Do survivors respond differently when alcohol abuse complicates suicide? Findings from the psychological autopsy study in Estonia

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Abstract

Background: When a person with alcohol use disorder commits suicide, do the immediate family members (parents, spouses, and children) react differently from the relatives of non-alcohol-related suicides?

Methods: From a series of 427 psychological autopsies conducted in Estonia we selected 261 cases of suicide where the key informants were close relatives. Of the 261 suicides, 148 met the DSM-IV criteria for alcohol use disorder (alcohol abuse and alcohol dependence), while 113 did not. Unconditional logistic regression was used to estimate the association in terms of emotions.

Results: The spouses of alcohol misusing suicides were significantly more likely to react with anger than those when alcohol did not complicate the picture (adjusted OR = 3.8, 95% CI = 1.4–0.4). The children of persons with alcohol use disorder, who committed suicide were less likely to feel guilty (adjusted OR = 0.2, 95% CI = 0.1–0.8) or abandoned (adjusted OR = 0.2, 95% CI = 0.1–0.7) than children of non-alcohol-related suicide victims. There were no statistically significant differences in surviving parents’ emotions.

Conclusions: Alcohol use disorder before suicide changes affective responses in spouses and children who are left behind. Bereavement counsellors should be alert for complex grief and mourning responses among this group of suicide survivors.

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Keywords: Alcohol use disorder; Suicide survivors; Bereavement risk factors; Emotions

1. Introduction

Bereavement from suicide usually portends a difficult and complex adjustment for the survivors, who are likely to develop psychiatric and other health problems, experiencing guilt, anxiety, helplessness, rejection, sadness and disappointment (De Groot et al., 2006; Silverman et al., 1994; Tekavcic-Grad and Zavasnik, 1992). The social perception is that suicide cowardly stigmatises both victims and surviving family members, imposing a further burden on the bereavement process (Cvijan, 2005). Farberow (1993) described survivors’ distress as marked by a search for ‘why’, guilt, stigma, identification with the suicide or modelling, trust problems and anger.

The Leiden Bereavement Study (Cleiren et al., 1994) showed small influence of the mode of death on the reactions of surviving relatives, but proximity of relationship strongly affected virtually all aspects of survivors’ functioning. Parents (particularly mothers), widowers, and sisters of the deceased were more strongly affected than adult children, brothers and widows. Leahy (1992) found that when women lost a child, their depression was distinctly higher than those who lost husbands or parents. Stroebe and Schut (2001) concluded that the loss of an adult child results in more intense or more persistent grief and depression than the loss of a spouse, parent or sibling. Reed and Greenwald (1991) reported parents and spouses experienced significant differences in guilt/shame and shock after sudden death: parents suffered greater guilt, shame and shock than spouses. Grief experiences

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of siblings and children fell in between (except for somatic complaints and rejection). Although survivors beyond the immediate family may suffer from complicated grief caused by suicide also (Parrish and Tunkle, 2005), closely related survivors (spouses, parents, children and siblings) experience nearly twice the level of complicated grief as more distantly related survivors (Mitchell et al., 2004). Nevertheless, it is not only proximity of kinship that colours the bereavement process. The quality of the relationship with the decedent affects the bereavement process. Conflicts with the deceased influence how person reacts to loss (Worden, 2001). When survivors have had an ambivalent relationship with decedents before death, they are left with the unfinished business of anger, and are likely to suffer self-reproach (Sanders, 1993).

Alcohol use disorder has an enormous confusing impact on relationships, generating anger and ambivalence. These effects are even more exaggerated in the face of suicidal behaviour. According to Wasserman (1993), many suicidal persons with alcohol dependence have borderline personality types; they split affective reactions and are often confused as to whether love or hate comes from others, or arise in themselves that results to difficulties in distinguishing between the good and evil impulses in themselves and other people. Copello et al. (2005), reviewing the literature, concluded that persons with drug and alcohol use disorders often behave in ways destructive to family life and relatives. Velleman and Templeton (2003) point that family members of all age groups (children, partners, siblings, parents, other close relatives) can be affected. Wolk-Wasserman (1986) noted that breaking off relations with a suicidal substance-abusing patient is often a lively concern before death, and clearly reflects hostile ambivalence. When breaking off a relationship was threatened, substance abusers increased their suicidal communication, which presumably further reinforced the significant others’ ambivalence.

Marshal’s (2003) study advanced two competing hypotheses relating alcohol use disorder and marital functioning. The first hypothesis treats alcoholism as primary, a disorder that stresses marriages and threatens to break them down. The second hypothesis proposes that alcohol use disorder is adaptive, a means for relieving distress arising from marital dysfunction, tending, when not too severe, to stabilize a marriage, and perhaps preventing dissolution. The study’s results overwhelmingly supported the view that alcohol use is maladaptive, that it is associated with dissatisfaction, negative marital interaction patterns, and higher levels of marital violence. Wolk-Wasserman (1986) found that the suicidal hints or threats were usually not taken seriously by partners of persons with alcohol dependence, even when suicide had been attempted previously.

Parents of substance-abusing suicide attempters fear their children will commit suicide, which makes them irresolute and desperate (Wolk-Wasserman, 1986). They often accused their partners of causing their children’s troubles, and reproached social service and psychiatric authorities for failing to look after them properly.

Velleman and Templeton (2003) described the impact of parental substance use disorder on adolescents and young adults. They concluded that offspring of persons with alcohol dependence are particularly likely to report detach, switch off, avoid the drinking parent, and to blame themselves. Offspring described a variety of ways of escaping childhood adversity, such as leaving home significantly earlier than others.

The purpose of the present study was to explore how the immediate family members (parents, spouses, and children) of persons with alcohol use disorder differed in emotional reactions to suicide from other close survivors of suicides where alcohol use disorder was not present.

2. Material and methods

2.1. Data collection

In 1999, a total of 469 suicide cases (code E950–E959 in the ICD-9 nomenclature) were registered in Estonia. Procedures for registering and diagnosing suicide were described previously (Värnik et al., 2001). A preliminary list of completed suicides, obtained from the police and the bureau of forensic medicine, was verified by data from the Estonian Statistical Office. In 427 suicide cases (91% of total) a psychological autopsy study (Shneidman, 1981) based on face-to-face interviews with relatives and intimates of suicides, was carried out by psychiatrists trained for the study. Twenty-eight per cent of the key informants were spouses (including cohabitants), 20% were parents, 15% adult children, and 37%, other relatives and friends. Additional information on the suicides was compiled from the medical records in hospital archives. The Karolinska Institute Research Ethics Committee North approved the ethical aspects of the study.

The questionnaire used for the semi-structured interviews had been drawn up in Finland for the National Suicide Prevention Project (Lönqvist, 1988), translated into Estonian and Russian (large minority in Estonia) and adapted. It comprised eight sections, two of which assessed more precisely the status and feelings of survivors (Lönqvist, 1988). The possible emotions were listed in the questionnaire, survivors were asked to mark the emotions they felt during the period after suicide happened. Interviews were conducted not earlier than 2 months after the suicides; the average time interval between suicide and the interview was 6.3 months (±3.3). For alcohol-related suicides, the average interval was 5.9 months (±2.9) and for non-alcohol-related suicides, 6.6 months (±3.8). On average the interviews lasted 1.78 h (±0.67 h). There were no significant differences between survivor groups in duration of interview.

2.1.1. Diagnoses of alcohol use disorder. Diagnoses of alcohol abuse and dependence were coded according to DSM-IV principles using the psychological autopsy data and medical documentation. The procedure of diagnosing is described in detail elsewhere (Kõlves et al., 2006). Suicides assigned to categories “alcohol abuse” and “alcohol dependence” are grouped together as “persons with alcohol use disorder” in this study. One of us (A.V.) coded alcohol-use disorders in all suicide cases independently, using a blind method based on psychological autopsy data and medical documentation, according to hierarchical DSM-IV principles (American Psychiatric Association, 1994).

The pattern of alcohol use was classified for all cases in the following categories: alcohol dependence, alcohol abuse, former alcohol abuse, abstinence, moderate alcohol use, and indistinct, or uncertain, when insufficient information was available.

Clinical diagnoses coded according to ICD-10 were available for all suicide cases if the individuals had been referred to medical institutions before the study. Clinical (lifetime) diagnoses proved to coincide with research diagnoses. The coding results were examined and disagreements between raters were resolved through consensus. Kappa inter-rater reliability was 0.988 (p<0.0001). There were debatable issues in the diagnosis in four cases.

2.2. Statistical methods

From the psychological autopsy study (total of 427 suicide cases) the group of close relatives were selected for comparing the effects of alcohol use disorder by suicidents to survivors’ emotions. To estimate the association in terms of survivors’ emotions and alcohol use disorder by suicidents, the odds ratios (OR) adjusted for gender of survivor from unconditional logistic regression with
Table 1
Interviewed suicide survivors by gender, their kinship to suicidents, and alcohol misused and non-misused suicide victims

<table>
<thead>
<tr>
<th></th>
<th>Alc(^a)</th>
<th>Non-alc(^b)</th>
<th>Total</th>
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<tr>
<td></td>
<td>n</td>
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<tr>
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<td>72.3</td>
<td>28</td>
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<tr>
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<td></td>
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<tr>
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<td>14</td>
</tr>
<tr>
<td>Grand total</td>
<td>148</td>
<td>56.7</td>
<td>113</td>
</tr>
</tbody>
</table>

\(^a\) Alc = alcohol misused suicide victims.
\(^b\) Non-alc = alcohol non-misused suicide victims.

95% confidence intervals (95% CI) were calculated using emotions of survivors as dependent variable(s) and alcohol use disorder by suicidents and gender of suicide survivors as independent variables. To compare differences in survivors’ groups, the χ²-test was used. The level of statistical significance was set at \(α = 0.05\).

3. Results

3.1. Subjects

In this study, the closest survivors included parents (\(n = 85\)), spouses/cohabitants (\(n = 119\)) and children (\(n = 65\)). Group of others (not related or not close relatives) (\(n = 158\)) and cases categorized as “indistinct cases” due to insufficient data for diagnosing alcohol use disorder (\(n = 8\)) were excluded, leaving for analyses the total number of 261 respondents (Table 1).

Suicide survivors differed significantly by gender (\(p < 0.001\)): 22.2% from parents, 12.9% from spouses, and 57.8% from children were males. The survivors of persons with alcohol use disorder differed significantly from non-alcohol-related suicide survivors (\(p = 0.02\)) (Table 1).

3.2. Emotions

Comparison of emotional reactions of parents of persons with alcohol use disorder to non-alcohol-related survivors showed that parents of the suicidents with no alcohol use disorder were more likely to have a greater range of affective experience, but not at a level that reached statistical significance (Table 2). The only significant difference between spouses of alcohol misusing and non-misusing subjects was for anger towards the deceased mate—spouses of suicidents with alcohol use disorder had significantly higher likelihood of feeling anger towards the decedent than spouses of suicidents with no alcohol use disorder (adjusted OR = 3.8, 95% CI = 1.4–10.4). Children of alcohol misusing suicides were significantly less likely to have experienced guilt (adjusted OR = 0.3, 95% CI = 0.1–0.8) or feelings of abandonment (adjusted OR = 0.2,
95% CI = 0.1–0.7) than children of non-misusing suicides (Table 2).

4. Discussion

We are unaware of any studies describing survivors’ bereavement responses in cases of alcohol use disorder related suicides compared to non-alcohol-related suicides. Survivor reactions to suicide are strongly influenced by the nature of the premortem relationship between survivor and the suicide. Kinship relationship and the quality of the relationship that the bereaved had with the deceased emerge as two important factors in the present study. Though we have no quantitative data respecting quality of relationship from the present study, it seems obvious that alcohol use disorder of deceased affects the grief patterns of those left behind after suicide. From the literature it is reasonable to conclude that alcohol use disorder invites ambivalence and conflicts to premortem relationships (Copello et al., 2005; Velleman and Templeton, 2003; Wolk-Wasserman, 1986).

Our results are consistent with those published elsewhere respecting the important effects of kinship status (Cleiren et al., 1994; Leahy, 1992). Significant differences in emotional reactions to the loss in different kinship groups revealed spouses and parents to be relatively more affected by loss than adult children. Emotions such as sorrow, depressive feelings, powerlessness, and guilt were most frequent among parents. Spouses were more likely to feel abandoned and angry.

Parents were more likely to blame someone else for suicide. Generally they feel more responsibility for a son or daughter and may manage their own implicit sense of guilt and shame to their eyes during the interviews and they experienced deep same time horrified by their own thoughts and words; tears came to their eyes during the interviews and they experienced deep guilt and anguish.”

Spouses, compared to other groups, reported the highest frequencies of anger and feelings of abandonment. Married people usually depend on their partners to support them and help them through life’s difficulties. When a spouse commits suicide, powerful feelings of confusion, betrayal, and anger are aroused. It can evoke feelings of betrayal and overwhelming confusion that can result in anger. To be left alone to face emotional, social and financial challenges without a mate seems too unfair.

Alcoholism in any close relationship causes tension and conflicts, contributing also to problematic bereavement outcomes. Spouses of suicide victims with alcohol dependence had significantly higher risk of feeling anger toward their dead partners than did those who lost wives or husbands to suicide in the absence of alcohol use disorder. There are indications that with alcohol complicating the picture, spouses left behind are even angrier when marriages were burdened with conflict (Worden, 2001).

Children reported fewer emotions than parents and spouses. This result is congruent with reports of earlier studies (Cleiren et al., 1994; Leahy, 1992), where the least affected by death were adult children of the deceased. Children of alcohol misusing suicides were significantly less likely to feel guilty or abandoned. Our results concur with previous studies—in ambivalent relationships the family members withdraw from each other (Cleiren et al., 1994; Velleman and Templeton, 2003; Wolk-Wasserman, 1986).

In conclusion, surviving parents (followed by spouses) were more likely to have experienced any kind of different emotions during the bereavement process than adult children in the same comparison. Parental emotions were not affected by alcohol use disorder when a child suicided, but some emotions of spouses (anger) and children (guilt and feeling of abandonment) were.

Bereavement experiences of survivors are not homogeneous, and are influenced by kinship proximity as well as the presence or absence of alcohol use disorder. This perspective may be important to counsellors and psychotherapists who attempt to help those left behind by suicide.

One of the limitations of the study was different time interval between suicide and the interview in different cases. However, the average time interval between alcohol-related and non-alcohol-related suicides was small: 5.9 and 6.6 months, respectively. Another limitation, “shame” as a frequent emotion in suicide bereavement was absent in the list of emotions survivors were asked to mark.

Further research should be done addressing the quality of relationship, emotional attachment, the impact of age (survivor and suicident) to bereavement and other factors that influence bereavement outcome.

Conflict of interest

All authors declare that they have no conflict of interest.

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Contributors: Author Tall, K. managed the literature searches, wrote the first draft of the manuscript and contributed in completing final manuscript. Author Kõlves, K. designed the study and undertook the statistical analysis. Author Sisask, M. contributed to the literature searches and summaries of previous
related work. Author Värnik, A. contributed to the literature searches, data management and supervised the process. All authors contributed to and have approved the final manuscript.

References


