EXPERT COMMENTARY

Providing Comfort After Suicide

More than 33,000 suicides occur in the United States each year, and 4.47 million people in this country have lost a family member or friend to suicide.

Considering these compelling statistics, it is incumbent upon us as mental health professionals to provide compassionate care for those affected by suicide, increase understanding of the devastation suicide can cause for those left behind, and help survivors find new meaning and ways to move forward.

BY NANCY RAPPAPORT, M.D.

I am a suicide loss survivor, a practicing psychiatrist specializing in at-risk teens, and I have been a patient in my own therapy. From these perspectives, I have explored the trauma of suicide in depth, drawing from my journey of healing after my mother's suicide when I was 4 years old.

Here are a few observations from the front line that I hope will assist psychiatrists and others in their work with patients who are survivors of suicide loss:

► Self-knowledge, understanding one's own beliefs, biases, and feelings as they might stem from one's past, is essential if the clinician is to be fully present for patients. Examining unconscious judgments about people who die by suicide and the anxiety it might evoke in clinicians also is critical.

Such an awareness deepens the capacity to empathize and to be an anchor when patients are overwhelmed by a suicide. Survivors often are in turmoil with a range of responses—betrayal, anger, idealization, and extreme guilt—but perhaps most troubling is the agonizing and relentless effort to understand why the suicide occurred.

► Providing factual information about the causes of suicide, and providing context to an inexplicable loss, can be enormously helpful. A patient's clearer understanding of suicide can mitigate the pervasive guilt and "what ifs" that linger on. Listening openly, while gently challenging faulty assumptions about the burden of responsibility around a suicide, is critical.

By recognizing that each patient grieves differently and at varying paces, clinicians can assist by supporting and exploring at key times, such as anniversaries, births, and family celebrations where the absence is felt more acutely. As patients heal, they will, ideally, move past agonizing over how the suicide happened and begin to appreciate the person they have lost.

► Feeling isolated or stigmatized after losing someone to suicide is common; groups with other "survivors" of suicide loss allow for sharing with those who are similarly grieving. A patient might gain perspective, feel less isolated and ashamed, and benefit from the wisdom of those who have found a healing path.

► Families often struggle with how to carry on and find it difficult to support one another after a suicide loss. Silent grief can be overwhelming when people nurse their pain alone. Sometimes previous problems can intensify, and blaming occurs as a way to avoid the sadness. Therapists can encourage families to communicate constructively and help them find comforting rituals to share, such as participating in religious observations, lighting candles, or creating and keeping a memory box.

► Family members might have markedly different perspectives depending on their relationships with the person who died. Although there are no "right answers," clinicians should provide guidance on how to ask questions, and how to tolerate and respect each family member's personal truth. The family must seek ways to speak about a parent's death with surviving children, and guidance about how death is perceived by children at different ages can be useful. Families might ask how to deliver the message, and how to encourage ongoing honesty and questions. The clear directive is to "tell the truth."

► Patients might worry that suicide (particularly if it has occurred in multiple generations) might be a prophetic death sentence. Reassuring patients that they can take certain protective steps is useful. Identifying and treating mental illness early, prioritizing self-care, and limiting substance use are protective precautions.

► A lethal combination of risk factors for suicide is mental illness, impulsivity, access to weapons, and/or substance abuse. Clinicians need to educate families about how to identify and mobilize quickly to ensure safe containment and treatment as a way of preventing another loss.

As therapists, we are often privileged to witness our patients' most harrowing experiences with the faith that they can find a way to endure. As Emily Dickinson astutely wrote, "Not knowing when the dawn will come, / I open every door." I firmly believe that one can grow in positive ways from negative life experiences. We can at least partly ease our patients' suffering by being there for them in the most committed way possible so they are not alone as they weave their pain, questions, and sorrow on the courageous journey to renewed purpose and meaning. ■

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EXPERT COMMENTARY

Informed Consent: One Size Does Not Fit All

All of us who have been involved in clinical research at one time or another have had to deal with institutional review boards and informed consent. I am sure that most of you, just as I did, find the process demanding, challenging, and sometimes arbitrary.

BY YUSUF YAZICI, M.D.

A lengthy form is forced upon the researcher regardless of what type of trial is being planned, what interventions will be used in the study, and what will be done with the data. There usually is no regard to reasonable exemptions, while an appreciation of what the planned study is actually about is often obscured.

Clearly, for most—if not all—treatment intervention trials, a strong IRB review and a long informed consent are needed. However, it is more difficult to make the same argument for observational or routine care studies. In those cases, most of the measures that would or should be followed in a group of patients are part of routine care. As good examples (especially in the cardiology and neurology literature) show, the act of consent itself can lead to different baseline characteristics in the group that consented and was studied vs. the group that did not give consent and hence did not participate in the trial. These baseline differences can have an important impact on the final results and can limit the external validity of the study.

It might be time to look at individual studies very carefully and try to identify where the process can be simplified without any additional risks to patients. It would also be in our patients' best interest if some valuable observational studies were not impeded by unreasonable IRB and informed-consent requirements.

Another problem to consider is what the patients understand from the informed-consent process. Informed consent is not only for documenting patients' acceptance into enrollment in a clinical trial. It is now the patient's and the public's main source of information regarding the reasons for the planned study, what is known in the field about the proposed trial, and what to expect regarding efficacy and harm.

Clinical trial registries that have been developed over the last 5 years have served to alert researchers, health care providers, and patients to trials. Such registries also provide a way to make sure every trial that has been started is finally published. Having such a watchdog helps combat the bias against publishing negative trials.

The concept of the clinical trial registry has been designed to disseminate knowledge about clinical trials. Currently, brief protocol summaries—including aims, primary outcomes, criteria for inclusion and exclusion, duration of the trial, and planned intervention—of all clinical trials are available on the Internet.

Missing from the clinical trials registries is any information on informed consent. The World Health Organization has developed a single international standard for the information that trial authors must disclose. The informed-consent form (original or subsequent versions, if the trial protocol necessitates) is not among the listed items. More recent schemes to expand registration of clinical trials also do not include full disclosure of informed-consent forms. The exclusion of informed consent is a serious omission in our current attempt to make clinical trials more transparent.

It is worth noting that the current practice of approving the clinical trial applications including the informed-consent forms at IRB does involve the input of the public. There is at least one lay member of the community who is part of the IRB board. However, this is a very limited and short-term public availability. This transparency must be made more widespread and permanent, thus greatly enhancing the public's, peers', and patients' awareness of what is being studied. Perhaps the informed consents used in a trial should be included in these registries as well. ■

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