Suicidal Behavior in Surviving Co-Twins

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Recent research has provided strong support for the existence of a familial risk for suicide, and efforts have been made to separate genetic from enviromental risk factors. Twin studies have played a major role in the identification of genetic factors, and the results indicate that the concordance rate for suicide is higher in identical than in fraternal twins (Baldessarini & Hennen, 2004). Moreover, Segal and Roy (1995) reported a significantly higher frequency of nonfatal suicidal attempts by monozygotic (MZ) than by dyzygotic (DZ) twins whose co-twins had committed suicide. However, doubts remain as to whether the increased risk of suicide in MZ twins is a response to the intense grief over the loss of a close relative, or whether a common genotype is associated with suicidal behavior. Sudden loss, which may carry a stigma in the case of a suicide, has been linked to increased persistent emotional stress and physiological changes (Epstein, 1993; Martin & Dean, 1993). A number of researchers have reported greater suicidal ideation among bereaved MZ twins as compared to DZ twins, suggesting that a loss due to suicide may increase the risk of suicidal behavior in the surviving co-twin (Segal & Bouchard, 1993; Segal & Roy, 1995; Segal et al., 1995). The aim of the present article is to address the issue of the intense grief experienced by twins after the co-twin suicide.

Psychache

Shneidman (1985) has proposed the following definition of suicide: 'Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution' (p. 203).

According to Shneidman (1993a), suicide is caused by psychache, the hurt, anguish and psychological pain in the mind. Suicide occurs when the psychache is deemed by that person to be unbearable and, therefore, Shneidman suggests that the key questions to ask a suicidal person are 'Where do you hurt?' and 'How may I help you?'. If the function of suicide is to put a stop to an unbearable flow of painful consciousness, then it follows that the clinician's main task is to ameliorate that pain. Shneidman (1993a) pointed out that the main sources of psychological pain, such as shame, guilt, rage, loneliness, hopelessness and so forth, stem from frustrated or thwarted psychological needs — especially those described by Murray (1938). These psychological needs include the need for achievement, affiliation, autonomy, succorance, exhibition, nurturance, order and understanding.

Shneidman (1993b) suggests that, 'Suicide is best understood not so much as a movement toward death as it is a movement away from something and that something is always the same: intolerable emotion, unendurable pain, or unacceptable anguish. Reduce the level of psychache and the individual who wants to commit suicide will choose to live' (pp. 23).

The Trauma for Survivors of Suicide

Survivors of individuals who committed suicide constitute a large population of individuals whose profound grief is almost always underestimated. A survivor of suicide is a family member or friend of a person who died by suicide. Survivors of suicide represent 'the largest mental health casualties related to suicide' (Shneidman, 1969, p. 22). Survivors often struggle with the reasons why the suicide occurred and whether they could have done something to prevent the suicide or to help their loved one. Feelings of guilt typically ensue if the survivor believes their loved one's suicide could have been prevented. There is evidence to suppose that between six and 24 survivors are affected by each suicide. Campbell (2006) and the *SOS: A Handbook for Survivors of Suicide* (Jackson, 2003), published by the American Association of Suicidology, report the trauma of losing a loved one to suicide as 'catastrophic'.

There is evidence to suppose that many health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients and clients, and do not know how to refer them properly for specialized assessment and treatment (Bongar et al., 1992; Ellis & Dickey, 1998; Ellis et al., 1998; Kleespies, 1998). Although a number of campaigns have addressed awareness of suicide as a major

Received 20 July, 2006; accepted 31 July, 2006.

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public health problem, gaps remain in training programs for health professionals and others who often come into contact with patients who require suicide assessment and intervention. Many health professionals also lack training in the recognition of risk factors often found in the grieving family members of loved ones who have died by suicide.

When suicide occurs it results in shock and disruption for those who may have witnessed the event or who arrived on the scene soon thereafter, as well as for the responding emergency medical personnel. These are emotionally charged situations that leave indelible memories for all those involved.

Family members, significant others, and acquaintances who have experienced the loss of a loved one due to suicide may be at increased risk for self-destructive behaviors, as well as for a range of adjustment problems, often directly linked to their sudden status as survivors.

Making Sense of a Twin Suicide

According to a study based on the Danish cause-of-death registry, twins have a reduced risk of suicide (Tomassini et al., 2003), suggesting that having strong family ties reduce the risk for suicidal behavior. However, there is some, although disputed, evidence that twins have a higher prevalence of psychiatric disorders than singletons, and this could increase the risk of suicide (Klaning et al., 1996).

The intensely close bonding which occurs between identical twins can result in levels of grief and loneliness for the rest of their lives following the death of one twin, and a death from suicide may make this psychache even more intense. Survivor twins may never be able to get beyond their loss of companionship of their 'womb-mate'.

The author's (MP) clinical experience of psychotherapy with a twin indicates that psychotherapy may sometimes be incomplete without the presence and cooperation of the co-twin. A patient (in therapy with MP) stated that proper understanding of unconscious process by the therapist was possible only if the missing twin was allowed into therapy. This bonding has, therefore, a great impact when one of the twins dies.

Psychoanalytic studies have reported that separation and individuation involve the twin as well as the mother, pointing to the fact that separation from the mother may be replaced by a prolonged symbiosis between the twins, whose separation and individuation from each other may be long delayed as a consequence (Engel, 1975). The loss of a co-twin seems to make the remaining twin aware that they have lost a person whom he/she had been together with from the very moment of conception. Parents often refer to them simply as 'the twins', implying that they are an entity with just one ego boundary and pointing to the vagueness of their self-concept.

Losing a twin involves a struggle to separate oneself from the dead twin. Experiences of depersonalization and confusion have been reported (Engel, 1975), perhaps based upon the narcissistic gain of the dual unit, suggesting that the living twin has lost not just an object but a part of the self.

How does a twin make sense of a twin suicide? If we conceptualize suicide as a solution to an unbearable mental pain and as a narcissistic act, the living twin must make sense of a selfish remedy that will affect his/her life, and he/she must come to understand and accept that the diffuseness of the ego boundaries was not as great as expected. The living twin must also accept the highly aggressive action toward the joint ego performed by the twin who committed suicide. On the other hand, death 'can mean reunion, that is, re-establishment of the longed-for and valued dyad, the twin unit' (Engel, 1975, p. 36). Persistent unresolved conflict may remain unconscious and effectively defended against, until reactivated by a stimulus, such as special dates, anniversaries, images and sounds.

Surviving Twin Suicide

The challenge of coping with a loved one's suicide is one of the most trying ordeals people have to face. There are people who have suffered breakdowns decades after a suicide because they refused or were forbidden to ever talk about it.

Krysinska (2003) reported that suicidal behavior is often precipitated by an individual's experience of loss by suicide and that suicide bereavement has certain typical characteristics that comprise a 'suicide survivor syndrome' and may be linked with increased risk of suicidal ideation and behavior. People's suicidal behavior and ideation can lead to suicide clusters, such as a group of suicides or attempts occurring close together in time and space. The risk of committing suicide is far greater for those who come from a family in which suicide has been committed. For example, Ernest Hemingway and two of his five siblings committed suicide in the years after the suicide of their father. Tomassini et al. (2002) reported that the risk of dying for a twin is highest in the first year after the death of the spouse as well as in the second year after the death of a co-twin.

A proper understanding of a twin survivor's grief and guilt is often lacking in clinicians. Such a loss is something that will last for the rest of the co-twin's life, and there is evidence to suggest that mental health professionals do not generally recognize that the loss of a co-twin leaves deep impressions, regardless of when in life it occurs. This lack of understanding arises perhaps because twins are noticed only when they are seen together. But precisely because twins feel so close do they need extra assistance in life to get over the loss of 'their other half'.

Another important consideration is the role of stigma in increasing suicide risk. Pompili et al. (2003) reported that stigma can lead to increased risk of suicide. Following the loss of a significant other by suicide, many individuals feel isolated or ignored by health professionals. Society still attaches a stigma to

https://doi.org/10.1375/twin.9.5.642 Published online by Cambridge University Press

Table 1

Feelings Involved in the Loss of a Co-Twin by Suicide and Possible Intervention to Cope With Loss

Feelings involved in the loss of a co-twin by suicide	Impact on daily life	Possible interventions for the living co-twin
Grief	Increased focus on suicide cues	Adopt the psychological autopsy method which allows examination of the deceased's records and collection of information from the living co-twin
Disbelief	Feeling of betrayal	Involve parents, relatives and friends who knew the individual who committed suicide
Denial	Increased concern with death issues	Point out the utility of the meeting in order to assess preventive measures
Guilt	Guilt	Emphasize how awareness of the problem can stimulate new coping skills
Shock	Possible increase in drug or alcohol abuse	Allow people more closely involved in patient's suicide to have opportunity to speak with the twin during specific sessions (without interruptions and in a quiet environment)
Anger	Intrusive thoughts of suicide	Point out what kind of coping strategies can be used
Fear of blame	Loss of self-esteem	Analyze the role of life events
Self-doubt	Disturbed relationships with family	Discuss possible reactions from patient's family
Decreased self-confidence	Dreams related to the suicide	Consider the possibility of meeting each patient's family members
Inadequacy	Social withdrawal	
Frustration	Disturbed relationships with friends	
Shame or embarassment		
Anxiety		
Anhedonia		

suicide, and suicide is often misunderstood. While mourners of those dying natural deaths typically receive sympathy and compassion, the suicide survivor may encounter blame, judgment, or exclusion. Not only does the stigma of survivors prevent people from seeking treatment, which in turn exposes them to a greater risk of suicide, but suicide can also appear to be the best solution for a stigmatized individual who feels trapped with his or her grief.

What to Do After a Co-Twin Suicide

Surviving a co-twin suicide is often a more devastating experience than the grief normally experienced by survivors in general. Although a number of agencies now provide programs for those who have lost a family member by suicide, such programs may not be tailored for individuals who have lost a co-twin by suicide. Furthermore, psychotherapy-based interventions may be too complicated, too expensive and not well accepted by survivors. Despite the fact that supporting groups for twins supervised by twin therapists are occasionally available, one option is to develop brief twin-oriented intervention for twin survivors of suicide. Feelings that may be involved in the loss of a co-twin by suicide, the impact on everyday life, and possible interventions to ameliorate the grief and the psychological pain are listed in Table 1.

Therapists should be aware of the particular kind of psychologcal pain that the surviving co-twin may be experiencing and should provide what Shneidman (1996) has called *anodynic psychotherapy*; noting that an 'anodyne' is a substance or agent that/who reduces the pain. Therefore the single most important key in anodyne therapy is a tailor-made focus on the alleviation of the patient's frustrated psychological needs that may have developed from the loss. Such an approach may be used even in brief supporting interventions. The patient and the therapist should redefine and fine-tune their understanding so that words like 'unbearable' and 'intolerable' really mean 'barely bearable' and 'somehow tolerable' (Shneidman, 2005).

In conclusion, we stress the need to increase our knowledge and understanding of the extreme grief experienced by the loss of a co-twin by suicide, an event that may reduce quality of life and increase suicide risk in the living twin.

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https://doi.org/10.1375/twin.9.5.642 Published online by Cambridge University Press

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https://doi.org/10.1375/twin.9.5.642 Published online by Cambridge University Press