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Research Article

Teen Suicide Attempt: The Subjective Experience of the Family

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Abstract

This study aimed to understand the impact of a teenage child's suicide attempt at a family level, based on the subjective experience of the family as a whole. A qualitative study based on an hour and a half interview with the entire family was performed within two weeks of the suicide attempt. Ten adolescents hospitalized in a psychiatric unit of a Health Service of the Metropolitan Region, in Chile, and their families, were interviewed. The interviews were recorded, transcribed and analyzed using the Grounded Theory methodology. Three major categories emerge from the analysis: Process Vision, Family Dynamics and Hospitalization Experience. Families perceive a before and after of the suicide attempt in the subsequent evolution of the family system. Changes occur in the way they 'read' the experiences and signs prior to the suicide attempt, in the understanding of what happened, and in the transformations of the relational dynamics as a consequence. Family resilience will depend on their history and how they have learned to cope with difficulties. Although one of the most recurrent reports regarding the suicide attempt refers to the traumatic component that it had in all the family members, they also state that this event has meant great learning as a family and an opportunity to grow, to get to know each other better and help each other. The benefits for the family of having a safe space to talk about how they feel and elaborate on what happened, without fear of being judged, has been highlighted. This enhance the need to incorporate the family as a whole when we think about an adolescent suicide attempt, both in understanding the phenomenon and in intervention and treatment.

Keywords: Traumatic; Intervention; Suicide; Family Dynamics

Introduction

This study considers families in which an adolescent child has attempted suicide

From the systemic tradition, the family is understood as a system that, as a whole, works differently from how each of its parts works. Every family has a certain structure and complex relational patterns that distinguish it from other families, although it is not without transgeneracional inheritance from both families of origin that help to constitute the nuclear family.

Due to the above, it is also important to emphasize that conflicts within families resonate in each of their members in a peculiar way, considering the position and to play in the system.

The primary task of development in adolescents is differentiation, which brings with it a series of ambivalent feelings, both in adolescents and in the rest of their families. In particular, the father and/or mother are often impotent in the face of the requirements of their adolescent child [1,2].

In addition to abrupt physiological changes, important psychological changes also occur as a consequence of this, or as part of the process of change. In fact, it has been shown that a large part of adolescents experiences depression, which is also coupled with suicidal ideas that are not exclusive to young people with depression [2,3].

New cognitive capacities acquired in adolescence allow young people to reflect on themselves and this often leads them to judge their own behaviors and those of their parents. At the same time, parents are immersed in a confusion that leads them to detach themselves from their children more than would be adequate with respect to the containment and care needs they require.

Depression arises as a symptom that could indicate some difficulty in the family system that demand attention. Some adolescent feels abandoned and lacked positive and validating relationships with their parents. Many times, there are secrets, alterations in the family structure or displacement of conflicts between parents and/or partner conflicts towards the child, which may be at the base of adolescent depression [2,4].

We can see depression and suicide attempts as a way that young people attack themselves instead of their parents. The adolescent wishes to protect them, both from the conflict that is within the family and from the feelings of anguish that they could have if he/she reveals his/her pain to them. However, the dramatic withdrawal of adolescents from their parents and their social context paradoxically provokes in them the anguish that he/she tries so hard to avoid them [2].

In general, parents are not conscious of the degree to which their children suffer from psychic pain, and it requires dramatic behaviors such as self-harm and/or suicide attempts to make them aware, and

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oblige them to take charge of the problem, but they don't always have enough tools to do that.

There has been little research focused on the needs of the family that survives a suicide attempt or the suicide of one of its members [5,6]. Most of the research aims at stigmatizing families, considering failures in the exercise in parenting are the sole culprit for the attempted suicide of one of their children [7]. It is thought that it is more useful to understand the systemic-relational impact that an event like this can have, since suicide attempt occur within families and is experienced as a traumatic event [8,9].

The suicide attempt or suicide of a family member affects every member of the family system and increases the risk of deterioration of mental health and/or relationship problems among family members and/or with others [10]. After the tragedy, the family feels fear, sadness, guilt, and a sense of loss [11]. If it is not the first time, they can feel frustration, deception and the temptation to give up in the face of events [12]. In short, life as they knew it until now has disappeared.

As a result of a suicide attempt, families are often left alone with the tragedy that has happened, in a state of emotional chaos, with permanent thoughts of death or accident [13]. Many families cannot even talk about it openly, for fear of reaction and rejection by others. They themselves often refuse to accept the reality that a loved one attempted or committed suicide and live with this denial and therefore refuse help. Bereaved children, faced with a lack of emotional support, may have their emotional and physical development potential damaged [12].

The family members cannot manage the crisis by themselves. A support system is needed to help make sense of the trauma they face. Freely talking about what occurred, about their own overwhelming feelings, helps them process what happened [13]. Not talking about it or ignoring the subject completely often further complicates the already complicated situation and may even increase the risk of future suicide attempts.

The period immediately after the suicide attempt can be critical for reconstructing interpersonal relationships and establishing trust between the suicide survivor and the other members of the family [14]. Often being able to talk to someone of trust often diminishes the intensity of the experience. In such dialogues, it is important to remember that when the person tried to commit suicide, she suffered strong emotional pain and great anguish.

However, in practice there is not much support for families facing a suicide attempt or suicide by one of its members, regarding the consequences of this tragedy. All therapeutic efforts focus on the individual who made the suicide attempt. The family needs family therapy before and after hospitalization by a trained therapist with experience in the subject of suicide [12].

The first task of the therapist is to empower the parents so that they can organize a way to care for their child and protect him from his self-destructive tendencies. This gives the teenager a clear signal that her parents can and want to take care of her, and that they will.

Parents need to be helped so that they can converse with their child and urge them to see their interest in the relationship and that suicide would end this bond forever. At the same time, help them listen the reasons that their child may have had for doing something like this, that they can empathize with their pain and endure whatever the adolescent tells them [2].

The therapist should dismiss the defensive responses from parents to allow the child to have a space where they can really express what they are feeling. Concurrently, the therapist must underline to the parents what appears to be novel or what was heard in a different way. In serious conditions such as major depression, which often occurs with suicide attempts, one of the most frequent relational patterns refers to the paradox "tell me/don't tell me" That parents display in the interaction with their adolescent children. In other words, they are interested in knowing what is happening to their child, but many of their attitudes deny this. For example, they can always do something while talking and/or minimize what the adolescent says, as well as showing themselves to be too anguished [2].

Likewise, to highlight the importance of the fact that the therapist allows parents to express their feelings of ambivalence, overwhelm and distress, without this appearing as a difficulty in taking care of the child or sacrificing the relationship with him/her. The therapist works to break the symptom cycle and thus be able to intervene in the emotional aspect of the relationship, especially in the balance between closeness and distance that parents must maintain at this stage. To this we must add the need to bring the entire family together, not only the symptomatic child with their parents, but also their siblings and, if necessary, the extended family.

Contrary to what has been described, basically two difficulties are noted in the extra - system. One of these refers to the lack of resources to obtain psychotherapeutic help, which forces families to drift and seek their own path for emotional healing [13]. The second difficulty occurs when families obtain therapeutic help, and they meet with a therapist who has the notion that it is only necessary to treat the adolescent to remove him/her from family problems that may be interfering with his development. With this, they leave the adolescent in greater isolation and further deactivate the possibility of containment that the family may offer. No doubt, this constitutes and is experienced by the parents and siblings as a complete disability, deepening family pain and intensifying the conflict.

Given the above, the present research aims to deepen in the understanding of the impact of a suicide attempt of one adolescent on the family, considering that family system itself should be the best source of healing.

It is hoped to access the subjective experience of the family through the representations, wishes, affections, thoughts, images and attitudes, as well as the internal dialogues that underlie this tragedy.

Methods

In order to explore the subjective experience of families when faced with a suicide attempt by one of their teenager children, a qualitative study was conducted based on interviews with the entire family, including the child who attempted suicide. The interviews were recorded, transcribed and analyzed using the Grounded Theory Methodology.

Grounded Theory is a simple, integrated and highly structured methodology that emphasizes discovering comprehensive theories

based on particular data, through an inductive process. It is a recursive process in a constant dialogue between data collection, data coding and the formulation of theoretical hypotheses [15]. The definition of the problem is usually provisional, and it is intended to capture the complexity of the phenomenon under study, including its context [16]. For this reason, the importance of considering negative cases is emphasized, that is the findings that do not agree with the majority, since they represent the opportunity to reconsider the expressions of the phenomenon studied and create new categories and new relationships among the different concepts. This methodology considers three stages: An Open Analysis, then a Relational Analysis (in which the most relevant conceptual categories that emerge are expressed) and finally, the Selective Analysis or central category.

Participants

Ten families from the psychiatric hospitalization of a Metropolitan Region Health Service were interviewed. The interviews were conducted with the maximum of two weeks after the suicide attempt. Families were from distinct sociocultural backgrounds. Adolescents who made the suicide attempt were between 14 and 18 years old, and 9 out of 10, were women. All the mothers were present at the interview, and only in 2 families, the father did not attend, since there was no contact with him. All the siblings who currently lived in the family home also attended the interview.

Since getting closer to the meaning of the representations of the subjects is the ultimate goal of qualitative methodologies, sampling is then a dynamic process that is at the service of the saturation of the encountered categories and not at the service of representativeness. Although the collection of the sample begins with the research question, it does not end there, but rather continues to expand and reconstruct itself over time with new questions and the categories that appear.

The research question that is part of this study determines certain characteristics of the sample that allowed us to account for the phenomenon to be studied, in this case, the subjective experience of a family in which one of their children attempted suicide.

Procedure

Adolescents who had attempted suicide and who lived with their family, either with one or both parents, were identified among patients admitted to a psychiatric hospitalization service. One of the researchers, with the agreement of the patient's treatment team, invited them to participate verbally and in private. The researcher explained the objective of the study, the need to carry out the interview with the entire family, and the voluntary nature of their participation, and provided the written informed consent form so they could read it with ease, and later they could ask for clarification about any doubts and give their response.

Many patients refused to participate for reasons such as not wanting one/s of the family members to find out that they had attempted suicide, fear of the conflict and/or aggression that could be generated within the family, not wanting to have the interview recorded, or living in another city, which would impede meeting with the entire family. Others agreed, but ultimately prevented the interview from taking place. In cases where the adolescent agreed to participate, authorization and contact details were requested to communicate with the parents and request their consent. There were cases in which the adolescent agreed to participate, and the parents did not. In the cases where both, the hospitalized adolescent and their parents gave their informed consent, the interview was coordinated with the team's expert family therapist. The interviews took place at the health service.

Instrument

As noted above, the data collection instrument was a family interview. A thematic script was prepared based on the research question and objectives. The interviews lasted approximately an hour and a half, and the themes made direct reference to the thematic script.

It is desirable that the researcher suspends any judgment during the fieldwork. However, this must be in permanent tension with the ability to generate theory, to think and analyze the data and be surprised by what the phenomenon shows, by the voice of the data. Theorizing concludes only when the discovered categories are saturated and the surprise ends for the one who knows.

In accordance with the previous, the narrative of the informant and not the researcher's was privileged, and the expression, as detailed as possible, of the subjective experience of everyone regarding the suicide attempt was favored. Because the interviews were being analyzed in parallel with other interviews being carried out, certain topics were deepened more than others, in order to complete the range of information.

Data analysis

The interviews were recorded and transcribed completely. Their content was analyzed with the Grounded Theory Methodology, which is consistent with the purpose of qualitatively exploring the subjective experience of the family.

The data was first processed in the form of codes that referred to the most relevant incidents. We then proceeded to an open analysis, where categories of different levels of abstraction were generated. Subsequently, based on the central categories, a relational analysis was carried out, with more abstract and comprehensive categories, and finally, it concluded with a selective analysis containing the observed central category. The central category implies the narrative axis of the investigation, the core of the studied phenomenon [17].

The investigator peer triangulation technique was employed to avoid introducing bias [15,16,18,19]. Consistent with the theoretical framework of the study, it was decided to analyze the interviews without distinguishing the different voices in the family, but as a system that operates as such and, therefore, has a single voice that is different from the sum of each of the members of the system.

Ethical aspects

The participants had full autonomy and freedom to decide to participate in the study or not, without any prejudice for refusing to do so. All family members signed informed consent forms that provided details on the objectives of the study, the requirements for their participation, benefits and risks associated with it, guarantee of their anonymity and the freedom they had to withdraw from the research at any moment that they wanted to.

In giving their consent, the family members also authorized

the audio recording and transcription of the interview. The Ethics Committee of the School of Medicine of the Pontificia Universidad Católica de Chile approved the informed consent protocol. To ensure confidentiality and the anonymity of the participants, their real names were known exclusively by the research team and the research material has been guarded safely.

Results

Relational analysis

Three major categories, which are discussed below, they arose from the open analysis: Vision of the Process, Family Dynamics y Hospitalization Experience.

Category I: Vision of the process

The first major category that emerges is the Vision of the Process. It refers to the family's idea about what they have experienced as part of a process that has a temporal dimension. They perceive as before, a during and an after of the suicide attempt in the evolution of the family system. Within this category, there are four subcategories (Figure 1).

Before the suicide attempt: Families discuss the signs they may have noticed before the suicide attempt, but many were misinterpreted, confused, minimized, and some were even ignored. This is explained by ideas about adolescents or as bad moments that a person goes through in the course of life.

"I didn't know how he was feeling, I didn't know it was such a severe depression" (E VII: 42).

"...We ourselves…everything that has happened has left us looking inside, because we had no sign…" (E IX: 61).

"... I had not heard her that way ... she felt that dying would solve everything ... I did not imagine that she felt like that, so badly, like she felt she was a weight on us" (E VI: 115, 116).

"... As adults, we think that it was like the typical crisis, of passing from adolescence to adulthood and we said OK, that she doesn't feel comfortable with us..." (E VIII: 8.46).

On the other hand, there is an attitude of denial and emotional disconnection, both in the face of the situation that they were living and of minimizing the symptoms, the young person presented.

"… But it is difficult, difficult to explain it; it is difficult to assume it as such. Although one understands it, one also minimizes gravity many times…" (E I: 285).

This is reflected in what the families describe as carelessness in the context of means of suicide available to the adolescent.

"... I looked at the pills and I searched for what they did if I took them in an overdose and it said that it produces a respiratory arrest, so I put them together with Aradix and then I took them all ... my nanny came and looked at all the empty pills and there were a lot, and there she goes and called my dad and he sent me to the clinic urgently…" (EX: 50).

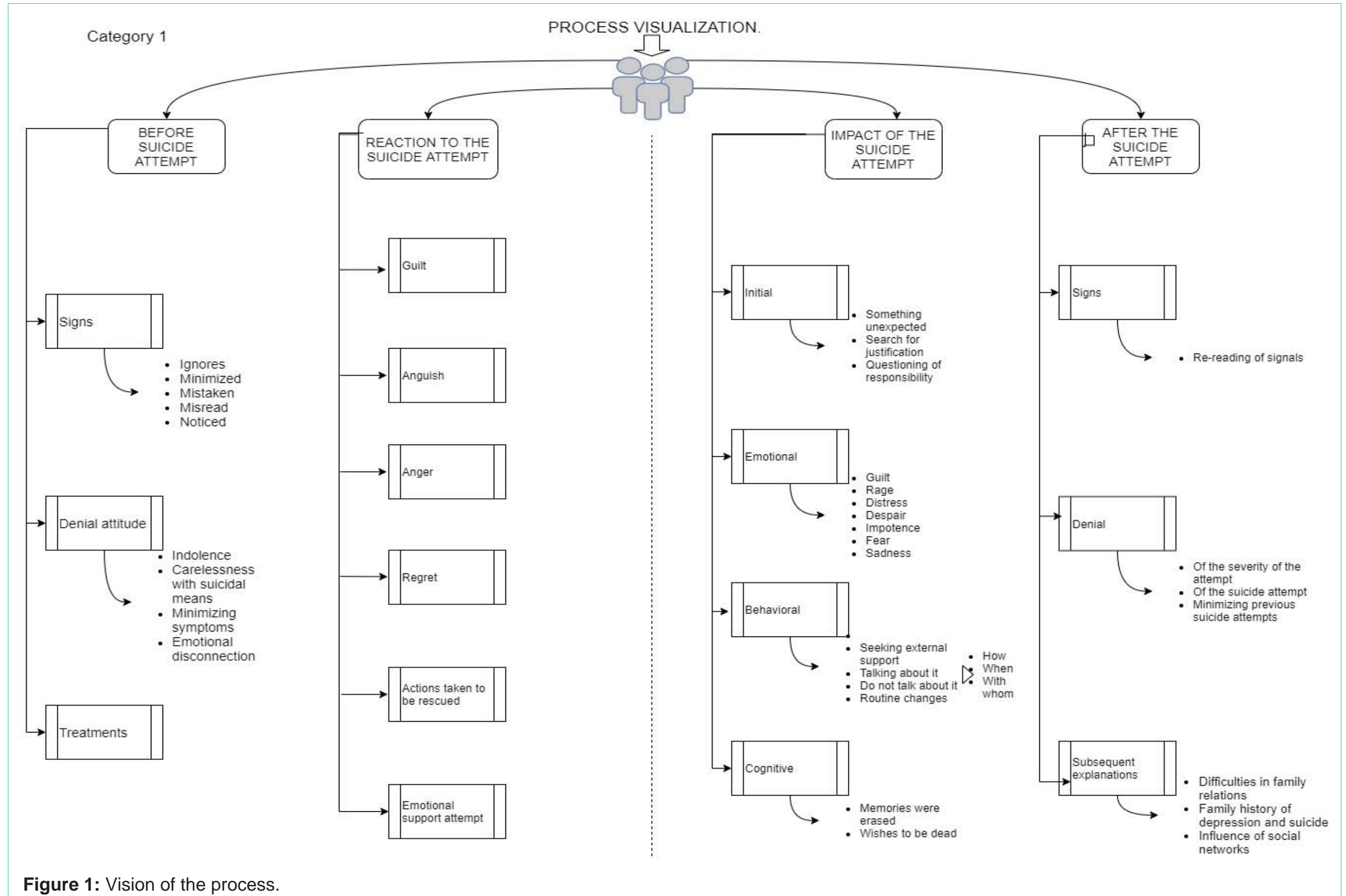

Figure 1: Vision of the process.

However, they also report having consulted specialists repeatedly and having attended different treatments.

"... In December, he began showing symptoms of an eating disorder and I didn't know if it was depression or anorexia, and it began a pilgrimage to different specialists..." (E V: 13).

"... He felt bad, he had tremors, he didn't see well, his vision was blurry ... we went to the doctor, the neurologist, the psychologist. They did thousands of exams and none of this ever appeared..." (E X: 84).

Reactions to the suicide attempt: The second subcategory refers to the moment immediately before and the moment when the suicide attempt occurs. The families agreed that a series of emotions, guilt, anguish, anger and regret completely overwhelmed them. Along with this, there are attempts at emotional containment, and subsequently a series of rescue movements. Part of this experience is difficult to remember in its entirety because they register it as a traumatic moment. Memories are erased and, in certain cases, the desire to be dead reappears.

"... I was very angry and I was very anguished that day ... I was overwhelmed by the situation ... when I found the butcher knife and cut my sweatshirt, I realized what I was doing ... what I was about to do to myself ... I called my mom and asked her for help, I asked for help ..." (E 8, 22, 30).

"... I didn't know fear ... I had never felt fear like that ... Fear of not having her, now the fear is insecurity," (E IX: 22, 24, 26).

"... Panic, fear, panic, panic ... I see her with the scissors in her hands, that she had cut her hair a little and that her whole arm was scratched as if starting to make cuts ... it was terrible ... all I did was hug her …" (E IX: 36, 40).

"... Then this scene ... he told me 'I'll take her immediately' and then he put her on his shoulder and got out, I don't know from where he got the strength, and he got in the car and left..." (E II: 148).

Impact of the suicide attempt: In relation to this subcategory, the feeling of something unexpected emerges, which they did not see coming was not expected, which leads them to seek justification and question the responsibility that each of them may have had. They also agree that they feel an emotional explosion of guilt, despair, fear, helplessness, anger, grief and anguish, linked to the idea of what could have happened and what might come ahead.

"... We probably never realized the magnitude of the problem … I discarded that it could reach at the same situation as what occurred..." (E III: 91).

"A bucket of cold water, a bucket of cold water, nothing gave us any indication that she was in this high state" (E VIII: 42).

"... After what happened today anything could happen, and I won't realize it..." (E I: 219).

"... Terrible if I lost her, because I cannot imagine life without her..." (E X: 108).

The actions taken speak of the need to seek external support, either from close family members and/or friends, even though it was difficult for them to speak and explain what had happened.

"… If someone from work asks me, I would also tell him, and tell him well, but it costs, it costs …" (E I: 285).

"… We were blocked up. Phone calls came and it complicated us. I came to tell my friend the following week, when in fact we were already with her at the house" (E I: 291).

The family is reluctant to talk about what happened with the extended family, co-workers, and persons from their school or social circles, and when they do, it is basically for fear of questioning and stigmatizing.

"…I didn't want to tell anybody. In fact, when I told my mom, I was already in the clinic…I told her crying because, because I had also isolated her from before, I said, 'they're going to criticize me for not having told them before'. But they took it well…" (E I: 281).

In the process of taking charge of what has happened and taking the appropriate measures, there is a change in family routines in order to face everything in the best possible way.

"... We called a therapist ... and she could not sleep alone, so that night she slept with us..." (E IX: 157).

"... Removed the latch from bedroom's doors, hide articles that could harm her ... I asked for leave from work to be home, so I stayed for two weeks..." (E IX: 158, 163).

After the suicide attempt: The fourth subcategory is associated to what appears in families after the survival emergency regarding has passed. The first thing that is noticed is a rereading of the signs of risk that were present and were not seen or were not given sufficient importance. However, there are families who showed an attitude of denial regarding the severity of what the suicide attempt might entail, also denying the report of previous attempts, and even denying this attempt itself.

"... What I felt and saw of her ... I felt it was as if she were in a tunnel without seeing, let's say, the light" (E III: 225).

"... In my family one of my sisters had done the same ... at that time it was not given importance ... nothing happened to her ... then I said it will be part of the same ... there, it is my fault ... I did not give it the weight that I should have before ..." (E VII: 114).

"... He Just ... ... he says he vomited; I have never felt him vomit..." (E II: 43).

"... It's not that there had been a suicide attempt on his part ... that he had taken an overdose of pills, or I don't know, that he had cut his veins, no". (E II: 49).

It is Important to note that families present a series of post suicide attempt explanations that allow them to understand what happened. They refer difficulties in family relationships that would have to be resolved. They talk about a family history of depression and suicide that connect with what happened and they refer to the inappropriate and/or excessive use of social networks, since they think that this does not help to solve such problems.

"... I was deeply depressed, she saw me cry a lot, so she has a vision that mom is very weak, mom cannot contain her..." (E X: 74).

"… It was because of problems at home, the problems with my

sister, my eating disorder…" (E VII: 152).

"... Let's see, from there you really begin to question what you saw, what you wanted to see, what you interpreted..." (E IV: 124).

"... I felt that she could trust me ... today I realize that everything I talked about, I am not guilty, but maybe it was not effective ... I give her a lot, but maybe I give her little quality ... she did not trust me or mom" (E X: 92).

Category II: Family dynamics

In this category, there is a clear difference between family dynamics before the attempted suicide and those that began to develop afterward (Figure 2).

Before the suicide attempt:

Relational style: The family's report that they worked with difficulty to achieve parental agreement, either because of lack of limits regarding norms and/or couple conflicts in which the children were involved, sometimes even feeling somewhat abandoned. There is also a lack of differentiation with respect to families of origin, which often hinders progress with the nuclear family and interferes with the parental role.

"... We did it really badly, we never had a good marriage, we always fought, we were worried about our fights, it was a disaster", "... We could never make family" (E X: 187, 190).

"… I'm the psychologist of this family… they call me doctor…" (E II: 182).

"At some point, I wanted to put on my brother-father role, but over time I have understood that I cannot be their father if I am only a 20-year-old…" (E VI: 126).

"... In fact, I tell her when I'm going out, I tell her everything I do, I have that relationship with her ... I always treat her more as an adult than a girl..." (E X: 106).

Furthermore, families report some problematic attitudes that were present, such as poor verbal interaction, which was often confusing, with mutual disqualifications and not showing support among each other. This involved hiding information that could be relevant about what was happening to them. And it was also linked to demanding behaviors that further increased the feeling of being overwhelmed.

"... In my house, there has always been an atmosphere of disrespect ... of fighting..." (E II: 101, 102).

"... He is an extremely manipulative man ... he is distorting the

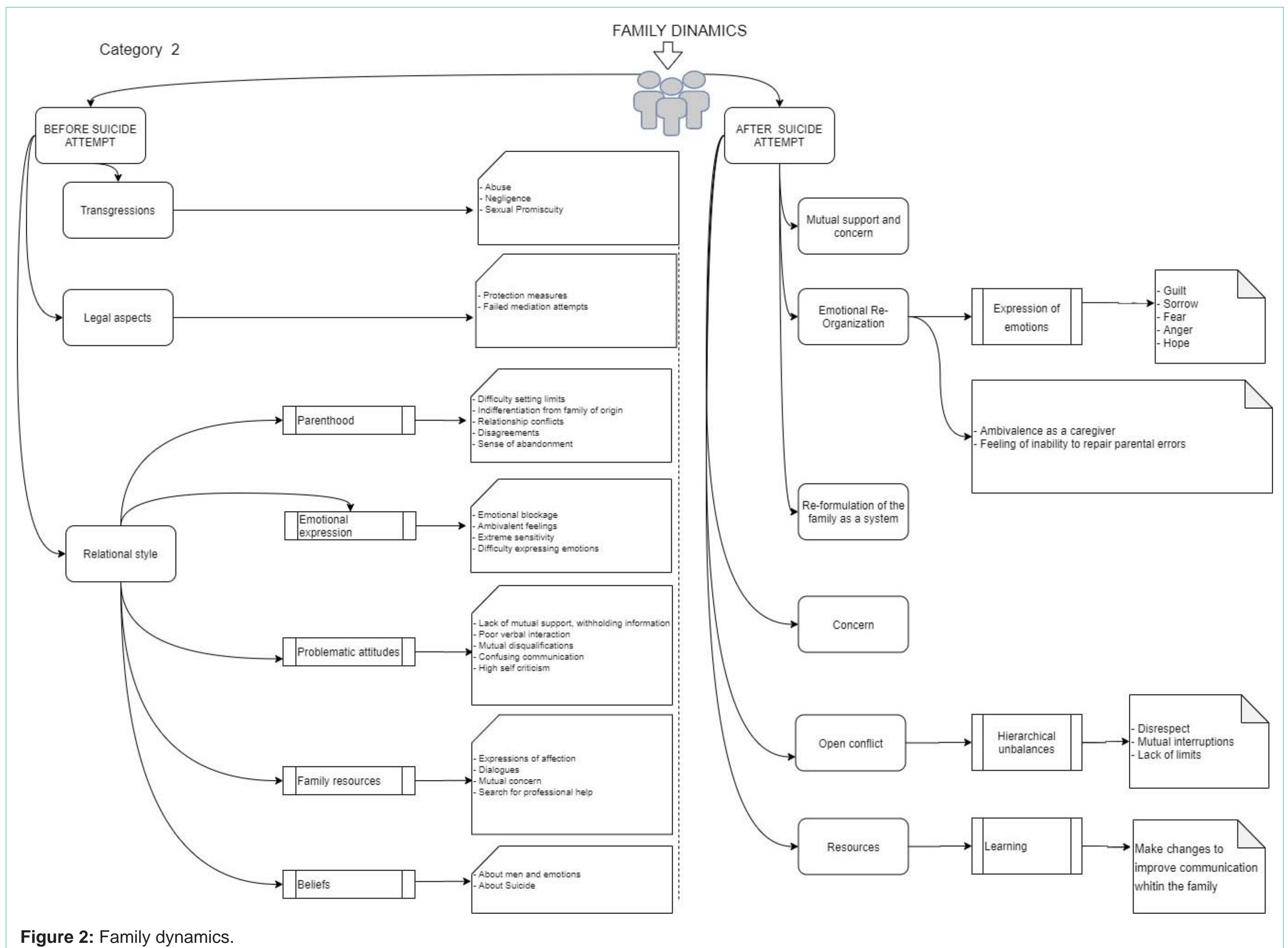

Figure 2: Family dynamics.

situation ... there is a dynamic of many mutual attacks in the house..." (E II: 122, 124, 264).

"... She endured a lot, she endured seeing me, my mother, my father very bad ... at some point in these two years we all went through a crisis, and she endured it all and there was not a moment when she exploded..." (E VI: 46).

"... We were exigent in the sense that when he had to study for a test he should focus on studying and we were irritating, and the result, and sometimes we made the mistake of comparing ... and maybe we inadvertently hurt him..." (E IX: 84).

This is linked to the emotional expression indicated by the family as an emotional block, as a difficulty in expressing emotions, especially those related to fear and grief. They mention recurring ambivalent feelings and extreme sensitivity.

"... I could never tell my parents what I wanted to do, or that I wanted to go to doctors, or that I wanted to because I didn't give... and they didn't realize how bad it was either, because I'm not very expressive either, because instead of being sad or crying I get angry or isolate myself…" (EX: 56).

"... And parents, we can never ... we are the ones who can never see the most critical parts of our children because emotionally we cannot do it, because it hurts us to much..." (E IV: 130).

The latter is connected with the beliefs that the family had not only about the expression of certain emotions by men, as a gender aspect, but also with prejudices about suicide.

"... Very weepy people in general are like this to attract attention ... men do not cry". "... You have it so internalized, so if you cry you feel very weak, very gay, you feel very bad". (E X: 155, 157 and 159).

"... For me these things happen to children who have major problems, family problems, or dysfunctional families, but it is not the case with us, so the explanation is not there..." (E IX: 67).

"Because people who do not say it do so ... almost always ... those who remain silent ... because people who commit suicide generally do not say anything..." (E II: 213, 218).

At the same time, they talk about some of the family resources present before the suicide attempt. The ongoing concern among them, although it was not always made explicit verbally, but through pampering and seeking professional help.

"... She regained her weight, ... she regained her period ... the psychiatric part ... with the medications she was doing well ... but on the psychological part I feel that was a disaster … she had a lot of demons, very ugly monsters and I always saw her lame there, so that period when she was very bad, she was without a psychologist…" (EV: 34).

"... When she slept badly, I said she cannot continue sleeping badly, so I got her to see doctors..." (E X: 121).

"... I have always tried to remain calm so that nobody notices what is wrong ... so that they do not feel bad, I have always put on the best face, but afterwards I get it out of my system elsewhere". (E VII: 112).

Transgressions: Another aspect that appears in some interviews is maltreatment, negligence and sexual promiscuity. The family exposes these phenomena as borderline situations they have had to live through and that can account for the suffering that consequently results in the suicide attempt.

".... Complicated and painful, because I feared that this would happen ... I have not stopped going to the house and there were times when I was very upset, I spoke to him, said something to him and he was upset..." (E VII: 92).

"... My mom has always said very hurtful things, very ugly things, to my sister too, to my dad too ..." (E V: 85).

"... My oldest daughter brought men into the house and the truth is that she slept with the men, with the boy right there ... I didn't want that ... because what happened ... they raped me when I was a girl ... it was very painful … I did not want the same thing to happen to my daughter" (E VII: 210).

Legal actions: This subcategory is linked to the previous one and includes protection measures and unsuccessful attempts at mediation in which some families have been involved.

"... It's that I wasn't at home; I was prohibited from approaching the girl. The helplessness of not being able to do anything was worse, because I had already lost a daughter and I did not want to lose another, for me it was very complicated…" (E VII: 72).

"... She was very bad because her aunt kicked her out and her father did not defend her, he did nothing ... there I sued him and then he begged me, he asked me, so I gave up the lawsuit…" (E VI: 95).

After the suicide attempt:

Mutual support and concern: There were families who displayed a series of attitudes aimed at supporting and actively caring for each other.

"... We are more concerned... more attentive ... attentive, but not to burden, but it costs like dad not to do it..." (E IX: 308, 311, 320).

"... The other day we went out for a walk and we walked around the plaza a thousand times talking, it helped me to get to my answers ... that conversation helped me a lot ... he let me tell him what bothered me and helped me to try not to let it happen again…" (E IV: 212).

"... In fact, Ihe is helping his sister to study ... yes; he spoils her and everything..." (E I: 224, 226).

Emotional reorganization: Clear expressions of grief, guilt, fear and hope are presented. This is associated with an ambivalence regarding the care of another and, at the same time, a feeling of the impossibility of repairing mistakes that are perceived as parental. All of the above is experienced as the need to reformulate family functioning.

"… We got more buddies, we tell each other what we should say, that we love each other. So, for me it has been good because she is fine, she is getting better ... I hope that this situation we went through, at first painful, is for the girl's good and that we all go out well and are more united ... even me and my ex are more united for the family, for all of us…" (E VII: 274).

"... We are not good at expressing feelings that is also what we

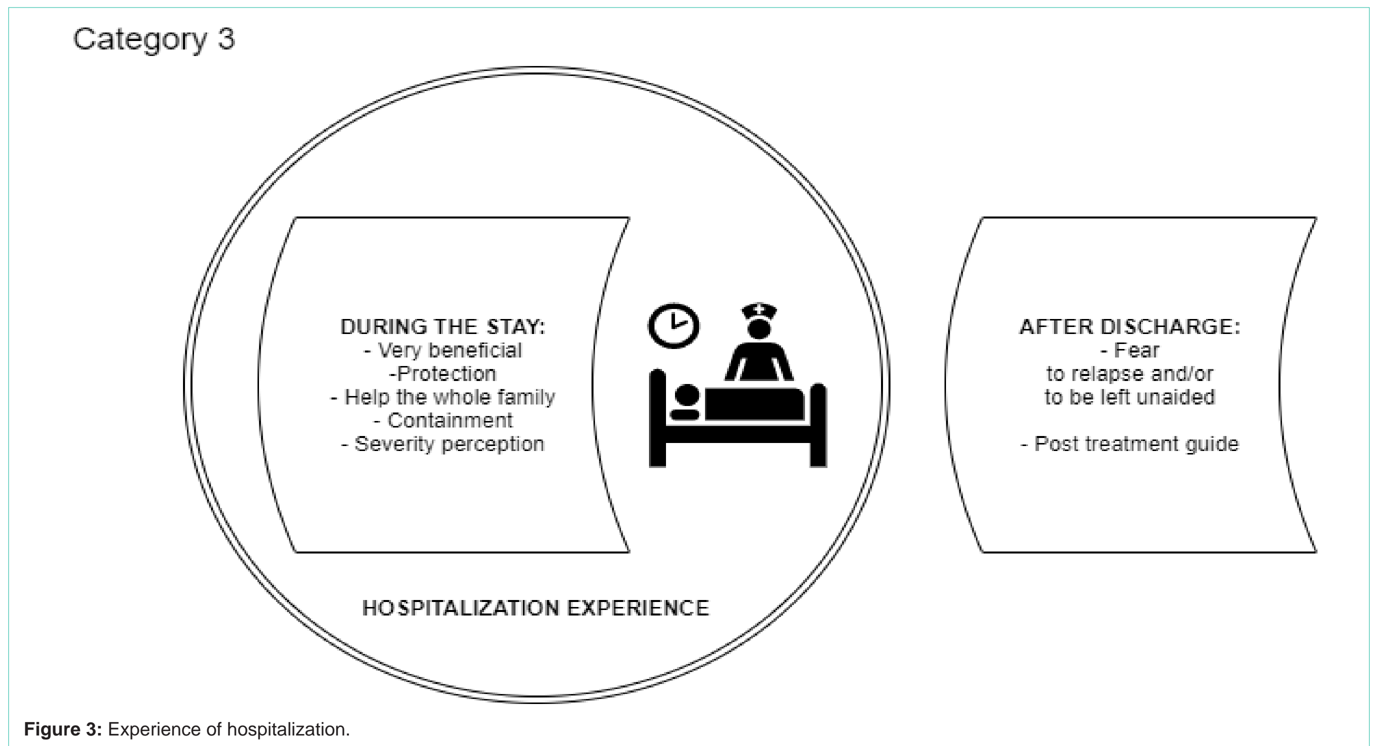

Figure 3: Experience of hospitalization.

have been told that we have to work on, as we do not allow ourselves to cry or feel sorry, we do not like it too much, always trying to be well...” (E IX: 255).

Open conflict: In contrast, there were families where the problems they had been facing turn into open conflict after the suicide attempt. They speak of very serious imbalances and disrespect, with permanent interruptions and mutual insults and criticism.

“... No, I am not angry, I am not angry with him, what I do find is that he is not aware of certain things, that ... that’s what I’m saying...” (E II: 54).

“No, I would not say mutual ... I believe that it is from him to all the members of the family, to his sister, to my mother, and to me”. (E II: 265).

“... And one thing that is quite worrying is that if they see me as I am now, they say ... no, he is fine ... or if I am not bleeding to death on the floor or crying for something ... I have to be fine”. (E II: 61).

Reformulation of the family as a system: Lastly, families refer to the learning they have acquired after the suicide attempt, which can be summarized under a broad umbrella relating to intended changes to improve communication qualitatively and quantitatively within the family.

“... We want her to participate in this new way of communicating, to learn to communicate, in what we are failing ... so I believe that this emotional impact... at this moment I do not believe that I as a mother... I do not believe that I am in a position to contain her so that… we would not know how to do it, I would first need support, in order to face this reality with her…” (E VIII: 4).

“... I have already told her that I can look for another job by day in which I could take her to therapy” (E VI: 269).

“... I have limits for all people, I learned to take care of myself, all my life I took care of my parents so that they did not fight, I took care of my sister when she got sick, I took care of my dad when he got sick, I have always taken care, but I have never taken care of myself…” (EX: 245).

“... I think that if I had to rescue something positive from what has happened to us, it is that this probably made us come together at one point, which is our daughter...” (E III: 185).

“Now we are very careful, we are attentive” (E I: 229).

“…We are no longer the family from before…” (E I: 161).

Category III: Experience of hospitalization

The third category raised represent the hospitalization experience, a category that does not have the same weight as the previous ones. Nevertheless, it is difficult to subsume it in any of these. It appears basically because the sample was taken from a psychiatric hospitalization. It is divided into two subcategories: Experience during and after hospitalization (Figure 3).

Experience during hospitalization: Families say how beneficial it has been for their son/daughter to be or has been hospitalized. Although it made them perceived the suicide attempt as a serious event, at the same time, it provided them with containment and protection. As well, they refer to having been treated with the whole family as one of the most important contributions. This helped them better understand not only what had happened, but also create adjustments that could make everyone feel better.

“... Until recently, I had no hope that it would improve, everything would continue just as bad ... you just can’t get out, it’s very difficult ...

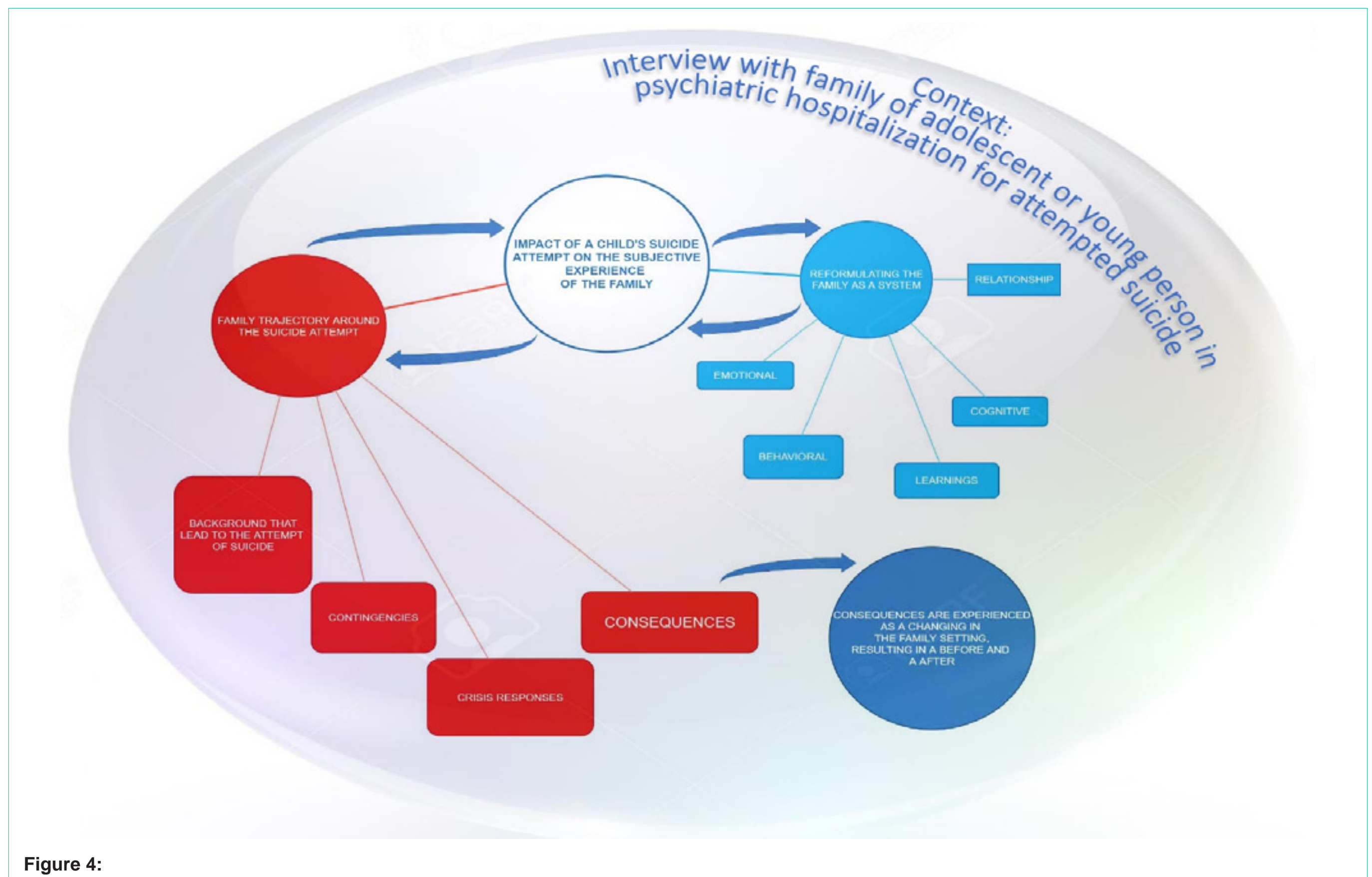

Figure 4:

we talk now ... we are the entire family, so this is not just for her, but also for us…" (EX: 239).

"... Here I am learning to express what I feel..." (E IV: 194).

Experience after hospitalization: On the other hand, the families talk about the fears they experienced or that could arise (depending on the case) when the patient was discharged. In other words, there is a fear of relapse and/or of being left without professional help. Regarding the latter, they emphasize the need to continue with family sessions in order to understanding and advancing in their process of change as a system.

"... All I want is that he come out from there soon, and at the same time I'm afraid he'll come out and fall again..." (E VII: 268).

They were very grateful for the facilitation of a post-treatment guide provided when the patient was discharged.

Selective analysis

The central phenomenon of the study is the effect of a suicide attempt by a teenager's on the subjective experience of the entire family, including him/her. This subjectivity is inscribed through the representations, emotions, ideas, behavioral patterns and dialogues that are maintained among all the members of the family system and with the extra-system (Figure 4).

The context in which we observe this phenomenon is a hospital psychiatric service where the adolescent was hospitalized after suicide attempt, and where the whole family was cited for an interviewed with a family therapist.

In this conflict, the family forces its relational resources by implementing behavioral guidelines that generally sharpen it and produce we termed Change 1, or "more of the same" [20]. Therefore, the adolescent's suffering increases and the family begins to run out of tools that allow them to provide containment and support.

Thus, we note that the family has a clear feeling that there is a "before" and an "after" in their history, and that life as they knew it until now, it would no longer be possible to continue living.

They warn that what happened to them, experienced as a trauma, has led them to stop, reflect and find new explanations that allow them to move forward and take care of all the members of the system. It promotes a reorganization of the family and its relationships, considering the structural-hierarchical arrangement and fine-tuning of communicational harmony.

What the families relate in the interviews confirms that suicide attempt of a child is lived in a much unexpected ways and has strong impact, with an explosion of diverse emotions. Changes occur in the way of 'reading' the experiences and signs prior to the attempt, in daily routines, in the search for explanations and understanding, as well as the need for support to process what happened. This support is not without fear of being questioned and stigmatized.

Changes also have taken place among them toward greater mutual support, with ambivalence regarding the care of the other and the possibility of repairing parental errors. The intention is expressed to

learn to communicate better and not to fear facing previous, current and/or future conflicts. At the same time, the containment and protection provided during the hospitalization period are valued, but fear of relapse and of remaining without adequate treatment arises. They express gratitude and the need to continue with the support of family sessions to advance in their learning and change processes.

Discussion

From the interviews with families of adolescents who have committed a suicide attempt, we could see that this episode causes a series of dramatic changes in the family group, with the clear experience of a "before" and "after" the suicide attempt. Likewise, it has been that prior to the suicide attempt, the adolescent participates in a unique family dynamic that, as in any family, is made up of protective elements and other destabilizing elements. The teenager, in addition, is in a moment in the life cycle of great change and vulnerability, without the necessary tools, depending to a greater extent on the resources of his/her immediate environment. Thus, the family is not only a witness, but also a protagonist in the configuration of events.

The family's greater or lesser ability to adapt is clearly manifested in the response to the breakdown in their emotional experience because of the attempted suicide by one of their children. Family resilience will depend on their history and how they have learned to cope with difficulties. Therefore, it is essential to strengthen the resources they have, so that this signal revealed by one of its members generates a movement that guides the entire system towards deep and sustained change over time.

Although the traumatic impact of the attempted suicide on all the family members is one of the most frequent references made, curiously families also state the opposite. In other words, this event has provided the family with tremendous learning and an opportunity to grow, to get to know each other better and help each other.

It has been possible to show how beneficial it is for the family to talk and explain about how they feel, without fear of being judged and even without fear of asking directly if the most afflicted child is thinking of ending with his/her life. The relevance of becoming aware of collective responsibility for the risk of suicide is also noted, since families may experience stigmatization and loneliness after what has happened. To overcome the trauma they require help, not only professional, but also from the extended family, from the work/school context in which they find themselves and from the social environment.

Another aspect that arises in the interviewer's experience is that within a few minutes into the interviews, the families showed the need to refer to and elaborate on what happened, and spontaneously talk about the relational difficulties they have had and/or are having. This connects with the idea that families are experts about themselves and know what is happening to them. The important thing is to help them organize a fruitful and restorative dialogue.

Thus emerges the need to incorporate the family as a whole when considering suicide attempt by an adolescent both to understand the phenomenon and from the point of view of intervention and treatment. From this perspective, an approach that looks at the adolescent in isolation lacks sufficient strength and impact to achieve real changes that prevent future suicide attempts. It can even be iatrogenic, since it generates a greater sense of loneliness and stigma in the teenager and, on the other hand, leaves their family powerless, invalidating their ability to provide support and care. The adolescent and her family system need to understand and work together to reach new and inclusive solutions for every family member. Apparently, they only need an environment of care and understanding conducive to exposing their pain and their desire to heal them.

The foregoing is of great relevance given that considering the opinion of the protagonists, not only when data is collected, but also when developing theories and seeking to influence in social changes, implies the conviction that knowledge cannot belong only to an elite, but must be co-constructed with society as a whole, actively including those who are part of the observed phenomenon.

This led us to consider the entire family system as a participant in the suicide attempt by one of their adolescent children. And not in accordance only with this, it was decided to analyze the data as if the system were a single subject, precisely to avoid stigmatization of one or another member of the family. This form of analysis is at the service of the thesis that the research team proposed, which is that suicide attempt can occur in any family and that in any family there are difficulties and misalignments in their relationships. Therefore, the aim is to observe and understand what these weaknesses are, not to stigmatize the family or the parents, but to know and help them cope with the painful situation they are going through. There is awareness on the part of the research team that the way in which the data was analyzed can be a contribution, as well as a limitation.

It should be noted that the interviewer was an expert family therapist and, as such, it was inevitable to observe interventions that were reflected in the need and assessment that families make of family therapy and the dismay they feel when asking why no one has suggested this to them before. It therefore remains a future task to socialize this knowledge in psychotherapy and psychiatry units specialized in suicide and, in general, in all the teams that contribute to mental health.

The literature review conducted as part of this study showed that many investigations highlight the "dysfunctionality" of families where a suicide attempt has occurred. There is a risk of stigmatizing families, assuming other families are "functional" or lacking in conflict. It is important to consider that children seek to express their pain, fear, or anger, through various symptoms or signs, which become alarms for the family system and also for the extra-system. However, they want and need to continue to belong to their family and only seek to shed light on the problem and thus support the parental and/or couple subsystem. It wants to underline the importance of interpreting the results, both of this study and of the referenced research, such that they contribute to our knowledge and to therapeutic help provided to consulting individuals and families.

The criteria applied in these investigations are probably rooted in classic ways of looking at family systems, where parenting failures that are present in the crisis are noted and highlighted. This deficit perspective is usually based on criteria of normality and categories of health and disease. The view proposed in this study goes along

the dimensional line, where there are weakened and strengthened aspects in relational dynamics, which can be modified and improved. In particular, in relation to the paternal and maternal functions, to restore the power and management of the family to the father and mother, along with removing from the role of the sick one from the son/daughter who made a suicide attempt.

This study focused on the subjective experience of families in which a teenager attempted suicide, as it seemed interesting to observe what happens at this stage of the life cycle, which is one of the most vulnerable periods in development and where there is usually a higher risk of suicide. Therefore, what is observed does not represent the subjective experience of other types of families in which an adult member commits a suicide attempt. Due to the particularities of the challenges of raising an adolescent, the family experience in other cases of suicide attempt probably represents new observations and dynamics that still need to be studied. Likewise, only the group that agreed to participate is represented; those who refused are not represented in this analysis.

A development expected from this study would be aimed at complementing the results, replicating the proposal with families where a member of the parental subsystem (mother or father) would have tried to commit suicide. It is believed that the categories found here could display different qualities.

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