

# Suicide is a Baobab Tree: A Narrative Medicine Case Study

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“A baobab is something you will never, never be able to get rid of if you attend to it too late.”<sup>1</sup>

— Antoine de Saint-Exupéry

## ABSTRACT

This case study is an example of applying narrative medicine as a useful tool for health professionals to manage an existential and complex scenario such as the suicide of a sibling. Some suicides are like baobab trees—these large and resilient trees grow deep roots for many years, only spreading their limbs above ground once they are firmly established. Like the baobab, when suicide or a suicide attempt occurs, suicidal ideations are well cultivated and have often already been repeatedly planted. Consequently, suicide is often difficult to prevent: once the death seed is planted, it is difficult to recreate life.

Every year, more than 800,000 people die by suicide worldwide (1.4% of all deaths), which is approximately 1 person every 40 seconds. These unexpected deaths, predominantly occurring among young and middle-aged adults, have a continuing ripple effect and result in a huge economic, social, and psychological burden for individuals, families, communities, and countries. The complexity of suffering and pain experienced by suicidal individuals and their families, regardless of the success or failure of the suicidal act, is intensified by strong stigmas attached to traditional concepts of sin and eternal damnation. This unfortunate reality emerges in the narrative as a tragic family drama, which is permeated by deep feelings of helplessness.

But suicide is preventable. Prevention requires 3 important factors: knowledge, public support, and creation of strategies to enact social change. Now is the time to act and make suicide prevention an imperative goal.

## CASE STUDY

Some suicides are like baobab trees—these trees are large and almost indestructible once established. They grow deep roots for many years, only spreading their limbs to the sky when they are firmly entrenched. Like the baobab, when suicide or a suicide attempt occurs, suicidal ideations are well cultivated and have often already been repeatedly planted. Consequently, suicide is often difficult to prevent. How can

one prevent something that has become part of an individual's identity and constitution?

Many suicidal individuals have planned their own death for years in the form of impulses and constant thoughts of how they will end their lives. Personally and professionally, I have witnessed the life course of individuals who showed, many years before they actually committed suicide, clear signs that one day they would kill themselves. I remember quite well my older brother, Edu, at age 18 saying life was often not worth it, because it was very unfair and full of suffering. My mother disagreed with him.

At that time she said, “I think it [suicide] is an act of extreme selfishness. One kills himself and doesn't think about the suffering of those who are left behind.”

Edu replied, “Selfishness is when people think they are the owners of the life of the one who is killing himself. Whose life is it anyway?”

This conversation took place in 1988, ten years before my brother died.

Five years before his death, in 1993, Edu also reportedly told a few friends, as they sat at the banks of the university lake, that it was “a beautiful place to die.” His death took place nearby in 1998.

I also remember Edu occasionally joking about other people's suicide threats. “Do you really want to commit suicide?” he would ask mockingly. “So hang yourself with a steel wire coated with grease. If you do that, there is no turning back.” Edu spoke as someone who believed most people who threatened suicide would not really do it, and that they used their threats only as a means to manipulate others. And he never threatened to kill himself.

For the ten years before Edu's death, I dealt with an extremely unpleasant fear that he would one day kill himself, but this dread was not enough to rid me of the devastating surprise of the reality of his suicide. Although we had clearly talked about suicide, I was not spared the shock of dealing with this kind of misfortune.

Five years before his death, Edu and I had a conversation in which he expressed concern about the possibility of me being suicidal. I was 21, and he was 23 years old. I said to him, “Brother, let's make it clear, the suicidal individual here is you and not me.”

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“And does that disturb you, do you worry too much about it?” he asked.

“Yes, it is very distressing. It is very, very unpleasant to imagine one day I will come home and find you hanged yourself, man.”

Our conversation continued and he tried to fix it, tried to show me he would take my distress seriously. He demonstrated empathy and realized the whole situation was painful for me. I thought to myself that this conversation had produced some benefits, that his concern for me would be enough to keep him alive. Unfortunately I was wrong. His baobab missed being watered only on that day or on the few days like that one. His baobab had already grown big, very big, and I had no idea of its hugeness in my brother's life.

### SINCE EDU'S DEATH

I have often said, “Suicide is a little plant. But do not plant it. If you have planted it, do not cultivate it and do not water it because it is a little plant that grows and turns into a baobab. Then it can become quite difficult to remove from your life.” Edu gave birth to his end of everything by hanging himself from a rope tied around his neck and fastened to a branch of a tree at the banks of the lake near the university where he had studied a few years before.

My brother somehow anticipated where and how he would die. It was only a matter of time, because he had been planting and cultivating his suicide for several years. A letter addressed to me, but never sent, was found in his drawer just after his death—he had hidden it there for more than nine months before his suicide. In the letter, Edu made it clear he was already very close to death. The letter began like this: “Yes, my brother, I have been talking to death closely and quite often. It whispers in my ear and pulls me by my feet.”

He left many other writings in his drawer. They were kept there so no one would mess them up and to keep Edu's privacy, which was well respected by the entire family. Several of these writings are part of a more complex picture about his motives and his history. In a letter written a few months before his death, he said, “I rode my bike, at night through deserted streets, and pedaled as fast as I could so that my heart would burst.”

I never stop thinking and imagining how his last day went by. He was living with some friends, very close to the university. He took his bicycle and went to the university. Inside his backpack there were his documents, a small notebook, and a pair of handcuffs. I figured that, in case of losing his will, he would handcuff himself so there would be no return. I know nothing else about that day: if he was crying; if he was calm; if he had ever visited that tree beside the lake before, to think or plan about ending his life. I do not know whether he stood there for hours, mustering his courage; whether he took the time to appreciate the landscape in an absurd and lonely farewell; or if there was despair and distress until the last moment.

He left farewell letters with justifications and apologies, one for me and one for my parents and my brother. “Mother, it is not your fault”; “I know a black shroud of pain will cover all of you, but I cannot bear my suffering any longer”; “It's nobody's fault.” Why did he leave a personal letter to me? Why?

The only thing I can guess is he really cared about me, as the loving older brother he was, and because he worried about how much suffering his suicide would bring me.

### PREVENTING A SUICIDE

Years later I learned, through his death and in my professional practice, the basics of preventing a suicide. Suicide is a very lonely act. Suicidal people are, in general, socially isolated and radically lonely in their pain. In the Sidebar: Years Later, I have included my attempt to further explore Edu's world of loneliness and pain.

Edu loved being with me and our youngest brother, but he was alone in his town, far from us and with no easy communication available. In Brazil in 1998, our family had no cell phones or personal computers or wireless Internet that allowed us to reach anyone at any time. We were separated by hundreds of miles, by several days without talking to each other, by our ignorance about suicide and the danger that was haunting Edu's life. He suffered with all these distances. During a phone call some days before his death, he said, probably knowing our recent visit was the last time he would see us, “It was very hard for me to see you leaving ...”

Now I know that in these moments it is crucial to have loved ones close by and part of our lives. Social gratifications are possibly the most relevant ones in a human being's life. We are social animals, fed by social interactions—*healthy* social interactions. We need to love and be loved. We need *real* love, which at its root involves proximity, being close and together, being present, interacting, and pushing the ghosts of unhealthy loneliness away.

When suffering comes, life takes a sudden stop and everything starts moving slowly. Time takes too long to pass and weighs on us unbearably. There, at this time, you are, fully and without escape, feeling all the pain you can experience. When this most extreme part of suffering goes away, another wave comes, although less intense: it is the echo of that past suffering. This is when the blanket of love that others weave for us plays a decisive role. If this blanket is effective, real, and supportive, we will feel that life is worthwhile despite all the pain and injustice in the world. This love is not a crumb of pleasure immersed in the suffering soup of existence deluding us. It is actually the base, often subtle, of a happy life.

It seems to me that this structure of a happy life remains primarily a history of comfortable and supportive relationships, largely provided by parents (or our first caregivers), that teach us how to love and be loved. Edu felt so safe when in contact with me and our youngest brother. We two seemed to offer a family structure that could support an important part of Edu's psychological well-being.

Long-gestated suicides, thought out and planned numerous times, often for years, grow like a baobab tree, acquiring and building size along with the person's identity. I think these deep-rooted intentions are the most difficult to prevent. They come from a long daily routine that feeds them for years.

For those of us left behind, what remains are the ashes, our feelings of helplessness and guilt, and, in my case, a lot of good

memories. Edu was an inexhaustible source of ideas, beauty, creativity, art, and surprise. Despite all his faults, he was a rare, beautiful, explosive, surprising, and all-too-brief event that passed through our lives and helped form who I am.

## DISCUSSION

We make sense of the world and the things that happen to us by constructing narratives to explain and interpret events both to ourselves and to other people. Furthermore, narratives also play an important role in touching readers. As a literary genre, the narrative is an important field of arts. A fundamental function of arts in our lives is awakening and vivifying our slumbering feelings, inclinations, and passions of every kind.<sup>2</sup> In this context, narrative medicine emerges as a medical practice model based on narrative competence: the capacity of human beings to acknowledge, to absorb, to interpret, and to react to stories that provide resources for the understanding of stories' meanings, leading to solutions and indicating a way to provide better holistic care.<sup>3-6</sup> Moreover, narrative medicine uses patient stories as a diagnostic, therapeutic, and educational tool. Our narrative is an example of applying narrative medicine as a useful tool to manage an existential and complex scenario such as the suicide of a sibling.

Some suicidal thoughts grow slowly from recurrent unconscious conflicts that do not arise from nothing.<sup>7-8</sup> Freud proposed inevitable intrapsychic conflicts from Eros (life drive) and Thanatos (death drive).<sup>9</sup> The complexity of suffering and pain experienced by suicidal individuals and their families, regardless of the success or failure of the suicidal act, is intensified by the strong stigmas attached to traditional concepts of sin and eternal damnation.<sup>10-12</sup> This unfortunate reality emerges in our narrative as a tragic family drama permeated by profound feelings of helplessness.

## A GROWING BAOBAB TREE

In our narrative, this suicide construction was compared to a growing baobab tree. The baobab is one of nature's oldest trees, native to Madagascar, mainland Africa, and Australia. Capable of living for thousands of years, this tree grows to 40 to 75 feet tall with a trunk diameter of 35 to 60 feet. Baobabs are hardy and seemingly indestructible—they are renowned for being difficult to kill and will even regrow bark if stripped of it or burnt. In one chapter of *The Little Prince*,<sup>1</sup> the classic novel by Antoine de Saint-Exupéry, the Little Prince and the author have a very important conversation about baobab trees. The Little Prince talks about how they are a constant threat to his tiny planet, and he has to pull up the little baobab saplings every morning. The Little Prince points out that these trees start out as tiny seedlings, but if not uprooted and discarded when they are small, they firmly take root and can even cause a planet to split apart. Saint-Exupéry states that the lesson to be learned from the story of the baobabs is so important that he has drawn them more carefully than any other drawing in the book.<sup>1</sup> On a metaphorical level, the baobabs stand for unpleasant things in our human nature—if we don't spot these unpleasant elements and weed them out early, they will take firm root and distort our personality. Edu's suicide grew and became like a baobab tree. His suicidal ideation was left to grow stronger and stronger, and it took root in his personality. His ideation grew for ten years or more in silence, in his and his family's silence. When his suicide happened, his ideation had been repeatedly planted long before. Some members of our family only realized its enormity when it happened.

## PUBLIC HEALTH PROBLEM

Suicide is an important public health problem that causes immeasurable pain, suffering, and loss to individuals, families, friends, and communities in the world.<sup>13,14</sup> Every year, more

## YEARS LATER

By Adriano Machado Facioli, PhD

*Almost 15 years after my brother's death, I wrote a poetic text, in first person, in which I play the role of a suicide, attempting to further explore my feelings about the world of Edu and others who lived something similar to his existential dilemmas.*

I am 28 years old and have long been carrying, in the empty space of my dark existence, the constant and raw idea that it makes no difference being dead or alive.

Since my adolescence I have been unable to navigate my thoughts otherwise away from the turbid basement of ideologies upon which I have been building the edifice

of my soul. Existentially, nothing puts me at a point beyond my morbid desires.

The infinity of the universe, its sparkling, dark, and deaf mysteries, or the absurdity of any inconceivable reality, only feed my desire of not existing, of returning the universe to as it once was before my birth. The immensity of everything swallows my soul into the mouth of the most savage impulses of killing myself or launching my existence to unpredictable and uncontrollable heights.

I am a man (though I have never felt like a man) who carries on my shoulders the weight of an insignificant history. I

carry also envy of the poorest I meet in the sad corners of the world, knowing the reality of life is unfair and that suffering is the first experience of our brutal collision with existence.

We exist so little in the scope of the existence of everything, and too much for ourselves. I cannot bear myself. I cannot handle this voracious struggle exploding inside me, yearning to invade the plagued field of my rationality.

Loneliness—this has always been my name, my identity from never having met any loving reflection of the starving people on my face in the mirror of life. ❖

than 800,000 people die by suicide worldwide (1.4% of all deaths), approximately one person every 40 seconds.<sup>11</sup> It is one of the top 10 causes of death in the US.<sup>14</sup> Globally, suicide is the 15th leading cause of death and the 2nd leading cause of death between the ages of 15 and 29 years; and it accounts for 50% of all violent deaths among men and 71% among women.<sup>11</sup> Death by suicide is only a small part of the problem—for every person who dies from suicide, there are more than 30 others who attempt it.<sup>14</sup> The heavy burden of long-lasting physical and emotional problems associated with suicidal behaviors affects countless individuals: family members of the person with suicidal behaviors, friends, coworkers, and others in the community. There is also a large economic impact, related to medical care costs and productivity loss.<sup>11,14</sup> In Canada, it has been estimated that direct and indirect costs due to suicide are over \$2.4 billion (\$850,000 for each suicide).<sup>13</sup> Another concerning fact is that almost 75% of suicides occur in low- and middle-income countries, where health services and resources for identification, treatment, and support are often scarce and limited. Indeed, suicide has a great impact on the most vulnerable populations, especially because of its high prevalence in minority, marginalized, and discriminated-against society groups, such as indigenous peoples, displaced persons, and individuals who are lesbian, gay, bisexual, transgender, or questioning their sexual identity (LGBTQ).<sup>10,11</sup> For instance, LGBTQ youths have a 3- to 4-fold higher suicide risk, and those who have been rejected by their families are 8 times more likely to commit suicide.<sup>10</sup> These striking facts make suicide a global health problem that must be considered a priority.<sup>10,11</sup>

### “SUICIDE”

In 1642, Sir Thomas Browne, a physician and philosopher, coined the term “suicide” in his famous work, *Religio Medici*.<sup>8</sup> People have worked to understand suicide throughout history and across disciplines of knowledge, such as philosophy, sociology, psychoanalysis, and psychiatry. Social representations regarding suicide have also changed with time: a constituent element of tradition or acceptable option in certain cultures such as Rome, a sin in the Middle Ages, and a sign of mental illness in the 19th century.<sup>15-17</sup> Currently, the idea that suicide is a legitimate option has permeated individual human rights and dying-with-dignity debates in certain circumstances.<sup>18-20</sup> Durkheim,<sup>21</sup> the late 19th-century sociologist who classified suicide types as egoistic, altruistic, or anomic, correlated suicide to the degree of social cohesion in a person’s life. He said family, church, and the state ceased to function as social integration factors after the social revolution, and nothing has replaced them to date. This analysis is a modern one in a world filled with conflicts.<sup>8,17,21</sup>

Although it is imperative to address suicidal behaviors as soon as possible, they are often met with silence and shame. Social reactions related to the stigma and taboo surrounding suicide are often a huge obstacle to those who need help when going through a crisis, which means many at suicide risk are left alone. Furthermore, a large segment of health services are not prepared to provide timely and effective help to those

who do seek help.<sup>10,11,14</sup> Between 2% and 7% of primary care patients have thought about committing suicide; 45% to 76% of individuals who commit suicide visited their primary care clinician in the preceding month.<sup>10</sup> Most primary care clinicians know there are suicidal patients in their practice, but they are not prepared to identify and to provide care for these patients.<sup>10</sup> This is an alarming situation. Indeed, physicians may avoid the topic of suicide with patients because they feel ill prepared to care for a patient going through a crisis.<sup>10</sup>

### SUICIDES ARE PREVENTABLE

Because suicide was historically associated with mental illness, suicide prevention was largely viewed as a mental health service competence. However, mental health is just one factor that can influence suicide risk. It is important to note that the vast majority of individuals with mental disorders do not have suicidal behaviors.<sup>11,14</sup> No single factor is sufficient to fully explain why a person commits suicide. Several risk factors frequently act cumulatively to increase vulnerability to suicidal behavior. Suicidal behavior is a complex phenomenon that is determined by the interplay between personal, social, psychological, cultural, biologic, and environmental factors. At the individual level, risk factors include previous suicide attempts, mental disorders, financial loss, chronic pain, family history of suicide, and alcohol and/or drug abuse. Some risk factors linked to community and human relations include wartime and natural disasters; acculturation stresses, such as those found among indigenous peoples or displaced individuals; discrimination; feelings of social isolation; abuse; violence; and conflicting relationships.

Suicide prevention requires coordination and collaboration among multiple society sectors, such as education, labor, business, agriculture, justice, law, politics, and the media. These efforts must be comprehensive, synergistic, and integrated because no single approach can address so complex an issue as suicide. All have a role to play in helping make suicide prevention more widely available.<sup>11,12,14</sup>

The foundation of any effective preventive response lies in the identification of suicide risk factors and the relief of these risk factors by implementing appropriate interventions. Strategies to counter risk factors are of three types: 1) universal prevention strategies, which are designed to reach an entire population; 2) selective prevention strategies, which target vulnerable individuals; and 3) indicated prevention strategies, which target specific vulnerable individuals with community support.<sup>11</sup>

Among all risk factors for suicide, a prior suicide attempt is the single most important in the general population. In these cases, follow-up care by health caregivers through regular contact, including by phone or home visits, together with community support, is essential. Decreasing access to suicide means is another way to reduce suicide rates. Context is imperative to understanding suicide risk. Many suicides occur impulsively in moments of crisis, and ready access to suicide means (such as pesticides, firearms, and certain medications) can determine whether a person lives or dies.<sup>11</sup> Other effective

measures include responsible suicide reporting in the media, avoiding language that sensationalizes suicide and avoiding explicit descriptions of methods used.<sup>11,12,22-25</sup>

In a recent report, the World Health Organization recommended that countries get a range of government departments involved in the development of a comprehensive coordinated response to prevent suicide.<sup>11</sup> Furthermore, high-level commitment is needed, not just in the health care sector but also within the education, social welfare, employment, and judicial sectors.<sup>11</sup> One recommended milestone is to place suicide prevention under national strategy, and to develop standards and guidelines with a multidisciplinary approach that addresses suicide in a comprehensive manner. Implementing timely and effective suicide prevention strategies can considerably reduce suicides rates.<sup>11</sup> It is necessary to respond rapidly when a person in crisis is identified. Youth-focused efforts to reduce suicide have reported up to a 40% decrease in deaths by suicide. Among the elderly, these strategies have decreased suicide rates by 33%.<sup>10,11,13</sup> In the World Health Organization Mental Health Action Plan 2013-2020,<sup>26</sup> World Health Organization member states have pledged to implement actions to reduce the suicide rate by 10% by 2020.

**CONCLUSION**

Every suicide is a tragedy. These unexpected deaths, occurring predominantly among young and middle-aged adults, have a continuing ripple effect and result in a huge economic, social, and psychological burden for individuals, families, communities, and countries. Suicide is preventable, and prevention requires social change. To create social change, three important factors are required: knowledge (both scientific and informed by practice), public support (political will), and a social strategy (such as a national response to accomplish suicide prevention goals). Every life lost to suicide is one too many. The time to act and to make suicide prevention an imperative goal is now.<sup>10,11,14</sup> If we attend to suicide when it is already too late, a baobab forest will have grown and we may never be able to get rid of it. ❖

**Disclosure Statement**

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