah, those of us who are involved with mental health matters are aware that self-harm, self-destruction, and suicide is both a clinical concern, and even a growing reality which must be contended with in our work with persons in crisis. Whereas the thoughts and recommendations which follow are not focused on treatment of persons who are involved in destructive practices, this article will nonetheless acknowledge that suicide is a phenomenon which we do contend with in our work with victims, witnesses and family, relatives and friends of those who attempt or who complete an act of self-destruction. Each year, our Project Chai teams are called in to crisis settings where suicide or attempted suicide has been a fact, and we are asked to address all of those who were affected in the ripple aftermath of that tragedy.

How can we understand the dynamics and motivations of self-harm? As stated earlier, many stresses may precipitate a person's decision, or urge and impulse, to end their life. At times, a single event may precede that sudden decision. At times, a series of acts may lead to a gradual mounting of a person's sense that they cannot go on. At times, a remote event, so troubling and shaming, may have set into motion a state of suffering which can culminate much later in a person reaching the breaking point.

More specifically, there are individuals who experience or who witness an event which is so shocking that their world, their assumptive reality – everything which they trusted and assumed to be real – has been shattered, and they feel unable to move on. It may be a matter of feeling betrayed, or disillusioned, or deceived by someone whom they respected. It may be unthinkable bad news. There can be single incident events which leave a person feeling that their life foundation has been removed, and they cannot fathom how they will ever trust others, or function happily, again. These are examples of sudden event triggers.

A series of events, as stated above, may lead to a gradual sense of defeat, of giving up. A child may be consistently bullied, or repeatedly abused, or an adult may feel hopeless because of a troubled ongoing relationship. There are persons who have been, essentially, stable, yet over the course of time, their resilient coping and their ability to resist distress ends. These are examples of ongoing stress preceding suicide.

A remote event from one's past, such as unprocessed trauma, may surface later in life, whether because of a trigger event reminiscent of the old trauma, or whether because life has gotten better and current stresses are minimal, and their emotional guard is now down, so that earlier trauma now returns to memory and haunts the person. At times, remote trauma has been suppressed and dormant, yet erupts without a clear objective cause. These are examples of how far reaching the shame, humiliation, rage, depression and pain of unresolved trauma can go in effecting a person.

Of course, there are individuals who have other levels of mental instability or disorder. Persons suffering from depression, persons with schizophrenia, persons with a range of other conditions, including addictions, may at times feel driven or impelled to end their misery through self-destruction. An overdose, an impulsive reckless act, a distorted urge to thrill-seek, may be implicated in suicides. At times, serious medical conditions cause pain and fear so that a patient may seek a rapid end to their suffering.

There are also suicidal persons who end their lives on philosophical grounds. At times, persons reach conclusions about the nature of reality, about their religious beliefs, about their sense of religious guilt and their perceived inability to atone for or correct their misconduct. People at times reason and conclude that there is not point to life, that there is not eternal afterlife, that there is no reward and punishment, and they act on this view as if nothing matters anyway. They may have concluded that life has no meaning for them, and that they serve no purpose in their existence.

And there are individuals for whom their perception of life stresses may engender hopelessness – too many debts, too much family unhappiness, life not matching their expectations and dreams, lifestyle choices now regretted – and they feel that they and their spouses, children, siblings or parents, would be better off without them and without the financial and/or emotional burdens which they cause.

Throughout the generations, our tradition has taken varying positions as to the suicidal person. When a person ends their life on philosophical grounds, i.e. out of a belief that there is no Divine Presence, no Torah, no afterlife, no consequence, and when they are fully in control of their mental faculties, such an act was regarded as a heinous sin and the consequences were to regard the dead person as having willfully set himself apart from the Jewish people and their way of life. That was regarded as "the sin of suicide."

In contrast, Torah tradition has always been mindful that when a person is mentally disordered, their status may be very different since the impelling force leading to death may have represented very disturbed thinking, distorted ideas, mood energy which was beyond control, and a "death wish", which means that a very ill person is suicidal because of their mental illness, and has little self-control at the moments preceding their suicidal act.

Additionally, Torah thought also recognizes the role which trauma may play in suicide. A person who has been subjected to molestation, to abuse, to public ridicule and humiliation, to personal shame and self-doubt, and who has been exposed to events for which they are not yet mature enough to make sense of and are thus confronted with shock which may block their ability to develop normally, are all in a state of traumatization, which can actually affect brain chemistry, brain functioning, and the ability to move on and overcome their shame and shock. At times, persons, even young children, who are victimized, may act on that "death wish" and be driven to self-harm.

A challenge facing those who must deal with the aftermath of suicide, whether as first responders, as interventionists, as clinicians, as educators and as clergy, and as other responsible persons to whom the community turns to for support and insight, is where and how to focus on other's reactions rather than focusing exclusively on trying to make sense of what drove the person to end their life. The information in this article centers on the interventions which can be provided the "survivors" – those who did *not* take their own lives, but who must continue to live with the knowledge that someone else did commit suicide.

Our task, as responsible adults, is not to pass judgement, not to discuss whether what happened was wrong, or was justifiable. Our task is not to minimize what has happened, nor to lecture about the dynamics of why it happened. Our focus, clearly, is to be there as others express the ways in which the horror is affecting them, to have a developmental grasp of what is a normal reaction to traumatic news and what may be atypical, and to assist others in finding the words to express the range of reactions which they are having, while also offering them some perspective of how their mind, brain and body are dealing with the shocking event. In that sense, suicide is a trauma and is processed as are all traumas.

REACTIONS TO LOSS BY SUICIDE

When dealing with the reactions of persons not directly related to, or not close friends of, the casualty, a central reaction may be the shock of disbelief. Sudden death always leads to shock, but when a person takes their own life, the reality itself is hard to make sense of. Most of us struggle and resist, when our life, or our breath, or our safety is at risk. Most of us struggle to stay alive and even fight to do so. When we try to grasp that someone did not struggle and instead, put themselves into a situation where their life would end, whether through asphyxiation, through blood loss, through intentional massive injury, through poison or overdose, or though intentionally careless behavior (crashing car, jumping, entering a dangerous zone), such actions are foreign to what we know about ourselves, namely, that most of avoid

pain and danger, not run to it or seek it. This leads to a disbelief not as to the fact that someone took their own life, but in fathoming that the fact can indeed be a reality for some people. “How could they do that?”; “Why would they?”; “How could they afflict suffering on themselves?”; “What became of the basic human will to live and to stay alive?”

As is the case with most cognitive questions which arise following trauma, we validate the confusion and the puzzle, the mystery, and we offer that this is a symptom of their distress, that right now, the way the shock is hitting them is at the “intellectual” or cognitive level. We do not attempt to answer their questions, and we should not try to reframe them prematurely. The “why” questions are powerful when a person is in traumatic shock, and there is little we can say which will reduce their pain and confusion. Validate, support, encourage them to process this reaction and to identify all levels in which they are reacting. Acknowledge the question and propose that with time, there may be more clarity.

Another layer of traumatic shock which can hit people when they learn of a suicide or witness it, are the physiological or somatic reactions of nausea, disgust, gasping for breath, rapid heartbeat and muscle tightness. Loss of appetite, sleep disturbance, shaking, trembling, and loss of energy can also be physical signs of distress. Encouraging a person to pinpoint that body symptom, to validate for them that this is where they are holding their distress, and that it is enclosed in one or more of those body areas, is a first level of intervention when the body is involved. Gently encouraging them to find words to discuss their physical reaction, reassuring them that this is how they are responding now but that their reactions will shift with the days ahead, and giving them permission to talk about their reactions, including their fears about what is happening inside of them, will open the door to soothe those initial reactions. At times, a relaxing exercise involving slow, paced and deep breaths can re-center a person to loosen up their body responses. Unless there is a known history of medical complications involving the heart, breathing or other conditions, the likelihood is that body symptoms are reflections of traumatic reactions and not signs of sudden new health concerns. Clearly if a person shares that they have a medical history and are reporting physical symptoms, they should be instructed to consult their physician.

Emotions, and moods, are commonly affected by shocking events. When a person is tearful, sad, irritable, withdrawing, angry, impatient, easily frustrated and restless, they are likely experiencing the trauma in the form of poorly regulated emotional reactions. This also is a common response to shocking events. Some people feel “survivor guilt”, plagued with the recurring thought that they could have or should have prevented the suicide, or detected it earlier. They may blame themselves, or they may focus on blaming others for not preventing the tragedy. For some, flashbacks and vivid memories of what they saw, may occupy their minds. It can be hard to forget the scene of a horrible death. Again, supportive intervention helps them identify what they are feeling, giving them the opening to vocalize it, validating that this is how they are reacting at this time and giving them the encouragement that their reaction is in fact one normal way of dealing with something which is unthinkable and hard to accept.

It is not uncommon for people's behavior to change in the aftermath of trauma. They may not be able to focus at school or at work, they may cease to adhere to a familiar routine and schedule, they may act in ways which are not typical for them, or neglect things which were once typical for them. They may neglect their appearance, they may avoid friends and social activities, and although some initial withdrawal is not uncommon, it is always important to encourage S-R-S ---- assuring that the person has structure, that they have a routine, that they have a schedule. Every person should be prompted to return to their SRS as rapidly as is reasonable, in order to stave off further deterioration or regression. Maintaining a schedule also helps prevent falling behind in school or at work. It is also frightening to a family when a traumatized person drops out of their normal life routine.

Spiritual reactions can also arise when one has been exposed to a tragic death-by-design. At times, people become very focused on wanting to be pious and to increase their religious intensity. At times, spiritual feelings begin to fade and people feel distant from religion. This needs to be validated and explored as a reaction to trauma but with the insight that while it may be a reaction and a common one, it is never wise to make radical changes or to give up suddenly a familiar system of support such as being active in one's religious life and faith community. If the person needs to talk about their religious struggles with a more learned individual or with a trusted religious mentor, then offer that to them as well rather than getting into a debate with them as to whether or not they are allowed to feel and think in ways which may temporarily put their religious fervor on hold.

FAMILY MEMBERS FOLLOWING SUICIDE

When dealing with those who are directly involved with the suicide, such as family and close friends, the dimensions of distress will be identical with those mentioned above. The intensity may be deeper. This is because the event is more than a shock and a trauma. It is also a loss. Loss, especially sudden and tragic loss, leads to other reactions, including shame, fear of being stigmatized, guilt over not being able to prevent the death or save the person, sadness knowing that they are gone forever and that there will be no second chance, embarrassment in facing others and anxiety about what others, including the media, will publicize, and worries about rumors and about how others may gossip, and the conclusions which they might jump to.

Generally, after surveying the ways in which a person is reacting to the loss, the first line of intervention might be the most "primitive" one, rather than the most intellectual one. That is, if a family member expresses guilt and sadness and worry about what people will say, the more personal and internal reactions are the sadness, then the guilt, then lastly the worried thoughts. Generally, we will focus on what a person is feeling before we process with them what thoughts they are having. Nonetheless, survey all of their reactions and if a person says that they first need to address a higher-level symptom i.e. they are obsessed with conflicting religious thoughts, allow them time to vocalize their thoughts before addressing deeper emotional turmoil.

Family may also need to discuss their immediate needs: do they have a home to return to, what might the home atmosphere be like, is someone in charge of dealing with the authorities, the coroner, the police, the press and media? Is someone going to look after the basic needs of the family for meals and other survival-safety requirements? Presenting family members with the sobering fact that at this time, their life circumstances may have changed very drastically and that it will take much time and effort before they are able to absorb and accept the lost, is a strong message yet one which may need to be introduced.

CHILDREN AND SUICIDE

When students and school age children are exposed to suicide, the impact can be intense and frightening. Someone they know killed themselves. Generally, very young children are not given the facts, and it is wise to protect them from the word “suicide”, “shot herself to death”, “drank poison” and other factual and vivid descriptions. The fact of death being permanent and terminal can be presented to a young child but little is to be gained by trying to explain to a child what happened. With time and maturity that information can be revisited but very young children have no reference place in their young minds to understand the concept, much less the reality, of suicide.

Children a bit older, say, third grade and above (generally) can be told that “he was very ill with a rare sickness and the pain was so strong that he were not able to think clearly” or a similar rendition of the event so that the child understands that this was a very unusual condition and that the death came because the person was unable to control their pain and ask for help. School age children may ask for a lot of facts and for more information and the adult needs to use discretion in what is shared with a child. As with all traumatic news, children need to be educated about not listening to or repeating rumors, and to check out any confusing gossip with a teacher, rabbi or parent rather than sharing it with others.

Older children and teens may ask more philosophical questions. They likely have heard that the death was a suicide and they are likely to have questions about this. Addressing their concerns, validating their confusion and doubts, acknowledging that there are many conflicts surrounding the matter, and encouraging them to discuss their reactions while also paying attention to other reactions which they might have in thought, body or emotions, are all part of the necessary processing. Older children and parents will need guidance about insulating younger ones from the grotesque and painful facts. They may need your guidance also in the event that younger children hear things and want clarification.

THE COMMUNITY

Whether the suicide was a well-known figure or was a hardly known member of the community, a child, adult, male or female, very religious, religiously liberal, well liked, hated, addicted, healthy… all of those

factors are not as important as is gauging the reaction and the ripple within the community. Loss of a member of the community by suicide often warrants some level of community discussion, by the rabbis, by professionals, particularly when the surviving family members may have been reticent and said little at the hespedim. As always, it is important to secure the permission of the family before embarking on a community gathering where suicide might be referenced. Similarly, before an assembly is held in school, it should be cleared with family as to what is going to be shared. There are ethical dilemmas at times, such as when the family wants the cause of death hidden yet it is already well known on the street. In situations like that, a protocol should be followed, including consultation with the school's "daas Torah" and with a trained professional, in determining how to juggle family preference versus community need.

At times a concern arises about "copy cat suicide", meaning that once someone has taken their life, others might be triggered to do the same. This concern is not without basis, and for that reason, a community discussion about improving our connections with our children, the family becoming a more open and comfortable environment, speaking to our children about their stresses and their fears, and providing them as needed with professional and clergy outlets to process their feelings, and also wholesome steps which can partially insulate others from entertaining self-harm. Parents do need to be mindful of their children's habits, vices, preoccupations, pressures and signs of potential self-harm ranging from drinking, drugs, cutting, sleep deprivation and other signs of latent or overt turmoil.

A tactful and caring discussion between a stable parent and children, addressing suicide and self-harm, will not precipitate a child taking lethal action. Failure to take a loving and concerned role in a child's life however can make their personal conflicts more intense. Thus, following a tragedy, it is important to provide parents with some tools for addressing their children. Project Chai is available for consultation and you can reach our staff at 855 3 CRSISIS.

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