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Triple taboo: considerations about suicide among children and adolescents

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Abstract *This article aims to understand the construction and repercussion of taboos involving suicides among children and adolescents, considering the discomfort, silence, and dread that the theme causes across society. Due to the recognition of a continuum of taboos (taboo of death < taboo of suicide < taboo of child suicide), the authors present, as an attempt to address this issue, the concept of a triple taboo, recognizing the incommensurability of self-inflicted deaths that have children and adolescents as protagonists. Developed from a qualitative study with paediatricians during their medical residence, this paper serves as a call to professionals who assist children and adolescents in the country. Paediatric training needs to recognise these taboos and the dimensions of suicidal behaviour as a manifestation of violence and as a threat to mental health. Their identification is a critical and urgent element in contemporary children and adolescents' care.*

Key words *Death, Suicide, Taboo, Child, Adolescent*

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Introduction

The aim of this article is to present the concept of triple taboo that permeates the "phenomenon" of suicide among children and adolescents in Brazil. This concept emerged from preconceived ideas *in continuum* that add and overlap, even if partially differentiated, on suicidal behavior: taboo of death < taboo of suicide < taboo of child and adolescent suicide. The latter is assumed and pinpointed here as a major taboo and incorporates the two preceding ones – a triple taboo – given the immeasurableness of a suicide when the protagonist is a child or an adolescent.

The idea of a triple taboo was developed by the authors of this article in the study "Perception and knowledge of physicians in paediatrics residence in Rio de Janeiro, focused on suicidal behaviour in childhood and adolescence". It was approved by the Research Ethics Committee of the National Institute of Women, Children and Adolescents' Health Fernandes Figueira, Oswaldo Cruz Foundation[1]. The research was conducted between 2018 and 2019 with the residents who revealed knowledge gaps regarding children and adolescents' suicide. We also remarked the construction and propagation of preconceptions that distance professionals from this topic, hamper the management of children and adolescents in psychological distress and crystallise the current preconceived ideas in society[2].

It is important to clarify that in a Western society with a predominant Christian background such as Brazil, a self-inflicted death has always been repudiated as a religious, cultural, and legal deviation[3]. Increasingly, however, sociological, psychological, and psychiatric studies show its occurrence as a plausible fact since childhood is associated with emotional distress, health problems and macro and microsocial issues[4-9]. However, the tendency of families, institutions and communities is to disregard, revealing an extreme difficulty and prejudice in dealing with suicide, or categorise as a problem of exclusive biomedical causality. On the one hand the risks of self-aggression within this age group have been amplified in the new media formats[8,10,11], on the other hand, the inability to address the problem and the silence prevail[2].

Despite the social silence and professional distancing regarding suicide among children and adolescents, the current paediatric clinical-epidemiological scenario in Brazil and worldwide is strongly marked by morbidity and mortality from external causes and the increasing prevalence of mental disorders[12-14]. National data corroborate the trend of a rising prevalence of suicidal thoughts and the incidence of suicide in the population aged 10 to 19 years, notably among adolescents of 15 to 19 years[15-17.] In the diverse universe of adolescents and young people aged 15 to 29 years, suicide is one of the main causes of death[17,18]. Suicidal behaviour, as a manifestation of violence and a noticeable emotional injury[4,5,19] needs to become a priority topic of comprehensive care for children and adolescents and be formally included in the health, education and social assistance agenda.

Thus, we recognise the need to identify the elements for strengthening information and problem-solving capacity that can contribute to its adequate understanding and management. From the elements developed in the above-mentioned research[1], we will address some notes on the *continuum* of taboos circumscribing this phenomenon: the taboo of death, the taboo of suicide and the taboo of child-juvenile suicide. In this research we acknowledge the relationship between the concept of taboo and the idea of the forbidden. That is the notion of a prohibition, of mentioning, touching, or approaching what is understood as dangerous, unclean, mysterious, or inexplicable, present, and validated in each culture[20,21].

Taboo of death

Despite the notorious acceptance of suicide as a form of death, this point is emphasised for the comprehensive sequence of the spectrum of taboos, from which it is not possible to reach suicide without first confronting death. So, suicides intrinsically carry the stigmas, fears, and fantasies of death.

Knowing and predicting the end, is an important trait of the human species in relation to other living beings on Earth. It is a peculiarity, a foundation of man and his existence, it drove different ways of dealing with the end of life, death, the moribund and the dead[20,22]. Although death is a natural and biological event and a component of the entire life cycle, the process of dying must be understood socially and culturally, inscribed in time and space. In reference to Norbert Elias[22], Menezes[23] quotes: "death is a problem of the living. The dead have no problems."[22](p.10).

It presents the transformations triggered by the civilisation process that led to individuation and the silence of the collective sense about death:

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There are several ways individuals deal with the idea of the finitude of life: one can avoid the idea of death through the mythologisation of the end of life, the cover-up of the unwanted idea, by believing in immortality itself or by looking at it as a fact of existence and adjusting life to this reality. Elias asserts that "currently there is a tendency to believe in immortality and to move away from the idea of death.[23](p.147).

This repression on death, over generations, emptied rituals of feeling and meaning practiced for centuries, stimulating autonomy and individuality to deal with it, creating spaces for gaps and semantic voids, favouring the emergence of silences and taboos[20,22].

The same author elicits in his argument that this taboo locks the speech and hands of society, preventing the demonstration of affection and deauthorising collective rituals, increasing the distance between the living and their dead and dying[22]. Justified by medical and scientific advances fostering this distance, the death scenario was sanitised, outsourced, and shifted to hospitals[24]. An aseptic, silent, isolated death, "an empty area on the social map"[22](p.36): a taboo.

Thus, the silence around death is reinforced by its displacement to hospitals, the home, symbol, and pole of medical practise, in ways that this taboo resonates and crystallizes. There are progresses to confront death, but not for a dialogue with it, forbidden from every day life[25].

A counterpoint, however, needs to be considered when Brazilian social and cultural construct is on the agenda: the taboo of death is concomitant with the triviality of dealing with some deaths, standing out the violent and/or early deaths of ethnic and racial minorities[26]. It is not because such events are representative of a rupture or reconstruction of this taboo, but because they represent and perpetuate a discriminatory the colonialist process. These deaths shown as trivia's, contrary to what may initially suggest, imputes further the segregating and moralising silence, disabled to trigger questions about the lancinating end of life, due to the lower value that these lives seem to have.

The embarrassment in dealing with the awareness of individual and collective annihilation is imbued with fundamental traits of socialisation and culture[23]. Thus, the identification and acknowledgment of the taboo of death do not represent a judgment, but a mechanism for understanding the common sense on how death, in its different formats and via its different agents, presents itself in contemporaneity.

Suicide taboo

Beyond the attempts of academic explanations about self-inflicted death, the most serious outcome of suicidal behaviour associated with mental disorders[19], or as a social fact understood and modulated from the Durkheimian dimensions of integration and regulation[27], it is daring to propose that its description as a self-inflicted experience, is the mark that most incites complexity and discomfort. Suicide is generally classified distinctly from any category of death. Although in other fatal violent events there is also a sudden anticipation in the natural course of life, in its daily proximity to death, the intentionality (although theoretical)[4] of suicide confers a transgression against human survival, representing a double aggression to humanity.

The embarrassment with death is thus magnified in a scenario where the same character is victim and culprit, injures the social space, representing the silence and the taboo - double taboo - as proposed by Dias[28]:

In this way, we can assume that the taboo imposed when talking about death resonates with the suicidal, preventing him to communicate openly about his motives - which, on the one hand, makes impossible to have social help to overcome his impasses, if any, and on the other hand, contributes to the establishment of a great enigma around the matter.[28](p.38).

As described by Dias[28], the silence of death extends to the suicide and the suicidal; of a polyphonic and polysemic possibility, the paradigm of no talking is imposed[3]. With such interdiction, it is possible to identify the allocation of suicide in the category of deviation, which corroborates its conception as a taboo. Three models in the history of the West prevail and overlap in this perception of suicide as deviation: sin, crime and disease[3]. Although such discussion is beyond the scope of this article, we underscore that the deviation tone historically conferred on suicide has fostered several elements of exclusion, imprisoning it to the social embarrassments of a death.

It is not new to point out the taboo of suicide, at a time when even prevention campaigns and educational materials are available in different media, have focused on it[4,5]. The construction of the spectrum of taboos advocated here is a reflection on the clarity that would be possible to advance on suicidal behaviours – and suicide if dialogue with death and the dying is not possible. As already suggested in this *corpus*, the presence, and the leading role of children in this and on

this singular but universal death, confer more embarrassing silences and taboos: a triple taboo.

Triple tabu

Even if based on the logic that suicide is defined as an outcome of suicidal behaviour[5,7], it is not difficult to imagine that it can also represent some new suffering of survivors and mourners and that of dealing with their taboo. The singularity represented by this death demands from the outliving who lost a loved one by suicide a more painful restart. They carry the family or affective marks of a suicidal person and, therefore, may require care and prevention approaches, given the impact this death can have on their lives[4]. In this spectrum, the interruption of children's lives - kind, angelic and symbols the perpetuity of the species - causes an additional strangeness, hurting the expectation that humanity has developed beyond instinctive care of their offspring.

The displacement of death from daily spaces during the civilising process[22] was accompanied by a paediatric element: the improvement of children's health care and the system's trust that they are the depository of hope for the future[29]. It can be considered that the birth of Paediatrics, as a medical specialty, is historically and socially linked to the movement to combat infant mortality as stated by Pereira[29] reflecting on the emergence of Brazilian Paediatrics:

The upcoming paediatricians would self-claim the role of protectors of life, capable of ridding families of the stigma of mortality and, above all, in line with the ideal of conducting the offspring to a supposed destiny of health, robustness and vitality.[29](p.15).

Thus, a paediatric *ethos* is justified, also extended to other professionals and social actors who deal with children, invested in combating mortality, immorality and the deviant patterns that threaten children and adolescents. An *ethos* that, although socially authorised to assume the voice of the "infants", cannot coexist with their deaths, nor dialogue with their situations of finitude and limitation of care, or even stimulate them to a frank reflection on death[2,29].

Orchestrated by this firm perspective of defence and protection of children's life, responsible for increasing the survival of this age group[12,14], we understand the silence about paediatric deaths and the immeasurableness about their self-inflicted condition. This firmness, though embarrassing, has constrained new and effective strategies to cope with morbidity and mortality in this age group. Disregard and have limited knowledge of how to deal with the reality of child-juvenile suicidal behaviour, proved to be an important clinical and epidemiological obstacle to paediatric care in Brasil, attitudes that denounce the propagation and strength of the triple taboo in professional education. This space and context of paediatric training, is silenced and self-contained and permeated by three taboos, are less likely to fulfil the purposes they sustain, halting and limiting plans and actions of promotion, prevention, treatment, and rehabilitation.

Moreover, the sweet, docile, and angelic representation of children in the social and paediatrician's imaginary, distance them from the existential themes embodied in daily care, even in the face of potentially fatal outcomes[29]. Consequently, the self-inflicted death or injury of a child or adolescent generates an even greater taboo and discomfort, making forthcoming interventions difficult. As one of the groups authorised to this care and control, the perception of paediatricians is prescriptive of the values transmitted to families and social groups[29]. It is assumed that the suicidal behaviour in children and adolescents is inadmissible, even if their own experiences and epidemiological knowledge reflect another scenario.

The premises for understanding the triple taboo are presented and provided here. We conceive suicide as the type of death that brings more complexity to human finitude, and it is also present in the existence of children and adolescents. It is acknowledged that the construction of categories can imply limitations and rigidity to knowledge. Yet we tried to counterpoint these, to expand the boundaries of interpretation on the continuum of suicide, not circumscribing it and acknowledging it in its plural dimensions[3].

Final considerations

This article did not intend to suggest degrees of intensity of suffering, quantify or rank the pain of mourners and outliving deaths, whether self-provoked or not. The objective was to try to understand the construction and repercussion of these taboos. These taboos withheld open dialogues on the subject and, therefore, prevented the dissemination of actions to assist and care for suicidal behavior and suicide of children and adolescents that bring together a maximum of pain, disturbance and pressure as postulated by Sheidman (apud Saraiva[30]).

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Thus, we offer here an orientation to professionals who assist children and adolescents in the country, especially those who act as trainers in health and education. Silences and taboos about death, suicide and child-juvenile suicide are not only present but rooted in paediatric scenarios and practises. The epidemiological transition experienced by Brazilian paediatrics and the definition of a "New Pediatrics"[12] were not sufficient for a critical appropriation of concepts and debates presented in clinical practise with this clientele and may prompt dread and discomfort to professionals. Formative gaps can be identified, reproducing common sense in teaching, and learning scenarios, preventing the modulation of a space that intervenes on an evident and worrying clinical and epidemiological reality, which permeates violence and psychic suffering[1].

It takes more than acknowledgement to work with of what this text has called a triple taboo, that is the development of strategies, debates, and procedures for sensible dialogues about death and suicide. It is also necessary to recognise the experiences and the paediatric languages, listening and enabling, without the chains of generational conflicts, the voice and subjectivity of children and adolescents in their plural expressions, manifestations, formats, and struggles, especially when they speak of their suffering.

Collaborations

OC Silva Filho and MCS Minayo participated in the conception and execution of the study, as well as in the preparation, review, and approval of the final version of this manuscript.

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